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An Analysis Of The Needs Of Re-Entry Nurses As Perceived By Re-Entry Nurses, Nurse Educators, And Nurse Administrators

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AN ANALYSIS OF THE NEEDS OF RE-ENTRY NURSES AS PERCEIVED BY RE-ENTRY NURSES, NURSE EDUCATORS, AND NURSE ADMINISTRATORS

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Chapter 1

THE PROBLEM, HYPOTHESES, AND DEFINITION OF TERMS

INTRODUCTION

One of the outcomes of the women's movement evidenced in the past few years has been the emergence of a group called "re-entry" women. These are women returning to the world of work and/or to the educational system after an absence ranging from a period of two years to as many as twenty.[1]

Statistics indicate that between 1947 and 1972 the female labor force almost doubled, increasing from 16.7 million to 32 million. In the ten years from 1950-1960 this labor force grew by nearly 6 million. About two-thirds of this growth occurred among those women 35-64 years of age, with the sharpest increase demonstrated between women aged 45-54. The growth of participation in the labor force by women in their middle years was

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[1]Carol K. Tittle and Elenor Denker, "Re-entry Woman: A Selective Review of the Educational Process, Career Choice, and Interest Measurement," Review of Educational Research, XLVII, No. 4 (Fall, 1977), 532.

especially reflected in occupations such as teaching, clerical work and nursing.[2]

Trends in college enrollment also indicate that reentry women have entered college in increasing numbers. The greatest proportion is seen in the 25-34 year age group; however, the number of women over 35 enrolled in colleges increased 32 percent from 1973 to 1974.[3]

The nursing profession, which historically has been one of the most popular career choices among women, has more than tripled in size over the last three decades. Despite the fact that more men are entering the nursing profession, they account for less than five percent of the total nurse population. Research done on the national level which compared professional nurses with other groups of women in the labor force revealed that the growth rate in the field of nursing increased 13.3 percent between 1950 and 1960 which is similar to that for other female labor market groups.[4]

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[2]Philip A. Kalisch and Beatrice J. Kalisch, The Advance of American Nursing (Boston: Little, Brown, 1978), p. 65.

[3]Tittle and Denker, op. cit., p. 533.

[4]Stuart Altman, Present and Future Supply of Registered Nurses, U.S., Department of Health, Education and Welfare Publication No. (NIH) 73-134 (November, 1971).

THE PROBLEM

Purpose of the Study

Despite the increased number of nurses who have entered the profession in the past few years, current shortages of nursing personnel and manpower projections within the health care system demonstrate an even greater need for registered nurses in the future.[5] As the nursing profession considers its supply of manpower, one source that should not be overlooked is the re-entry nurse.

Since female nurses are the ones most likely to find their careers interrupted, they are the group most likely to be concerned with re-entry. For this reason, and because of the small percentage of male nurses, this study focuses on women in nursing and uses the feminine referrant throughout.

To date, the literature does not provide evidence of permanent programs designed to facilitate re-entry nurses back into the work force. Developing such programs for re-entry nurses requires decisions about content and processes to be incorporated into program planning. Through increased knowledge about nurses who are interested in returning, nurse educators and nurse administrators will be able to design, implement and evaluate programs relevant

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[5]Howard V. Stembler and Paul Schwab, The Supply of Health Manpower, Washington D.C., Department of Health, Education and Welfare Publication No. (HRA) 75-38 (December, 1974), p. 122.

to the needs of re-entry nurses. If this collaborative effort is to be seen as successful, nurse educators and nurse administrators, and the nurses themselves, must have an understanding of each other's perceptions of the needs of re-entry nurses.

The central purpose of this investigation is to determine if re-entry nurses, nurse educators, and nurse administrators differ in their perceptions of the barriers to re-entry and the knowledge and skills that are important for re-entry.

Rationale

Current statistics reveal that there are 1,400,000 registered nurses in the United States. Of this number, 30 percent or 422,000 nurses are inactive.[6] In California, an extensive study done by the Department of Health in 1975 found that 28 percent of the 131,841 licensed nurses residing in the state were not employed in the health field. Findings also indicated that of those who were inactive, nearly 10,000 were "available for employment" which meant they would accept full-time or part-time employment if suitable jobs were available.[7]

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[6]Letitia Cunningham, "Nursing Shortage? Yes! Special Report," American Journal of Nursing, LXXIX, (March, 1979), 469.

[7]Lois Lillick, The Supply and Characteristics of Nurses Licensed and Employed in California by Health Service Area and County (Sacramento: Department of Health, January, 1975), p. 7.

A study done in 1978 by the California Hospital Association revealed that there is a chronic shortage of registered nurses in the state. In addition, this study indicated that although there were large numbers of registered nurses in the state, and the nurse-to-population ratios exceeded those of the rest of the country, at the time, scarcely more than half of these licensed nurses were active in the labor force.[8]

Future projections on the national level indicate that during the next ten years, registered nurse positions will account for 20 percent of the total job opportunities in the health field. Growth in employment of registered nurses is expected to be faster than the average for all other occupations because of changes which are occurring within the health care system.[9] At present, it is estimated that the growing complexity of the health care system will require 48 to 104 percent more registered nurses in 1982 than in 1976.[10] As the profession strives to ameliorate present shortages and plans to meet projected needs for the future, the major sources of nursing manpower must be examined.

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[8]Paul B. Mahan, and Charles H. White, A Study of Recruitment of Registered Nurses by California Hospitals and Nursing Homes, (Sacramento: California Hospital Association, 1978), p. 1.

[9]Cunningham, op. cit., p. 471.

[10]Analysis and Planning for Improved Distribution of Nursing Personnel and Services, Western Interstate Commission for Higher Education No. (HRA) 231-74-0803 (1978).

According to Johnson, there are two principle ways of increasing the supply of nursing manpower. This may be accomplished by increasing the number of nurses entering the profession or by increasing the number returning after previous withdrawal from the work force.[11] An analysis of recent data relative to nursing education indicates that enrollment in basic education programs has decreased in growth rate for the first time in 20 years.[12] This decline in the number of nursing personnel entering the profession from educational institutions mandates that the nursing community look more closely at re-entry nurses as a source of increasing the nursing manpower supply.

Interest in these nurses in the past has been sporadic and frequently the result of nursing shortages reaching crisis proportions.[13] Programs developed to prepare nurses to return to the field, for the most part, were developed by those in nursing service in acute care settings. These programs were generally short-term and were designed only to meet the immediate needs of the facility.

For the profession to be able to consider re-entry nurses as a supply of manpower, resources must be established

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[11] Walter L. Johnson, "Supply and Demand for Registered Nurses: Some Observations on the Current Picture and Prospects to 1985," Part 2, Nursing and Health Care, I (September, 1980), 73-75.

[12] _____, "Supply and Demand for Registered Nurses," Part I, Nursing and Health Care, I, No. 1 (July/August, 1980), 18.

[13] Signe Cooper, "Activating the Inactive Nurse: A Historical Review," Nursing Outlook, XV (October, 1967), 62-65.

to prepare nurses for an orderly transition into the work force. Collaborative planning between nursing education and nursing service is essential for the development of these programs. Without this type of cooperative effort, program development is fragmented and ineffective. To insure this supply of nursing manpower on a long-term basis, planning must also include input from the nurses themselves. Ideas from nurse educators and administrators reflect needs relative to organizational priorities and skill requirements of individual jobs, while input obtained from the re-entry nurse focuses on the individualized needs of the group. Therefore, to insure that priorities are kept in balance, input is needed from all three groups.

It is recognized that the expanding health care system will require more registered nurses, and that re-entry nurses are a potential resource for this increased demand; therefore, this study focuses on re-entry nurses as it seeks to identify the needs of these nurses as perceived by specific groups within the nursing community.

Significance of the Study

There have been numerous studies of re-entry women in education and in the labor force; however, there have been few which are specific to the nursing profession. Available information relative to re-entry nurses is dated and focuses almost exclusively on refresher programs

developed to meet manpower crisis situations.[14]

At present, nursing personnel represent nearly 50 percent of health care workers, yet the problem of shortage persists. Better utilization of the current supply or innovative new patterns of manpower utilization must be developed.[15] Planning for the future demands that information about re-entry nurses be obtained as a basis upon which the nursing community can:

1. develop strategies in manpower planning that include re-entry nurses;

2. evaluate ways to utilize resources for the continuing education of re-entry nurses;

3. explore alternatives in staffing patterns and personnel policies that are cost effective and still responsive to the specific needs of this group.

Without a clear understanding of the nurse's perceived needs and concerns relative to re-entry, nurse educators and nurse administrators cannot adequately evaluate present policies and practices to determine which ones should be preserved and which ones should be modified to meet these needs.[16] Therefore, the significance of this

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[14] Cooper, op. cit., p. 62.

[15] A Review and Evaluation of Nursing Productivity, U.S., Department of Health, Education and Welfare Publication, (Public Health Service, November, 1976), p. 33.

[16] Donnie Dutton, "Should Clientele be Involved in Program Planning," Adult Leadership (December, 1970), 181-192.

study lies in its implication that collaborative effort within the nursing community will result in program development that will facilitate nurses' re-entry into the profession.

Statement of the Problem

When considering the needs of re-entry nurses, do re-entry nurses, nurse educators, and nurse administrators differ in their perceptions of the barriers to re-entry, and the specific knowledge and skills that are important for re-entry?

HYPOTHESES

The primary thesis of this study is that, when considering the needs of re-entry nurses, perceptual differences exist among nurses who want to return to the profession and nurse educators and nurse administrators. To test this premise, the following hypotheses have been developed:

Hypothesis 1. There are significant differences among re-entry nurses, nurse educators, and nurse administrators in their perceptions of the barriers to re-entry.

Hypothesis 2. There are significant differences among re-entry nurses, nurse educators, and nurse administrators in their perceptions of specific knowledge and skills important for re-entry.

Hypothesis 3. There are significant differences between nurses who are interested in re-entry and those who are not interested in returning to the profession (non-re-entry nurses) in their perceptions of the barriers to re-entry.

In addition to the investigation of these hypotheses, the study attempts to answer the following ancillary questions:

1. What differences exist among the age groups of the nurses and their perceived barriers to re-entry?

2. What differences exist among the nurses' educational backgrounds and the specific knowledge and skills deemed important for re-entry?

3. What factors emerge as the most influential in the nurse's decision to re-enter the profession?

4. What is the relationship between the educator/administrators' experiences with re-entry nurses and their perceptions of barriers, knowledge and skills important for re-entry.

ASSUMPTIONS AND LIMITATIONS

Assumptions

This investigation is based on the assumption that:

1. There are within the population of women in the nursing community who are currently not working, some nurses who are interested in re-entry into the profession, and others who are not.

2. Those nurses who are not interested in re-entry see greater obstacles to returning than do nurses who want to re-enter.

3. Nurses interested in re-entry share a group of common needs that can be identified by considering barriers to re-entry and knowledge and skills important for re-entry.

4. This kind of investigation is necessary to provide direction to the nursing community and thus strengthen present and future program plans as they relate to re-entry nurses.

Limitations

1. The questionnaire format is limited due to possible misrepresentation of questionnaire items and inability to assess motivation of the respondent.[17]

2. Sampling procedure for re-entry nurse group gives more weight proportionately to counties with smaller rosters.

DEFINITION OF TERMS

For purposes of this study, the following definitions are used:

Basic nursing education program: A program preparing students for licensure as registered nurses; diploma,

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[17]Fred N. Kerlinger, Foundations of Behavioral Research (New York: Holt, Reinhart and Winston, 1964), p. 397.

associate degree, and generic baccalaureate programs.

Re-entry nurse: A female nurse, licensed in California, who is not currently employed in nursing and who wants to return to work in the health care field as a nurse.

Refresher program: A program designed to update nursing skills and to reorient the nurse to medical and surgical nursing; historically provided in the hospital setting.

Non-re-entry nurse: A nurse responding to the questionnaire who is already employed in nursing or another profession, retired or not interested in returning to the nursing profession.

Nurse administrator: A nurse who represents the potential employers of nurses, having responsibility for providing qualified personnel to meet the needs of patients in a variety of health care settings.

Nurse educator: A nurse in either a service or educational setting who is responsible for developing or participating in educational programs for nurses.

Nurse participation rate: Percentage of total supply of nurses working as nurses in the labor force.

Nursing Registry (Temporary Service): Agency that provides temporary nursing personnel to health care facilities such as hospitals.

Nursing Service Department: The department within a health care agency that is primarily responsible for delivery of direct patient care.

Perception: An individual's representation of reality, based on one's prior experiences.

Second Step Program (Upper Two): An upper division program designed expressly for registered nurses to obtain a baccalaureate degree in nursing.

SUMMARY

An overview of the problem and the hypotheses have been presented in the first chapter. The investigation is designed to determine what differences exist in the perceptions of re-entry nurses, nurse educators, and nurse

administrators regarding the needs of re-entry nurses. The need for the study and relevance of the findings were supported by statements regarding the study's rationale and significance.

In Chapter 2, a review of the related literature supporting the study is presented. Described in Chapter 3 are the research design and procedures utilized in the development and validation of the questionnaire as well as the collection and analysis of the data. The data are analyzed in Chapter 4. The summary, conclusions and recommendations for further study are presented in Chapter 5.

Chapter 2

REVIEW OF THE LITERATURE

INTRODUCTION

The increased participation rate of women in the labor force over the past few years has been attributed to a number of demographic and social changes. These include the women's movement, rising longevity of women, increasing numbers of women interested in educational mobility, and the shortened span of time occupied by the activities of motherhood. All of these factors have resulted in more women remaining in the work force as well as more women seeking jobs amenable to their skills.[1]

Despite this steady increase in the number of women in the work force, there is a shortage of manpower within the nursing profession. The most recent American Hospital Association estimates indicate a national shortage of 100,000 hospital nurses alone.[2] Critical shortages have been reported from all parts of the country and the situation

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[1] A Review and Evaluation of Nursing Productivity, U.S. Department of Health, Education and Welfare (Public Health Service, November, 1976), 33.

[2] Gail Warden, "Hospitals Face Critical Issues," American Nurse, XIII (March, 1981), 3.

has reached crisis proportions in many states. The effects of these shortages have been most blatantly demonstrated through the reports of the media. National news coverage over the past few years has increasingly reported the shortage of nurses as well as the ingenious and creative measures hospitals have taken to recruit nurses.

A variety of alternatives to solving the shortage problem have been offered by sources outside of the nursing profession. One alternative offered by the Carter administration in Washington and the hospital associations was to bring inactive nurses back to the bedside. This recommendation has been met with mixed reactions from the nursing community. While some within the nursing profession believe this is an appropriate course of action, others point out that because nurses place home responsibilities before professional obligations, they will not return to work.[3]

Since this study has identified re-entry nurses, i.e., those who are licensed and eligible to return to active nursing as an important potential resource in nursing, the foregoing discussion of the nursing shortage substantiates the need to obtain information as to why nurses leave nursing, and the reasons they fail to return. Accordingly, this chapter is organized into three sections.

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[3]Walter Johnson, "Supply and Demand for Registered Nurses: Some Observations on the Current Picture and Prospects to 1985, Part 2," Nursing and Health Care, I (September, 1980), 78.

The first part provides an historical perspective on the nursing shortage, and the second section focuses on specific reasons for nurses' withdrawal from the work force. The final portion relates to the motivations for re-entry and the barriers which women who wish to re-enter the work force must face, with emphasis on the literature relevant to re-entry nurses.

NURSING SHORTAGE

Over the past fifty years the persistent shortage of nurses in this country has increasingly drawn attention to the potential contribution of inactive nurses. However, the literature indicates that no on-going coordinated effort has been made within the profession to facilitate this re-entry. Only in times of crisis has there been genuine interest in preparing the inactive nurse for return to active nursing.[4] This preparation has been accomplished by refresher programs designed to upgrade the nurses' skills to meet the needs of the hospital. For example, Kelly's suggestion for courses to help keep the nurses up-to-date during the Depression was the earliest reference to refresher courses found in the literature.[5] At that time, there was concern from the nurses that they

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[4]Signe Cooper, "Activating the Inactive Nurse: A Historical Review," Nursing Outlook, XV (October, 1967), 62-65.

[5]Cooper, op. cit., p. 63.

would be unable to maintain their clinical skills during periods of enforced unemployment.[6]

From that time on, concern for activating the inactive nurse appears in the literature at about ten year intervals. The next period was shortly before World War II in the early 1940's. However, at this time, the objective was to supplement the nurse employment level to insure an adequate supply of nurses for both military and civilian purposes.[7] Specifically, funds were allocated for refresher courses to update the skills of retired nurses and to increase the number of students in undergraduate classes.[8] As a result, about 3,700 inactive nurses re-entered the field.[9] At this time, there was also a concerted effort to train volunteer nurse assistants to extend the service of the registered nurse. Additionally, the Cadet Nurse Corps was established to increase the student nurse population.

During the war a shortage developed, so that by the end of World War II, despite the fact that the total number of nurses had increased, there were still not

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[6]Philip A. Kalisch and Beatrice A. Kalisch, The Advance of American Nursing (Boston: Little, Brown, 1978), pp. 72-105.

[7]Cooper, op. cit., p. 63.

[8]Kalisch, op. cit., p. 49.

[9]Dorothy Reese et al, "The Inactive Nurse," American Journal of Nursing, LXIV, No. 11 (1964), 124-127.

enough nurses to meet the country's needs. A post war study of 31,000 nurses in the Army Nurse Corps revealed that only 26 percent of the nurses planned to return to civilian hospital nursing. These nurses, who had enjoyed increased responsibility and more flexible and autonomous roles offered in the military, did not want to return to the rigidity of civilian hospital nursing.[10]

The nationwide shortage at this time was attributed to high rate of turnover, increased demands for nursing manpower, low salaries, and a decrease in the output of new graduates following the demise of the Nurse Cadet Corps. This precipitated another surge of interest in inactive nurses from within the profession which resulted in increased statewide planning. This planning was productive, at least in some states, for in 1951 a study done by the American Nurses Association found that there were 57 refresher courses available for re-entry nurses in 19 states.[11] While attempts were being made to find ways to bring nurses back into the work force, little attention was being given to social and economic factors that were significant in nurse retention.[12] Studies revealed that new

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[10]Mary Percival, "We Can Help," American Journal of Nursing, XLIX (July, 1949), 413.

[11]"American Nurses Association, Professional Counseling and Placement Service: Refresher Courses," American Journal of Nursing, (June, 1952), 518-516.

[12]Eugene Levine, "Nurse Manpower Yesterday, Today, and Tomorrow," American Journal of Nursing, LXIX (February, 1969), 290-296.

graduates were not remaining active in the profession, and a substantial proportion were dropping out within the first three years.[13]

Reports that hospitals were unable to fill 23 percent of their positions for general duty nurses in the early 1960's brought the inactive nurse into focus once again.[14] At this time, the Division of Nursing, Public Health Service, surveyed the inactive nurse population in twelve states in an effort to determine why nurses were inactive.[15] The findings revealed that of the number who did not plan to return to work, a major reason was occupational obsolescence due to inactivity. Another reason offered was the lack of a strong incentive to return. For those who did plan to return, the major reason preventing them from doing so was the presence of children in the home. However, of the 10,141 inactive nurses in the survey, 4,500 or 44 percent planned to return to work. Of those nurses intending to return, 65 percent wanted a refresher course within a twelve month period.[16]

A report from the Surgeon General's Office in response to the economic aspects of hospital nursing shortage at this time yielded four specific recommendations. First

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[13]Levine, op. cit., p. 293.

[14]Altman, op. cit., p. 1.

[15]Altman, op. cit., p. 105.

[16]Reese, op. cit., pp. 127-29.

on the list was to improve and expand refresher courses for inactive nurses. Other recommendations included expansion of all types of nursing programs, improvement of the economic security program for nurses, and reevaluation of the need for professional nurses by hospital administrators.[17]

Federal funding in 1967 created the Manpower Development and Training Act (MDTA) which provided refresher training for nurses enabling them to re-enter the profession, thus helping to alleviate the nursing shortage.[18] This government-sponsored national campaign to recruit inactive nurses was based on statistics which indicated that growth in the supply of nurses during the 1950's had resulted more from the return of inactive nurses than from increased numbers of graduates entering the field.[19]

The response to this nationwide appeal and the availability of federal funding resulted in the rapid development of refresher programs in hospitals across the country. However, this enthusiasm soon waned as hospitals found these programs were not cost-effective and few nurses

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[17]Report from Surgeon General's Consultant Group. "Toward Quality in Nursing Needs and Goals," (Washington, D.C. Government Printing Office) #019-001-0086-8.

[18]Elda S. Popiel, "The Many Facets of Continuing Education in Nursing," Journal of Nursing Education, VIII (January, 1969), 9.

[19]Reese et al, op. cit., p. 128.

actively returned to the labor force.[20]

At this time, the failure of nurses to respond to the "call for help" was attributed in part to the liberating changes occurring in society. The lack of follow-through also may have been because the refresher courses, for the most part, were designed to meet the needs of the workplace and the needs of the re-entry nurse seemed less carefully considered.

The lack of consideration of the needs of the re-entry nurses is reflected in the paucity of research studies or articles found that describe strategies developed to meet identified nurses' needs. However, over the past 20 years inactive nurses have been specific in providing the reasons why they leave nursing. These reasons include lack of child care facilities, lack of flexible time schedules, lack of opportunity for personal growth and over-emphasis on non-nursing tasks. Yet little is found in the literature relative to innovative programs that have been instituted to meet these needs. As an example, flexible work schedules and job sharing have been tried on a limited basis; however, the literature does not reflect findings that are cost-effective or significant enough to entice most hospital administrators to risk

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[20]Marjorie Kelley, "Low Cost Refresher Program Helps Inactive Nurses Make Comeback," Hospitals, XXXIII (January, 1969), 75.

implementation.[21] At the present time, it seems that rather than develop programs directed toward meeting the needs of their nurses, hospitals have turned to temporary services or nursing registries for staffing patient care units. For example, Mahan and White report that in California 60 percent of the hospitals, 58 percent of nursing homes and 51 percent of other health care facilities use agency nurses.[22] Kaiser Permanente Hospital in Northern California is reported to have spent seven million dollars on nursing registry personnel during 1979.[23]

The major advantage in utilization of registries for the hospital is that it provides for adequate staffing on a short-term basis to meet fluctuating nursing needs. The advantage for the nurse is the opportunity to arrange her time to meet the needs of her family. Additionally, the nurse is afforded some autonomy in making decisions about her working schedule.[24] Within this structure, the nurse can also benefit from competitive salaries and can arrange to work in close proximity to her home. All of

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[21] P. Shaw, "The 19 Hour Work Week in the 4 Day Week," Supervisor Nurse, IX (1978), 47-56.

[22] Paul B. Mahan and C. H. White, A Study of Recruitment of Registered Nurses by California Hospitals and Nursing Homes, (Sacramento: California Hospital Association, 1978), p. 14.

[23] Oakland Tribune, March 16, 1981, Section B, p. 1, col. 2.

[24] Lynne Donovan, "What the Rent a Nurse Trend Means to You," RN, XLI (November, 1978), 73.

these factors have been identified in the literature as reasons why nurses are not available for working full-time in acute care settings.

The major disadvantages for both the nurse and the hospital with this type of contractual agreement include lack of continuity of patient care and superficial screening of applicants who work out of the temporary service.[25] A study done by Langford and Prescott to identify issues relating to temporary nursing personnel services revealed that major concerns centered around the quality and continuity of care they give and the morale among hospital nurses.[26]

This review of the literature in this area has revealed that the problem of nursing shortage is not new; and if history is any indicator, the shortage will continue to plague the health care delivery system into the foreseeable future. The nursing shortage is a complex phenomenon that involves both the supply of nurses as well as the demand or need for nurses. This is evidenced by the literature which attributes the current shortage to increased need for health care services and advances in technology, as well as the misutilization of services, and the

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[25] Ibid.

[26] Jenny Langford and P. A. Prescott, "Hospitals and Supplemental Nursing Agencies: An Uneasy Balance," Journal of Nursing Administration, IX, No. 2, (1979), 16-20.

unemployment of registered nurses.[27]

An additional facet of the problem stems from the definition of the word "shortage." Hospital administrators frequently use the word to mean unfilled budgeted positions, whereas the nursing profession views it from the perspective of misutilization or inappropriate utilization of nursing personnel. This is especially clear when media releases, advertisements, and manpower surveys are reviewed. For example, the administrative perspective was reflected in a recent report from the California Hospital Association which indicated that hospitals spend $183,000,000 in recruitment annually to meet their need for nurses.[28] At the same time, the California Nurses Association reported that there has been an overall increase in nurses in the last decade and alleged that the "shortage" is contrived.[29] The professional organization further maintains that the problem is one of utilization rather than shortage and is attributed to the health care industry itself. Hospitals, as the employers of the largest number of nurses, are accused of operating with outmoded priorities and performance systems, and failing to update these systems

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[27]Letitia Cunningham, "Nursing Shortage? Yes! Special Report," American Journal of Nursing, LXXIX (March 1979), 468-480.

[28]Mahan and White, op. cit., p. 1.

[29]Toni Propotnick, "Is there Really a Nursing Shortage," California Nurse, LXXIV (November 1978), 2.

and re-evaluate priorities in the delivery of health care.[30,31,32,33]

Whether the current problem is a misuse of professional nursing skills or an actual shortage, the fact remains that of the 1,400,000 nurses currently licensed, approximately 400,000, or 30 percent, are not employed in nursing.[34] This becomes particularly significant in view of national projections which indicate that over the next ten years 83,000 registered nurses will be required annually to meet the needs of the expanding health care system.[35]

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[30]M.F. Kohnke, "Do Nursing Educators Practice What is Preached?" Nursing Outlook, LXXIII (September, 1973), 27-32.

[31]Virginia Cleland and C. Razornick, "Appropriate Utilization of Health Professionals," Journal of Nursing Administration, I (November/December, 1971), 37-40.

[32]Michael Miller, "Work Roles for the Associate Degree Graduate," American Journal of Nursing, LXXIV (March, 1974), 468-470.

[33]Linda Aiken, "Hospital Changes Urged to End Nurse Shortage," American Nurse, XIII (February, 1981), 4.

[34]"ANA Sample Survey Offers Profile of RN's," American Nurse, XI (April, 1979), 1.

[35]The Occupational Outlook Handbook, 1978-79 Edition, U.S. Department of Labor, Bureau of Labor Statistics. (Washington D.C.: Government Printing Office).

NURSES' WITHDRAWAL FROM THE WORK FORCE

In comparing the working patterns of nurses with other groups of women, Altman found that nurses compare with female college graduates in the high participation rate following graduation from school and in the decrease in participation during the child bearing ages. However, nurses work patterns differed substantially from other groups in the rate of return after the child bearing years. The participation rate of college graduates between the ages of 35 and 64 increased by 24 percent, while the return rate for nurses in this same age group increased only three percent.[36] These findings are supported by statistics available in the literature which reveals that currently more nurses are leaving the profession than are returning from inactive status.[37]

According to Kramer, the exact magnitude of the nurse exodus from the profession is unknown. In her study, which focused on nurses who left nursing as a result of conflicting bureaucratic and professional values, she found that 11 percent of the nurses in the study dropped out of nursing in the first six months and 29 percent left at two

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[36]Stuart H. Altman, Present and Future Supply of Registered Nurses, U.S. Department of Health, Education and Welfare Publication (NIH) 73-134 (November, 1971), p. 104.

[37]Walter Johnson, "Supply and Demand for Registered Nurses," Part I, Nursing and Health Care, I (August, 1980), 18.

years due to job dissatisfaction.[38] Additionally, she found the new graduates lacking in "interpersonal competence."[39] She described this dimension as including self-confidence in performance of duties, the ability to predict the behavior of others who are operating from a different value system, and a repertoire of behaviors appropriate to influence others. As a result of her findings, she concluded that new graduates are unable to convert the professional-bureaucratic conflict which they experience into growth producing change for themselves or the health care system, and as a result they withdraw from the work force.[40]

Cowden attributed nurses' withdrawal to changing values. He maintained that our changing attitude toward nursing in the 20th century coupled with contemporary social changes have shifted the emphasis in nursing, and the profession now appeals to a different set of values than its historical roots. Thus, the trend toward professionalism, with its potential for choice and autonomy for nurses, has resulted in ambiguity of purpose about the nurses' work and has culminated in yet a new dissatisfaction for nurses

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[38]Marlene Kramer and C. Baker, "The Exodus: Can We Prevent It," Journal of Nursing Administration, (May/June, 1971), 15-30.

[39]Marlene Kramer, Reality Shock, (St. Louis: C.V. Mosby, 1974), p. 30.

[40]Ibid.

in the workplace.[41]

The reward system in nursing is also identified within the literature as a major reason why approximately 70 percent of the staff nurses in hospitals resign every year. This turnover is often the result of inadequate rewards and incentives, and many leave the field to seek a profession where rewards are better defined and easier to come by.[42]

A number of studies over the past few years involving graduates has revealed their frustration with the reward system. Their ideas of rewards differ from those of their supervisors, and their supervisors' expectations are different from those previously expressed by their instructors.[43,44] In a journal article in 1972, Sheahan summed up the lack of rewards in nursing rather succinctly in her statement:

> At present, no nurse is anything distinctive. There are not incentives nor imperatives for advanced preparation, no distinctions in

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[41]Peter Cowden, "Dissatisfaction and the Changing Meaning and Purpose of Nurses Work," Nursing Forum, XVII, No. 2, (1978), 202-209.

[42]Jerome P. Lysaught, ed., Action in Nursing--Progress in Professional Purpose (New York, McGraw-Hill, 1974), p. 354.

[43]Kramer, loc. cit.

[44]Kenneth Benne and Warren Bennis, "Role Confusion and Conflict within Nursing," American Journal of Nursing, I (1959), 196-198.

> advancement. . .only the profession can change this.[45]

Recognizing that no single factor is responsible for nurses leaving the profession, this study sought to discuss the variables most frequently given as contributing to the withdrawal of nurses from the work force using Wandelt's broad categories of "economics," "family responsibilities," and the "job conditions" as an organizing framework.[46]

Economics

There are a number of factors that have prevented nurses from achieving financial compensation comparable to other disciplines. One of the biggest reasons for poor salaries is the fact that the profession is composed of 96 percent women and historically women have received lower salaries than men. Another factor that makes the labor market for nurses unusual is that a large proportion of nurses are secondary wage earners.[47] In addition, there has been a strong historical influence promulgated by the profession which views nursing as service to others, therefore, those who provide this service should have little

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[45]Dorothy Sheahan, "The Name of the Game: Nurse Professional and Nurse Technician," Nursing Outlook, XX (July, 1972), 440-444.

[46]Mabel Wandelt and others, Conditions Associated with Registered Nurse Employment in Texas, (Austin: University of Texas, 1980).

[47]A Review and Evaluation of Nursing Productivity, op. cit., p. 35.

regard for monetary gain.[48] Another significant factor involves hospitals as the dominant employer of nurses. Collective action on the part of the nursing profession has been slow in developing, and since hospitals have employed the largest percentage of nurses in the field, they have effectively controlled the market conditions in nursing until the advent of collective bargaining in the 1960's.[49]

Even though the economic picture within nursing is better today, there are still inequities within the profession itself. There is currently little difference in the salary obtained by the nurse with several years of experience and the nurse just beginning her career.[50] Although salary is not seen as the primary reason for nurses' withdrawal from the work force, it is invariably one of the areas of dissatisfaction identified in the literature.[51,52,53]

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[48]Kalisch, op. cit., p. 674.

[49]Donald E. Yett, "The Nursing Shortage," Health Economics, ed. M. H. Cooper and A.J. Culyer (Penguin Books, 1973), pp. 172-209.

[50]Cunningham, op. cit., p. 471.

[51]Wandelt, op. cit., pp. 24-27.

[52]Beaufort Longest, "Job Satisfaction for Registered Nurses in the Hospital Setting," Journal of Nursing Administration, (May/June, 1974), 46-52.

[53]Glennadee Nichols, "Job Satisfaction and Nurses Intentions to Remain with or to leave an Organization," Nursing Research, XX (May/June, 1971), 218-228.

Family Responsibilities

Research prior to 1975 indicated that marriage and child bearing were the two reasons most frequently given by nurses for leaving the profession.[54,55] Cleland's study of married registered nurses revealed that time conflicts with immediate family activities were perceived as a major barrier to returning to nursing.[56] Most recent research shows that inflexible work schedules and rotating shifts which cause major problems in arranging child care, and transportation for school-aged children continue to be primary reasons for large numbers of nurses withdrawing from active status.[57]

According to Knopf, the predominant reason women selected nursing as a career was to "help people" and to "gain personal satisfaction." It would follow that, for those nurses who perceive nursing as essentially a nurturing role, childrearing may be a rewarding substitute for bedside nursing and reason enough to withdraw from the work force.[58]

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[54]Alma Woolley, "Inactivitis," American Journal of Nursing, LXVII (December, 1966), 2661-2663.

[55]Lucile Knopf, RN's One and Five Years After Graduation, (New York: NLN publication, 1975), p. 62.

[56]Virginia Cleland and others, "Decision to Reactivate Nursing Career," Nursing Research, XIX (September/October, 1970), 446-452.

[57]Wandelt, op. cit., p. 43.

[58]Knopf, op. cit., p. 72.

Job Conditions

Within the health care field, nurses have been the group most frequently studied relative to job satisfaction. The results have indicated that the presence of non-nursing tasks which interfere with the basic role of the nurse have been central to the nurse's dissatisfaction for over three decades.[59] Additional studies have identified numerous factors which contribute to nurses' dissatisfaction.[60] Included are work schedules, work assignments, expectations in the workplace, and lack of autonomy. Unpredictable or changing work schedules are reported to prohibit continuity of patient care and also interrupt the personal lives of nurses.[61] Another area of concern was related to patient or unit assignment; frequently nurses are assigned to areas where they feel unqualified to provide appropriate care.[62]

In the research of Benner et al, it was found that experienced nurses leave nursing because of inability to deliver the level of patient care they believe in; whereas the novice or new graduate leaves because the expectations

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[59]Everett Hughes, Helen Hughes, and Irwin Deutscher, Twenty Thousand Nurses Tell Their Story, (Philadelphia: J. B. Lippincott, 1958), pp. 240-241.

[60]Nicholas Imparato, "Job Satisfaction Patterns Among Nurses: An Overview," Supervisor Nurse, III (March, 1972), 53-57.

[61]Cleland, op. cit., p. 448.

[62]Mahan, op. cit., p. 25.

of her performance by nursing service administrators are not congruent with her own expectations of performance.[63]

A more recent source of frustration supported in the literature involves autonomy. As health care has become more complex and specialized, the role of the nurse has expanded. This role expansion has resulted in nurses assuming more autonomy in the workplace. While the expanded role has motivated many nurses to remain in the profession, the increased autonomy has contributed to others' dissatisfaction with the traditional roles of the nurse and has led to their subsequent withdrawal.[64]

The literature reflects a change in the reasons nurses are leaving the work force. Research done in the 1950's and 60's revealed that family responsibilities were the major reasons nurses left nursing. More recent studies reflect that dissatisfaction with job conditions is the primary reason nurses withdraw from the workforce.

MOTIVATORS/BARRIERS TO RE-ENTRY

In the next section of this chapter a brief discussion of the motivations for re-entry precedes the review

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[63]Patricia Benner and others, "From Novice to Expert," AMICAE Project Report (San Francisco; University of San Francisco, January, 1981), p. 81.

[64]Bonnie Bullough, "Influences on Role Expansion," American Journal of Nursing, LXXVI (September, 1976), 1476-1481.

of the barriers which interfere with the re-entry of women to school or to the work force. Letchworth and Brandenbrug refer to adult women who are considering returning to work, entering a vocational training program, or completing their education as having problems similar to the adolescent in the midst of an identity crisis.[65,66] Identity crisis is defined by Erikson as that period of time when an individual evaluates herself and comes to terms with her attitudes, as well as decisions surrounding her occupational and societal roles.[67] Therefore, although a woman may have achieved an identity as a wife and mother, after a period of ten to fifteen years she again questions who she is, where she is going, and whether or not her need for achievement has been met.[68,69] At this time achievement motives, submerged during the child-rearing years, may re-emerge especially as traditional role demands are declining.[70]

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[65] G. E. Letchworth, "Women Who Return to College: An Identity-Integrity Approach," Journal of College Student Personnel, XI (1970), 103-106.

[66] J. F. Brandenburg, "The Needs of Women Returning to School," Personnel and Guidance Journal, LII (1974), 11-18.

[67] Erik Erikson, Childhood and Society (New York: W. W. Norton, 1963), p. 261.

[68] Judith Bardwick, The Psychology of Women (New York: Harper & Row, 1971), pp. 188-205.

[69] M. A. J. Guttman & P. A. Dunn, Women and ACES Perspectives and Issues (Washington, D.C.: Commission for Women, 1974), 86-88.

[70] Helen Astin, "Continuing Education and the Development of Adult Women," The Counseling Psychologist, VI, No. 1, (1976), 55-60.

Studies demonstrate a temporal cycle in the achievement motive associated with age and family situation. The increased achievement need that a woman has before she begins a family appears to be followed by a decline in achievement need until children are grown, then this need returns to its previous high level.[71]

This reawakened need for achievement is frequently the force that motivates re-entry women. However, as pointed out in the literature, this is not a period of easy transition.[72] Programs in both education and in the work place which were established for mature women, low income women, and those who are heads of households have demonstrated that a lack of self-confidence and fear of competition with younger people were specific deterrents to re-entry.[73,74]

Astin described another source of conflict observed in re-entry women called "integrity crises."[75] This crisis

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[71]Wilma Philips, The Motive to Achieve in Women as Related to Perceptions of Sex Role in Society (University of Maryland, 1974), p. 212.

[72]Ruth Moulton, "Some Effects of the New Feminism," American Journal of Psychiatry, CXXXIV, No. 101, (1977), 1-6.

[73]W. A. Hiltunes, "A Counseling Course for the Mature Woman," Journal of National Association of Women's Deans & Counselors, XXX, No. 2, (1968), 93-96.

[74]J. S. Brockway, A Design for Counseling Adult Women Using a Paradigm of Rational Decision-Making (University of Oregon, 1974), pp. 87-92.

[75]Astin, op. cit., p. 56.

involves fundamental existential questions such as "what is the meaning of life and how can I relate to the world?" Resolution of the problem, according to Hill, finds the woman actively interested in developing a lifestyle or seeking an occupation that gives her life meaning and is significant, rather than one that satisfies her identity needs of money, position and recognition.[76] Given the fact that most married women today live one-third of their lives after the youngest child is married, it is less than surprising that integrity crises are frequently seen in re-entry women.[77]

Data available on women returning to college reflect both identity and integrity crises as the motivating forces behind womens' re-entry. While the specific reasons vary with individuals, they frequently include personal growth, relief from boredom, desire to have an interesting job, escape from responsibilities, and change in marital status.[78,79]

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[76]C. E. Hill, "A Research Perspective on Counseling Women," The Counseling Psychologist, VI (1976), 53-55.

[77]E. Kelman and Bonnie Staley, The Returning Woman Student: Need of an Important Minority Group on College Campus, U. S. Educational Resources Information Center, ERIC Document ED 103 747, 1974.

[78]Helen S. Astin, ed., Some Action of Her Own: The Adult & Higher Education (Lexington: Lexington Books, 1976), p. 56.

[79]Marilyn F. Jackson, "Factors Affecting the R.N.'s Decision to Enter a Second Step Programme," Researching Second Step Nursing Education, Vol. 2, ed. K. L. Jako (Rohnert Park: Sonoma State University, 1981), pp. 79-92.

In addition to research which examined the motivations for re-entry, much work has been done in identifying concomitant factors which interfere with a woman's re-entry. These barriers originate from a variety of sources and represent internal conflicts as well as those imposed by society. A few of the factors identified as impeding women's re-entry are self-expectations, norms of the subculture, role expectations, and lack of support systems.[80,81]

In an effort to make the literature more meaningful as it relates to the many barriers to re-entry, Ekstrom categorized the factors which prevent or impede a woman's re-entry into three groups.[82] These are identified as institutional, situational and dispositional barriers. Although this model was developed to categorize barriers to women's participation in post-secondary education, it is applicable to nurses who are returning to the work force as well as those returning to educational programs.

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[80]E. Moses and A. Roth, "Nurse Power, What Do Statistics Reveal About the Nations Nurses?," American Journal of Nursing, LXXIX (October 1979), p. 1745.

[81]C. K. Holahan and L. A. Gilbert, "Interrole Conflict for Working Women: Careers vs. Jobs," Journal of Applied Psychology (March 1979), 297-304.

[82]Ruth B. Ekstrom, Barriers to Woman's Participation in Post-Secondary Education: A Review of the Literature," U. S. Educational Resource Information Center ERIC Document Reproduction ED 072-368, October 1972, pp. 2-82.

Institutional Barriers

These barriers are related to institutional rules and regulations. They include traditional admission policies, lack of financial aid for part-time students, insufficient personnel services, and negative faculty and staff attitudes.[83] In nursing, a study investigating the advantages and disadvantages of returning to work found that 58 percent of the inactive nurse respondents saw institutional provisions for salary, shift rotations and personnel policies as major disadvantages to returning to work.[84]

Policies in some hospitals have implicitly, if not explicitly, served to demotivate nurses who are considering re-entry. While not reported in the literature, discussions with inactive nurses have revealed that institutions frequently dictate that nurses who have been inactive for over five years cannot be hired without a refresher course. In a number of instances, no such program was available at the institution or in the immediate community to enable the nurse to obtain the required training.

Another barrier for the re-entry nurse has resulted from the position of organized nursing relative to levels of nursing practice. The professional association has mandated that educational preparation for the professional level be the baccalaureate degree and preparation for the

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[83]Ekstrom, Ibid.

[84]Cleland, op. cit., p. 450.

technical level be the associate degree.[85] This pronouncement received varied responses. In general, nurses who had obtained their basic education in a three-year diploma program felt disenfranchised. They felt being classified as technical nurses as opposed to professional was depriving them of their achieved status. It is clear that the association's position was based on the belief that education has a direct relationship to nursing practice as well as on the existing demand and need projections for the future. However, this position has had significant implications for re-entry nurses, most of whom are diploma graduates from hospital schools of nursing and who, despite three years of education, have neither the associate or the baccalaureate degree. For many, the emphasis on the college degree has had a negative influence on the decision to return to nursing.

Furthermore, those nurses who have considered returning to school have found the lack of provision for articulation between different types of educational programs to be a major problem.[86] Some institutions have established policies that make upward mobility virtually impossible to all but a select group. Nurses seeking educational

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[85] Educational Preparation for Nurse Practitioners and Assistants to Nurses: A Position Paper (Kansas City: American Nursing Association, 1965).

[86] B. Bullough and V. Bullough, "A Career Ladder in Nursing: Problems and Prospects," American Journal of Nursing, LXXI (October, 1971), 1938-1943.

mobility have found that institutional policies relative to prerequisite courses, challenge examinations, stringent transfer policies and high costs all serve to deter those who are motivated for returning to school.[87] These barriers have accounted for many nurses seeking educational advancement in other disciplines.[88]

The development of the "second step" or upper division programs designed specifically for registered nurses, active or inactive, has done much to facilitate career mobility.[89] However, they are few in number and are not without a unique set of barriers. For example, the process for obtaining credit for lower division work is cumbersome and time consuming. The lack of access to these programs is a real problem to rural nurses attempting to return. Classes given only during traditional school hours provide another obstacle. Hillsmith describes an additional, more insidious barrier to be reckoned with. This is the pervasive hostility toward organized nursing which is demonstrated by nurses enrolled in these programs and impedes the learning process.[90]

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[87]Anna Marie Maagdenberg and Jean Vetro, "The Educational Career Mobility Ladder--Fact or Fiction." California Nurse, LXXIV (December, 1978), 12-16.

[88]Susan C. Slanenka, "Baccalaureate Programs for RN's," American Journal of Nursing, LXXIX (January, 1979), 1095.

[89]Mary Searight, ed., The Second Step (St. Louis: C. V. Mosby, 1976), pp. 7-25.

[90]Katherine Hillsmith, "From RN to BSN: Student Perceptions," Nursing Outlook, XXVI (February, 1978), 98-102.

Situational Barriers

These barriers, as identified by Ekstrom, include sociological, familial, financial, residential, and personal constraints and have a primary focus on the "here and now." Research has revealed that the attitudes of husbands and family responsibilities frequently act as deterrents to woman's re-entry.[91] Family reactions to a woman's decreased availability to husband and children are frequently a source of conflict. Research has shown that there must be some resolution of this conflict before a woman can re-enter the work force.[92] Time conflict with family activities has frequently been identified in the literature as a major barrier for re-entry women.[93] According to Leahy, this conflict is frequently related to feelings of role conflict brought about by the additive nature of the mother's role. Often a woman does not merely make a transition from one role to another. Instead, she assumes a career role in addition to her domestic roles.[94]

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[91]Ekstrom, op. cit., pp. 43-60.

[92]Kathleen Moqul, "Women in Midlife: Decisions, Rewards and Conflicts Related to Work and Career," American Journal of Psychiatry, CXXXIX (September 1979), 1139-1143.

[93]Leahy et al, "Attitudes Toward Parenting in Dual Career Families," American Journal of Psychiatry, CXXXIV (April, 1977), 391-95.

[94]Ibid.

Situational barriers are especially demoralizing for the woman who is the sole support of the household. She is often confronted not only by the lack of financial support available to her, but also by attitudes of employers toward continued education. Statistics reveal that at the present time, about three-fifths of all women workers are self-supporting or have husbands on reduced salaries; and of all families, one out of every four is headed by a woman.[95] These data clearly demonstrate that financial support is essential for the woman returning to school.

Added difficulties for a nurse seeking to re-enter the work force include her lack of recent training or work experience which may limit her ability to perform competently.[96] The rapid advancement in the health care field has resulted in many inactive nurses feeling that their basic preparation is obsolete and they are ill-equipped to return to active nursing. These feelings of inadequacy coupled with the emphasis on credentials by both the employer and society have become imposing barriers to the re-entry nurse.[97]

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[95]Betty Ann Stead, "Why Help Women Into Careers: A Look at Today's Reality," Vital Speeches, XLIV (December 15, 1977).

[96]Wilma Donahue ed., Earning Opportunities for Older Workers (Ann Arbor: University of Michigan Press, 1955), pp. 35-50.

[97]Kathleen Mogul, op. cit., p. 41.

The recent emphasis on continuing education within the profession has resulted in a law in California which requires 30 hours of continuing education every two years to maintain nursing licensure. Some nurses see this legal mandate as a way to remain current in the field, while others perceive it as one more barrier. This is particularly a problem for inactive nurses who may not have the financial resources to enroll in specific courses. These nurses are caught in a double bind situation; they cannot afford the courses because they are not working; but at the same time, they cannot become employed without such courses.

Dispositional Barriers: Those attitudes of a woman about herself and her fear of the unaccustomed world of work impose yet another category of obstacles which Ekstrom has defined as Dispositional barriers. These barriers which are less amenable to social action include attitudes, motivation and personality.[98]

The personality characteristics which act as barriers affecting re-entry women are demonstrated in feelings of passivity and dependency associated with the feminine role.[99] Additionally, the tendency for both men and women

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[98]Ekstrom, op. cit., pp. 61-69.

[99]Esther E. Matthews, "The Counselor and the Adult Woman," Journal of National Academic Women Deans and Counselors (Spring, 1979), 115-121.

to undervalue the work of women becomes a barrier.[100] This latter point is discussed by Cook and Stone who contend that although there are more women enrolled in college, the formal educational experience seems to be an end in itself for many women rather than a means to prepare for life's career.[101] Research indicated that fewer women than men leave college for academic reasons, but more women than men leave for non-academic reasons such as marriage and home responsibilities.[102]

Women's ambivalence about home and career has appeared frequently in the literature relating to re-entry barriers. Farmer and Bohn studied working women, both married and single, and found that the level of vocational interest in women, irrespective of their marital status, would be raised if the home/career conflict were reduced. They concluded that the source of conflict between home and career was not related to the fact that more than one role is possible for women, but that there existed a cultural lag between social opportunity and social sanction.[103]

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[100]Philip Goldberg, "Are Women Prejudiced Against Women," Transaction, V (April, 1960), 28-30.

[101]Barbara Cook and B. Stone, Counseling Women, Guidance Monograph Series VII: Special Topics in Counseling (Boston: Houghton Mifflin, 1973), 39-63.

[102]J. Marecek and C. Frasch, "Locus of Control and College Women's Role Expectations," Journal of Counseling Psychology, XXIV, No. 2, (1977), 132-136.

[103]Helen Farmer and M. H. Bohn, "Home-Career Conflict Reduction and the Level of Career Interest in Women," Journal of Counseling Psychology, XVII, No. 3,(1980), 228-232.

An extensive study done with inactive nurses in the early 1960's revealed that the main reason nurses were not working at that time was due to family responsibilities. The majority of the respondents held the value that the mother should be in the home while the children were young.[104] Recognizing this as a significant problem for inactive nurses, day care centers have been recommended as one means of reactivating this population.[105] While this seems like an appropriate way of approaching the home/career conflict, Keller suggested that child care centers are a threat to some women who believe it is a mother's sole responsibility to rear children. For this reason, there is a reluctance on the part of some mothers to use these resources when they are available.[106] This adherence to the traditional woman's role may account for the apparent contradictions identified by Woolley when she found that although many inactive nurses said they needed to be in the home, closer review of their lifestyle demonstrated that these women were engaged in many activities outside of the home and child care was frequently delegated to babysitters.[107]

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[104]Reese, op. cit., p. 126.

[105]Carl Platon and D. Pederson, "Can More Part-Time Nurses be Recruited?," Hospitals JAHA, XLI (May, 1967), 77-82.

[106]Marjorie Keller, "The Effect of Sexual Stereotyping on the Development of Nursing Theory," American Journal of Nursing, LXIX (September, 1979), 1584-1587.

[107]Alma Woolley, op. cit., p. 2662.

The women's movement may have had some impact in this area within the nursing profession. This has been indicated in recent research done with nursing students. Findings revealed that students' values about women changed while they were in nursing school. Students subscribing to the traditional woman's role on entrance were found to identify more with the women's movement as they moved through the nursing program. This research also demonstrated that the internalization of feminist values continued into the professional work role.[108]

Ambivalent feelings also result from sex role socialization practices which are still operant within our society and become barriers to women and their career decisions.[109] Prior to the 1960's, the literature reflected that both men and women believed that women were less competent and intelligent. Studies published since 1980 do not reflect this trend except in the area of management. There is still apparent bias against hiring and promoting women in managerial positions. One principle reason given for the lack of women in management roles is lack of career commitment.[110]

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[108]Dianne Moore, S. Decker and M. Dowd, "Baccalaureate Nursing Students Identification with the Woman's Movement," Nursing Research, XXVII (September/October, 1978), 291-295.

[109]C. F. Epstein, Woman's Place: Options and Limits in Professional Careers, (Berkeley: University of California Press, 1971), pp. 50-70.

[110]Alice Gold, "Re-examining Barriers to Woman's

A closer look at career commitment revealed that, historically, society has mandated that man work outside of the home, whereas women have had a choice of joining the work force or remaining within the home. While many women work outside of the home because of economic need, the married, middle class, re-entry woman may not need to work for financial reasons. Bailyn viewed this "choice factor" as seriously affecting commitment. She concluded that when women are faced with barriers in the work place, dissatisfaction, and a lack of reward for their work it is easier to choose not to work. This decision is encouraged not only by the needs of children and family, but also receives strong social support.[111]

This section of the review has concentrated on identifying the barriers to re-entry. From the review, it is evident that the barriers to a woman's re-entry, regardless of the discipline, are many and complex.

SUMMARY

In the first section of the literature review it was pointed out that the need for re-entry nurses as a potential labor resource has been apparent for the last

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Career Development," American Journal of Orthopsychiatry, XLVIII (October, 1978), 690-702.

[111]L. Bailyn, The Women in America, ed. R. J. Lifton, (Boston: Houghton Mifflin, 1965), p. 239.

50 years. In the past, federally funded, short-term programs were made available to meet the immediate need of hospitals, however, there was no evidence of plans for an orderly transition for the re-entry nurse into the work force.

The second section of the review examined the reasons why women leave nursing and it was determined that in the past family responsibilities were offered as the primary reason for leaving the profession. However, in the last ten years, the reasons for withdrawal have been more closely related to job conditions. The literature further revealed that nurses are continuing to withdraw from the work force and many fail to return, which reinforced the need to consider re-entry nurses as a viable manpower resource.

The final section concentrated on the barriers to re-entry. From this review, specific barriers with implications for re-entry nurses were identified. The mere identification of these barriers is not sufficient. If the nursing profession is to be responsive to the needs of re-entry nurses, these barriers must be acknowledged and incorporated into the planning of nurse educators and nurse administrators for the development of future programs designed to facilitate the nurse's return to active status.

Nurse educators and nurse administrators are the appropriate agents to do this planning in view of their

respective positions within the profession. In general, there is agreement that these two groups need to work together more closely in many areas within nursing, however there are too few examples of such collaboration. While there are multiple reasons for this, one problem that has been identified as blocking collaboration between the two groups is the difference in perceptions of nursing practice.[112] Therefore, it would seem appropriate for nurse educators and nurse administrators to have increased knowledge of each other's perceptions of the barriers and the knowledge and skills deemed important for re-entry to facilitate joint planning for re-entry nurses.

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[112]Phyllis Dexter and Juanita Laidiz, "Breaking the Education Service Barrier," Nursing Outlook, XXVIII (March, 1980), 179-182.

Chapter 3

RESEARCH DESIGN AND METHODOLOGY

The research methodology and the procedures used in this investigation are presented in this chapter. The research design is described under the following headings: (a) Population and Sample; (b) Questionnaire Distribution; (c) Instrumentation; (d) Data Treatment; and (e) Research Hypotheses.

POPULATION AND SAMPLE

The population for this study included inactive nurses, nurse educators and nurse administrators. The sample which consisted of three groups, each representing a different segment within the population, was drawn from 13 counties in California. The 13 counties included Alameda, Contra Costa, Santa Clara, San Francisco, Marin, San Mateo, Sacramento, San Joaquin, San Bernardino, San Diego, Riverside, Orange, and Los Angeles. These counties were selected because they had the highest percentage of "available unemployed nurses" according to the most recent data on the state level.[1]

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[1]Lois Lillick, The Supply and Characteristics of Nurses Licensed and Employed in California by Health

Inactive nurse group: This population included 1000 names. No central list of inactive nurses was available at this time from the state licensing board, the professional organization, or any other centralized source. For this reason, the population from which the sample of 474 inactive nurses was drawn was obtained from the mailing rosters of three continuing education courses which were offered to these inactive nurses. This list which included names from all 13 counties assured a relatively high yield of nurses within the study who were interested in re-entry. Since the number of names from each county varied, the sample of the inactive nurse group included the total list of available names from eight counties and a random sample of names from five counties. This method was used in an effort to obtain a sample that more accurately reflected the percentage of nurses available for re-entry from each of the counties included in the study.[2]

Nurse educator group: This population was obtained from the files of the Board of Registered Nurses. This group of approximately 2,000 educators includes those who have received approval from the Board of Registered Nurses to offer continuing education courses for credit to registered nurses in California. The sample of 209 nurse

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Service Area and County (Sacramento: Department of Health, January, 1975), p. 53.

[2]Ibid.

educators represented those who were responsible for planning and implementing programs for professional nurses within the study area. This group included educators from academic institutions with nursing programs, in-service educators from a variety of health care agencies, and independent nurse educators who provide continuing education programs that are not associated with either an academic institution or a service agency, but who are approved by the Board of Registered Nurses. A Table of Random Numbers was utilized to select the ten percent sample from this population which resulted in the sample size greater than 100 thus reducing the sampling error to acceptable levels.

Nurse administrator group: The source for this population was the California Department of Health. The names of 2,100 licensed health care facilities within the state were available within this department. These licensed agencies included acute psychiatric facilities, home health agencies, general acute care hospitals, skilled nursing care facilities and clinics. A Table of Random Numbers was utilized to obtain a ten percent stratified random sample to insure a representative sample of health care facilities from each of the counties within the study area. A total of 253 nurse administrators from these facilities made up this sample.

QUESTIONNAIRE DISTRIBUTION

A questionnaire was used for data collection and was mailed to the sample of re-entry nurses, nurse educators, and nurse administrators. A cover letter accompanied each questionnaire in which the purpose and potential contributions of the study were described. (See Appendix A) Self-addressed, stamped envelopes were enclosed and the participants were requested to respond within 15 days. While confidentiality was insured, the questionnaires were coded so that follow-up might be accomplished in an efficient manner.

A total of 936 questionnaires were distributed within the 13 counties; 474 were sent to re-entry nurses, 209 were sent to nurse educators; and 253 were distributed to nurse administrators. Follow-up procedures included sending a reminder, a second copy of the questionnaire and a stamped, self-addressed envelope to non-respondents approximately three weeks after the initial requests were distributed.

INSTRUMENTATION

The rationale for the questionnaire was based on the literature review and informal feedback from inactive nurses. Since the instrument was to be utilized by different sample groups, two questionnaires were developed. One form was developed for re-entry nurses and the other

focused on the nurse educator/nurse administrator groups.

Each questionnaire was divided into three parts and included items designed to obtain factual data, as well as those probing the nurses' perceptions. The factual questions related to demographic data, educational background, career patterns, and motivation for returning to the profession. The perceptual questions focused on the barriers to re-entry and on the knowledge and skills necessary for re-entry. Both structured and open-ended questions were utilized in the instrument. Parts I and II were the same for all groups, whereas, the items in Part III differed. (See Appendix A)

Part I of the questionnaire was comprised of 16 items identified as "barriers to re-entry." The respondent was asked to rate each item on a three point Likert-type scale with options ranging from "great barrier" to "not a barrier." The barriers identified were adapted from the work of Ekstrom and reflected situational, dispositional, and institutional barriers.[3]

Information about nurses included in the sample who were not contemplating re-entry was also considered important in this study. For this reason, these nurses were requested to explain the reason they were not interested in re-entry nursing, to provide biographical data, and to

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[3]Ruth B. Ekstrom, Barriers to Women's Participation in Post-Secondary Education: A Review of the Literature," U.S. Educational Resource Information Center, ERIC Document Reproduction ED 072-368, October, 1972.

respond only to Part I of the questionnaire.

Part II consisted of 25 items. Included were 12 items related to knowledge areas and 13 items related to skills identified as important for the re-entry. These items were based on information in the literature and on a survey of continuing education offerings. Respondents indicated their perceptions of the importance of the items on a three-point Likert-type scale with options ranging from "great importance" to "not important."

Part III of the questionnaire which was sent to the nurses focused on education, career patterns, and motivating factors in the decision to return to the profession. Additional biographical data relating to age, family status, annual income, and children were also requested from the re-entry nurses. Part III of the questionnaire that was sent to nurse educators and nurse administrators included items which focused on employment setting, current position, educational preparation, and previous experiences with re-entry nurses.

To determine content validity of the instrument, a draft of each of the questionnaires was submitted to a panel of experts from a variety of settings. (See Appendix D) Included on this panel was a professor of education, a nurse educator from a continuing education setting, a nurse educator representing baccalaureate education, a nurse educator representing a two-year academic setting, a nurse administrator from an acute care setting, a director of

a home health care agency, and a nurse clinician from an acute care setting. The final draft of the questionnaires incorporated the panel's suggestions regarding format, substantive content and directions. A field test was conducted with a representative sample of nurses from five of the counties within the study area to further validate the survey instrument. The nurses in the field test were among those attending two different continuing education courses in which the investigator was involved.

A total of 28 nurses were included in the field test. Of this group, 20 were interested in re-entry; three were not interested for reasons of health or age; and five were currently employed in the profession. The participants were given the questionnaires and were requested to submit criticism and suggestions relative to clarity, format and wording of directions. (See Appendix E) The area that received most criticism was the format. The subjects were confused by five options in the Likert-type scale which was originally planned and generally utilized only three options.

To insure reliability of the instrument, test-retest procedures were then carried out. The test was administered to the field test group and two weeks later the questionnaire was sent to them again as a retest. (See Appendix F) The return for the procedure totaled 60 percent with no follow-up. Twenty-six Pearson product moment correlations were computed to analyze the paired

responses of the pilot group to the two tests for the areas relating to barriers to re-entry and knowledge and skills necessary for re-entry. The test-retest reliability coefficient for the barriers to re-entry section was .54; for the Knowledge and Skills section, the coefficient was .57. The reliability coefficient for the section identifying motivating factors most influential to the nurse considering re-entry was .60. On analysis of the results of the field testing, it was decided that specific items should be clarified or eliminated which would increase the reliability of the instrument.

DATA TREATMENT

Data analyses were designed to determine whether significant differences existed among re-entry nurses, nurse educators and nurse administrators in their perceptions of barriers to re-entry and the knowledge and skills necessary for re-entry. Analyses were also carried out to determine which groups were significantly different. The ancillary questions posed by the study also required analysis that would reflect differences within each of these groups.

Data from the returned questionnaires were coded and transferred to punch cards. The data were run at the Computer Services Department, University of Pacific, Stockton, California. The data obtained from the questionnaires were analyzed as follows.

The basic statistics of the re-entry nurse sample were described as to the demographic data; next their responses relating to barriers, knowledge, and skills were compared to indicate how the group responded as a whole. The responses in the re-entry nurse sample were then compared to determine if nurses interested in re-entry responded differently to the items than did nurses who were not interested in re-entry.

Analysis of variance (ANOVA) procedures were employed to determine whether inter-group differences existed in the perceptions of re-entry nurses, nurse educators, and nurse administrators. This factorial design was also used to analyze group differences as to the barriers to re-entry and the knowledge and skills necessary for re-entry. The .01 level of significance was adopted as being the most appropriate for each aspect of the investigation.

The Tukey multiple comparison method was then utilized to determine which groups were significantly different. Finally, Pearson correlation procedures were employed to determine the relationship between the educator/administrators' experience with re-entry nurses and their perceptions of barriers to re-entry and knowledge and skills necessary for re-entry.

NULL HYPOTHESES

The central hypotheses of this investigation stated in null form allege that there are no significant differences among the perceptions of nurses who want to return to the profession, nurse educators and nurse administrators regarding the needs of re-entry nurses. Stated in null form, the research hypotheses include:

Hypothesis 1. There are no significant differences among re-entry nurses, nurse educators, and nurse administrators in their perceptions of the barriers to re-entry.

Hypothesis 2. There are no significant differences among re-entry nurses, nurse educators, and nurse administrators in their perceptions of specific knowledge and skills important for re-entry.

Hypothesis 3. There are no significant differences between nurses who are interested in re-entry and those who are not interested in returning to the profession (non-re-entry nurse) in their perceptions of the barriers to re-entry.

An additional aspect of the investigation included the following ancillary questions:

1. What differences exist among the age groups of the nurses and their perceived barriers to re-entry?

2. What differences exist among the nurses' educational backgrounds and the specific knowledge and skills deemed important for the re-entry nurse to know?

3. What factors emerge as the most influential in the nurse's decision to re-enter the profession?

4. What is the relationship between the educator/administrators' experiences with re-entry nurses and their perceptions of the barriers, knowledge and skills important for re-entry?

SUMMARY

In this chapter the population selected for the study, the sampling process utilized, were described. The development of the questionnaire was presented, and the field test described. The procedure for data collection was explained, and finally, the hypotheses of the study were presented.

Data analyses appear in Chapter 4, and summary, conclusions, and recommendations for further research are found in Chapter 5.

Chapter 4

PRESENTATION AND ANALYSIS OF DATA

The purpose of this study was to determine if differences exist in the perception of re-entry nurses, nurse educators, and nurse administrators as to the needs of re-entry nurses. Specifically, those needs were identified through examination of the barriers to re-entry, and the knowledge and skills important for re-entry. Presented in this chapter are data pertaining to the analysis of the sample information, the research hypotheses and the ancillary questions.

ANALYSIS OF THE SAMPLE INFORMATION

The data for this investigation were generated from response to a questionnaire sent to three groups of registered nurses. The sample groups were derived from inactive nurses, nurse educators and nurse administrators within 13 counties in California. Information relative to the distribution of the sample and return of the questionnaire is summarized in Table 1.

A total of 936 questionnaires were distributed to the three groups. Responses received from the re-entry nurse group totalled 232 by the initial deadline. Follow-up

procedures yielded another 117 questionnaires, making the final return of 349 or a total of 74 percent.

By the initial deadline, 113 questionnaires had been returned from the nurse educator group and follow-up efforts yielded 39 additional responses for a total return of 73 percent.

Of the total 936 questionnaires mailed to the three groups, 681 were returned for an overall response rate of 73 percent. On comparing questionnaires returned from the first mailing and those returned after follow-up activities, no substantial differences were noted.

Response patterns on 23 questionnaires indicated that the respondent was not interested in the study or had misunderstood the directions. For this reason, these questionnaires were deleted from the study. Additional questionnaires received after data processing had begun were also rejected. Thus, research findings for this study were based on data generated from 658 questionnaires, or a 70 percent response.

The three groups making up the sample were re-entry nurses, nurse educators and nurse administrators drawn from 13 counties within California. Presented in Table 2 is a summary of the questionnaire distribution and response returns by county. These data indicate that the percent of return from each of the groups adequately reflected the sample in each of the 13 counties.

Table 1

Summary of Sample Distribution and Percentage of Total Returns

Group	Number Sent	% Return by Group
Re-entry Nurses	474	74
Nurse Educators	209	73
Nurse Administrators	253	71
Totals	936	73

Table 2

Questionnaire Distribution and Percent of Return by County for Three Groups

County	Re-entry Nurses			Nurse Educators			Nurse Administrators		
	No. Sent	No. Ret'd	%	No. Sent	No. Ret'd	%	No. Sent	No. Ret's	%
Alameda	61	38	62	23	21	91	22	14	64
Contra Costa	58	47	81	9	7	78	18	11	61
Marin	32	28	88	4	4	100	20	15	75
San Mateo	42	25	59	5	4	80	21	11	52
Santa Clara	18	14	78	20	13	65	19	16	84
San Joaquin	31	23	74	7	4	57	18	15	83
San Francisco	27	19	70	35	14	40	18	14	77
San Bernardino	27	19	70	4	3	75	19	12	63
Riverside	12	9	75	2	1	50	20	10	50
Sacramento	24	18	75	13	11	85	16	11	69
San Diego	57	36	63	13	8	62	20	17	85
Los Angeles	61	30	49	59	46	78	24	18	75
Orange	24	17	71	15	14	93	18	12	67
Totals	474	323		209	150		253	176	

An analysis of the demographic data obtained from the re-entry nurse group revealed that approximately 90 percent of the respondents in that group were evenly distributed between the age groups of 25-44 years and 45-64 years. The greatest percentage of these nurses were married (86%), had children (88%) and reported an annual family income of over $21,000 (72%). These data are summarized in Table 3.

Comparisons of the nurse educator and nurse administrator groups were done to determine the range of employment and educational experiences within the two groups. These comparisons are summarized in Table 4. These data reveal that the nurse educator group emanated from both clinical and educational settings. However, the majority of respondents represented educational settings and were evenly distributed among the areas of in-service, continuing education, and schools of nursing. In the nurse administrator group, there were more respondents from long term care facilities than acute care facilities, and the smallest representation came from community health facilities.

When compared with the nurse administrators, the educational background of the nurse educator group indicated a slightly skewed distribution with more respondents prepared at the masters and doctoral level, while the nurse administrator group demonstrated a larger percentage of respondents from the associate degree and diploma level.

Table 3

Age, Family Status, Income, and Children (Age and Number) of Re-entry Nurse Group

N=306

	Number	Percent
Age		
21-24 years	2	<1
25-44	141	46
45-64	143	47
over 65	20	7
Family Status		
married	264	86
single	9	3
divorced/separated	15	5
widowed	18	6
Annual Income		
less than $10,000	15	5
$10,000 - $20,999	68	23
$21,000 - $31,000	79	26
over $31,000	137	46
Number of Children		
none	36	12
1-3	205	68
4 or more	60	20
Age of Youngest Child		
no children	29	10
0-5 years	48	16
6-12	83	28
13-19	55	19
over 20	79	27

Table 4

Frequency Distribution and Percentage of Nurse Educator/Nurse Administrator Groups by Employment Setting and Educational Background

	Nurse Educators N=141		Nurse Administrators N=174	
	N	%	N	%
Employment Setting				
Acute Care	40	28	56	32
Long-term Care	5	4	79	45
Community Health	6	4	27	16
In-Service	33	23		
Continuing Education	19	13		
School of Nursing	27	19		
Other	11	8	12	7
Educational Background				
Less than BS Degree	23	16	86	49
BS Degree	40	29	54	31
MS Degree	59	42	33	19
Doctorate	19	13	1	<1

RESEARCH HYPOTHESES

Descriptive and inferential statistical procedures were employed to determine significant differences among the three groups relative to each of the research hypotheses.

Data Pertaining to Research Hypothesis 1

The questionnaire which served as the data collection instrument was comprised of three parts. Part I listed 16 barriers to re-entry and all three groups were asked to rate each item on a Likert-type scale indicating "great barrier," "slight barrier," or "no barrier."

In analyzing the data from the responses, it was decided that the mean values would be placed on a continuum from 1-3 as follows: "great barrier" (1.0 - 1.5); "moderate barrier" (1.5 - 2.0); "slight barrier" (2.0 - 2.5); and "not a barrier" (2.5 - 3.0). In Tables 5, 6 and 7 are presented the rank order of the barriers and the mean scores and standard deviations of the three groups as they responded to Part I of the questionnaire.

Hypothesis 1. There are no significant differences among re-entry nurses, nurse educators, and nurse administrators in their perceptions of the barriers to re-entry.

A review of the findings in Table 5 reveals that, generally, re-entry nurses did not perceive any of the listed items to be a "great barrier," however, these data indicate that "outdated knowledge," with a mean score of 1.67, "lack of technical skills," with a mean of 1.70, and

"home/family responsibilities" with a mean of 1.71 were ranked highest by re-entry nurses. "Lack of self-confidence," with a mean of 1.82, was ranked fourth by this group. The next seven barriers were rated as "slight barriers," while "physical capabilities," "lack of nurses' support," "geographic location," "lack of financial assistance," and "cultural values" were not perceived as barriers.

Presented in Table 6 are the mean scores and standard deviations provided by nurse educators when considering barriers to re-entry. The data reveal that nurse educators perceived "lack of self-confidence" (M=1.32) and "outdated knowledge" (M=1.40) as "great barriers" to re-entry and ranked them highest. The only item not perceived as a barrier to nurse educators was "physical capabilities" (M=2.52) which was placed in lowest rank order.

In Table 7 are presented the mean scores and standard deviations obtained for the nurse administrator group when considering barriers to re-entry. This group, like the nurse educator group, viewed "lack of self-confidence" (M=1.39) and "outdated knowledge" (M=1.43) as "great barriers" to re-entry nurses. These data also indicate that the item "cultural values" (M=2.62) was not perceived as a barrier to re-entry by nurse administrators.

To determine if there were significant differences among the three groups relative to the barriers to re-entry, analysis of variance procedures (ANOVA) were carried out, thus providing the data leading to the acceptance or

Table 5

Rank Order of Barriers to Re-entry as Perceived by Re-entry Nurses

Rank Order	Barrier	Mean	SD
1	Outdated nursing knowledge	1.67	.685
2	Lack of technical skills	1.70	.688
3	Home/Family responsibilities	1.71	.738
4	Lack of self-confidence	1.82	.794
5	Inflexible personnel policies	2.11	.767
6	Availability of re-entry programs	2.21	.815
7	Inability to effect change	2.28	.755
8	Lack of financial motivation	2.34	.750
9	Inadequate salary/benefits	2.38	.742
10	Limited job opportunities	2.40	.706
11	Lack of satisfaction from working as a nurse	2.41	.754
12	Physical capabilities	2.49	.665
13	Lack of support from employed nurses	2.56	.660
14	Geographic location of facility	2.57	.638
15	Lack of financial assistance	2.61	.650
16	Cultural values	2.72	.547

Table 6

Rank Order of Barriers to Re-entry as Perceived by Nurse Educators

Rank Order	Barrier	Mean	SD
1	Lack of self-confidence	1.32	.524
2	Outdated nursing knowledge	1.40	.545
3	Lack of technical skills	1.57	.598
4	Availability of re-entry programs	1.65	.774
5	Home/family responsibilities	1.69	.625
6	Lack of satisfaction from working as a nurse	1.93	.716
7	Inability to effect change	2.03	.767
8	Inflexible personnel policies	2.11	.746
9	Lack of support from employed nurses	2.15	.749
10	Lack of financial assistance	2.16	.768
11	Lack of financial motivation	2.23	.701
12	Inadequate salary/benefits	2.32	.762
13	Geographic location of facility	2.40	.651
14	Cultural values	2.42	.674
15	Limited job opportunities	2.49	.707
16	Physical capabilities	2.52	.577

Table 7

Rank Order of Barriers to Re-entry as Perceived by Nurse Administrators

Rank Order	Barrier	Mean	SD
1	Lack of self-confidence	1.39	.579
2	Outdated nursing knowledge	1.43	.564
3	Lack of technical skills	1.55	.616
4	Home/family responsibilities	1.72	.661
5	Availability of re-entry programs	1.77	.745
6	Lack of satisfaction from working as a nurse	2.04	.792
7	Lack of financial motivation	2.12	.745
8	Lack of financial assistance	2.14	.761
9	Inadequate salary/benefits	2.17	.835
10	Inflexible personnel policies	2.18	.691
11	Inability to effect change	2.20	.740
12	Lack of support from employed nurses	2.23	.725
13	Geographic location of facility	2.36	.700
14	Limited job opportunities	2.40	.762
15	Physical capabilities	2.41	.624
16	Cultural values	2.62	.521

rejection of the null hypothesis. These data which include the mean scores of each group, "F" ratios and levels of significance are found in Table 8. A review of these data reveals that there are significant differences at the .01 level among re-entry nurses, nurse educators and nurse administrators in their perceptions of eight of the sixteen barriers to re-entry. These specific barriers are:

(1) lack of self confidence;

(5) outdated nursing knowledge;

(10) geographic location of facility;

(11) lack of satisfaction from working as a nurse;

(12) availability of re-entry programs;

(13) lack of support from employed nurses;

(15) cultural values;

(16) lack of financial assistance.

Based on these findings, the null hypothesis was rejected. To find out which pairs of means were significantly different, the Tukey method of multiple comparisons was applied. The results of this analysis are presented in Table 9.

These data reveal significant differences between re-entry nurses and nurse educators and re-entry nurses and nurse administrators in the comparisons for six of the barriers. These included: "lack of self-confidence," "outdated knowledge," "lack of satisfaction as a nurse," "availability of re-entry programs," "lack of support from employed nurses," and "lack of financial assistance."

Table 8

ANOVA Table of "F" Ratios Illustrating Differences Among Three Groups' Perceptions of Barriers to Re-entry

Barriers to Re-entry	Re-entry	Nurse Educ.	Nurse Adminis.	"F"	Signif.
1. Lack of self-confidence	1.82	1.32	1.39	24.979	.0000*
2. Home/family responsibilities	1.71	1.69	1.72	.103	.9584
3. Limited job opportunities	2.40	2.49	2.40	.681	.5639
4. Physical capabilities	2.49	2.52	2.41	1.202	.3083
5. Outdated nursing knowledge	1.67	1.40	1.43	8.777	.0000*
6. Lack of technical skills	1.70	1.57	1.55	2.743	.0424
7. Inflexible personnel policies	2.11	2.11	2.18	.297	.8279
8. Inadequate salary/benefits	2.38	2.32	2.17	3.127	.0253
9. Inability to effect "change"	2.28	2.03	2.20	3.563	.0141
10. Geographic location of facility	2.57	2.40	2.36	4.876	.0023*
11. Lack of satisfaction from working as nurse	2.41	1.93	2.04	16.529	.0000*
12. Availability of re-entry programs	2.21	1.65	1.77	21.380	.0000*
13. Lack of support from employed nurses	2.56	2.15	2.23	14.779	.0000*

Table 8--Continued

Barriers to Re-entry	Re-entry	Nurse Educ.	Nurse Adminis.	"F"	Signif.
14. Lack of financial motivation	2.34	2.23	2.12	3.326	.0194
15. Cultural values	2.72	2.42	2.62	9.178	.0000*
16. Lack of financial assistance	2.61	2.16	2.14	22.195	.0000*

*Significant at .01 level

Table 9

Tukey Multiple Comparisons
Barriers to Re-entry

Barrier to Re-entry	Re-entry Ns Educator	Re-entry Ns Adminis	Ns Educator Ns Adminis	HSD*
1. Lack of self-confidence	.5042	.4332	NS*	.1998
5. Outdated knowledge	.2657	.2353	NS	.1813
10. Geographic location of facility	NS	.2117	NS	.1914
11. Lack of satisfaction as a nurse	.4788	.3612	NS	.2213
12. Availability of re-entry programs	.5555	.4379	NS	.2291
13. Lack of support from employed nurses	.4054	.3308	NS	.2030
15. Cultural values	.2983	NS	-.1989	.1653
16. Lack of financial assistance	.4539	.4712	NS	.2059

*NS = not significant

*HSD = Honestly significant difference

Comparisons for the barrier relating to geographic location revealed significant differences only between re-entry nurses and nurse administrators. The nurse educator group and the nurse administrator group differed significantly only on one barrier, this was the barrier relating to cultural values.

Data Pertaining to Research Hypothesis 2

Part II of the questionnaire listed 12 knowledge areas and 13 abilities (skills) identified as important for re-entry. The data from these questionnaires were analyzed by descriptive statistics and simple ANOVA. Tables 10 through 15 present the rank order of these knowledge areas and skills and provide the mean scores and standard deviations based on responses of the re-entry nurses, nurse educators and nurse administrators. In analyzing the data, the responses were interpreted as follows: "great importance," (1.0 - 1.5); "moderate importance." (1.5 - 2.0); "important" (2.0 - 2.5); "not important" (2.5 - 3.0).

Hypothesis 2. There are no significant differences among re-entry nurses, nurse educators and nurse administrators in their perceptions of specific knowledge and skills important for re-entry.

In Table 10 the mean scores and standard deviations obtained from re-entry nurses regarding the importance of knowledge important for re-entry are presented. These data indicate that "knowledge of drug interactions" produced

a mean score of 1.21 and was ranked first in importance. Additionally, the data reveal that "nursing research" with a mean score of 1.88 was ranked lowest; however, all of the knowledge areas perceived by this group to be between "great" and "moderate" importance for re-entry.

In Table 11 the mean scores and standard deviations obtained from re-entry nurses regarding the importance of specific abilities to re-entry are presented. These data indicate that, generally, re-entry nurses perceive the ability to "administer medications and to recognize side effects" as being of "great importance" with a mean score of 1.07. "Taking a nursing history" produced a mean score of 1.62 and while ranked lowest among the items, it was still rated as moderately important by this group.

In Table 12 the mean scores and standard deviations obtained from nurse educators regarding the importance of specific knowledge for re-entry are presented. These data indicate that "knowledge of drug interactions" with a mean score of 1.28 was ranked highest by the nurse educators. Of the remaining items, "nursing research" ranked lowest, with a mean score of 2.07 which rated this knowledge area as moderately important by this group.

In Table 13 the mean scores and standard deviations obtained from nurse educators regarding the importance of specific abilities to re-entry are presented. These findings indicate that, generally, nurse educators ranked "problem solving," "administration of medications" and

Table 10

Rank Order of Areas of Knowledge Important for Re-entry as Perceived by Re-entry Nurses

Rank Order	Knowledge Important for Re-entry	Mean	SD
1	Drug Interactions	1.21	.419
2	Laboratory findings	1.30	.472
3	Pathophysiology	1.39	.498
4	Changes in the health care system	1.40	.519
5	Recent modes of therapy	1.41	.546
6	Legal aspects of nursing	1.43	.532
7	Psychological/social and cultural aspects of patient care	1.44	.516
8	Nutritional needs	1.54	.545
9	Alternatives in patient care management	1.61	.583
10	Organization and time management	1.63	.596
11	Health care costs	1.87	.547
12	Role of nursing research in patient care	1.88	.615

Table 11

Rank Order of Abilities Important for Re-entry as Perceived by Re-entry Nurses

Rank Order	Ability Important for Re-entry	Mean	SD
1	Administer medications	1.07	.268
2	Emergency nursing procedures	1.13	.344
3	Recognize limitations and verbalize own learning needs	1.30	.469
4	Administer I.V. therapy	1.31	.539
5	Use technological equipment	1.43	.590
6	Problem-solving process	1.46	.544
7	Teach patients and family	1.47	.518
8	Communication skills (R/R)	1.47	.536
9	Basic nursing skills	1.48	.593
10	Communication skills (interpersonal)	1.49	.537
11	Develop and evaluate nursing care plans	1.55	.543
12	Physical assessment	1.56	.600
13	Nursing history	1.62	.605

Table 12

Rank Order of Areas of Knowledge Important for Re-entry as Perceived by Nurse Educators

Rank Order	Knowledge Important for Re-entry	Mean	SD
1	Drug interactions	1.28	.469
2	Legal aspects of nursing	1.36	.484
3	Psychological/social and cultural aspects of patient care	1.37	.513
4	Changes in the health care system	1.44	.551
5	Pathophysiology	1.45	.539
6	Laboratory findings	1.47	.541
7	Recent modes of therapy	1.59	.558
8	Organization and time management	1.64	.573
9	Nutritional needs	1.64	.507
10	Alternatives in patient care management	1.65	.545
11	Health Care costs	1.89	.586
12	Role of nursing research in patient care	2.07	.611

Table 13

Rank Order of Abilities Important for Re-entry as Perceived by Nurse Educators

Rank Order	Ability Important for Re-entry	Mean	SD
1	Problem-solving process	1.19	.417
2	Administer medications	1.20	.405
3	Recognize limitations and verbalize own learning needs	1.22	.419
4	Emergency nursing procedures	1.26	.474
5	Communication skills (interpersonal)	1.31	.481
6	Communication skills (R/R)	1.34	.531
7	Develop and evaluate nursing care plans	1.39	.569
8	Teach patients and family	1.40	.531
9	Nursing history	1.42	.536
10	Administer I.V. therapy	1.47	.578
11	Physical assessment	1.60	.594
12	Basic nursing skills	1.61	.637
13	Use technological equipment	1.79	.646

"recognizing limitations" high in importance with means of 1.19, 1.20 and 1.22, respectively. The "use of technical equipment" ranked lowest with a mean score of 1.79.

In Table 14 the mean scores and standard deviations obtained from nurse administrators regarding specific knowledge important for re-entry are presented. These findings indicate that "knowledge of drug interactions" with a mean score of 1.22 was ranked highest in importance by this group while "nursing research" with a mean score of 2.10 ranked lowest.

Presented in Table 15 are the mean scores and standard deviations obtained by nurse administrators regarding specific abilities important for re-entry. The ability to "administer medications" with a mean score of 1.15 was ranked highest by this group. The nurse administrators, like the nurse educator group, rated the "use of technical equipment" as moderately important, with a mean score of 1.86 even though it received the lowest ranking of the items.

Analysis of variance procedures (ANOVA) were carried out to determine if significant differences existed in the perceptions of the three groups as to knowledge and skills important for re-entry. These results provided direction for accepting or rejecting this null hypothesis.

Data presented in Table 16 and 17 reveal that statistical differences were found at the .01 level among re-entry nurses, nurse educators and nurse administrators

Table 14

Rank Order of Areas of Knowledge Important for Re-entry as Perceived by Nurse Administrators

Rank Order	Knowledge Important for Re-entry	Mean	SD
1	Drug interactions	1.22	.420
2	Legal aspects of nursing	1.32	.495
3	Laboratory findings	1.46	.511
4	Changes in the health care system	1.48	.535
5	Psychological/social and cultural aspects of patient care	1.50	.546
6	Pathophysiology	1.52	.557
7	Nutritional needs	1.56	.552
8	Recent modes of therapy	1.65	.588
9	Organization and time management	1.67	.573
10	Alternatives in patient care management	1.71	.580
11	Health care costs	1.94	.603
12	Role of nursing research in patient care	2.10	.568

Table 15

Rank Order of Abilities Important for Re-entry as Perceived by Nurse Administrators

Rank Order	Ability Important for Re-entry	Mean	SD
1	Administer medications	1.15	.361
2	Emergency nursing procedures	1.28	.476
3	Recognize limitations and verbalize own learning needs	1.35	.479
4	Develop and evaluate nursing care plans	1.37	.544
5	Problem-solving process	1.39	.536
6	Teach patients and family	1.42	.519
7	Communication skills (Interpersonal)	1.43	.542
8	Communication skills (R/R)	1.50	.567
9	Nursing history	1.53	.578
10	Basic nursing skills	1.57	.623
11	Administer I.V. therapy	1.60	.667
12	Physical assessment	1.61	.575
13	Use technological equipment	1.86	.646

Table 16

ANOVA Table of "F" Ratios Illustrating Differences Among Three Groups' Perceptions of Knowledge Important for Re-entry

Knowledge Important for Re-entry	Re-entry	Nurse Educ.	Nurse Adminis.	"F"	Signif.
1. Changes within the health care system	1.40	1.44	1.48	1.094	.3355
2. Legal aspects of nursing	1.43	1.36	1.32	2.086	.1252
3. Laboratory findings	1.30	1.47	1.46	6.588	.0015*
4. Drug interactions	1.21	1.28	1.22	1.454	.2345
5. Recent modes of therapy	1.41	1.59	1.65	10.180	.0000*
6. Health care costs	1.07	1.89	1.94	.821	.4406
7. Role of nursing research in patient care	1.88	2.07	2.10	7.638	.0005*
8. Organization and time management	1.63	1.64	1.67	.318	.7274
9. Alternatives in patient care management	1.61	1.65	1.71	1.334	.2642
10. Nutritional needs	1.54	1.648	1.56	1.808	.1649
11. Pathophysiology	1.39	1.45	1.52	2.917	.0550
12. Psychological/social and cultural aspects of patient care	1.44	1.37	1.50	2.207	.1111

*Significant at the .01 level.

Table 17

ANOVA Table of "F" Ratios Illustrating Differences Among the Three Groups' Perceptions of Abilities (Skills) Important for Re-entry

Ability Important for Re-entry	Re-entry	Nurse Educ.	Nurse Adminis.	"F"	Signif.
1. Problem-solving	1.46	1.19	1.39	11.978	.0000*
2. Take nursing history	1.62	1.42	1.53	5.220	.0057*
3. Physical assessment	1.56	1.60	1.61	.502	.6056
4. Administer medications	1.07	1.20	1.15	6.549	.0016*
5. Basic nursing skills	1.48	1.61	1.57	2.039	.1312
6. Perform emergency nursing procedures	1.13	1.26	1.28	6.855	.0011*
7. Teach patients and family	1.467	1.40	1.42	.821	.4405
8. Use technological equip.	1.43	1.79	1.86	26.395	.0000*
9. Develop and evaluate nursing care plans	1.55	1.39	1.37	6.172	.0022*
10. Administer I.V. therapy	1.31	1.47	1.60	11.684	.0000*
11. Recognize limitations; verbalize own learning needs	1.30	1.22	1.35	3.096	.0461
12. Communication skills (R/R)	1.477	1.34	1.50	3.820	.0225
13. Commun. skills (interpersonal)	1.49	1.31	1.43	5.108	.0064*

*Significant at the .01 level.

in their perception of knowledge and abilities (skills) important for re-entry. These differences are:

Knowledge areas:

(3) relationship of laboratory findings to patient's physical status;

(5) recent modes of therapy (eg. chemotherapy, radiation, acupuncture);

(7) role of nursing research in patient care.

Abilities (skills):

(1) use of problem-solving process in patient care situations

(2) take a nursing history;

(4) administer medications and recognize side effects;

(6) perform emergency nursing procedures;

(8) use technological equipment;

(9) develop and evaluate nursing care plans;

(10) administer I.V. therapy;

(13) use communication skills (interpersonal).

Based on these findings, Hypothesis 2 was rejected. Next, the Tukey method of multiple comparisons was applied to determine which pairs of means were significantly different. In Table 18 those findings are presented.

The information presented in Table 18 indicates that significant differences exist between re-entry nurses and nurse educators and re-entry nurses and nurse administrators in all three of the knowledge areas. There were no significant differences between the responses of nurse educators and nurse administrators in these areas.

In the area of abilities or skills, the data demonstrated that there were significant differences between the re-entry nurse group and the nurse educator group in five of the eight abilities. These included "problem-solving," "nursing history," "administering medications," "utilization of technological equipment" and "communication skills (interpersonal)." The re-entry nurse group and nurse administrator group differed significantly in only three of these areas; "performance of emergency procedures," "utilization of technological equipment," and "administering I.V. therapy." These findings also indicate there were significant differences between nurse educators and nurse administrators in only one of the eight items; this was in the "ability to use the problem-solving process in patient care situations."

These data further reveal that no significant differences were found among the three groups regarding the ability to "develop and evaluate nursing care plans." The Tukey method, being a conservative test, did not discern differences between means in this area. Therefore, the modified Fisher LSD (least significant difference) approach was used. As a result of this test significant differences were found at the .01 level between re-entry nurses and nurse educators, and re-entry nurses and nurse administrators regarding the ability to "develop and evaluate nursing care plans." However, no significant differences

Table 18

Tukey Method of Multiple Comparisons
Knowledge Areas and Skills

	Re-entry Ns Educator	Re-entry Ns Adminis	Ns Educator Ns Adminis	HSD*
Knowledge				
3. Laboratory findings	-.1667	-.1556	NS*	.1650
5. Modes of therapy	-.1849	-.2477	NS	.1848
7. Nursing research	NS	-.2198	NS	.1980
Abilities (Skills)				
1. Problem-solving	.2644	NS	-.1930	.1683
2. Nursing history	.2003	NS	NS	.1914
4. Administer medications	-.1282	NS	NS	.1122
6. Emergency procedures	NS	-.1443	NS	.1419
8. Technological Equip.	-.3585	.4299	NS	.2046
9. Dev. nursing care plans[1]	NS	NS	NS	.1815
10. I.V. Therapy	NS	-.2932	NS	.1947
13. Communication Skills (Interpersonal)	.1808	NS	NS	.1716

*HSD = Honestly significant difference

*NS = Not significant

[1]Modified Fisher LSD indicated significant differences at .01 level between re-entry nurses and nurse educators (T=2.88) and re-entry nurses and nurse administrators (T=3.41).

were found between nurse educators and nurse administrators on this item.

Data Pertaining to Research Hypothesis 3

It was assumed that some nurses within the sample who responded to the questionnaire would not be interested in re-entry. It was further assumed that this group would differ in their perceptions of barriers from those nurses who were interested in re-entry. Therefore, the questionnaire was designed so that nurses not interested in re-entry could complete only Part I and the demographic section of the instrument. In addition, they were requested to explain the reason they were not interested in re-entry.

Hypothesis 3. There are no significant differences between nurses who are interested in re-entry and those who are not interested in returning to the profession in their perceptions of the barriers to re-entry.

Of the nurses responding to the questionnaire who were not interested in re-entry, ten percent were employed and eighteen percent of the respondents gave no reason for their lack of interest in re-entry. Of the group who did provide a reason, home/family responsibilities was the reason most frequently given. The reasons for non-entry are presented in Table 19.

To determine if there were significant differences between the nurses interested in re-entry and those not interested in re-entry in their perceptions of the

Table 19

Frequency Distribution and Percentage for Reasons for Non-interest in Re-entry

Reason for Non-Interest	N	%
Home/Family Responsibilities ie., children, time conflicts, husband's attitude	32	29
Health	12	11
Age	12	11
No financial need	9	8
Cannot afford continuing education	3	3
Personal inadequacy	11	10
No reason given	20	18
Employed	11	10

barriers to re-entry, analysis of variance procedures (ANOVA) were employed. Presented in Table 20 are the mean scores, "F" ratios and levels of significance obtained from the two groups regarding the barriers to re-entry. The results of these statistical procedures reveal that the nurses interested in re-entry and those not interested differed significantly only in "availability of re-entry programs." Since there were no significant differences between the two groups in their perceptions of 15 of the barriers to re-entry, the null hypothesis was accepted.

Data Pertaining to Ancillary Questions

An additional purpose of this study was to determine if perceptual differences could be found within the re-entry nurse group, particularly as they relate to age and barriers to re-entry, and educational background and knowledge and skills perceived important in re-entry and factors influential in re-entry. Also, the study sought to determine relationships between the experiences of nurse educator/administrators with re-entry nurses and their perceptions of barriers to re-entry.

Ancillary Question 1. What perceptual differences exist among the age groups of the nurses and the perceived barriers to re-entry?

Analysis of variance procedures (ANOVA) were used to determine the statistical differences among age groups of re-entry nurses and perceived barriers to re-entry.

Table 20

Differences in Perceptions of Barriers to Re-entry
Between Nurses Interested in Re-entry
Nurses Who are Not Interested

Barriers to Re-entry	Int*	Not Int*	"F"	Signif.
1. Lack of self-confidence	1.79	1.88	.892	.35
2. Home/family responsibilities	1.72	1.69	.133	.72
3. Limited job opportunities	2.38	2.45	.836	.36
4. Physical capabilities	2.55	2.39	4.150	.04
5. Outdated knowledge of nursing theory	1.65	1.72	.670	.41
6. Lack of technical skills	1.69	1.73	.284	.59
7. Inflexible personnel policy	2.08	2.21	2.160	.14
8. Inadequate salary/benefits	2.38	2.42	.132	.72
9. Inability to effect "change" in the system	2.30	2.45	.439	.51
10. Geographic location of facility	2.57	2.60	.200	.65
11. Lack of satisfaction from working as a nurse	2.40	2.44	.185	.67
12. Availability of re-entry or refresher programs	2.09	2.45	14.650	.0002*
13. Lack of support from employed nurses	2.55	2.60	.518	.47
14. Lack of financial motivation	2.34	2.34	.005	.94
15. Cultural values regarding "woman's place"	2.72	2.73	.001	.97
16. Lack of financial assistance (scholarships, loans, etc.)	2.61	2.63	.063	.80

*Int = Nurses/Interested

*Not Int = Nurses/Not Interested

*Significant at .01 level

(See Appendix G, Table 21) An analysis of the data generated from these procedures revealed differences that were statistically significant in the barriers of "home/family responsibilities" and of "physical capabilities."

Ancillary Question 2. What differences exist among the nurses' educational backgrounds and the specific knowledge and skills important for re-entry?

Analysis of variance procedures (ANOVA) were used to determine statistical differences among types of basic education and knowledge and skills important for re-entry. (See Appendix H and I, Tables 22 and 23) An analysis of the results revealed no significant differences among nurses from different types of basic education in their perceptions of the knowledge and skills necessary for re-entry.

Ancillary Question 3. What factors emerge as the most influential in the nurse's decision to re-enter the profession?

Mean scores and standard deviations were compiled on the ten factors ranked "most influential" (1) to "least influential" (10). (See Appendix J, Table 24) Of the ten factors influencing nurses' re-entry, the data revealed two factors closely ranked and rated highest by the group. These factors were "loss of spouse" with a mean score of 2.6 and "need to be productive outside of the home" with a mean score of 2.7. The factor that was ranked lowest as influencing nurses' re-entry was the "need for nurses," with a mean score of 5.07.

Ancillary Question 4. What is the correlation between the educator/administrators' experiences with re-entry nurses and their perceptions of the barriers and the knowledge and skills important for re-entry?

Pearson correlation procedures were employed to ascertain relationships between these variables. Correlation coefficients were computed for the 16 barriers, 25 knowledge areas and skills as it related to each of the 13 different types of experiences indicated by the nurse educator and administrator groups. (See Appendix K, Table 25)

Analysis of the data generated revealed a number of correlation coefficients that were statistically significant despite their small values. These relationships were most prevalent in the barriers relating to lack of self-confidence, lack of support from employed nurses, and lack of financial assistance. In the analysis of knowledge and experiences, the data revealed the greatest number of significant relationships in items relating to laboratory findings, modes of therapy, and nursing research. The most significant correlation within the abilities was the relationship between experiences and utilization of technological equipment.

SUMMARY OF FINDINGS

Presented in this chapter were findings from this investigation. An analysis of the sample information revealed that the respondents from each of the three

groups, re-entry nurses, nurse educators and nurse administrators, adequately reflected the sample in each of the 13 counties included in the study. Demographic data were analyzed and it was determined that the re-entry nurse group generally reflected the profile of inactive nurses found in the literature. The respondents in the nurse educator and nurse administrator groups provided varied educational and professional backgrounds on which to base their responses.

The central hypothesis of this study was to determine if there were differences in the perceptions of nurses who want to return to the profession and the perceptions of nurse educators and nurse administrators when considering the needs of re-entry nurses. A secondary purpose was to determine if there were differences between the perceptions of nurses interested in re-entry and those not interested in re-entry in their perceptions of the barriers to re-entry. Additional objectives of the investigation sought to determine: (1) if differences exist among the different age groups of the nurses and their perceptions of barriers to re-entry, and the nurses' basic education and their perceptions of specific knowledge and skills important for re-entry; (2) what factors are most influential in the nurse's decision to re-enter the profession; and, (3) is there a relationship between the nurse educator/administrators' experiences with re-entry nurses and their perceptions of the barriers and knowledge

and skills important for re-entry?

These objectives were achieved through an analysis of the responses to the survey instrument, the Re-Entry Nurse Questionnaire. Findings generated from the statistical analyses were presented within the chapter and illustrated in Tables 1-25 and are summarized under the headings used in the questionnaire: (a) barriers to re-entry; (b) knowledge important for re-entry; (c) abilities important to re-entry; (d) factors influencing re-entry; and, (e) ancillary questions.

Barriers to re-entry. An analysis of the data pertaining to the perceptions of barriers to re-entry suggests that:

1. There were significant differences among the perceptions of re-entry nurses, nurse educators and nurse administrators in eight of the 16 items.

2. Nurse educators and nurse administrators, in general, rated the barriers of greater magnitude than did the re-entry nurse group.

Knowledge important for re-entry. An analysis of the data pertaining to the perceptions of knowledge important for re-entry suggests that:

1. There were significant differences among the perceptions of re-entry nurses, nurse educators and nurse administrators in three of the 12 items.

2. The re-entry nurse group, in general, considered the knowledge to be more important than did

the nurse educator and nurse administrator groups.

Abilities important for re-entry. An analysis of the data pertaining to the perceptions of abilities important for re-entry suggests that:

1. There were significant differences among the perceptions of re-entry nurses, nurse educators and nurse administrators in eight of the 13 abilities.

2. Nurse educators rated three specific abilities as more important than the re-entry nurse group and the nurse administrator group.

3. Nurse administrators rated one ability more important than re-entry nurses and the nurse educator group.

Factors influential in re-entry. An analysis of the data pertaining to the factors most influential in the nurse's decision to return to nursing suggests that:

1. No one factor emerged as most influential in the nurse's decision to return.

2. The factors ranked highest by re-entry nurses were "loss of spouse" and "need to be productive outside the home."

Ancillary questions. An analysis of the data suggests that:

1. There were no significant differences among the age groups of re-entry nurses and their perceptions of the barriers to re-entry.

2. There were no significant differences among

the basic education of re-entry nurses and their perceptions of the knowledge and skills important for re-entry.

3. Correlation analyses between the experiences of nurse educators and nurse administrators and perceived barriers, and knowledge and skills revealed a number of statistically significant coefficients in all three areas, despite the small obtained values.

Chapter 5 includes summary, conclusions and recommendations.

Chapter 5

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

SUMMARY OF THE STUDY

It has been established that there is a need for nurses across the country and that inactive nurses are a potential resource to meet this need. However, there is an obvious lack of resources available to assist inactive nurses to return to school or work. For this reason, it is important that the nursing community direct its attention to the development of programs that will facilitate nurses' re-entry into the profession. The central problem of this investigation deals with perceptual differences among re-entry nurses, nurse educators, and nurse administrators related to the needs of re-entry nurses. There is evidence to suggest that re-entry programs developed in the past focused on the needs of hospitals rather than the needs of nurses, which in turn limited program effectiveness in terms of motivating nurses for re-entry. Therefore, the perceptions of re-entry nurses, as well as the perceptions of nurse educators and nurse administrators who are responsible for developing these programs must be analyzed to insure the relevance and effectiveness of future programs.

To test the premise that perceptual differences exist among re-entry nurses, nurse educators and nurse administrators when considering the needs of re-entry nurses, three research hypotheses were derived from this central hypothesis. These hypotheses focused on perceptions of the barriers to re-entry, knowledge and skills important for re-entry, and barriers perceived by non-interested nurses.

Ancillary aspects of the study investigated the group differences within the re-entry nurse group relative to age and perceived barriers to re-entry; basic education and perceived knowledge and skills; and factors influencing re-entry. Additionally, the study sought to identify relationships between the nurse educator/administrators' experiences with re-entry nurses and their perceptions of barriers, and knowledge and skills important for re-entry.

CONCLUSIONS

Analyzed in the preceding chapter were the responses of re-entry nurses, nurse educators, and nurse administrators when considering the needs of re-entry nurses. Conclusions resulting from the analysis and interpretation of the data are presented under these headings: (a) null hypotheses, (b) ancillary questions, and (c) general observations.

Null Hypotheses

Hypothesis 1. There are no significant differences among re-entry nurses, nurse educators, and nurse administrators in their perceptions of the barriers to re-entry.

In considering the barriers to re-entry, the rejection of the null hypothesis indicates that significant differences were found among re-entry nurses, nurse educators and nurse administrators in their perceptions of eight of the barriers to re-entry. These included: lack of self-confidence, outdated theory, geographical location of facility, lack of satisfaction as a nurse, availability of re-entry programs, lack of support from employed nurses, cultural values, and lack of financial assistance.

Barriers to re-entry. Although each of the three groups placed the barriers to re-entry in a different rank order, there were no significant differences between nurse educators and nurse administrators in their perceptions of the barriers to re-entry.

In general, both nurse educator and nurse administrator groups considered all of the eight significantly different barriers to be of greater magnitude than did the re-entry nurse group, with two exceptions. Those barriers were "geographic location of the facility" and "cultural values." Only the nurse administrator group perceived "geographic location" to be a greater barrier than did the re-entry nurses. In addition, the nurse educator group considered "cultural values" to be a greater barrier than

either the re-entry nurses or nurse administrator group. Discussion regarding each of the eight barriers indicating significant differences follows.

Lack of self-confidence. This barrier was rated as a "great barrier" and was ranked highest by the nurse educator and nurse administrator groups; however, the re-entry group considered it less of a barrier and ranked it fourth. Kramer's work with neophyte nurses has implications in this area. She theorized that the phrase "lack of self-confidence" frequently masked the nurse's underlying problem, which was a "lack of interpersonal competency." According to Kramer, the nurse is perceived by others as lacking self-confidence when, in fact, she is attempting to cope with a situation that is governed by a different set of values and she is unable to understand or predict why things are happening as they are.[1] This seems most applicable for the re-entry nurse who lacks current knowledge and technical skills and is not fully cognizant of the changes within the health care delivery system.

Outdated knowledge. This barrier was ranked first by the re-entry nurse group although it was rated as a "moderate barrier." It was ranked second by both nurse educator and nurse administrator groups, who rated it as a "great

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[1]Marlene Kramer, Reality Shock (St. Louis: C. V. Mosby, 1979), p. 29.

barrier." The data suggest that although all three groups recognize the implications of the knowledge explosion in the health care field for the nurse returning to the profession, the nurse educators and administrators may have a clearer perception of the expanding role of the nurse. This finding is supported by Abruzzese, who emphasized that it is no longer acceptable to focus on the treatments and procedures of the acutely ill. The nurse must have knowledge of physics, chemistry, anatomy and physiology, in addition to people skills and technical competence.[2] Marram goes on to say that content changes so rapidly that an absence of two years makes much pharmacological and technological knowledge obsolete.[3]

Geographic location of the facility. This barrier was rated as "moderate" by nurse administrators. However, re-entry nurses did not consider it a barrier at all. Significant differences were found only between nurse administrator and re-entry nurse groups. The discrepancy between the responses of the two groups may be reflective of a "reason for withdrawal" from the work-force rather than a barrier to re-entry. Findings reveal that "moving"

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[2]Roberta Abruzzese, "Role Change LPN to ADN," Coping with Change through Assessment and Education (New York: National League for Nursing, 1976), pp. 90-93.

[3]Gwen Marram, Margaret Schlegel and Em O. Bevis, Primary Nursing: A Model for Individualized Care (St. Louis: C. V. Mosby, 1974), p. 30

was the reason most frequently given by the re-entry nurse group for withdrawing from the work force initially. This finding is supported by the literature which indicated that approximately five percent of the nurse population moves annually.[4]

Lack of satisfaction. This item was considered more of a barrier to re-entry by nurse educators and nurse administrators than by the re-entry nurses. The low ranking given to this barrier by re-entry nurses is consistent with the results of a recent study commissioned in response to the nursing shortage, which revealed that only 13 percent of the 300 unemployed nurses who responded were dissatisfied with nursing as a career. In addition, the respondents ranked this item as twelfth on a list of 15 dissatisfiers.[5] This evidence contradicts the work of Slavitt and others, who support the premise that there is a relationship between withdrawal from the work place and satisfaction. In view of the amount of literature that

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[4]Evelyn Moses and Aleda Roth, "Nurse Power, What do Statistics Reveal about the Nation's Nurses?" American Journal of Nursing, LXXIX (October, 1979), 1745-1755.

[5]Maria D. Canfield, ed., A Study of Registered Nurses and Licensed Vocational Nurses in the San Joaquin Valley, San Joaquin Valley Health Consortium, (September, 1979), p. 76.

[6]Dinah Slavitt, and others, "Nurses' Satisfaction with Their Work Situation," Nursing Research, XXVII (March-April, 1978), 114-120.

supports the perceptions of the nurse educators and nurse administrators, it might be speculated that after a period of time the re-entry nurses remember the positive aspects of their employment more clearly than the negative.

Availability of re-entry nurse programs. Although this item was placed in approximately the same rank order by all three groups, the re-entry group ascribed considerably less value to it than did the other two groups. The variability apparent within the re-entry group reflects the responses of those nurses who are not interested in re-entry and have a tendency to see availability of re-entry programs as "not a barrier." The responses of the nurse educators and nurse administrators were consistent with the literature which indicated that the development of refresher programs has been sporadic, generally in times of great need and have ceased to exist as soon as the need was met.

Lack of support from employed nurses. This barrier was rated as less of a barrier by re-entry nurses than by nurse educators and nurse administrators. These findings are not consistent with the literature which described the lack of support in both school and work.[7,8] Benner found

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[7]Marilyn F. Jackson, "Factors Affecting the RN's Decision to Enter a Second Step Programme," Researching Second Step Education, Vol. 2, ed. K. L. Jako (Rohnert Park: Sonoma State University, 1981), pp. 79-80.

[8]Jeanne Greenleaf, "Out of the Woodwork onto the

this same lack of support with new graduates. She referred to employed nurses as being reluctant and unprepared to offer sponsorship to the new graduates because of their own limited tenure and limited familiarity with the organization due to high turnover and temporary staffing.[9] While not indicated in the literature, it is conjectured that the technical vs. professional conflict may play a part in this barrier. This is the result of re-entry nurses, in general, having been educated in two- and three-year schools, "technical programs," while many younger, employed nurses are baccalaureate graduates from "professional programs."

Cultural values. There were significant differences in the perceptions of "cultural values" among the three groups. While nurse educators rated this item as a "slight barrier" and ranked it fourteenth, nurse administrators and re-entry nurses placed "cultural values" as last in the rank order and considered it "not a barrier." It is conjectured that the low value ascribed to this item by all groups may be the result of lack of understanding the item on the part of the respondents or the lack of recognition as to how these cultural values implicitly and explicitly affect nurses' roles and responsibilities at

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Floor," American Journal of Nursing, LXVIII (July, 1968), 1462-64.

[9]Patricia Benner and Richard Benner, The New Nurse's Work Entry: A Troubled Sponsorship (New York: The Tiresias Press, 1979), p. 17.

home or at work.[10] The literature is quite clear that nurses, and especially re-entry nurses, have adhered to the traditional role of women.[11] The uniformly low ranking of this item by all groups suggests there is a need within the nursing community to explore this area of cultural values as it relates to the status of nursing within the health care system. Nurses must become more aware of the social mores and folkways about women and refuse to reinforce the system by playing these roles.[12]

Lack of financial assistance. This barrier related specifically to re-entry into school and was considered of greater magnitude by nurse educators and nurse administrators than by re-entry nurses. The data reveal that the majority of the re-entry nurse group is not currently enrolled in school. Therefore, it might be speculated that this would not be considered a barrier by this group. In addition, the specificity of the item may have affected the rating of "moderate barrier" ascribed by the nurse educator and nurse administrator groups. The literature has revealed that insufficient funds have been an

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[10]Rose Marie Roach, "Honey Won't You Please Stay Home," Personnel and Guidance Journal, LV (October, 1976), 86-89.

[11]Joann Ashley, Hospitals, Paternalism and the Role of the Nurse (New York: Teachers College Press, 1976).

[12]Marram, op. cit., p. 34.

obstacle in the development of re-entry programs for some time and continues to be a problem, especially for nurses who want to return to school.[13]

Hypothesis 2. There are no significant differences among re-entry nurses, nurse educators and nurse administrators in their perceptions of specific knowledge and skills important for re-entry.

In considering the knowledge and skills important for re-entry, the rejection of the null hypothesis indicates that significant differences were found among re-entry nurses, nurse educators and nurse administrators in their perceptions of three specific knowledges and eight abilities or skills. The knowledge areas were "laboratory findings," "modes of therapy" and "role of nursing research in patient care." Abilities indicating significant differences among the three groups were: "problem solving," "taking a nursing history," "administering medications," "performing emergency procedures," "using technological equipment," "developing nursing care plans," "administering I.V. therapy" and "using interpersonal communication skills."

Knowledge important for re-entry. In the area of knowledge, the findings indicate that the re-entry nurse group, in general, considered these factors to be more important than the nurse educator and nurse administrator groups. An exception was the area of legal aspects of nursing which

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[13]Jackson, op. cit., p. 86.

nurse educators and administrators viewed as more important.

Among the areas of knowledge, three items were placed in the same rank order by all three groups. "Drug interactions" were ranked highest in importance. "Changes in the health care system" ranked fourth and the "role of nursing research" was ranked last. Discussion of the significantly different areas of knowledge follows.

Laboratory findings. All groups rated this knowledge as being of "great importance." However, it was the second highest ranked item for re-entry nurses and third for nurse administrators, while nurse educators placed it sixth in rank order. These findings reflect the experiential background of the majority of the re-entry nurses and nurse administrators, which is the acute care setting. This setting emphasizes the importance of objective as well as subjective data in planning direct patient care. It is conjectured that the low ranking of this item by nurse educators may be a subtle reflection of the different expectations between nurse educators and nurse administrators relative to nursing practice discussed by Benner.[14]

Modes of therapy. The re-entry nurses rated this factor more important than either of the other two groups and

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[14]Benner, op. cit., p. 18.

ranked it higher as well. It might be surmised that the re-entry nurses perceived themselves as the care givers and since they were less familiar with new modes of therapy, this was considered a knowledge of "great importance." This is consistent with the literature which revealed that 67 percent of the employed nurses who give direct patient care routinely sustain and support persons who are impaired or ill during programs of diagnosis or therapy.[15] Further review of the data suggests that the baccalaureate graduate considered this factor more important than the associate degree or diploma graduates.

Nursing research. All three groups ranked nursing research last. However, the re-entry nurses ascribed a higher value to it than did the other two groups. The low rank given this factor by nurse educators and nurse administrators reflects the value placed on nursing research within the nursing community. The data also reveal that there was a wider spread of scores within each group, relative to the role of nursing research, which suggests a greater variety of responses in this area and may be indicative of changing attitudes within the profession.

It is noteworthy that the highest factors in the rank order of areas of knowledge as perceived by the re-entry nurse group pertain to direct patient care. While there were no significant differences between the groups,

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[15] Moses and Roth, op. cit., p. 1753.

it is speculated that the higher ranking of "legal aspects of nursing" by the nurse educator and nurse administrator groups may be attributed to the importance of this item from their experience as educators and administrators.

In general, these findings indicate that while nurse educators and nurse administrators placed the specific areas of knowledge in different rank order, there were no significant differences between these two groups.

Abilities important for re-entry. In the area of abilities important for re-entry, the data suggest that all of these abilities were rated as of "great importance" or "important" by re-entry nurses.

Each of the groups ranked the abilities in a different order with the exception of "recognizing limitations and verbalizing learning needs." This item was ranked third by all groups and rated as most important. Findings reveal that nurse educator and nurse administrator groups considered three abilities significantly more important than did the re-entry nurse group. These items included "problem-solving," "taking a nursing history," and "communication skills (interpersonal)." Two abilities were rated significantly higher by re-entry nurses. These included "administering medications" and "use of technological equipment. Discussion follows regarding the abilities that were significantly different among the groups.

Problem-solving. This ability was rated significantly higher by nurse educators than by re-entry nurses and nurse administrators. In addition, nurse educators ranked it first, while nurse administrators and re-entry nurses ranked it fifth and sixth, respectively. This ranking suggests that nurse educators considered problem-solving central to all other abilities important for re-entry. While this position is defendable, it reflects a more theoretical perspective than the other two groups.

Taking a nursing history. Nurse educators rated this ability as being of "great" importance." However, they placed it ninth in rank order as did nurse administrators who rated it as "important." Re-entry nurses rated it as "moderately important" but ranked it last. It is conjectured that this ability, like physical assessment, is seen as less important by re-entry nurses because these activities have been outside of the purview of nurses up until the last decade. The literature reflects that currently obtaining a nursing history is coming into wide use as a systematic way of collecting data about patients.[16] Research supports this thinking as indicated by the results of a nationwide survey which indicated that 58.9 percent of the nurses giving direct patient care are routinely involved in obtaining a health history.[17]

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[16]Nancy Diekelman and others, Fundamentals of Nursing (New York: McGraw Hill, 1980), p. 50.

[17]Moses and Roth, op. cit., p. 1753.

Administering medications. The data reveal that re-entry nurses and nurse administrators ranked "administering medications" first and all three groups rated it as being of "great importance." These findings are consistent with a national survey of nurses involved in direct patient care, which revealed 84 percent of these nurses routinely administer medications.[18]

Performing emergency procedures. This ability was rated a being of "great importance" to all three groups although re-entry nurses rated it higher and ranked it second as did nurse administrators. Nurse educators placed it fourth in rank order. The importance of this ability is reflected in current practices within the nursing community. Cardiopulmonary rescussitation classes are frequently a job requirement and many continuing education programs also offer classes in emergency procedures. This fact was confirmed by further review of the data which revealed that re-entry nurses who were interested in re-entry after a continuing education course, were more likely to perceive performing emergency skills as important than were other re-entry nurses.

Use of technological equipment. Re-entry nurses rated this item significantly higher than did the other two groups and ranked it fifth, while nurse educators and nurse

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[18] Ibid.

administrators placed in a much lower rank order. Kramer supports the re-entry nurse group's responses as she points out that nurses will continue to be faced with a skill-demanding public. In addition, both patients and physicians tend to describe nurses primarily in terms of manual activities.[19] It might be added that nurses in the work place frequently measure the nursing skill of a peer through observing her ability to use equipment. These responses reflect a technical perspective rather than a professional perspective. This is confirmed by a further review of the data which revealed that nurses graduating from associate degree and diploma programs ascribed a slightly higher value to it than did baccalaureate graduates.

Developing nursing care plans. All three groups rated this item as being of "great importance" although the nurse educators and nurse administrators rated it significantly higher than did re-entry nurses. It was ranked fourth by nurse administrators, while the nurse educators ranked it as seventh and the re-entry nurses ranked it lowest as number eleven. It is surmised that the variation in responses relative to "developing and evaluating nursing care plans" reflects the experiential background of the nurses. For example, nurse administrators view care plans as most important since this area has become increasingly significant as nurses are held accountable for their interventions.

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[19] Kramer, op. cit., p. 222.

Nurse educators, on the other hand, perceive care planning as only one facet of the problem-solving process which they perceive as most important. Re-entry nurses' perceptions of developing nursing care plans no doubt reflect the extensive care plans termed "busy work" that were required as students as well as the difficulty they experienced as practicing nurses in trying to maintain current care plans for their assigned patients. The literature supports the position of the nurse administrators and nurse educators and indicates that nursing care planning is emerging as necessary to nursing's professional integrity rather than busy work done at the demand of others.[20]

Administering I.V. therapy. This ability was rated as "important" by re-entry nurses and nurse educators and they ranked it fourth and tenth, respectively. The re-entry nurses' responses relative to this ability may reflect a lack of knowledge about I.V. nurses, employed in most hospitals specifically to administer intravenous therapy. A review of the data indicates that associate degree graduates saw this slightly more important than did diploma and baccalaureate graduates.

Communication skills (interpersonal). Nurse educators rated this ability as being of "great" importance and

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[20]Ann Marriner, ed., Current Perspectives in Nursing Management, (St. Louis; C. V. Mosby, 1979), pp. 34-47.

ranked it fifth. Nurse administrators ranked it seventh and rated it slightly lower. The re-entry nurse group ascribed a much lower rank to this ability. However, the rating was comparable to the nurse administrator group. The literature reflects that there has been an increasing emphasis on communication skills in the past twenty years, which is a reflection of the increased emphasis on the psycho-social aspects of nursing care. It might be conjectured that the re-entry nurses perceive communication skills as less important because of the time period in which they were socialized into the profession. Another consideration is that, as mature women, they feel this is an area for which they are better prepared for re-entry.

Hypothesis 3. There are no significant differences between nurses who are interested in re-entry and those who are not interested in returning to the profession in their perceptions of the barriers to re-entry.

In considering the barriers to re-entry, the acceptance of the null hypothesis indicates that no significant differences were found between nurses who were interested in re-entry and those who were not interested in their perception of the barriers to re-entry. In general, the findings reveal nurses not interested in return considered all the barriers to be of less magnitude than did the nurses interested in re-entry. However, these differences were not statistically significant.

The data reveal that home/family responsibilities were the primary reason respondents gave for non-interest

in returning to the profession. Additionally, the results indicated ten percent of this non-interested group gave reasons relative to lack of self-confidence or lack of preparation. Although the number of respondents that referred to continuing education costs as a reason was negligible, the data suggest that these costs may be a barrier for some nurses considering re-entry.

The data indicate the difference for only one barrier was statistically significant and suggest that nurses who are not interested in re-entry perceived the "availability of re-entry programs" less of a barrier than did nurses who are interested in re-entry. It is speculated that these nurses are not looking for such programs and, therefore, are less aware of their availability.

Ancillary Questions

Ancillary Question 1. What perceptual differences exist among age groups of the nurse and the perceived barriers to re-entry?

The data reveal significant differences between age and perceived barriers to re-entry in only two items and no significant differences in the other 14 barriers.

The data suggest that nurses between the ages of 25-44 saw"home/family responsibilities"more of a barrier than nurses 45 years and older. On the other hand,"physical capabilities"were generally seen as more of a barrier to nurses 45 and older, while the data suggest that nurses under 44 did not see this as a barrier at all.

The data also reveal that younger nurses saw the barriers fairly evenly distributed in the continuum of "great barrier" to "not a barrier," while the older aged groups rated the barriers more consistently as "moderate" or "slight barriers." These findings are consistent with the results of Jackson's study with students in second step nursing programs. She found that as the age and work experience of the nurse increased, the number of barriers to overcome also increased.[21]

Ancillary Question 2. What differences exist among the nurses' educational backgrounds and the specific knowledge and skills important for re-entry?

The findings reveal no significant differences among re-entry nurses from three different types of educational backgrounds, and their perceptions of specific knowledge and skills important for re-entry. The data suggest there was a tendency for baccalaureate graduates to rate the knowledge and abilities (skills) as more important than either associate degree or diploma graduates.

Ancillary Question 3. What factors emerge as the most influential in the nurse's decision to re-enter the profession?

The data suggest that the re-entry nurses found no one factor as the most influential in their decision to return. Of the factors provided, the findings indicate that while the "loss of a spouse" was ranked highest among the factors influential in the re-entry nurse's

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[21]Jackson, op. cit., p. 88.

decision to return, it was rated only slightly above the factor "need to be productive outside the home."

Further, the data suggest that there may have been some ambiguity to the factor "loss of a spouse," which affected the response patterns of some re-entry nurses. In addition, the item assumed the specific marital status of the respondent, which also would have affected responses.

The data also suggest that personal reasons are more influential in the decision to return than other factors and perhaps most interesting is the finding that the need for nurses is least influential in motivating nurses to return to the profession.

Ancillary Question 4. What is the correlation between the educator/administrators' experiences with re-entry nurses in the past five years and their perceptions of the barriers and the knowledge and skills important for re-entry?

The data reveal significant relationships between the experiences of nurse educators/administrators and barriers to re-entry and knowledge and skills important for re-entry. Although these values were low, the data suggest that, in general, nurse educators and nurse administrators, with a variety of experiences, considered a larger number of items to be barriers than nurse educators/administrators who had not had a variety of experiences with re-entry nurses. This was particularly evident with the barrier "lack of self-confidence." The data further

suggest that there is a tendency for nurse educators/administrators, who have had experiences with re-entry nurses, to rate more knowledge and abilities as less important than nurse educators/administrators who have fewer experiences with re-entry nurses.

General Observations

Based on the findings of this study, it is concluded that nurse educators and nurse administrators consistently perceived the barriers to re-entry to be of greater magnitude than did re-entry nurses. In all of the barriers, the nurse educators/administrators' ratings were equal to or higher than those of the re-entry nurses. The data further suggest that although the re-entry nurses did not perceive any of the items as being "great barriers," there are a number of barriers which are closely related and, when combined, have prevented them from returning to the profession.

In general, all knowledge areas important for re-entry were ranked by re-entry nurses as equal to or more important than the nurse educator/administrator groups. In the area of abilities, re-entry nurses rated seven of the 13 abilities as equal to or more important than did the nurse educator/administrator groups.

An analysis of the composite ratings of barriers, knowledge and abilities (skills) revealed that the three groups rated four barriers as "great," 13 "moderate,"

25 "slight" and six "not a barrier." Of the areas of knowledge and abilities (skills), 46 factors were rated to be of "great importance" and 29 were rated "important." No area of knowledge or ability was rated less than "important."

Thus, it is concluded that there are differences among re-entry nurses, nurse educators and nurse administrators in their perceptions of the needs of re-entry nurses.

A corollary to that conclusion is that, in general, re-entry nurses, regardless of educational background, perceive the knowledge and skills that reflect the technical level of practice as more important than those areas focusing on the professional level of nursing care. This is important for nurse educators and nurse administrators to know in developing programs that will meet the needs of re-entry nurses and still prepare them for the changes within today's health care delivery system.

Another conclusion of the study is that inactive nurses who are not interested in re-entry perceive the barriers to re-entry no differently than nurses who are interested in returning to the profession. In general, home and family are the major reasons given for the nurses being inactive, although there are a variety of reasons that prevent them from returning to active status in nursing. In addition, the study found there is no one factor that is most influential in the nurses' decision

to return to nursing. However, this decision is more likely to be based on personal motivations than on professional motivations such as the nursing shortage.

Finally, it may be concluded that, in general, the perceptions of the nurse educators and nurse administrators were similar throughout the study, despite the fact that there were statistically significant differences between the two groups in three areas. This finding suggests that the difference in perceptions among the three groups may reflect activity status in nursing as opposed to roles. Thus nurse educators and administrators, by virtue of being active in the profession may have a different perspective than that of nurses who are not actively involved.

RECOMMENDATIONS

The following recommendations are based upon the review of the literature and the findings of the study. A review of the literature has revealed that there is an increasing demand for nurses and that more nurses are leaving nursing than are returning. Yet the profession has continued to introduce obstacles to nurses and has done little to establish programs within the profession to assist the inactive nurse in re-entry. It also has been determined that nurse educators and nurse administrators must work collaboratively in the development of these programs. In addition, this study has identified

that perceptual differences exist among re-entry nurses and nurse educators and administrators, therefore, it is essential that input from re-entry nurses be considered in this program development. Further, it has been theorized that without input from re-entry nurses, differences in perceptions among these three groups may impede the planning and limit program effectiveness. For example, if nurse educators and nurse administrators who are active in the field are not aware of what inactive nurses perceive as important for re-entry, they may design programs that the nurses feel are not relevant to their needs. In addition, a lack of awareness of the values and goals of the re-entry nurses may result in added barriers to re-entry. Based on these considerations, the following recommendations are made.

Nursing Education

1. Nurse educators and nurse administrators must cooperatively plan and evaluate programs for re-entry nurses. The program format and content included must be based on the knowledge of the needs of re-entry nurses, therefore, these nurses must be involved in the planning and evaluation of these programs. Through this process of mutual program planning, priorities can be established and discrepancies in perceptions can be minimized.

2. To insure the continuing existence of re-entry programs, they must be made part of the permanent nursing

education structure. These programs would provide continuing education for inactive nurses and opportunities for self-evaluation and career counseling. This kind of system could also provide a network for inactive nurses within the community and enable them to maintain continued involvement within the profession thus remaining potentially active as opposed to inactive.

Nursing Service

1. The American Nurses' Association must officially take a position that recognizes the interrupted career pattern of women in nursing as legitimate and encourage the recuitment of inactive nurses back into the profession. Only through this type of professional sanction will the nursing community recognize the re-entry nurse as a potential source of manpower and develop resources at the local level to facilitate re-entry.

2. Nursing administrators must direct efforts toward providing opportunities for personal and professional growth along with increasing salaries and benefits to enhance recruitment of re-entry nurses. In addition, information should be provided to re-entry nurses after the decision has been made to re-enter and before they begin work or school. Research has proven that information specific to policies, philosophy, and objectives, provided to employees at this time helps to insure satisfaction

and retention after employemnt or enrollment.[22]

3. Joint planning by nurse educators and nurse administrators is needed to develop mentor programs. Such programs would provide a mentor for each re-entry nurse thus facilitating interactions between employed nurses and re-entry nurses. In addition, this type of program would increase understanding and provide support for re-entry nurses. Since most working nurses today are married, this type of program would also provide re-entry nurses with role models who are successfully managing their multiple roles.

4. Nurse administrators must consult re-entry nurses regarding selected personnel policies, flexible patterns in work schedules and the provision of support services such as child care. This does not mean that policies would be designed according to re-entry nurses expectations, however, this kind of cooperative planning provides a firm foundation on which to launch innovative programs that will be mutually beneficial.

5. The professional nursing organizations must encourage the development of manpower planning strategies designed to take advantage of the constant flow of nurses in and out of the profession. Such planning might involve an intermittent contractual design where the nurses work

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[22]Daniel Ilgen and William Seely, "Realistic Expectations as an Aid in Reducing Voluntary Resignations," Journal of Applied Psychology, LIX, No. 4, (1974), 452-455.

for a predetermined period of years and then are inactive for a comparable number of years, before returning to active nursing. This would insure a relatively constant staff and yet enable nurses to pursue personal interests without sacrificing time, benefits and credibility.

Future Research

It is recommended that additional research be conducted to:

(1) evaluate the self-confidence level of nurses who have returned to nursing using an ethnographic approach;

(2) further investigate the perceptual differences between nurse educators and nurse administrators in situations that provide opportunity for role exchanges.

(3) replicate the study to compare perceptual differences between inactive nurses and employed nurses;

(4) develop a pilot study for a permanent re-entry program established within the present educational structure and;

(5) analyze the viability of an intermittent contractual agreement for nursing manpower planning.

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APPENDIX A

COVER LETTERS AND

RE-ENTRY NURSE QUESTIONNAIRES

UNIVERSITY OF THE PACIFIC

SCHOOL OF EDUCATION Stockton, California Founded 1851
95211

DEPARTMENT OF
EDUCATIONAL ADMINISTRATION

October 1, 1979

As you know, recent projections within the health care system indicate an increased need for registered nurses. To meet this need, I am most interested in helping nurses who are inactive and want to return to the profession. Through your participation in continuing education you have demonstrated an investment in the future of nursing, for this reason I am inviting your assistance in this undertaking.

The enclosed questionnaire is part of my doctoral study designed to identify the needs of "re-entry nurses." For purposes of this research, the "re-entry nurse" has been defined as the nurse, licensed in California, who is not employed in nursing and who wants to return to work in the health care field. More data are needed from nurses who are inactive to appropriately define the needs of the re-entry nurse.

Your assistance in this study is vital, for your personal experience in nursing will contribute significantly to identifying the needs of these nurses. In addition, your participation will insure input to the nursing community in the planning of future programs and practices for re-entry nurses.

I hope that you can take a few minutes of your time to complete the enclosed questionnaire. The responses to the questions will be considered confidential and at no time will individuals be identified as participants. A self-addressed, stamped envelope has been enclosed for your convenience and I would appreciate your response by October 15, 1979. I will be happy to send you a summary of the questionnaire results at your request.

Thank you for your time and interest in furthering our understanding of the nursing profession.

Sincerely yours,

Jean P. Ruxton

Jean P. Ruxton, R.N., M.S.
Doctoral Candidate

RE-ENTRY NURSE QUESTIONNAIRE

Please encircle the one number that best represents your answer from the options provided or fill in the response as indicated.

BIOGRAPHY

1. YOUR AGE
   (1) 21-24 years
   (2) 25-44 years
   (3) 45-64 years
   (4) over 65 years

2. YOUR FAMILY STATUS
   (1) married
   (2) single
   (3) divorced/separated
   (4) widowed
   (5) other, specify
   _____

3. ANNUAL FAMILY INCOME
   (1) less than $10,000
   (2) $10,000-$20,999
   (3) $21,000-$31,000
   (4) over $31,000

4. NUMBER OF CHILDREN
   (1) none
   (2) 1-3
   (3) 4 or more

5. AGE OF YOUNGEST CHILD
   (1) no children
   (2) 0-5 years
   (3) 6-12 years
   (4) 13-19 years
   (5) over 20 years

6. NUMBER OF DEPENDENTS FOR WHOM YOU ARE THE MAIN SOURCE OF SUPPORT
   (1) none
   (2) 1-3
   (3) 4 or more

PART I

The following items have been identified as "barriers to re-entry." Please rate each item as to how much of a barrier you perceive it to be for a nurse who wants to return to work in the nursing profession.

BARRIERS TO RE-ENTRY	GREAT BARRIER	SLIGHT BARRIER	NOT A BARRIER
1. lack of self confidence	_____	_____	_____
2. home/family responsibilities	_____	_____	_____
3. limited job opportunities	_____	_____	_____
4. physical capabilities	_____	_____	_____
5. outdated knowledge of nursing theory	_____	_____	_____
6. lack of technical skills	_____	_____	_____
7. inflexible personnel policies (i.e., staffing, promotion)	_____	_____	_____

BARRIERS TO RE-ENTRY	GREAT BARRIER	SLIGHT BARRIER	NOT A BARRIER
8. inadequate salary/benefits	_____	_____	_____
9. inability to "effect change" in the system	_____	_____	_____
10. geographic location of facility	_____	_____	_____
11. lack of satisfaction from working as a nurse	_____	_____	_____
12. availability of re-entry or refresher programs	_____	_____	_____
13. lack of support from employed nurses	_____	_____	_____
14. lack of financial motivation	_____	_____	_____
15. cultural values regarding "woman's place"	_____	_____	_____
16. lack of financial assistance (scholarships, loans, etc.)	_____	_____	_____
17. other, please specify _____	_____	_____	_____

Of the following alternatives, please encircle the one number that best describes your position.

(1) I am interested in re-entry nursing
(2) I am not interested in re-entry nursing

If your response to the above is (1), please go on to Part II. If your response is (2), please explain the reason and return the questionnaire in the stamped envelope provided.

_____

_____

Thank you for your time and interest.

PART II

The following lists of specific knowledge areas and skills have been identified as important for nurses to know. Please rate each item as to your perception of its importance.

How important is it for the re-entry nurse to HAVE KNOWLEDGE OF:	OF GREAT IMPORTANCE	IMPORTANT	NOT IMPORTANT
1. changes within the health care system	_____	_____	_____
2. legal aspects of nursing	_____	_____	_____
3. relationship of laboratory findings to patient's physical status	_____	_____	_____
4. effects of drug interactions	_____	_____	_____
5. recent modes of therapy (e.g., chemotherapy, radiation, acupuncture)	_____	_____	_____
6. health care costs	_____	_____	_____
7. role of nursing research in patient care	_____	_____	_____
8. principles of organization and time management	_____	_____	_____
9. alternatives in patient care management (e.g., primary care, team nursing)	_____	_____	_____
10. nutritional needs of patients	_____	_____	_____
11. pathophysiology underlying patient's condition	_____	_____	_____
12. psychological/social and cultural aspects of patient care	_____	_____	_____
13. other, please specify _____	_____	_____	_____

How important is it for the re-entry nurse to HAVE THE ABILITY TO:	OF GREAT IMPORTANCE	IMPORTANT	NOT IMPORTANT
14. use the problem-solving process in patient care situations	_____	_____	_____
15. take a nursing history	_____	_____	_____
16. perform a physical assessment (e.g., head, chest)	_____	_____	_____

HAVE THE ABILITY TO:	OF GREAT IMPORTANCE	IMPORTANT	NOT IMPORTANT
17. administer medications and recognize side effects (e.g., I.V., I.M., oral)	_____	_____	_____
18. perform basic nursing skills (e.g., bed, bath, treatments)	_____	_____	_____
19. perform emergency nursing procedures (e.g., C.P.R., Heimlich maneuver, transporting)	_____	_____	_____
20. teach patients and family	_____	_____	_____
21. use technological equipment (e.g., ventilators, cardiac monitor)	_____	_____	_____
22. develop and evaluate nursing care plans	_____	_____	_____
23. administer I.V. therapy (e.g., venapuncture, calculate, regulate and remove)	_____	_____	_____
24. recognize limitations and verbalize own learning needs	_____	_____	_____
25. use communication skills (e.g., technical, records/ reports)	_____	_____	_____
26. use communication skills (e.g., interpersonal, interview)	_____	_____	_____
27. other, please specify _____	_____	_____	_____

PART III

The last section requests additional information that will enable comparisons to be made among the re-entry nurses included in the study as to their educational backgrounds and career patterns. Please encircle the one number that best represents your answer from the options provided or fill the response as indicated.

EDUCATION

1. What was your basic education in nursing?

   (1) Associate Degree
   (2) Diploma
   (3) Baccalaureate Degree

2. Please indicate the highest level of completed education

   (1) Associate Degree, nursing
   (2) Diploma in nursing
   (3) Baccalaureate Degree, nursing
   (4) Baccalaureate Degree, other field
   (5) Master's Degree, nursing
   (6) Master's Degree, other field
   (7) Other, please specify _____

3. Are you currently enrolled in a formal education program?

   (1) not at this time
   (2) yes, full time student
   (3) yes, part time student

4. What degree are your pursuing? _____

5. What is your major? _____

CAREER PATTERN

6. How long have you actively worked as a nurse?

   (1) less than one year
   (2) 1-10 years
   (3) 11-19 years
   (4) 20 years or more

7. How many jobs have you held as a registered nurse?

   (1) 1-3
   (2) 4-6
   (3) 7-10

8. In what setting were you employed longest?

   (1) acute hospital
   (2) long-term care facility
   (3) psychiatric hospital
   (4) ambulatory care setting
   (5) community setting
   (6) school of nursing
   (7) other, please specify _____

9. What is the title that best describes the last position that you held before you left nursing?

   (1) staff nurse
   (2) team leader
   (3) charge nurse
   (4) asst. head nurse
   (5) head nurse
   (6) supervisor
   (7) nursing instructor
   (8) public health nurse
   (9) office nurse
   (10) other, please specify _____

10. What was the primary reason for leaving nursing at the time you left? _____

11. Have you ever returned to nursing in the past? Yes___ No____

12. If yes, please state the length of time you worked as a nurse _____

13. What was your reason for leaving? _____

14. How long has it been since you were last employed as a nurse?

    (1) less than two years
    (2) 2-5 years
    (3) 6-9 years
    (4) 10 years or more

15. Please rank the following factors as to the amount of influence each factor would have should you decide to re-enter nursing at this time, #1 being the MOST INFLUENTIAL and #10 being the LEAST INFLUENTIAL factor.

    ___ financial need
    ___ commitment to the profession
    ___ boredom
    ___ personal growth
    ___ need for nurses
    ___ renewed interest after continuing education course
    ___ women's liberation movement
    ___ encouragement from family
    ___ loss of spouse
    ___ need to be productive outside of home/family responsibilities.

16. Numerous incentives are currently being offered to attract nurses to specific health care settings (e.g., salary, benefits). Please list two incentives that you view as the most important in choosing a job.

    (1)_____ (2)_____

Please return the completed questionnaire in the stamped envelope provided.

Thank you for your time and interest.

UNIVERSITY OF THE PACIFIC

SCHOOL OF EDUCATION Stockton, California Founded 1851
95211

DEPARTMENT OF
EDUCATIONAL ADMINISTRATION

October 1, 1979

Dear Nurse Educator:

The enclosed questionnaire is part of my doctoral study designed to identify the needs of "re-entry nurses." For purposes of this research, the "re-entry nurse" has been defined as the nurse, licensed in California, who is not employed in nursing and who wants to return to work in the health care field. The investigation will attempt to identify the needs of this group as perceived by re-entry nurses, nurse educators, and nurse administrators.

The results of the study will enable the nursing community to cooperatively plan and evaluate programs and practices based on the identified needs of re-entry nurses. Your assistance in this study is vital for your personal experience will contribute significantly to identifying the needs of this group from an educator's perspective.

I hope that you can take a few minutes of your time to complete the enclosed questionnaire. The responses to the questions will be considered confidential and at no time will individuals or facilities be identified as participants. A self-addressed, stamped envelope has been enclosed for your convenience and I would appreciate your response by October 15, 1979. I will be happy to send you a summary of the questionnaire results at your request.

Thank you for your time and interest in furthering our understanding of the nursing profession.

Sincerely yours,

Jean P. Ruxton

Jean P. Ruxton, R.N., M.S.
Doctoral Candidate

UNIVERSITY OF THE PACIFIC

SCHOOL OF EDUCATION Stockton, California Founded 1851
95211

DEPARTMENT OF
EDUCATIONAL ADMINISTRATION

October 1, 1979

Dear Nurse Administrator:

The enclosed questionnaire is part of my doctoral study designed to identify the needs of "re-entry nurses." For purposes of this research, the "re-entry nurse" has been defined as the nurse, licensed in California, who is not employed in nursing and who wants to return to work in the health care field. The investigation will attempt to identify the needs of this group as perceived by re-entry nurses, nurse educators, and nurse administrators.

The results of the study will enable the nursing community to cooperatively plan and evaluate programs and practices based on the identified needs of re-entry nurses. Your assistance in this study is vital for your personal experience will contribute significantly to identifying the needs of this group from an administrator's perspective.

I hope that you can take a few minutes of your time to complete the enclosed questionnaire. The responses to the questions will be considered confidential and at no time will individuals or facilities be identified as participants. A self-addressed, stamped envelope has been enclosed for your convenience and I would appreciate your response by October 15, 1979. I will be happy to send you a summary of the questionnaire results at your request.

Thank you for your time and interest in furthering our understanding of the nursing profession.

Sincerely yours,

Jean P. Ruxton

Jean P. Ruxton, R.N., M.S.
Doctoral Candidate

RE-ENTRY NURSE QUESTIONNAIRE

Nurse Educator/Administrator Perspective

PART I

The following items have been identified as "barriers to re-entry." Please rate each item as to how much of a barrier you perceive it to be for the nurse who wants to return to work in nursing.

BARRIERS TO RE-ENTRY	GREAT BARRIER	SLIGHT BARRIER	NOT A BARRIER
1. lack of self confidence			
2. home/family responsibilities			
3. limited job opportunities			
4. physical capabilities			
5. outdated knowledge of nursing theory			
6. lack of technical skills			
7. inflexible personnel policies (i.e., staffing, promotion)			
8. inadequate salary/benefits			
9. inability to effect "change" in the system			
10. geographic location of facility			
11. lack of satisfaction from working as a nurse			
12. availability of re-entry or refresher programs			
13. lack of support from employed nurses			
14. lack of financial motivation			
15. cultural values regarding "woman's place"			
16. lack of financial assistance (scholarships, loans, etc.)			
17. other, please specify _____			

PART II

The following lists of specific knowledge areas and skills have been identified as important for nurses to know. Please rate each item as to your perception of its importance.

How important is it for the re-entry nurse to HAVE THE KNOWLEDGE OF:	OF GREAT IMPORTANCE	IMPORTANT	NOT IMPORTANT
1. changes within the health care system	_____	_____	_____
2. legal aspects of nursing	_____	_____	_____
3. relationship of laboratory findings to patient's physical status	_____	_____	_____
4. effects of drug interactions	_____	_____	_____
5. recent modes of therapy (e.g., chemotherapy, radiation, acupuncture)	_____	_____	_____
6. health care costs	_____	_____	_____
7. role of nursing research in patient care	_____	_____	_____
8. principles of organization and time management	_____	_____	_____
9. alternatives in patient care management (e.g., primary care, team nursing)	_____	_____	_____
10. nutritional needs of patients	_____	_____	_____
11. pathophysiology underlying patient's condition	_____	_____	_____
12. psychological/social and cultural aspects of patient care	_____	_____	_____
13. other, please specify _____	_____	_____	_____

How important is it for the re-entry nurse to HAVE THE ABILITY TO:	OF GREAT IMPORTANCE	IMPORTANT	NOT IMPORTANT
14. use the problem solving process in patient care situations	_____	_____	_____
15. take a nursing history	_____	_____	_____

HAVE THE ABILITY TO:	OF GREAT IMPORTANCE	IMPORTANT	NOT IMPORTANT
16. perform a physical assessment (e.g., head, chest, etc.)	_____	_____	_____
17. administer medications and recognize side effects (e.g., I.V., I.M., oral, etc.)	_____	_____	_____
18. perform basic nursing skills (e.g., bed, bath, treatments)	_____	_____	_____
19. perform emergency nursing procedures (e.g., C.P.R., Heimlich maneuver, transporting)	_____	_____	_____
20. teach patients and family	_____	_____	_____
21. use technological equipment (ventilators, cardiac monitors)	_____	_____	_____
22. develop and evaluate nursing care plans	_____	_____	_____
23. administer I.V. therapy (e.g., venapuncture, calculate, regulate and remove)	_____	_____	_____
24. recognize limitations and verbalize own learning needs	_____	_____	_____
25. use communication skills (e.g. technical-records/reports)	_____	_____	_____
26. use communication skills (e.g. interpersonal-interview)	_____	_____	_____
27. other, please specify _____	_____	_____	_____

PART III

This last section requests additional information that will enable comparisons between the responses of nurse educators and nurse administrators as to present responsibilities, work experiences, and educational backgrounds.

Please encircle the one number that best represents your answer from the options provided or fill in the response as indicated.

1. Employment setting:

   (1) acute hospital
   (2) long-term care facility
   (3) ambulatory care setting
   (4) community health agency
   (5) nurses registry
   (6) in-service/staff development
   (7) continuing education - private enterprise
   (8) continuing education - academic setting
   (9) school of nursing - generic B.S.N. program
   (10) school of nursing - "second step"
   (11) other, please specify _____

2. Educational preparation: please indicate highest level of education you have completed.

   (1) Associate Degree, nursing
   (2) Diploma
   (3) Baccalaureate Degree, nursing
   (4) Baccalaureate Degree, other field
   (5) Master's Degree, nursing
   (6) Master's Degree, other field
   (7) Doctorate, nursing
   (8) Doctorate, other field

3. Current position, please specify _____

4. Length of time in current position:

   (1) less than one year
   (2) 1-5 years
   (3) 6-10 years
   (4) more than 10 years

5. Major area of responsibility:

   (1) administration/supervision
   (2) education
   (3) other, please specify _____

6. Number of registered nurses employed in your facility/enrolled in your program:

   (1) less than 25
   (2) 26-50
   (3) 51-100
   (4) over 100

7. Does your agency hire/enroll registered nurses who have been inactive in nursing for five years or more?

   (1) yes
   (2) no
   (3) if "no" please describe policy _____

   _____

8. What types of experiences have you personally had with re-entry nurses in the past five years? Please check more than one if appropriate.

___ no experience
___ interviewing
___ hiring
___ counseling
___ teaching classes that included re-entry nurses
___ clinical supervision
___ working as a peer in the clinical setting
___ fellow student
___ evaluating performance
___ planning programs (refresher, re-entry)
___ orienting to facility/program
___ personal experience as a re-entry nurse
___ volunteer or community work
___ other, please specify _____

9. How many re-entry nurses have you worked with in any of the above areas in the past five years?

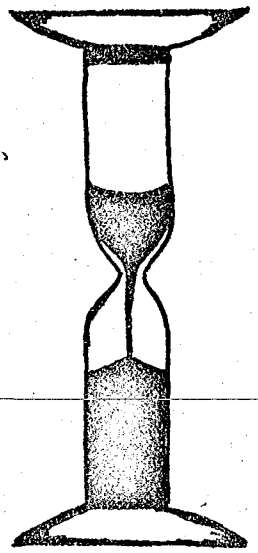
(1) less than 25
(2) 26-50
(3) 51-100
(4) over 100

Please return the completed questionnaire in the stamped envelope provided.

Thank you for your time and interest.

APPENDIX B

FOLLOW-UP CORRESPONDENCE



TIME IS RUNNING OUT AND I NEED YOUR HELP

You recently received a questionnaire in the mail which focused in the needs of RE-ENTRY NURSES. Have you filled it out? If you have, please drop it in the mail today. If you have not yet had a chance to fill it out, please take a few minutes of your time to do so. I'd very much like to include your responses along with those of other nurses from various parts of California who are particpating in this study.

In the event that you did not receive the questionnaire or it has somehow become misplaced, I have enclosed another copy along with a self-addressed envelope for your convenience.

Thanks again for your assistance in this study and your interest in furthering our understanding of the nursing profession.

Sincerely yours,

Jean P. Ruxton

Jean P. Ruxton, R.N., M.S.
Doctoral Candidate,
University of the Pacific

APPENDIX C

LETTER OF INSTRUCTION

TO PANEL OF EXPERTS

UNIVERSITY OF THE PACIFIC

SCHOOL OF EDUCATION Stockton, California Founded 1851
95211

Thank you for assisting me in my doctoral study. The central purpose of this investigation is to identify the needs of re-entry nurses as perceived by re-entry nurses, nurse educators and nurse administrators.

The rationale for the enclosed questionnaire is based on a review of the literature as well as personal experience with nurses who want to return to nursing. The questionnaire is divided into three parts. It includes items that have been identified as barriers to re-entry, and specific knowledge areas and skills described as important for re-entry, as well as demographic data to be collected.

Your task as one of the "panel of experts" is to assist me in validating the instrument by responding to the following questions.

1. Are the barriers to re-entry as identified clear? Are there additional barriers that should be identified? Are there barriers that should be deleted?
2. Are the identified knowledge areas and skills appropriate? Are there others that would be more appropriate considering the varying lengths of time that the re-entry nurses have been inactive? Are there knowledge areas and/or skills that should be deleted because they are too general or too specific?
3. Are there additions or deletions necessary in the demographic section? Are the options appropriate?
4. Are the directions clear? Do you have any suggestions for modification?

If you have any questions please call me at 339-1786. Thanks again for your assistance in this phase of my study. I would appreciate your response by June 15, 1979.

Sincerely yours,

Jean P. Ruxton, R.N.

APPENDIX D

PANEL OF EXPERTS

APPENDIX D

PANEL OF EXPERTS

Cynthia Campbell, R.N., M.S.
Coordinator-Nursing Program
Contra Costa College
San Pablo, California

Jean Hunter, Ph.D., R.N.
Chair, Nursing Department
Holy Names College
Oakland, California

Sharon Iversen, R.N., M.S.
Director, Project Renewal
Continuing Education for Nurses
Oakland, California

Ruth Johnson, R.N.
Director
TriCo Home Health Agency
Melbourne, Florida

Dorothy Merrell, R.N., M.S.
Assistant Administrator, Nursing
Highland General Hospital
Oakland, California

Roger Reimer, Ph.D.
Professor of Education
University of the Pacific

Karen Sanders, R.N., B.S.
Coronary Care Unit
Alta Bates Hospital
Berkeley, California

APPENDIX E

DIRECTIONS FOR FIELD-TEST

PILOT STUDY QUESTIONS

1. Were the directions clear? Suggestions for improvement:

2. Were the questions clear?
   a. Barriers to re-entry: Suggestions for improvement:

   b. Knowledge areas and skills: Suggestions for improvement:

3. Did you have any problems in completing the questionnaire? If yes, please explain and give any suggestions for modification that you might have.

4. Approximately how long did it take you to complete the questionnaire?

Thank you very much for your time and interest in this study.

APPENDIX F

REQUEST FOR RE-TEST OF INSTRUMENT

UNIVERSITY OF THE PACIFIC

SCHOOL OF EDUCATION Stockton, California Founded 1851
95211

June 4, 1979

Dear

Thank you for your participation in the pilot testing of the questionnaire for my doctoral dissertation. Your involvement in this particular phase of development is necessary before I can proceed with the study.

In order to utilize the questionnaire for re-entry nurses it is necessary to determine whether or not it is a reliable instrument. To do this the questionnaire must be given to a sample group at two different times. For this reason, I am requesting that you assist me once again. I would appreciate it if you could take a few minutes of your time to fill out the enclosed questionnaire and return it to me in the stamped, self-addressed envelope as soon as possible.

Although the questionnaire does not apply to some, it is necessary that I send it to all of you since there is no way of identifying those nurses who are employed or those who are not interested in re-entry. Thanks again for your interest and assistance in this endeavor.

Yours truly,

Jean P. Ruxton, R.N.,M.S.
Doctoral Candidate

APPENDIX G

Table 21

APPENDIX G

Table 21

ANOVA Table of "F" Ratios Illustrating Intragroup Differences among Age Groups and Their Perceptions of Barriers to Re-entry

Barriers to Re-entry	Age Groups				F	p
	21-24	25-44	45-64	Over 65		
1. lack of self-confidence	2.0	1.76	1.84	2.11	1.18	.32
2. home/family responsibilities	1.5	1.36	1.99	2.25	27.70	.0000*
3. limited job opportunities	2.0	2.37	2.46	2.30	.77	.51
4. physical capabilities	3.0	2.66	2.34	2.35	6.72	.0002*
5. outdated knowledge of nursing theory	1.5	1.75	1.55	1.90	2.80	.04
6. lack of technical skills	1.0	1.80	1.60	1.74	2.76	.04
7. inflexible personnel policies	2.0	2.02	2.17	2.33	1.51	.21
8. inadequate salary/benefits	2.50	2.39	2.34	2.56	.47	.70
9. inability to effect "change"	2.0	2.31	2.24	2.16	.43	.73
10. geographic location of facility	3.0	2.63	2.49	2.61	1.53	.21
11. lack of satisfaction from working as a nurse	2.0	2.37	2.41	2.63	.85	.46
12. availability of re-entry programs	1.50	2.19	2.18	2.57	1.50	.13
13. lack of support from employed nurses	2.50	2.59	2.54	2.47	.23	.87

APPENDIX G

Table 21--Continued

Barriers to Re-entry	Age Groups				F	p
	21-24	25-44	45-64	Over 65		
14. lack of financial motivation	3.0	2.31	2.30	2.58	1.30	.27
15. cultural values regarding "woman's place"	3.0	2.68	2.77	2.74	.80	.50
16. lack of financial assistance	3.0	2.66	2.54	2.72	1.32	.27

*significant at .01 level.

APPENDIX H

Table 22

APPENDIX H

Table 22

ANOVA Table of "F" Ratios Illustrating Intragroup Differences among the Re-entry Nurses from Different Basic Education Backgrounds and Their Perceptions of the Knowledge Important for Re-entry

Knowledge Important for Re-entry	Basic Education			F	p
	Assoc. Degree	Diploma	Bacca. Degree		
1. changes within the health care system	1.48	1.40	1.323	.406	.67
2. legal aspects of nursing	1.52	1.39	1.492	1.060	.35
3. laboratory findings	1.37	1.30	1.29	.311	.73
4. drug interactions	1.30	1.20	1.21	.628	.53
5. recent modes of therapy	1.59	1.42	1.32	2.306	.10
6. health care costs	1.81	1.88	1.92	.355	.70
7. role of nursing research in patient care	2.03	1.91	1.77	1.868	.16
8. principles of organization and time management	1.63	1.61	1.67	.201	.82
9. alternatives in patient care management	1.63	1.60	1.66	.172	.84
10. nutritional needs of patients	1.67	1.54	1.47	1.148	.32
11. pathophysiology	1.44	1.40	1.34	.446	.64
12. psychological/social and cultural aspects of patient care	1.52	1.48	1.32	2.370	.10

*significant at .01 level.

APPENDIX I

Table 23

APPENDIX I

Table 23

ANOVA Table of "F" Ratios Illustrating Intragroup Differences among Re-entry Nurses from Different Basic Education Backgrounds and Their Perceptions of the Abilities Important for Re-entry

Abilities Important for Re-entry	Basic Education			F	p
	Assoc. Degree	Diploma	Bacca. Degree		
1. the problem-solving process	1.48	1.51	1.35	1.670	.19
2. take a nursing history	1.54	1.66	1.58	.663	.52
3. perform a physical assessment	1.62	1.54	1.61	.354	.70
4. administer medications	1.11	1.08	1.07	.250	.78
5. perform basic nursing skills	1.48	1.47	1.49	.041	.96
6. perform emergency nursing procedures	1.04	1.14	1.16	1.425	.24
7. teach patients and family	1.52	1.46	1.46	.149	.86
8. use technological equipment	1.44	1.43	1.46	.048	.95
9. develop and evaluate nursing care plans	1.56	1.55	1.58	.033	.97
10. administer I.V. therapy	1.23	1.33	1.32	.357	.70
11. recognize limitations and verbalize own learning needs	1.44	1.28	1.29	1.409	.25
12. use communication skills (records/ reports)	1.67	1.48	1.41	2.208	.11
13. use communication skills (interpersonal)	1.63	1.50	1.46	.970	.38

*significant at .01 level

APPENDIX J

Table 24

APPENDIX J

Table 24

Mean and Standard Deviations of Rank Order of Ten Factors Influencing Nurses' Re-entry Ranked Most Influential (1) to Least Influential (10)

Rank	Factor	Mean	SD
1	Loss of spouse	2.60	2.92
2	Need to be productive outside the home	2.78	2.20
3	Personal growth	3.14	1.88
4	Financial need	3.15	2.90
5	Women's movement	3.71	3.95
6	Renewed interest after continuing education course	4.34	2.28
7	Commitment to profession	4.77	2.50
8	Boredom	4.88	3.43
9	Encouragement from family	4.91	2.62
10	Need for nurses	5.08	2.53

APPENDIX K

Table 25

Table 25

A Summary of Pearson Correlation Coefficients Illustrating the Relationship between Nurse Educators/Administrators' Experiences with Re-entry Nurses and Their Perceptions of the Barriers, Knowledge and Skills Important for Re-entry

Barriers to Re-entry	Experiences with Re-entry Nurses: No Experience	Interviewing	Hiring	Counseling	Teaching Classes	Clinical Supervision	Working as a Peer	Fellow Student	Evaluating Performance	Planning Programs	Orienting to Facility	Personal Experience	Volunteer
Lack of Self Confidence	.127*	.172*	.173*	-.005	.052	.110	.240*	.116	.135*	.114*	.181*	.228*	.205*
Home/Family Responsibilities	.098	.060	.164	-.062	.071	.112	.005	.146*	-.008	-.014	-.061	-.075	.036
Limited Job Opportunity	-.085	-.084	-.054	-.058	.022	.022	-.037	-.031	-.064	.002	-.032	-.010	-.102
Physical Capability	-.003	.040	-.037	-.006	-.021	-.096	-.025	.017	.060	.058	-.005	.00.	-.055
Outdated Knowledge	-.058	.060	.088	-.087	-.132*	.064	.045	.075	-.002	.011	.100	.093	.088
Lack of Technical Skills	.154	.038	.040	-.014	-.032	.026	.138*	.045	.007	.013	.060	.024	.034
Inflex. Personnel Pol.	.003	.010	-.113	-.115	.027	.092	-.060	-.052	.130*	-.055	-.086	-.123*	-.070
Inadequate Salary	-.006	.078	-.113	-.018	.049	.008	.061	.055	.123*	.063	.024	.029	.041
Inability to Effect Change	.033	.000	-.175	-.016	.029	.113	.059	.018	.186*	.059	.112*	.042	.022
Geographic Location	.022	.021	-.065	-.045	-.028	.022	.040	.023	.094	.081	.067	.090	.043
Lack of Satisfaction as Nurse	.039	.073	-.021	-.007	.024	.039	.098	.116	.222*	.152*	.165*	.191*	.089
Availability of Re-entry Programs	.043	.059	.130*	-.163*	-.016	.082	.142*	.075	.027	.009	.084	.137*	.182*
Lack of Support From Employed Nurses	.052	.112*	-.058	-.125	-.006	.068	.124*	.133*	.208*	.108	.161*	.131*	.084

APPENDIX K

Table 25--Continued

Barriers to Re-entry	Experiences with Re-entry Nurses: No Experience	Interviewing	Hiring	Counseling	Teaching Classes	Clinical Supervision	Working as a Peer	Fellow Student	Evaluating Performance	Planning Programs	Orienting to Facility	Personal Experience	Volunteer
Lack of Financial Motivation	.017	.032	-.077	.030	-.038	.083	.059	.097	.056	.098	.082	.084	.062
Cultural Values	.050	.027	.024	-.067	.003	.126	.132*	.147*	.124*	.025	.078	.057	.086
Lack of Financial Assis-tance	.056	.151*	-.018	-.113*	-.077	.079	.184*	.116	.226*	.186*	.184*	.166*	.140*

*Significant at .01 level.

Table 25--Continued

Areas of Knowledge Important for Re-entry	Experiences with Re-entry Nurses: No Experience	Interviewing	Hiring	Counseling	Teaching Classes	Clinical Supervision	Working as a Peer	Fellow Student	Evaluating Performance	Planning Programs	Orienting to facility	Personal Experience	Volunteer
Changes in the Health Care System	⁻.033	⁻.050	⁻.019	⁻.055	.026	⁻.035	.086	⁻.037	⁻.160*	⁻.019	⁻.075	⁻.098	⁻.054
Legal Aspects of Nursing	.052	⁻.018	.076	.011	.097	.056	.107	⁻.014	⁻.042	.061	.146*	.046	.091
Laboratory Findings	⁻.067	⁻.123*	⁻.014	⁻.034	⁻.013	⁻.088	⁻.054	⁻.125*	⁻.148*	⁻.070	⁻.129*	⁻.139*	⁻.078
Drug Interactions	⁻.022	⁻.034	.068	⁻.022	.011	⁻.028	.047	⁻.081	⁻.021	⁻.011	⁻.004	⁻.089	⁻.028
Modes of Therapy	⁻.091	⁻.166*	⁻.048	⁻.041	⁻.018	⁻.104	⁻.065	⁻.120*	⁻.113	⁻.146*	⁻.138*	⁻.152*	⁻.105
Health Care Costs	⁻.069	⁻.052	⁻.012	⁻.085	.073	.030	⁻.020	⁻.083	⁻.076	⁻.078	.004	⁻.024	.002
Nursing Research in Care	⁻.142*	⁻.116*	⁻.002	⁻.030	⁻.064	⁻.038	⁻.062	⁻.119*	⁻.184*	⁻.154*	⁻.110*	⁻.187*	⁻.066
Principles of Organization and Time Mgment	⁻.037	⁻.033	.086	⁻.019	.139*	.032	⁻.012	⁻.130*	⁻.018	.006	⁻.043	⁻.061	.080
Alternatives in Patient Care Mgment	⁻.082	⁻.079	.008	⁻.020	⁻.008	⁻.069	⁻.049	⁻.149*	⁻.041	⁻.132*	.004	⁻.066	.090
Nutritional Needs	⁻.066	⁻.057	⁻.025	.021	⁻.065	⁻.063	⁻.049	⁻.048	⁻.080	⁻.052	⁻.008	⁻.056	⁻.075
Pathophysiology	⁻.056	⁻.050	.066	.015	.040	⁻.073	⁻.067	⁻.065	⁻.039	⁻.099	⁻.068	⁻.096	⁻.050
Psychological/Social and Cultural Aspects	⁻.082	⁻.048	⁻.043	⁻.022	.008	.040	.004	⁻.034	.009	.000	⁻.013	⁻.029	.028

*Significant at .01 level.

APPENDIX K

Table 25--Continued

Abilities Important for Re-entry	Experiences with Re-entry Nurses: No Experience	Interviewing	Hiring	Counseling	Teaching Classes	Clinical Supervision	Working as a Peer	Fellow Student	Evaluating Performance	Planning Programs	Orienting to Facility	Personal Experience	Volunteer
Use Problem-Solving Process in Patient Care	⁻.059	⁻.048	⁻.001	⁻.092	.127*	.107	.167*	⁻.036	.087	.036	.137*	.066	.103
Take Nursing History	⁻.033	⁻.017	⁻.014	⁻.073	.020	.090	.114	⁻.067	.027	.043	.108*	.038	.063
Perform a Physical Assessment	⁻.067	⁻.019	⁻.070	⁻.042	⁻.020	⁻.006	⁻.058	⁻.116	⁻.057	⁻.037	⁻.048	⁻.102	⁻.056
Admin. Med/ Recog. Side Effects	⁻.019	⁻.104	⁻.031	⁻.016	.013	⁻.058	⁻.042	⁻.088	⁻.071	⁻.054	⁻.126*	⁻.125*	⁻.081
Perform Basic Nursing Skills	⁻.044	⁻.072	.046	.014	.013	.086	⁻.052	⁻.069	⁻.021	.043	⁻.025	⁻.084	⁻.072
Perform Emergency Nursing Proced.	⁻.068	⁻.068	⁻.097	⁻.055	⁻.048	⁻.011	⁻.057	⁻.069	⁻.037	⁻.035	⁻.080	⁻.130*	⁻.097
Teach Patients and Family	⁻.093	⁻.014	.033	⁻.053	.048	.089	.030	⁻.013	⁻.008	.013	.038	⁻.021	.062
Use Technological Equipment	⁻.107*	⁻.172*	⁻.096	⁻.043	⁻.043	⁻.149*	⁻.183*	⁻.151*	⁻.197*	⁻.191*	⁻.228*	⁻.274*	⁻.160*
Develop and Evaluate Nursing Care Plan	⁻.047	⁻.018	.048	⁻.049	.057	.074	.106	⁻.015	.077	.128	.174	.088	.140*
Admin. IV Therapy	⁻.059	⁻.063	⁻.072	⁻.030	⁻.002	⁻.077	⁻.123*	⁻.134*	⁻.138*	⁻.102	⁻.134*	⁻.108*	⁻.078
Recog. Limit. & Verbalize own Learn. Needs	⁻.063	⁻.082	.042	⁻.046	.150*	.088	.112	⁻.012	⁻.030	⁻.024	.016	⁻.093	.027
Use Commun. Skills (Technical)	⁻.045	⁻.006	.052	⁻.048	.144*	.036	.039	⁻.049	.029	⁻.002	.117*	.012	.032
Use Commun. Skills (Interper.)	⁻.039	⁻.036	.006	⁻.049	.192*	.155*	.057	⁻.048	.042	.045	.132*	⁻.004	.075

*Significan at .01 level.