

# Consequences of Organizational Communication for the Quality of Life at Work for Nurses

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## Abstract

*This study aimed to investigate the Quality of Life at Work (QLW) of hospital nurses at three institutions based on the Richard E. Walton model. This model was chosen as an analytical model because its dimensions encompass broad indicators, aimed both at hygiene and motivational factors, with better adaptation to the Brazilian socioeconomic culture. A questionnaire was used to collect sociodemographic and occupational data, as well as perceptions and states in relation to the factors of quality of life at work. Data were analyzed using the Microsoft Excel Office XP program and were treated by means of descriptive statistics, calculating the average of the dimensions and their respective factors. The results from the three institutions revealed "Helping Others" as the main reason cited by nurses for choosing the profession. The main difficulties expressed in terms of professional development were "Lack of Recognition of the Profession" and "Lack of Maturation". The rates of dissatisfaction focused on the dimensions that addressed fair and adequate compensation, working conditions and the relationship between work and personal life. Satisfaction was expressed predominantly in social relevance, followed by social integration and constitutionalism. In verifying the areas of dissatisfaction in institutional care, the caregiver can provide meaningful information that can be used to build strategies in developing organizational reforms.*

**Key Words:** Communication, Quality of Life at Work (QLW); Nurses.

## Introduction

Nursing professionals are decreasing in numbers globally, resulting in increased difficulty in recruitment and retention in many institutions. Might the cause be related to the devaluation of human dignity and the lack of nurses' quality of life at work, conflicting with the delivery of humanized care to patients and their families? Knowledge of the difficulties that affect nurses' motivation promotes the necessary changes so that the real work of nurses is developed efficiently and effectively through the adequacy of their quality of life at work (Beaudoin & Edgar, 2003; Milton, 2011).

Companies need people who are motivated and committed to their goals and philosophy. The identification of motives may increase the understanding of human behavior through interpretations of personal differences, reflected in personal lives and, consequently, in working relationships.

In Brazil, nurses as health workers are subjected to poor working conditions and make little effort to change them; thus it is fundamental to determine their correlation with the political, social and economic world in order to emancipate themselves, broaden their independence and improve the quality of their personal and professional life, as well as team work, which will reflect in the quality of care (Camargo et al., 2008).

Hooper et al. (2010) discuss how directors and nursing leaders are continually faced with the conflicting demands of managing patient satisfaction, maintaining harmony among staff and improving the quality and safety of care and quality of life at work, including satisfaction and fulfillment, which require the identification of signs and symptoms of

dissatisfaction, exhaustion and fatigue, in order to keep nurses working and motivated (Hooper et al., 2010).

It is expected as part of the nurse's role to carry out his/her own valuation and to seek a harmonious balance between work and life, allowing him/her to gain fulfillment and personal satisfaction at work (Araújo et al., 2010).

These aspects can be understood as a way of reviewing the placement of people in relation to work and the community. The study of indicators to measure these elements emerged with the development of the theme known as *Quality of Life at Work* (QLW), looking at new ways to manage work and invest in human potential, the indices of which can identify interfering factors in satisfaction, as well as personal and collective motivation, reflected in organizational excellence (Marquis & Huston, 2010).

These elements enable learning regarding how people feel about various aspects (both internal and external) of a company and how to manage this data, transforming this information into strategies that promote increased involvement.

## Theoretical framework and significance

A community hospital can be described just like any other business organization, which may be influenced by factors both internal and external to the organization (Marquis & Huston, 2010). However, it has unique characteristics involving professional performances directly related to the principles of maintenance and restoration of health, and therefore the sources that support their very existence. Nurses often experience situations caused by activities related to their function, involving negative elements provided by an environment characterized by illness (Weil, 2000). They spend many hours in the workplace; if these hours were pleasant, they might be

more motivated and more involved with the company's goals (Gil, 1994).

In restoring the welfare of others, nurses are subject to factors that affect their quality of life, due to the nature of their activities and by organizational conditions, which may influence other aspects of their personal and professional life, compromising motivation. This reality is even more evident in hospitals, where professionals "live the paradox of being as or more subject to illness than the patients entrusted to their care" (Campos, 2005).

In general, the organizational structure of the hospital community is based on medical power, ownership of growth and management of the work process in health, and by its identification with the ruling classes of different historical times, "producing the discourse, knowledge and technology needed to maintain the *status quo* and the established social order, unlike common sense, which understands that the physician's supremacy in the sector is due to the superiority of medical knowledge" (Pires, 1989).

This supremacy of knowledge is fragmented by the growth of medical specialties, causing a total loss of human vision, not only of the patient but even within the relationships of the hospital community (Ibid. 1989). Observing hierarchical medical authority on a regular basis, individuals who work indirectly in the service or who serve functions with less visibility (i.e., diagnostic or therapeutic procedures) might have the illusion of a lesser degree of importance.

Several authors have worked within the concept of QLW, developing models and criteria borrowed from the Socio-Technical approach, from Maslow's Hierarchy of Needs, from McGregor's conclusions about the nature of man and from Herzberg's analysis of factors affecting work.

Among these authors, one can highlight the approaches of Walton, Hackman & Oldham, Westley and Werther & Davis regarding the individual's satisfaction with environmental conditions and the work they perform itself, indicating alternatives to obtain good QLW, such as restructuring of positions and the reorganization of posts or formation of teams, with the involvement of employees in decision-making (Fernandes, 1997).

In Hackman & Oldham's Position Enrichment model, a variety of tasks stimulates skill and talent, with tangible results denoting significance and importance, offering freedom and independence for work and achievement. Performance feedback gives meaning to the work, to the results and to personal responsibility. Rodrigues (2008) found that its applicability to nursing was only partially efficient because it does not address basic factors regarding compensation and remuneration, working hours, environmental conditions, career opportunities and freedom of expression. Westley's Four Dimensions model is broader in terms of the elementary aspects, but it also focuses on aspects of cooperation and relates participatory management to QLW, in light of motivational factors, which does not correspond to the reality of hospitals (Fernandes, 1997).

Werther and Davis's model focuses on social expectations and personal skills, clear identification of tasks and efficiency with autonomy, and does not really apply to the hospital structure as it has a vertical flow, with hierarchy based on medical authority (Fernandes, 1997; Rodrigues, 2008).

Therefore, it was decided that for verification of QLW, a model more suited to the Brazilian reality was needed. Walton's model was selected, as it counteracts human values and technology, verifies hygiene and motivational factors, and considers QLW as a major concern for humanistic and environmental values. It was also chosen for its magnitude, with eight criteria that contain 21 factors covering basic working aspects and merging factors from the internal and external environment (Lima, 1995; Rocha 1998), namely:

*1. Fair and Adequate and Compensation:*

a. Adequate income for the work performed: considered fair compared to the activities performed, degree of effort required, necessary qualifications, skills and responsibility demanded;

b. Internal equity: equal remuneration between employees performing the same or similar activities; and,

c. External equity: there is no significant difference in remuneration compared with other organizations similar in size, sector and tasks.

*2. Working Conditions:*

a. Working Hours: lawful workload that does not cause undue fatigue, stress, and physical and/or mental exhaustion; and,

b. Safe and Healthy Physical Environment: safety standards and respect for the physical and mental integrity of employees.

*3. Opportunity to Use and Develop Skills:*

a. Autonomy: ability to solve tasks without permission;

b. Task Significance: accomplishment of the activity, personally and collectively.

c. Task Identity: satisfaction with the work performed;

d. Variety of Skill: requires different knowledge and skills, both dynamic and attractive; and,

e. Feedback: return regarding performance and work.

*4. Growth Opportunity and Security:*

a. Career Possibilities: promotion for those properly trained and qualified;

b. Professional Growth: employee development and training; and,

c. Security and Employment: sense of security in employment.

*5. Social Integration at Work:*

a. Equal Opportunities: absence of favoritism, respecting qualifications, skills and merit; and,

b. Relationship: good interpersonal relationships and mutual commitment.

*6. Constitutionalism:*

a. Respecting Labor Laws and Rights: constitutionally guaranteed rights;

b. Personal Privacy: respect for privacy, unless the behavior interferes with work;

c. Freedom of Expression: openness to suggestions and ideas by hierarchical superiors; and,  
d. Standards and Routines: clearly defined, disseminated, discussed, understood and accepted.

7. *Labor and Personal Life:*

a. Balanced Working Role: balancing work and other personal activities, including leisure and privacy.

8. *Social Relevance of Life at Work:*

a. Company Image: excellent image with regards to employees, current and potential customers, social media, suppliers and community.

**Objective**

The research aimed to investigate the Quality of Life at Work (QLW) of nurses from three institutions in São Paulo, SP, Brazil, based on Richard E. Walton's model, to identify the perceptions of the participants in regards to remuneration, working conditions, opportunity to use and develop abilities, professional growth and security at work, social integration, constitutionalism (working conditions, freedom, privacy and standards), relationship of work to other aspects of personal life and social relevance of life at work.

**Methodology**

The study was conducted through descriptive and exploratory field research, with three focus groups of hospital nurses. The institutions were selected because they excel at complex patient care, are located in areas of high demand in the metropolitan region of São Paulo and have different administrations both within the government sector and the private sector, to investigate the differing levels of

satisfaction among nurses from different locations and consequent reflections on their quality of life at work.

The surveyed hospitals were identified as A, B and C to maintain privacy. The profile of each is as follows:

A: state public hospital, predominantly surgical, large size (400 beds), with nurses in general and support units (ICU, Emergency Room, Surgical Center, Outpatient Clinic, Supply Center, Equipment Center) and all research participants (n=54).

B: philanthropic entity, nonprofit managers elected by open voting. With an average stay of 110 patients/day, it employs 60 nurses and counts on the participation of 20 of them from different sectors and working hours, therefore, 33.33% of the total staff (n=20).

C: state public hospital, predominantly clinical care, 200 beds, with administrative characteristics similar to Hospital A (both part of the state network). Differs in board management by individual order characteristics and specialties. It employs 90 nurses, 20 of which participated in the survey, accounting for 22.22% of the total staff (n=20).

The data collection instrument was a structured questionnaire.

The first part outlined the profile of the participants by gender, job type (care, supervision or management), age, shift, employment relationship, time in profession and institution, marital status, children and proximity of residence. The second part consisted of 56 closed questions, modeled on the dimensions and their factors developed by Walton to measure the degree of dissatisfaction/satisfaction using the Likert Scale, ranging from 0 (total dissatisfaction) to 5 (total satisfaction), considering the mean value of (2.5) as a position of neutrality, as per Chart 1.

**Chart 1. Likert scale adapted to measure the level of dissatisfaction / satisfaction in the QLW dimensions of the Richard E. Walton model.**

DISSATISFACTION			SATISFACTION		
TOTAL	A LOT	SOME	A LITTLE	A LOT	TOTAL
0	1	2	3	4	5

Included were open questions about what led the individual to choose nursing as a profession and other observations that participants wished to express.

The questionnaires were distributed by professionals from the individual institutions to avoid any influence by the researcher, accompanied by the informed consent form. The forms were collected later.

Data were analyzed using the Microsoft Excel Office XP program and were treated by means of descriptive statistics. The average of the dimensions and their respective factors were calculated, because according to Stevenson (2001) the use of averages for treating ordinal scales is justified by the fact that this central tendency measurement enables better interpretation and comparison of variables, accounting for any change in extreme values.

**Results and Discussion**

The socio-demographic profile of the participants is presented in Table 1.

**Table 1 Comparative distribution of the percentage of socio-demographic variables in Hospitals A, B and C.**

VARIABLE	CATEGORY	HOSPITAL A	HOSPITAL B	HOSPITAL C
Gender	Female	98.15	80.00	87.50
	Male	1.85	20.00	12.50
Age Group	20-30 years	14.81	55.00	12.50
	31-40 years	11.11	35.00	12.50
	41-50 years	57.41	5.00	56.25
	51-60 years	16.67	5.00	18.75
Length of Time Nursing	≤ 05 years	27.78	55.00	25.00
	06-10 years	18.52	25.00	12.50
	11-15 years	5.56	10.00	6.25
	16-20 years	25.93	5.00	37.50
	21-25 years	18.52	0.00	6.25
	≥ 26 years	3.70	5.00	12.50
Marital Status	Married	44.44	20.00	50.00
	Single	46.30	65.00	37.50
	Other	9.26	15.00	12.50
Children	None	37.04	65.00	56.25
	One	25.93	20.00	18.75
	Two	24.07	10.00	12.50
	Three	12.96	5.00	12.50

Hospital A= 54; Hospital B= 20; and Hospital C= 20.

Females prevail in the three institutions. The age group between 20-30 years of age is most prevalent in the private hospital (B) and between 41 and 50 years of age in the public hospitals. The proportional length of service in nursing is equal to or less than five years in Hospital B, related to the prevalence of younger professionals, and in the public hospitals the distribution is accentuated in two peaks: between 16-20 years of age and equal to or less than five years.

Being single and having no children is

predominant in the professionals from Hospital B, correlating with the prevalent age group, and in Hospitals A and C the distribution between married and single professionals was equitable, as was the lack of children. In the open-ended questions, aiming to discern the reasons for choosing the profession and any relevant comments relating to the perceptions of the professionals, the responses were classified by association of meaning, arriving at the categories seen in Tables 2 and 3 respectively.

**Table 2 Distribution of the percentage breakdown related to the main reason for choice of profession by respondents at Hospitals A, B and C.**

REASONS	A	B	C
Helping others	42.59	50.00	56.25
Didn't answer / Doesn't know	20.37	10.00	12.50
Identification	18.52	15.00	12.50
By chance / Curiosity	7.41	10.00	12.50
Market / Career	5.56	15.00	6.25
A gift from God / Traditional female profession	5.56	0.00	0.00

Hospital A= 54; Hospital B= 20; and Hospital C= 20.

It can be observed that "helping others" as a reason for choosing nursing as a career was prevalent in the three institutions, reinforcing what was previously noted by Germano (1996), who considers this as being due to a preponderance of

ethics unique to Brazilian nursing, demanding "individual sacrifice, obedience, submission to an unrestricted authority, power, external coercion", based on a historical and conservative style grounded in deep religious feelings and beliefs.

Qi et al (2013) reported that Chinese nurses, unlike their Western counterparts, have a relatively low social status and often complain of being verbally and physically assaulted, not only by patients and

their families, but also by administrative and medical staff (verbal abuse).

**Table 3** Distribution of the percentage breakdown related to the main difficulties perceived in professional development at work, cited by respondents at hospitals A, B and C.

OBSERVATIONS	A	B	C
Didn't answer	70.37	35.00	68.75
Lack of professional knowledge	14.81	30.00	6.25
Revolt within the profession	14.81	5.00	0.00
Presence of submission and self abandonment	0.00	10.00	6.25
Perception of functional discrimination	0.00	5.00	0.00
Lack of maturity	0.00	5.00	12.50
Disunity	0.00	5.00	0.00
Inadequate staffing	0.00	5.00	6.25

Hospital A= 54; Hospital B= 20; and Hospital C= 20.

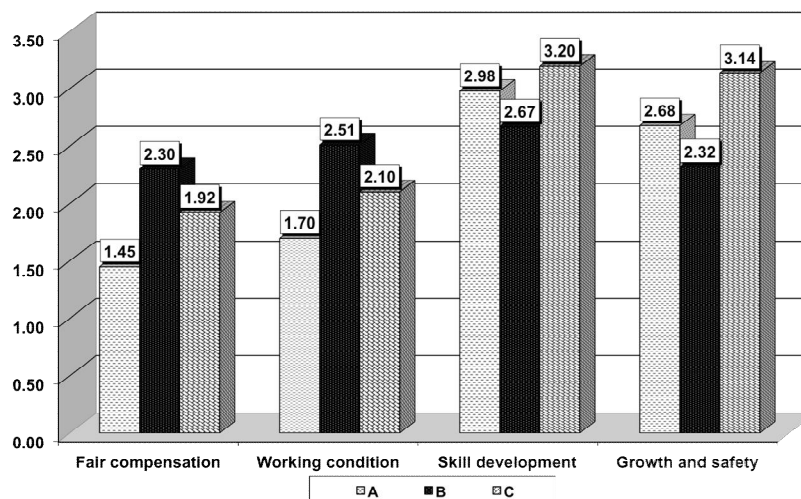
The most commonly cited aspects reported with higher frequency were the absence of recognition of the profession and maturation and revolt over working conditions, which is considered to be associated with the previous answer.

Lack of recognition is also addressed in Germano's review (1996), regarding the essential characterization of the professional nurse, who is often viewed as inferior in the social hierarchy of the

health team, reflecting inequality and a posture of non-questioning of the established order. Thus, the incongruity of proposing relief to the suffering of others is maintained, while one also maintains a state of self-alienation to the suffering often generated by professional exploitation and lack of autonomy within the health team.

The results obtained from the overall averages of the eight dimensions are provided in graphs 1 and 2.

**Graph 1** Distribution of the total averages from the first four dimensions of Richard E. Walton's QLW model



The dimension regarding fair compensation averaged within a level of dissatisfaction in all three institutions, especially in Hospital A, whose dissatisfaction average was also prevalent in the dimension related to working conditions. The private hospital (B) presented working conditions within the mean of neutrality (2.5). In research from Araújo et al. (2010), nurses reported many difficulties in everyday life, highlighting the financial factor due to the wage gap imposed by the absence of a fair policy to ensure

not only survival but also a decent life, resulting in the need for multiple jobs.

The need to hold more than one job leads to an excess of hours worked; in addition, the demand of the labor market and new technology that requires greater skills reduces the time available for personal life, family life, leisure and the necessary rest (Araújo et al. 2010).

In more developed countries nurses demand professional recognition and development; however, in Brazil there has been no significant movement in this area

(Schmidt & Dantas, 2006).

The global economic crisis accentuates the underemployment of nursing professionals, as employers seek to economize by reducing the number of hospital beds and nursing staff. We observe the mobility of nurses in the European Union and the immigration of nurses seeking better wages from countries in Africa and Latin America to Europe, the United States and Canada, where there is a shortage of nursing professionals (Krempel, 2012).

A study by Dalmolin et al. (2009) identified the organizational environment as a source of moral suffering for nurses, highlighting insufficient human and material resources, requiring improvisation and greater concentration, effort and dedication of fewer staff to ensure effective care.

In a study by Nogueira (2007) with a sample of 135 nursing professionals, each of whom had at least one health problem, 81.5% believed that the diseases mentioned in the study are associated with their work or aggravated by their work. He concludes that effective measures are essential to prevent or minimize damage to health, although absenteeism

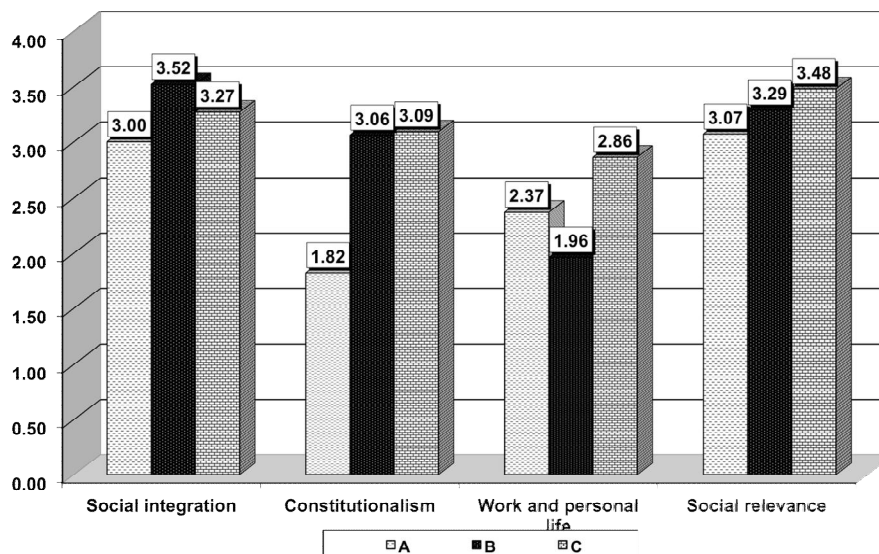
through sickness is one of the most important indicators not only of the health of the professionals, but especially for human resources policies and working conditions.

While the dimensions of skill development and growth and safety showed higher levels of dissatisfaction in the private hospital (B), the public hospital (C) is highlighted as it already showed a range within the level of satisfaction.

Management policies for each organization differ in specificity, variety of customers and external and internal factors, influencing the way in which workers experience their work, the different activities that they can develop and how they are integrated into strategic decision-making, which is reflected in the actual institutional development (Candeias et al. 2011).

In a study conducted by health professionals in Pakistan (Kumar et al., 2013), 45% stated they were somewhat satisfied and 14% were very dissatisfied, due to their working environment and pressure to work more quickly, in addition to low wages, inadequate financial rewards, inadequate supervision and lack of opportunity for improvement and training.

Graph 2 Distribution of the total averages from the last four dimensions of Richard E. Walton's QLW model



The results for the measurements obtained in the last four dimensions are presented with prevalence in the rates of satisfaction, except in Hospital A related to the dimension of constitutionalism. Rates of dissatisfaction were also prevalent in the dimension of work and personal life in hospital A; the private hospital (B) also revealed dissatisfaction in this dimension.

Dalmolin et al. (2010) found evidence of suffering when nurses found it difficult or impossible to make suggestions for changes due to a culture of authoritarianism and humiliation, remaining silent for fear of being penalized. Disrespect for the rights of patients, disregard for the necessary care, (i.e., repeat prescriptions in the absence of daily medical visits), the lack of information provided to patients and

even the occurrence of deaths that nurses considered preventable caused suffering for nursing professionals.

Nogueira (2007) comments that inadequate working conditions for nursing staff in hospitals, the complexity of organizations, ergonomic and psychosocial factors, occupational hazards, employee diversity, patients in traumatic situations, the emotional wear and tear of the role and the frequent experience of being on the threshold between life and death, as well as the specificity of the environment, lack of autonomy and unhealthy work activities have been a problem under consideration for a long time.

Santos (2005) mentions that, although health professionals sometimes feel transformed by working relationships, they pay little attention to themselves, sometimes ignoring their own needs and the resources

available to improve their working lives, with a negative impact on their individual well-being.

Jarrin (2012) highlights that nursing theories mainly focus on patient care and optimizing the environment for patients, and few address the importance of the work environment for nurses who must actually provide the care.

Stacciarini (2000) notes that there have been few studies regarding occupational stress and the quality of life of nurses in the Brazilian literature, with more studies devoted to the aspects that characterize it. It can be observed in earlier studies that the same factors are mentioned, showing that the problems remain, as evidenced by the study of Cox, Griffiths and Cox (2003), which examined working conditions, facilities and well-being in the International Labour Office in Geneva: "Work-related stress in nursing: Controlling the risk to health".

Karasek (1979) drew attention to the possibility that job characteristics are not simply additive in their effects on health, but that they combine interactively in relation to such effects. For example, analyzing data from Sweden and the United States, he found workers in jobs with low freedom of decision-making and high job demands were particularly likely to report poor health and low job satisfaction.

In 1980, Bailey *et al.* included management difficulties, interpersonal relationships with other nurses and medical staff, matters involving patient care, concerns about knowledge and technical skills,

workload and career issues. This profile of issues was also reflected in the work of Leatt and Schneck (1980), with an interest in "head nurses". In 1981, Ivancevich and Smith (1981) summarized the tasks of nursing that required significant physical and/or mental effort to complete. In 1981, Gray-Toft and Anderson (1981) identified seven important sources of tension: dealing with death and dying, conflict with physicians, inadequate preparation to deal with the emotional needs of patients and their families, lack of support staff, conflict with other nurses and supervisors, workload and uncertainty concerning treatment.

Beaudoin & Edgar (2003) cite several studies regarding the dissatisfaction of nurses in the workplace, mentioning variables that address stress, commitment, communication, autonomy, recognition and conditions at work and in work activities, noting that the studies point to a deterioration of work over the years.

In the study by Schmidt *et al.* (2008), concern was voiced regarding research on QLW in Brazil, citing 47 Brazilian studies that had QLW or job satisfaction of nurses as its main theme. Among those included, aspects related to pay, professional status, task requirements, autonomy, organizational policy and opportunity for growth stood out, but they also mentioned the need for expansion and further learning on the theme.

After tabulating the responses obtained, the percentage of dissatisfaction in each dimension addressed was arrived at, as shown in Table 4.

**Table 4 Comparative distribution of the percentage frequencies for the dissatisfaction index in the QLW dimensions from the Richard E. Walton model in hospitals A, B and C.**

DIMENSIONS	% DISSATISFACTION		
	A	B	C
1-Compensation	76.00	58.00	60.00
2- Working conditions	71.00	42.00	63.00
3- Skills Development	33.00	36.00	22.00
4- Growth and Security	42.00	53.00	24.00
5- Integration	29.00	11.00	19.00
6- Constitutionalism	44.00	37.00	28.00
7- Work-Life Balance	47.00	58.00	27.00
8- Social relevance	28.00	32.00	10.00

Hospital A= 54; Hospital B= 20; and Hospital C= 20.

Significant variations in the first two dimensions were observed, which address fair compensation and balanced internal and external working conditions, with rates of dissatisfaction close to or exceeding 50%, with a marked predominance in Hospital A, followed by Hospital B. In turn, Hospital B shows the highest rates of dissatisfaction in the fourth dimension, which addresses growth and security, followed by Hospital A, which can be explained by the instability of the contracted emergency staff in public hospitals. In hospitals A and B some indexes are located very close to the midpoint, or point of neutrality, especially the seventh dimension related to work and life.

Excluding the first two dimensions, Hospital C

showed notably lower levels of dissatisfaction. In general, a high level of satisfaction is revealed by dimensions that encompass social aspects, relationships and development of potential in the three institutions. In contrast, dissatisfaction prevails in the aspects that address remuneration, valuation, working conditions and investment in formal and professional education.

The Gallup Organization (Connelly, 2002), in the work developed in the Toyota Motor Sales USA branch office, considered excellence in the management of people, highlighting:

- People and their talents are more important for businesses than management systems, the company culture and training programs;
- The ideal situation is to treat people as they would like to be treated. Talent, skill and knowledge are different

and their combination defines the competence of an employee. Knowledge and skills can be taught. Talent cannot; it is the very style of the person, how he/she thinks, acts and feels. Helping employees to direct that talent toward excellent performance is the major key to the success of an administrator; and,

- The best administrators believe that their role is not to instruct and control, but to use the same principle that governs nature: the river winds through valleys, border rocks, flows down and around hills and reaches its destination, just like people, who get to where they need to go but travel more easily and productively if they follow their own course. Therefore, trust in employees is one of the brightest stars in the constellation of great administrators.

There are many tendencies in people capable of making them act, such as the desire for power, achievement, the need for company, personal and family security, self-realization, learning new things (curiosity) or destroying obstacles to satisfy needs (aggression), and they may present themselves with greater or lesser intensity (motivation) (Maslow, 2001).

The difference between incentive and motive is that there is no involvement of "I" in incentive, with actions influenced by external pressures such as taking some advantage or avoiding punishment. In motive the "I" is involved, because the person is driven by an inner force, because he/she likes and wants. Using incentives can lead people to action under limited conditions; a lasting action is only possible when it emanates from a true motivation, internally generated within the person, with there being no greater need for external impulse because he/she will have to perform the tasks (Maslow, 2001).

It is essential that the organizational environment provide satisfactory working conditions, not only in regards to the constitution of the work environment, but especially in the professional support structure, so they can take what is within their jurisdiction, exercising care in their beliefs and values for a healthy and harmonious working environment, respecting differences and recognizing values (Dalmolin et al., 2009).

#### **Final considerations**

It is considered that the Richard E. Walton model proved to be suitable for the verification of QLW indexes in the hospitals researched, allowing for reflection on the aspects involving the nurse, in regards to both professional and personal life.

Pain, sickness and death are part of everyday nursing, adding to the distress and anxiety of the patient experiencing compromised integrity, altered family dynamics, painful and invasive care procedures

and an alien environment, baring their weaknesses and exposing them in their fragility. In addition, factors that constitute the organizational structure directly compromise professional development and performance in the absence of recognition of work, poor communication, lack of planning and salaries incompatible with the function. This association endangers motivation and satisfaction, contributing to low productivity and a reduction in quality of service.

It was observed that pride in the work itself and in the institution served is in direct conflict with remuneration that is considered unfair, as well as unsatisfactory working conditions due to overwork in a profession that is already stressful in itself. Nursing still has a predominant percentage of women workers, supported by the present study and data from official statistics that, throughout history, were quite restrained in their expression and, even today, still reflect difficulties in self-recognition, self-respect and self-care.

For the work to have importance it is not necessary to involve matters of great historical significance; however, the work needs to have meaning for those who do it. The person needs to feel that it is a job that is worth being done, strengthening their self-image as part of a larger process.

It is possible to create strategies for dealing with inconsistencies: if we cannot realize our importance, identify our needs or treat ourselves lovingly and patiently, how will we be able to raise these values authentically with each other?

The same applies to institutions: if in providing you with your own "body" of work (clinical staff, nursing or administration) there is no investment, attention, or search to identify obstacles to harmony and balance in working relationships, what will really be changed and improved in our care? When the health institution does not provide an organizational structure that meets the needs of its own working "body" (team), it promotes the proliferation of "pathogenic elements" (disagreements, dissatisfaction, poor quality care, error in procedures) that can take the organization to ill administrative states or even to institutional death due to multiple "organ" (workers) failure.

Prevention strategies as regards working conditions may promote better health, preventing wear and tear and accidents, in addition to increasing job satisfaction and personal fulfillment, with consequent improvement in working conditions and an increase in the efficiency and effectiveness of the care provided.

Thus, it is considered that in verifying the dissatisfactions present in institutional care, the caregiver can provide a basis for developing organizational reforms. There cannot be full organizational quality concomitant to the detriment of the quality of life of its employees. Thus, conditions can be created for personal and professional growth of the community, which may be expressed in a more productive and safe service with unquestionable quality, guaranteeing the very health of the organization.



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