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ORIGINAL RESEARCH

A Case Study of Critical Reasons Behind Hospital Nurses Turnover Due to Challenges Across System Levels

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Purpose: The aim of this study was to analyze how critical factors at different levels in a health-care system interact and impact nurses' intention to leave and decision to quit their job at a hospital unit.

Methods: A case study of assistant and registered nurses' intentions to leave as well as staff turnover at a smaller Swedish public hospital was performed. Employee surveys and interviews with assistant and registered nurses who had quit their job at four units in the hospital during the period 2012–2019 were performed. Critical factors regarding nurses' intention to leave and staff turnover are analyzed by combining narrative methods with a critical incidence technique.

Results: Three main themes emerge from the analysis of factors contributing to the decision to quit, namely *lack or loss of buffering factors, not owning your spare time* and *not feeling valued by and listened to by upper management*.

Conclusion: Decision-makers, including hospital management, need to consider how supportive factors in nurses' closest work environment that promote staff retention may be impacted by decisions at higher levels, such as health-care reorganizations and stricter governance. In this context, upper management adopting a servant leadership approach might contribute to employees to a greater extent feeling valued and being listened to. Finally, the results indicate that individual nurses' recovery, ability to work and ability to coordinate their personal life with their work life need to be supported by policies and decisions at higher levels in order to retain nurses in intensive and emergency health-care settings.

Keywords: case study, health care, intention to leave, system theory

Introduction

Nursing shortages and staff turnover have been identified as one of the greatest threats regarding both employee health and patient safety in the health-care sector worldwide.[1,2] Recent studies imply that nurses turnover intention has increased significantly during the COVID-19 pandemic[3,4] with workplace stress as one of the main contributing predictors of turnover decisions.[3] This is alarming since statistics in Sweden indicate an existing shortage of nurses with both basic and specialized training.[5] However, nurses who quit a specific health-care workplace do not necessarily leave the nursing profession. A study shows that about 90% of registered nurses (RNs) in Sweden remain in the profession. The same study, however, also indicates that an increased proportion of RNs leave workplaces in Swedish regions, including hospitals, in order to work for other health-care providers.[6] A Swedish study shows that 50% of those quitting a hospital unit move on to another hospital unit, 40% move on to an external employer and 10% retire.[7] Some Swedish regions do not report the same difficulties in terms of recruiting assistant nurses, but the shortage of assistant nurses is still expected to accelerate over the next 10 years, which means that Sweden can expect a general shortage of assistant nurses in the coming years.[5] Numerous previous survey studies have identified factors correlated to staff turnover and the intention of nurses to leave.[2,8–10] However, there is also research indicating that intentions to leave and staff turnover do not always necessarily depend on the occurrence of single factors at a specific point in time,

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but could in many cases rather be seen as a result of individual and organizational factors interacting over a longer period of time.[2,11] There is, however, a shortage of studies on staff turnover based on this kind of system perspective.[12,13] This study adopts a narrative approach to achieve a deeper understanding of critical factors at different levels of health-care systems that over time contribute to intentions to leave and, consequently, actual staff turnover. These results are important for identifying relevant measures at different levels in a health-care system to prevent staff turnover.

A system approach to staff turnover requires a broad consideration of how factors and conditions in the individual life situation (individual level) interact with circumstances in the closest work and home environment (micro-level), the organization's regulations, strategies and norms (meso-level) and societal policies and conditions (macro-level).[13–15] Moreover, to achieve a more multidimensional understanding of staff turnover, time aspects (chrono-level) should be added to analyze, based on a time perspective, how factors and conditions at one system level shape and affect critical conditions and factors at other system levels.[13,15] The focus in this article is how factors affecting nurses' intentions to leave and eventual final decisions to quit a hospital workplace unit develop in interactions with factors and conditions at the individual, micro-, meso-, macro- and chrono-levels.

It is not possible to prevent all staff turnover and there are reasons for quitting at an individual level to a lesser extent impacted by factors at organizational system levels, such as geographic distance to work or an individual strive for career opportunities not possible to achieve within the existing organization.[16] Previous research, however, has described that intentions to leave and individual decisions to quit are often correlated to factors related to employee motivation and job satisfaction at the micro-level.[17] Being satisfied with one's salary is a motivational factor at an individual level having been shown to play an important role for intentions to leave,[18] although the importance of being satisfied with one's pay has been interpreted with caution in other studies.[9] In fact, a qualitative study shows that nurses differ in their perception of the importance of pay.[19]

More clearly, numerous studies show the importance of health factors, including exhaustion and mental strain at the individual level, when it comes to nurses' intentions to leave.[20–24] Such health factors often interact with social and organizational conditions at micro-levels. For instance, previous research indicates that intentions to leave and staff turnover are affected by micro-level work stressors, such as demands linked to patient work, including role conflicts, time pressure and illegitimate tasks.[2,8,9] Other working conditions at the micro-level impacting nurses' intention to leave include their development opportunities as well as good relationships with and support from colleagues and their closest managers.[2,8,9,25–27] In addition, working hours and work schedules have been shown to play a crucial role when it comes to intentions to leave.[28] Smaller work units, outpatient units and units with day patients also appear to exhibit a lower degree of staff turnover,[19] which may be due to, for example, greater access to leadership resources or less work demands in the form of healthier patients.

Studies also indicate that leadership strategies and values at the meso-level (eg, strategies employed at higher management levels or overall perceptions of the organizational culture) play a role in terms of staff turnover. However, there is a shortage of studies looking at these kinds of factors from broader system perspectives.[29] A "mixed method" study shows that hospitals with a lower proportion of staff intending to quit are characterized by a participation-oriented leadership style; for example, visible leadership and having the opportunity to participate in development projects.[12] Another study shows that hospitals with low staff turnover are characterized by a leadership culture based on care and justice.[30] In the literature, this kind of leadership style has been labeled servant leadership, a form of leadership focused on developing working conditions that support employees in their professional performance and development. Servant leadership is described as based on caring for others, the common good and ethical behavior.[31] Previous research confirms that applications of a servant leadership style in hospital settings are correlated to nurses' job satisfaction[32,33] as well as organizational trust and intentions to leave.[34]

Macro factors are interesting to include as they interact with and may shape factors at other system levels. Macro factors might include conditions in the job market (eg, how easy it is to find a new job) or specific regional or national policies affecting work conditions within health-care organizations. For example, politically initiated structural changes in health-care systems, including hospital merges or introducing systems for debiting internal costs, have concurred with factors related to intentions to leave, such as perceptions of providing good care, work pace and employee health.[35,36] To

our knowledge, no studies have explicitly included the importance of factors at the macro-level when studying staff turnover.[37]

Previous research has indicated that mechanisms at the chrono-level contribute to employee choices to quit. For example, it has been shown how access to psychosocial resources at work shape employee motivation and job satisfaction, which, in turn, interact with intentions to leave and the final choice to quit.[11,38,39] Hom et al[11] point out that the specific characteristics of the triggering factors regarding the intention to leave affect whether and how fast these factors lead to the actual choice to quit. For example, this means that harassment at the workplace may trigger an employee's urgent decision to quit, while a more global dissatisfaction with general working conditions may contribute more slowly to the choice to quit. Staff turnover among nurses has also been described as a gradual process, where a nurse often first chooses to switch to another unit within the same health-care organization, followed by moving on to another organization within the health-care sector before making the choice to leave the profession altogether.[40] A European study shows that nurses who left the profession considered quitting one year before they actually did quit.[2]

In summary, there is extensive knowledge on factors impacting nurses' intention to leave[2,8,10] and there are studies looking at factors affecting actual staff turnover.[9,22,37] However, only a few studies analyze how factors at different levels in a health-care system, including meso-, macro- and chrono-levels, interact with each other and impact intentions to leave and staff turnover. There are, as far as we know, no studies on how different individual and organizational factors interact with each other during the process when nurses consider quitting their jobs and which critical factors at different system levels affect the choice to actually quit.[41] The aim of this study was to analyze how critical factors at different levels in a health-care system interact and impact nurses' intentions to leave and decisions to quit their job at a hospital unit.

Materials and Methods

Study Design

A case study of assistant and registered nurses' intentions to leave and staff turnover at a smaller Swedish public hospital was performed. At the time, the hospital had approximately 100 beds, 700 employees and served a population of 100,000 people. Assistant nurses and RNs having quit their jobs at four units in the hospital during the period 2012–2019 were included in the case study. These units included the emergency department (ED), the intensive care unit (ICU), a medical ward (cardiovascular) and an orthopedic ward. Three of the units provided 24-hour care (ie, including both day and night shifts for the employees), whereas the fourth unit provided care between 8 a.m. and 9 p.m. seven days a week. A Swedish assistant nurse does not have a licensed job title but a college degree in nursing, while a Swedish RN has a formal license and a university degree in nursing. All individuals participating in the study had more than five years of experience working in their profession.

The data collection methods used in the study included employee surveys and qualitative interviews performed during 2019. The descriptive results of the survey and interviews have been presented in a previous study. These results showed that the main reasons for quitting included poor working conditions, a lack of possibilities for recovery, salary, poor management, development opportunities and work demands.[42] For this study, mainly the responses to open-ended survey questions and interviews with RNs and assistant nurses were analyzed to achieve a more in-depth understanding of how specific incidences, including the interplay between factors at different system levels, affected the choices of quitting a hospital unit.

Data Collection

The questionnaires were sent to 85 individuals, 55% of whom (47 individuals) responded after two reminders. Thirty percent of respondents were assistant nurses, and 91% self-identified as women. Of the respondents, 28% represented the ED, 30% the ICU, 19% the medical ward and 23% the orthopedic ward. This meant that nurses from the medical and orthopedic wards were slightly underrepresented. Assistant nurses were somewhat underrepresented all in all, and to an even greater extent when it comes to the ED.

The responses to open-ended research questions were used in this study where the respondent was asked to describe: the main reasons for quitting their position at the hospital unit in question, the reasons for pursuing their current job, and what is most important for them to continue working as a RN or assistant nurse. A majority (43 individuals) answered the open-ended questions. The questionnaires ended with a question whether the respondent would like to participate in a qualitative interview on their reasons for having quit. Five assistant nurses and six RNs agreed to participate in such an interview. Qualitative telephone interviews were carried out with four assistant nurses (one from the ED, two from the ICU and one from the medical ward) as well as six RNs (one from the ED, one from the ICU, three from the medical ward and one from the orthopedic ward). These interviews lasted between 40 and 60 minutes and were recorded and transcribed. The interviews were aiming at achieving a more in-depth understanding of how specific incidences, including the interplay between factors at different system levels, affected the choices of quitting a hospital unit. The interview questions were developed and validated by the project research group according to critical incidence and narrative methodology.[43–45] The main purpose for these interviews was that the respondent should be able to construct a narrative by telling a chronological story that started when they began working at the unit in question, continued to when they quit, and the proceeded to their current position or occupation to see whether they still have an intention to leave or consider that they now are in the right work place. To aid in the telling of the chronological narrative, the interviewer asked the respondent to start telling their story from when they started working at the unit and then encourage them to create a detailed timeline, if needed by asking questions relevant to their story such as "when did you start thinking about quitting your job?" or "for how long time did you feel that your work had a negative effect on your health?". During the telling of this chronological story, the respondent was also asked for critical incidents that informed their choices and decisions, and that shaped the story, such as "Leading up to your decision to leave, do you remember anything in particular that made you decide to actually quit?" or "What you just told me about your work environment, how important would you say that was for your future sick leave?".

The study was approved by the regional ethical research committee in Stockholm, Sweden (reference number 2014/5:11). Informed consent was applied. The study complies with ethical considerations ruled out the Declaration of Helsinki.

Analysis

The analysis was performed by combining narrative methods[43] with a critical incidence technique.[44] First, the whole material (ie, both the open-ended responses from questionnaires and the interview responses) was analyzed to identify critical incidences at different system levels with an impact on the respondents' intentions to leave. Second, each qualitative interview was analyzed as a whole in order to understand the narrative and the chronological order of how different incidences at different system levels interacted with each other and over time impacted decisions to quit the hospital. Motivational factors related to applying for a new job or staying at the current workplace were included in this analysis. The narrative of each interview was summarized in a "storyline" including the different critical incidences at different system levels contributing to the decision to leave. Finally, the identified critical incidences and content of the different narrative storylines were compared with each other, and different themes were created summarizing the contributing reasons for quitting expressed across the material. For the results section below, the narratives of five nurses were selected as being representative. Their narrative stories included factors and processes at different system levels that were found in the entire analyzed material, thus serving as illustrations of the content of the identified main themes. The names of the nurses in the results section have been altered and the names of the units where the nurses worked have also been left out to prevent the identification of individual participants.

Results

In the questionnaire, personal reasons were highlighted as the main reason for quitting. Almost one-third (15 individuals) pointed out that their decision to quit the work unit was not related to work environment factors but rather related to single individual reasons. These reasons included finding a job closer to home, personal developmental goals or a decision to retire. Personal developmental goals for quitting included fulfilling childhood dreams of specializing as an ambulance nurse or to change career by starting to work as a teacher in an educational institution. Salary was an

important factor mentioned at the individual level, but salary was seldom described as the main factor triggering an intention to leave. Rather, it was described as one of several important factors and less important than factors related to working hours and workload. The majority of the nurses (30 individuals) in the study who mentioned personal reasons for quitting described how individual factors for their intention to leave interacted with factors at other system levels. The first part of the following results section presents the three main themes having emerged from the analysis on contributing reasons for quitting, namely *lack or loss of buffering factors, not having control over your spare time* and *not feeling valued by and listened to by upper management*. The second part of the below results section presents representative narratives illustrating the content of the different themes by giving details from the nurses' own stories of how critical incidences at different system levels contributed to them quitting.

Main Reasons for Quitting

Lack or Loss of Buffering Factors

A majority of the nurses described a high workload and health factors as the main factors impacting their intention to leave and decision to quit the hospital unit. An overall good atmosphere between colleagues or having a stimulating and varying job was described as factors contributing to staying and also, to some extent, serving as a buffer for high demands at work. A lack or loss of these kinds of buffering factors contributed to intentions to leave. In this context, an example of a critical incidence at the meso-level impacting nurses' intentions to leave involved a decision to change the division of responsibilities between assistant nurses and RNs. Assistant nurses described how this decision contributed to fewer responsibilities in their job descriptions and as something that made their work assignments feel both unjust and less stimulating. It was also said that this decision triggered conflicts between assistant nurses and RNs. In one case, the closest management level was described as contributing to intentions to leave by not intervening in conflicts and by treating employees differently. Overall, however, it was said that the closest manager at the micro-level served as a buffering factor as they did what they could to create as good working conditions as possible, including changing work schedules based on individual needs. The closest manager being switched to a manager with less concern for the employees' work situation was in this context expressed as a critical incidence contributing to increased intentions to leave.

Not Owning Your Spare Time

A critical factor when it comes to intentions to leave and quitting concerns how individual nurses experience not owning their spare time, which has implications in terms of both coordinating their personal life as well as their needs for recovery. For example, several nurses mentioned that working irregular hours resulted in conflicts and problems in terms of coordinating their work hours with family life. A critical incidence at the macro-level triggering decisions to quit involved regional decisions on a new policy stipulating that all employees had to work night shifts, which made it more difficult to adapt the nurses' work schedules to their individual life situation, including family life and individual needs for recovery. Another aspect of limited control over work schedules was related to staff shortages at the micro-level (ie, unit level). Especially at one of the included hospital units, it was said that the nurses were constantly afraid of phone calls from the workplace during their free time, meaning that they were ordered to come into work due to staff shortages.

The analysis showed that issues related to not owning your spare time increased for individual nurses after critical incidences at the macro-level. A critical incidence at the macro-level included, for example, the above-mentioned regional policy that all employees had to work night shifts. Following this, some nurses highlighted that they were unable to adapt their sleep patterns to their irregular work hours, which meant that their recovery suffered. Another critical incidence described at the macro-level involved changing the closing hours of the emergency unit (ie, the unit closed the night reception for patients). This was said to result in longer shifts working nighttime, where the nurses working night had to stay late until all the work was finished. This was described by the nurses as having a negative impact on individual recovery between work shifts, which, in turn, contributed to intentions to leave among nurses working in the emergency care department.

Not Feeling Valued by and Listened to by Upper Management

Not feeling valued by and listened to by upper management was also a recurrent theme related to intentions to leave and quit. This was especially related to rationalization decisions made by hospital management (eg, at the meso-level). This included a reorganization that meant cutting down the number of staff. This decision was described as having an impact on stress and workload in ways that triggered decisions to quit the unit. Frustration as a result of not being listened to by hospital management when trying to argue that the reorganization would not work was described by study participants as contributing to intentions to leave. Overall, all individuals interviewed described a lack of direct dialogue with hospital management and a feeling that upper management did not care about the employees. An image of an absent hospital manager/management that did not take action regarding high workloads evolved from several of the interviews.

Stories of Critical Incidences Contributing to Quitting

Lisa's Story

Lisa, an assistant nurse, described that she already at an early stage in her career reflected on that she would not be able to cope with working in an emergency care unit when getting older. Her greatest concern was the irregular and long working hours, and her reasons to quit were related to a lack of recovery and *not having control over her own spare time*. "[I] would have stayed for longer if someone had said – Lisa we will organize this for you when you are no longer able to cope – but it does not work like that."

Buffering factors contributing to her staying at the unit for several years included a good atmosphere between colleagues and a supportive management at the clinic. For example, a first-line manager, who was at the unit for some years, did what she could to adapt the work schedules to the needs of the individual nurses. However, a change of first-line management (*loss of buffering factor*) and the emergency unit being closed at night (political decision at the macro-level) meant that Lisa found the working schedule to be unsustainable. Simultaneously, she also experienced fewer responsibilities in her professional role as an assistant nurse, which she felt contributed both to less stimulating work and to a deteriorating work climate (*loss of buffering factor*) with more conflicts between professional groups. A change was made regarding the responsibilities of assistant nurses, which meant that previous work tasks, such as taking down patient reports, were only allowed to be carried out by RNs. Lisa experienced that having less qualified work tasks was an obstacle to her professional development.

> You regressed instead of developed […] I think that assistant nurses were declared to be idiots. Just an example: All of a sudden, we could not receive the report from the ambulance when they came in with a regular patient […] In all of my years [as an assistant nurse], I have received patients and received the report, but all of a sudden – no, now it needs to be a [registered] nurse.

The overall working conditions contributed to Lisa starting to apply for a new job. It took some time for her to get a new job, and she quit the hospital unit as soon as she had another job offer. Lisa is now content about having a job with a significantly higher salary and daytime hours, but she misses the stimulating work with emergency care.

Mary's Story

Just like Lisa, the registered nurse Mary was also preparing for not staying in a 24-hour care unit for the remainder of her career. Mary's family situation was challenging to coordinate with irregular working hours, so her reason to quit was to a great extent related to *not owning her own spare time*. Hence, she early on decided to specialize as a public health nurse to be able to switch to daytime work. However, after obtaining her specialization degree, she decided to stay in the ED as she truly enjoyed her job at the unit. Over time, however, she was negatively impacted by colleagues quitting. A feeling started to grow of *not feeling valued and listened to by higher management*. "[I felt] just like one in the crowed […] they don't need me, they can just hire others."

The negative feeling of being an interchangeable employee in combination with the struggle of coordinating her personal life with her working hours contributed to Mary looking for a new job. She found it easy to find a job as a public health nurse, and she quit shortly after starting to look for a new job. Mary is now happy about working in a smaller private care health-care organization where she has a daytime job and where she feels listened to by management.

Margarethe's Story

Margarethe, an RN, from time to time worked part time at one of the hospital units. Due to an urgent staff shortage, hospital management decided to put aside the policy that RNs needed to have two years of experience to work at the unit. As she was not sure that she would have the support from experienced colleagues, for Margarethe this meant a *loss of a buffering factor*. Margarethe felt that she could not cope with another summer of working with the stress of being responsible for the work of less experienced nurses. She thus decided not to continue to take offers to work at the unit. She now works at a private care organization having a daytime job with a salary she could only dream of before. She feels listened to and respected by upper management at her new workplace in a way she never did in the hospital. "They [the management of the hospital] just saw us as interchangeable bricks, they did not care [about us], but rather just hire a new RN."

She expresses that she now has her dream job where she wants to stay until retirement.

> I discovered that working in care can actually look like this. You don't need to run around, tying yourself in knots and trying to please everyone without getting anything in return.

Celine's Story

Assistant nurse Celine's main reasons for quitting the hospital unit were related to *not owning her spare time*, as well as a *lack and loss of buffering factors*. Celine described that she had generally enjoyed the patient work at the hospital care unit. However, she highlighted that a new regional policy at the macro-level that all nurses had to work night shifts contributed to her not getting enough recovery, as she found it difficult to switch between night and day shifts. She also experienced that the new policy contributed to increased conflicts regarding professional roles between assistant nurses and RNs. She believed that these conflicts were due to assistant nurses having to work with less experienced RNs who had not previously worked night and that these RNs challenged existing ways of dividing up the work in ways that belittled the competence of the assistant nurses. In relation to the policy change, Celine started to train herself in another client-oriented profession. She planned to work part time in her new profession as a way of getting a better work-life balance.

Following policy changes regarding night shifts, however, she experienced an increased number of conflicts and decreased cohesion in the work teams (ie, *a loss of buffering factors*).

> And sometimes, it felt as if [you were treated as] you had no competence at all. Not all [RNs] were like that but it became more and more like that. There was more competition and whining.

She did not feel that first-line management took the conflicts in the work teams seriously, nor the health concerns of employees. Nor did management allow her to schedule her work time in a way that would facilitate her working part time in her new profession. Several others quit the unit, and Celine started to question why she stayed on. She came to a point where she felt that she just had to get away from the conflict-ridden work environment.

A change in her personal life (ie, factors at the individual level) made her less dependent on making a steady income, which made her make the final decision to quit her job. With her own well-being in mind, she decided to work full time with her own client-oriented business.

> I had the opportunity, [so I thought] I'll try and I can always go back if it does not work. […] So, if I hadn't had gotten the money [to start my own business], I would probably have stayed [at the unit], but on the other hand, I would not have been feeling all that well and I wouldn't have dared. [to quit and start my own business].

She is currently feeling well by being able to work more regular hours and being able to have a job where she can focus on one client at a time. However, running her own business is economically straining for her, and she is considering looking for a job in primary health care in a couple of years.

Anna's Story

Anna's health suffered by the high workload and the irregular hours at the medical unit (ie, her main reasons for quitting were also related *to not having control over her spare time*). There was a nurse shortage for a longer period of time at the

hospital unit where she worked. Over time, she felt resigned over how they as nurses *were not listened to by upper management* on how the staff cut affected the nurses on the floor. During this time, however, she had no intention to quit her job at the unit as she truly enjoyed her job, as she appreciated her closest managers and as there was such a good atmosphere between colleagues. Due to the regional policy, she was not allowed to only work daytime, so she tried to work night shifts only as an attempt to get regular sleep. However, she did not manage to get enough recovery in-between shifts.

> We were a very good team and we to a great extent survived as we were able to make jokes and laugh. But when you day in and day out need to cut down on your breaks and you are finally worn out as a human being and don't cope [at work] nor cope at home – then it doesn't work anymore. Then you just need to prioritize that everyone is getting their breaks; that you are allowed to be off the day it says you should be off in the schedule so that you don't go around at home being nervous that your telephone will ring. Are they calling from work? Do I need to come in and work? And you have small children at pre-school. There is a lot that needs to fall in place and be organized. It means both stress when at work and when at home. You need to get some respite, which is probably the most important thing.

Anna's health and recovery suffered to such an extent over time that she became ill. After some rehabilitation attempts, Anna realized that she would never be able to cope with the workload and working hours at the hospital unit, so she started to apply for a new job. She now works in the municipality where she enjoys the patient work and where she is satisfied with having a regular schedule without any risk of being ordered to work extra hours and where she has enough time for recovery between work shifts. However, she notes that the municipality is facing a deteriorating financial situation and that this seems to contribute to an increased workload, management being less stable and her salary not increasing as much as she would like. Anna stresses that future developments in terms of these tendencies will decide whether or not she wants to stay as an RN in the municipality. She reflects that she will leave her job the day she feels that she can no longer stand behind the care she is providing due to poor working conditions.

Discussion

The results of this study point to how critical factors at different levels in a health-care system interact and impact nurses' intentions to leave and decisions to quit their job at a hospital unit. The results confirm previous research that decisions to quit are often a gradual process.[2,11] This study shows more specifically how factors at macro- and meso-level impact working conditions at micro-level, which in turn interplay with, and over time, impact individual decisions to quit. These kind of processes are exemplified in this case study by the impact of a new regional policy on working hours. These narrative stories witnessed how, over time, this policy contributed to both a deteriorated work climate at micro level, as well as less recovery at individual level. This in turn contributed to nurses' decisions to quit. The negative interplay created by upper managements' (ie, meso-level) taking decision on re-organizations without including nurses opinions and experiences on how it would impact the work environment at micro-level, was another critical factor. The analysis showed that upper management's lack of servant leadership approaches[31] impacted nurses' decisions to quit both indirectly (through a negative impact on the work environment) and directly (through nurses not wanting to stay in an organization where they did not feel valued by and listened to by upper management).

This study specifically shows that buffering factors at the micro-level, including relationships with the closest colleagues and managers, contribute to staying in a strained working environment. This is in line with previous research showing that support from colleagues and managers is important for lowering the intentions of nurses to leave[2,11,45] and that leadership styles are related to nurses' intention to stay.[46] However, our study shows that these buffering factors cannot in the long-term counteract the possible negative impact of leadership cultures and decisions made at the meso-level (eg, higher management) and the macro-level (eg, political level). Relevant measures taken by upper management to counteract staff turnover seem to consist of leadership practices, including authentic ways of prioritizing employees' work environment concerns so that nurses feel valued and listened to, which can be compared to a servant leadership style focused on serving instead of using employees.[43]

The results also indicate that decision-makers responsible for health care need to include the potential impact of decisions at different system levels on employees' work environment in order to counteract staff turnover. A suggestion

when it comes to practical measures involves developing health impact assessments that include potential impacts on staff turnover. Health impact assessments are evaluations of the health consequences of policies, projects or programs that may not primarily target health outcomes.[47] This study highlights the importance of developing health impact assessments that incorporate a chrono-perspective on how decisions at higher system levels may, over time, interact with and contribute to a deterioration of working conditions at a micro-levels and intentions to leave and deteriorated health at an individual level.

The results confirm previous research underlining that nurses do not want to leave their profession.[6] This study also shows that the nurses experience their jobs at intensive and emergency care units in hospitals as stimulating but that unpredictable work schedules, irregular working hours, a high workload and not feeling valued contribute to nurses quitting their jobs. The data in this study was collected just before the Covid-19 pandemic. Health problems affecting nurses linked to workload and working hours have increased during the pandemic,[48] which in turn has contributed to nurses' accelerated turnover intentions.[3,4] This means that it is even more urgent to take measures supporting the retention of experienced nurses. Otherwise, there is a risk of comprising quality of care within the fields of specialized and emergency care in hospital settings. More work is needed on how to develop a supportive work culture and a work organization that support nurses' control over their spare time as well as individual nurses' ability to work in intensive and emergency care settings. This means that organizing and planning work should focus on ensuring breaks and recovery during and in-between work shifts. This may also include how a health-care organization may support nurses based on a life span perspective, such as support in combining working in shifts with family life, individual measurements and work adapted for nurses with sleeping disorders and possibilities for work rotation and adapting work tasks when employees get older. It should be emphasized that these kinds of adaptions might not be easy to implement in practice as they may result in a clash of different stakeholder perspectives and needs as well as a lack of actual opportunities for adaptation. Hence, a servant leadership style[31] at all levels in the health-care system is required in order to initiate trials aimed at improving and adapting working conditions.

There are some limitations associated with the study. All nurses in this study had at least five years of experience within their profession, and less experienced nurses might highlight other critical factors regarding their intention to stay. There might also be a selection bias of nurses in that those with more negative experiences of their workplace were more likely to participate in interviews and surveys. Capturing the narratives of those with negative experiences may, however, be seen as valuable in itself as their stories can be used for preventing staff turnover. Furthermore, the survey presented a broader picture where individuals participated who quit mainly due to reasons not related to workplace factors. There might also have been a limitation of depth and nuances in the results as the interviews were carried out on the telephone. However, all participating nurses were eager to share their stories and the researchers did not find the format of telephone interviews to be limiting in terms of getting answers to questions made during the interviews. Finally, the results are impacted by the study being performed at a single hospital where the specific organizational culture and structure, development opportunities and regional labor work market probably had an impact on the results. However, the case study of four units in one hospital offered the opportunity to perform an in-depth analysis of how critical incidences at different levels in a health-care system impacted decisions to quit.

Conclusion

Through a narrative approach, this study has contributed to a deeper understanding of how critical factors at different levels of the health-care systems over time contribute to intentions to leave and, consequently, actual staff turnover. Contributing reasons for quitting are related to the themes *lack or loss of buffering factors, not owning your spare time* and *not feeling valued by and listened to by higher management*. The results show that the negative impact of decisions made by management at higher levels can rarely in the long term be buffered by the actions of first-line managers. The results indicate that servant leadership approaches at all levels in the health-care system is required, ie, all decision-makers need to consider how supportive factors in nurses' closest work environment that promote staff retention may be impacted by decisions at higher system levels (eg, reorganizations of health care and stricter control). Thus, upper management adopting a servant leadership approach could contribute to employees to a greater extent feeling valued and being listened to. Finally, the results indicate that individual nurses' recovery, ability to work and ability to coordinate

their personal life with their work life need to be supported by policies and decisions at higher system levels in order to retain nurses in intensive and emergency health-care settings.

Data Sharing Statement

The raw data supporting the conclusions of this article will be made available by the authors without undue reservation.

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Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

Disclosure

The authors report no conflicts of interest in this work.

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