Challenges related to the organizational climate of the nursing team in a public hospital - nurses' perception

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Abstract *The organizational climate is related to the degree of motivation of its employees. This perception is essentially felt, it is neither seen nor touched, but it is real. This study aims to identify difficulties and potentialities related to the organizational climate of the nursing staff at a public hospital in the Federal District. Methodologically, a descriptive and exploratory study was carried out characterized by a qualitative approach. The thematic content analysis led to three interpretative dimensions: environment and working conditions; communication, interpersonal relationship and work flows; motivation to improve the work environment. The results indicate a deficit of human resources, scarcity of material resources, supplies, precarious physical structure, in addition to interpersonal relationship problems, such as the (de)valuation of professional nurses and nursing. The challenges posed to managers go beyond the technical and structural dimension, the technological complexity of equipment without maintenance, as it unfolds through the human dimension, feelings and unmet needs (of appreciation) of nursing, which needs to be cared for, valued, heard and seen in their care process.*

Key words *Public Hospitals, Collaborative Workplace, Nursing Team, Interpersonal Relations*

Introduction

The organizational climate corresponds to the workers' perception of an organization regarding their work environment[1]. It is important to know this perception, as the feeling people have about the company has a profound impact on how and how much they work. According to Chiavenato[2], the organizational climate is the quality of the organizational environment perceived by the organization members and which influences the personal behavior of each professional. It can be favorable when it meets the workers' personal needs, unfavorable when it results in frustration of the needs and neutral when this climate is indifferent to the participants, leading them to not care about what happens in the organization.

This perception of the climate is essentially felt by workers, it cannot be seen or touched, but it is real. For each worker, in particular, the climate takes the form of a set of attitudes and expectations that describe the organization, either in terms of static characteristics, such as the degree of autonomy, or in terms of behavioral variables. Therefore, the organizational climate maps the internal environment of the institution, translates tensions and desires, captures personal satisfactions and dissatisfactions, and paints a picture of the problems that the experienced situation causes[3].

Despite the theoretical plurality on the subject, certain dimensions are common to most authors when it comes to the organizational climate of health institutions, with safety, interpersonal relationships, leadership, and motivation being the most discussed ones[4-7]. Health organizations present themselves as one of the important settings in which interpersonal relationships take place and the hospital environment, although endowed with specific nuances, preserves the same dynamics as other organizations[8]. Good organizational performance requires managers to have a high capacity to merge the different elements that make up their organizational structure.

The internal environment and institutional arrangements existing in healthcare organizations *versus* the level of motivation of each professional are important elements for analyzing the organizational climate, which, in a certain way, influences motivation, performance, quality of services, as well as users' and workers' satisfaction[1,9]. The hospital environment, the focus of this study, presents itself as a scenario in which interpersonal relationships are necessary to carry out tasks, and although it has specific nuances, it preserves the same dynamics as in other organizations[1].

In view of the above, this study aims to identify the main difficulties related to the organizational climate among employees of a public hospital in the Federal District, Brazil, aiming to present suggestions that can improve team performance and patient care.

Method

This is a qualitative, exploratory-descriptive study. The qualitative approach seeks to understand practices and discourses as objectified human actions, resulting from social interactions, since the particularities of the environment disclose to the subjects peculiar traits that are revealed based on the meanings it establishes, considering the broad universe of beliefs, values , aspirations, meanings, motives and attitudes that are inserted in the world of human relationships and which are not perceptible in average and statistical variables[1,10].

The research was carried out with 46 nurses from a public hospital in the Federal District. Nurses from all care sectors were invited, including nursing supervisors, which characterizes the amplitude of the research. The inclusion criteria for participants comprised: being a nurse, working in the Hospital care units and accepting to participate in the study. The exclusion criteria comprised being a nurse, working in the care units of the assessed hospital and not accepting to participate in the study[1].

A non-probabilistic convenience sample[1,11] of 46 nurses who work in both care and management was used in the study. Nurses who work in the adult Emergency Room, Children's Emergency Room, Obstetric Center, Rooming-in Service, adult ICU, NICU (neonatal ICU), Internal Medicine Unit (ward), Surgical Clinic Unit (ward), Pediatrics (ward), Surgical Center and Material and Sterilization Center (MSC) participated in the study. The exhaustion of new topics in the respondents' discourses was used as a sample saturation parameter[1,12]. Interview data collection took place from October 10 to November 30, 2021. A semi-structured interview guide with open questions was used, in accordance with the objectives of the study[1].

The interviews were carried out at the nurses' workplace, in an environment chosen by them, after explaining the objective, the dynamics of the interview and after ensuring anonymity, autho-

rization was requested to record the interviews, clarifying that this procedure would facilitate the study. As much as possible, we sought to make the environment as comfortable as possible, in an informal way, without imposing barriers to communication with the interviewees.

Each employee was interviewed once, and no time limit was set for the duration of the interview[1]. They were asked about their perception of the main difficulties that corroborate dissatisfaction in the work environment and how these difficulties could be corrected. The interviews were recorded on digital media for subsequent transcription and data analysis[1]. To ensure the anonymity of the statements, the respondents were identified with the letter (N=Nurse) followed by the ordinal numbering and sector of origin of the subjects (N1-NICU).

The data were analyzed using Bardin's content analysis[1,13]. Based on the researchers' experience in the researched scenario, an attempt was made to interpret the phenomenon from the respondents' perception, recovering from the speeches the significant statements in relation to the organizational climate and identifying the corresponding cores of meaning. The speeches collected through the interviews were transcribed and each of them was read several times aiming to recover from these speeches the significant statements that emerged with the topic. Therefore, the respondents' statements were reduced into units of meaning and categorized into three meaning cores: 1 - Environment and working conditions; 2 - Communication, interpersonal relationships and workflows; and 3 - Motivation to improve the work environment. No software was used to support the qualitative data processing.

All methodological paths of this study followed the standards of Resolution number 466, of December 12, 2012, of the National Health Council, and the project was approved by the Research Ethics Committee of the State Health Secretariat of the Federal District - CEP/SES /DF under Opinion No. 4,975,835, of September 15, 2021.

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Results and discussion

Regarding the participants' characteristics, all are nurses, and 88.6% are female. Age ranged from 28 to 63 years, with an average of 45 years. Regarding the time working in the sector, 4.5% have been working for less than 1 year, and 35% have been working for more than 10 years, with the average time at SES/DF being 20 years.

Based on the reports it was possible to find three cores of meaning, which were divided into three thematic categories, allowing the interpretations made in the discussion to be substantiated and interpreted in accordance with scientific production.

Environment and working conditions

The conditions of the working environment were the main difficulty highlighted by respondents and are largely linked to the scarcity of human resources, work overload, scarcity of material resources, supplies and equipment that lack maintenance. In line with such data, Pol et al.[1,14] point out that health professionals expect to find available and adequate resources, supplies and material, as well as appropriate equipment and physical structure to efficiently perform the functions inherent to each category. For Nouri et al.[1,15] the high workload, lack of nursing resources and work stress constitute barriers to an adequate and respectful work environment.

I see that our main difficulty is the lack of HR, we have a huge HR deficit, this imposes sacrifices to the people who are working, and we also need to point out that there is a lack of communication and respect between the categories who work in the sector, the nursing and the medical teams, there are many problems related to communication and respect between the teams (N9-OC).

Similar studies have found that working with a persistent lack of human resources, materials and supplies, in addition to corroborating dissatisfaction in the work environment, reduces the quality of the provided care[1,16].

I will point out our difficulty as nurses, we have few nurses, so we are having to undertake the risk classification, and keep this classification active, all the time and that impairs care, because there is only one nurse providing assistance with vaginal births, the surgical center with cesarean sections, with observation beds, with newborns and critically-ill newborns, so a nurse has to take on all this care responsibility, it is very difficult for us nurses, taking on such a tight work schedule and with a very high workflow [...] (N23-OC).

As an example of the difficulties related to the amount of human resources in the entire health care network, studies carried out with tertiary care nursing professionals demonstrated that the excessive number of patients assigned per profes-

sional are risk factors for the occurrence of illness among nurses[1,17]. In a way, working conditions directly influence work activities, worker's health and satisfaction. For Santos *et al.*[1,18] in hospitals with precarious working conditions, the demand from users to have their needs met increases the intensity of the work of the Nursing team, as they need to improvise to replace resources, in addition to recreating the organization of the work itself to meet the needs, even with a limited number of workers or supplies.

I believe that the first difficulty we face and which generates a lot of dissatisfaction is the lack of a permanent team. It is a sector that works with a lot of overtime lately, the medical team is not permanent either, they do not recognize the location, there is no continuity in work due to this fact, because the patients have needs and there is a long delay in the examinations of patients, which makes discharges difficult and we are here to work on this with them, you know, the fact that they improve and go to their homes as soon as possible (N5-NICU).

The lack of a permanent team was a difficulty revealed in the investigated scenario. This difficulty corroborates the break in the maintenance of the routine team (doctors, nurses and other categories) who work daily horizontally in the continuity of care and in the creation of bonds between professionals and patients/family members. It is worth highlighting the relevance of horizontal communication as a powerful tool to promote shared decisions that favor the effectiveness of teamwork[19]. However, offering overtime to cover the work schedule was the alternative found to avoid closing hospital beds.

The main difficulty, which I consider as number 1, is the lack of HR, even if we have available hours, the number of leaves of absence is very high. Then I try to understand the origin of so many absences and it is really related to health issues even among long-time employees [...] (N28-RIS).

Currently, absenteeism due to illness is one of the biggest problems in the public service, and in response to this demand, the Health Secretariat of the Federal District has used overtime processes for all care sectors, aiming to cover absences and maintain the operation of the units. Estimates indicate that, in 2040, the Brazilian population of working age will consist of approximately 57% of people over 45 years of age. However, this demographic effect, associated with working conditions, favors functional aging, which is observed before chronological aging, affecting the ability to work[20]. Therefore, considering the old employees

working in the Rooming-in Service (RIS) of the assessed hospital, it is possible to understand the higher prevalence of sick leave among employees with longer service time.

[...] Another difficulty we also observe and that ends up leading to an increase in absenteeism, is work overload, which leads to many colleagues taking leave of absence, sick leave, and everything else, [...] so this is what we see, this devaluation, this lack of support, which ends up leading to work overload and consequently to professionals becoming sicker, more dissatisfied and, consequently, producing less, this is a cascade (N13-OC).

Regarding the condition of the equipment, nurses reported that it is old and has no maintenance contract. They mentioned that the hospital's own maintenance service is inefficient, there is a lack of materials and human resources to meet the institution's demands. They suggested the return of preventive and corrective maintenance contracts with specialized companies, emphasizing that they waste time with the PDPAS (Progressive Decentralization of Health Actions Program) process, which does not solve the problem, as the equipment is not repaired[1].

What I have noticed lately that generates more dissatisfaction is the lack of medical-hospital material, supplies, technological material, because the neonatal ICU is very technology-based, so our work depends on the equipment. If we don't have the equipment, we practically don't work and what has been happening lately is the wrecking of equipment, in addition to the lack of supplies, you know, we keep managing, we're missing this, we're missing that, and we have to do things in the right way without having what is right. There is equipment that doesn't work and, the ones that work very badly, if I show you the storeroom where the damaged material is stored, which has not undergone maintenance for a long time [...] We work under very bad conditions, with things working badly, with alarms going off all the time and it's a place that should be silent and it isn't, this has caused a lot of dissatisfaction among the team (N12-NICU).

Without a doubt, working conditions directly influence work activities, worker's health and satisfaction[1]. Long working hours are one of the main factors that lead workers to become dissatisfied and stressed, leading to illness[1,21,22]. Stress can occur when the demands of work exceed the worker's abilities to face them, which can result in excessive physical and psychological wear and tear on the body, interfering with productivity. For Santos *et al.*[1,18] in hospitals with precarious working conditions, the demands from users to

meet their needs increases the intensity of the Nursing team's work, as they need to improvise to replace resources, in addition to recreating the organization of the work itself to meet the needs, even with a limited number of workers or supplies.

I think the biggest difficulties are the lack of materials and equipment, these things cause a lot of stress, we spend a lot of time on things that we could do very quickly, so I think this gets in the way a lot, when we want to solve a problem, to provide care and you don't have that material that is often simple and could have been resolved quickly and simply (N14-NICU).

I think that the difficulties we have as a team, I think that my difficulties, are related to the acknowledgement of the nursing team, and so, in general, lack of materials, lack of supplies and because it is an emergency room, I think the overload, I think this ends up discouraging the team very much [...] (N35-Adult Emergency Room).

The physical structure, the lack of medical-hospital material and damaged equipment without maintenance are identified as potential generators of occupational stress, with a direct influence on the quality of the service provided. These findings corroborate studies that verified that the physical structure, materials and equipment of good quality, combined with qualified and motivated professionals, produce health and are capable of transforming supplies into results, optimizing work and providing a better quality of life[1,16].

One problem we have is the bed that doesn't work [...] Another point that doesn't depend on the hospital team, but is something much higher (in hierarchy) is the issue of work overload, understaffed teams; for instance, I currently, here in the sector, I have four nurses to cover 100% of the week, both day and night, so, it gets very busy, no matter how much people talk, ah, there is also the overtime process, but it is not the same thing as a member of the staff, often an overtime worker, they come here just to meet the schedule, so we can't push too hard, otherwise we'll lose them, or if we want to implement a lot of things, they will give it up on doing it in the sector, you know, so we are left like this, in a minefield [...] so, if we were to list them, first of all it would be beds and lack of HR (N32-Surgical Clinic).

It is worth highlighting that the organizational climate reflects a momentary state of the organization, which can be altered by any changes in the environment or context[1,23]. However, it is worth emphasizing that in public services, such

as the assessed hospital, the government has a dual role: both as a regulator and supervisor of working conditions, based on regulatory norms and other standards, and as an employer, which must provide working conditions. However, a contradiction can be observed: the same government that regulates and monitors working conditions is also the one that makes its services precarious, putting users and workers at risk, such as in public health services[1,18].

Communication, interpersonal relationships and workflows

Regarding the interaction between workers, the majority of respondents considered that it could be improved. The speech about the (de)valuation of professional nurses and nursing stood out specifically in the Obstetric Center and in the Adult Emergency Room. Each hospital service presents itself as one of the important scenarios in which interpersonal relationships take place, and the hospital environment, although full of specificities (tension, chronic stressors, high demands, lack of human resources, materials and social support), has the same dynamics of many organizations[24].

In the work context, it is common for teams to show low integration between their members, ineffective communication and non-collaborative behavior[1,25]. To improve this process, the manager must pay attention to the professionals who constitute the team and the relationships between them, since being a "team" is strongly associated with carrying out tasks, activities shared between different people and which, together, achieve a desired result[1].

What contributes to my dissatisfaction is mainly the nurses' lack of autonomy; doctors don't respect what the nurses say; we say no, they go there and do it, and so, I think there is a lack of appreciation and, the lack of teamwork, right, because in fact we are a team (N7-OC).

Several things, including those that have already been mentioned but will not be solved, I would need hours here to talk about things that could be improved, starting with local management, who could listen to the people who have been here longer, and not overwork the team as it's been happening; some days there's a surplus of workers and on other days there's a shortage, then on the day you arrive and there is an absent shift worker, everyone is stressed, struggling in the corridors and on the next day, people are calmer, so, it's a lack of really listening to what people have to say, and a

series of other things in relation to management, so, in general, we don't have a shortage of anesthesiologists, we have an unoccupied room. Some suggestions have already been made regarding this, of an anesthesiologist not staying in the specialty, but staying in the room, surgery hours that don't start on time, because first the surgeon goes to teach a class and then they come to start the surgery at nine, ten in the morning, then we have a team that didn't do anything until nine in the morning, but they have to be there because there's a surgery to be performed in that room, so, there are so many suggestions that have already been given and we don't see anything happening, so that is discouraging, the patient appointments, patients that are scheduled at a short notice, so patients come without exams, unprepared, the number of surgeries being suspended is very high, so the feeling I really have is that during several of my shifts, I stay, receiving my salary and watching public money being wasted, because I see the operating room unused and not working, and they still sometimes call me to participate in meetings asking to increase the number of surgeries; there is no need to increase surgery shifts, we have to make production with the rooms we have, this production doesn't happen due to lack of what again, the management thing that doesn't happen in the health department (N40-Surgical Center).

I think that especially in terms of the interpersonal relationships between the employees, the teams themselves, within the emergency department, we don't have a good relationship [...] because the doctors often interfere a lot in the risk classification, sometimes they don't accept a nurse's classification, [...] we have to work together and the employees themselves will feel more satisfied to be collaborating with their colleagues, it's a whole team that needs to work to make the service operational and I think that everyone will be more satisfied (N43-Adult Emergency Room).

In line with these findings, other studies[25,26] report that it is clear that the lack of value attributed to the profession demotivates them, causing the professionals themselves to question their importance and value to society. The difficulties found come from the lack of recognition, professional autonomy and the difficulty of working with the multidisciplinary team, especially with doctors.

When looking at health practices, one realizes how much there is to be deconstructed and re-signified in this field, as the hegemony exercised by the biomedical power acts as a power line to manage professional acts[27]. The nurse and

other non-medical professionals in the multidisciplinary team are unaware of the extraordinary strength they have to deconstruct this current model and to make radical changes in the way care is produced, where the worker's self-government over their work process places them at the position of being the main agent of change.

This devaluation reported by nurses directly reflects on professional satisfaction in their work environment. The difficulties encountered by nurses, in relation to the lack of autonomy, as a reflection of the lack of recognition of their value and importance for the health sector are characteristics present in several countries. The prejudice experienced by nursing is analyzed in the social relationships that corroborate the experience of exclusion of nurses, who often accept this condition because they are inserted in a social context in which this limited concept is crystallized[26]. Many conflicts experienced by the nursing staff arise from the predominance of the biomedical model, in which the professional is unable to practice their profession autonomously, being subordinate to the orders/approvals that doctors impose.

Another aspect identified in the participants' statements was dissatisfaction with the lack of routines and workflows in the hospital. Teamwork planning constitutes one of the strategic components for coping with the growing complexity of the organization of health care services[1,28]. These actions can make workers see themselves in the workplace, identifying weaknesses and potentials, remembering that each worker in their work environment is unique, endowed with capabilities and difficulties and motivated by different factors[1,23].

There are some issues related to the organization of workflows, and the patient ends up being harmed [...] these things disrupt and impair the service and leave us very dissatisfied (E14-NICU).

The surgical center is a multidisciplinary sector, so you can't implement anything without the effort of the other departments together, which includes anesthesiologists, surgeons, as well as the other clinics also involved, because the patient passes through here, but they come from another place and they go to another one, so if all this doesn't work out, we end up getting a lot of stress in here for these reasons. I think the biggest cause is the lack of management we have over the other teams that are here, you know, and then you can't implement anything, because everything you implement, you can only involve the nursing staff, you can't involve the other teams and then you demand

from your team, for example, that the surgery has to start at lunch time and that we have to manage and resolve it, but the ICU doesn't want to receive the patient at lunch time. The surgical clinic doesn't want to receive the patient at lunchtime, so, for us, we can do everything, we have to find a way around everything, but the other sectors are not aligned with the same thinking... do you understand? (N40-Surgery Center).

Resistance is something natural for human beings, especially when they feel threatened in their work environment. Resistance to change is one of the dimensions that influence the environments of healthcare organizations. This dimension is related to changes in work routines into a more efficient one and involves the participation of employees in this process of implementation and adaptation to a new system. The change process generally occurs through meetings between managers and employees and, as in any proposed change in the institution's work process, it is important to involve all employees who will be affected directly or indirectly[29].

Motivation to improve the work environment

The respondents believe that the management can invest in a Human Resources replacement policy, replacement of materials and supplies and in the search for agreements on equipment maintenance contracts, aiming to offer better working conditions. In a similar study, it was found that when the physical structure is inadequate and there is a persistent lack of human and material resources, wrecked equipment, in addition to corroborating dissatisfaction in the work environment, there is a reduction in the quality of assistance provided[1,16].

The speeches point out the need to prioritize moments of collective dialogue with the team; they suggest holding sporadic meetings, recorded in minutes and made available in the Electronic Information System of the Health Secretariat of the Government of the Federal District (SEI/GDF) for the signature of participants[1]. These ordinary and sporadic meetings are crucial for strengthening teamwork, as it is on this occasion that the "dirty laundry" can be aired, when problems common to work teams and all services are raised and discussed in the light of reason and the technical knowledge of the multidisciplinary team. These moments encourage the sharing of collective experiences and establish trust among team members[1,14].

If there were more attentive eyes at higher hierarchical levels, they could draw up strategies because these are not difficult problems to fix, but they need to be looked at carefully, and they need to be prioritized (N9-OC).

So we need this support precisely because we are a reference sector, we must have this closer look, this look even with affection to precisely value the worker and value the service itself (N13-OC).

Leadership skills constitute one of the most important skills in the organizational environment. Leadership is the process of leading actions and influencing other people's behavior and mentality to achieve established objectives and goals. In the hospital environment or in any organization, leadership is intertwined with another dimension of the organizational climate, which is motivation, and each employee will have a perception of whether they are motivated or not[29].

In search for quality of life at work, it is necessary to make efforts to improve the quality of life in the organization, establish more satisfactory and productive positions for employees, implement different techniques to reformulate and align work functions and processes with employees. A high quality of life can be achieved through the joint effort of individuals and the organization[30]. For Rodrigues *et al.*[31] although it is possible to individualize conditions that both facilitate and hinder the process of implementing changes, it is essential to consider them from a systemic and integrative perspective.

Create a routine of meetings where mature people raise problems, write them down in Minutes, everything is documented, point out these problems and try to resolve them in a very mature way (N11-PED).

In-service education and monthly meetings, [...] on virtual platforms, sometimes bringing the whole team together is very complicated, but I think the supervisor has this vision of trying to integrate at least the nurses, because we are propagators of improvements here [...] (N15-RIS).

Despite all the difficulties, both nurses and doctors, nursing technicians, they do everything for the patient, so this commitment, this work done with love, with dedication, with interest in the patient, a humanized work, in which you see that it is a work truly done with love, then this is one of the most favorable and most important points that sustains our day-to-day work, seeing that the team is interested in doing their best every day (N19-Adult Emergency Room).

According to Borges *et al.*[32] there is no doubt that the environment and organization of work

are essential for the quality of life at work, patient safety and employee motivation. Therefore, it is important to promote, in organizations, cultures in which the involvement and empowerment of professionals are aligned with transformational leadership, a predictor of quality of care in health organizations[31]. That current managers seek dialogue with care professionals and be open to suggestions from employees who rely on teamwork and aim to promote changes and improvements in the work environment is desirable[1,33].

Final considerations

We understand that the objectives proposed for this study were achieved. It was possible to obtain a general understanding of the main challenges related to the organizational climate of employees at the assessed public hospital. The respondents' statements disclosed the dissatisfaction related to working conditions, lack of human resources/ work overload, scarcity of material resources and supplies, and equipment requiring maintenance.

We highlight that in certain sectors, such as the Obstetric Center and the Adult Emergency Room, the greatest dissatisfaction was due to the devaluation of nursing when compared to other categories; in the rooming-in service, it was revealed that sick leaves increase absenteeism rates in the unit and overloads the team; in the NICU, in addition to the difficulties common to all sec-

tors, there was a shortage of medical-hospital material, and damaged equipment that lacked maintenance. The lack of organization of work flows and protocols was the focus of the respondents, mainly for the Surgical Center, MSC, Obstetric Center and NICU.

The challenges posed to managers go beyond the technical and structural dimension, the technological complexity of equipment without maintenance; it unfolds through the human dimension, the feelings and the unmet needs (for appreciation) of nurses and nursing, which needs to be cared for, valued, heard and seen in their care process. It goes through the feelings and unmet needs of the NICU team when they despair due to the lack of incubators and other equipment necessary for the Unit operation and, due to the illness of rooming-in professionals, which increases the organization's absenteeism rates.

Regarding the limitations of the present study, we highlight that the data collection period occurred in the context of the COVID-19 pandemic, which may have influenced the organizational climate.

We expect that the results found can support managers in promoting strategies aimed at people management, work environment, working conditions, work safety, cooperation, communication, appreciation and recognition, to intervene with conditions considered inadequate, increasing the capacity to manage, cope with and modify the identified scenario.

Collaborations

EMP Carvalho participated in the conception and design, data collection and analysis, interpretation, writing and review of the version to be published. CLM Brito, MBP Villas and GC Muniz participated in data collection and writing of the manuscript. LBD Göttems and CRSL Baixinho contributed to the critical review of the version to be published.

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