A Focus on Nurse Wellness

Time for Action

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ABSTRACT

The perceptions of staff wellness by Registered Nurses (RNs), Registered Psychiatric Nurses (RPNs) and Licensed Practical Nurses (LPNs) employed in acute care in a southern Alberta hospital were investigated. From a total of 372 staff nurses, 75 nurses were randomly selected to complete a 129 question survey questionnaire. 45 nurses completed the questionnaire.

Respondents reported experiencing a wide variety of stress-related symptoms including headaches, sleep disturbances, tiredness, frustration, moodiness and anxiety.

Other findings from the study identified stressors in the workplace, sources of job satisfaction and dissatisfaction, and concerns about recognition and empowerment. The greatest stressors at work identified by respondents included no control over workload, feeling undervalued, inadequate staffing, highly demanding patients/family, work overload, and coworkers who don't make an equal contribution at work.

The majority of respondents were satisfied with their jobs, the hospital as a place of work, and the quality of care provided to patients. However, sources of job dissatisfaction included pay and benefits (for LPNs), the gap in communication with administration, lack of support for continuing education, and poor promotional aspects. A discrepancy was also identified by the respondents in the importance of recognition from the different levels of management and the actual frequency of recognition.

Recommendations to improve staff wellness, according to the respondents, included recognition programs, reducing workload, exercise facilities, improved communication with management, support groups and increased educational support.

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CHAPTER ONE

Introduction

This study was conducted in order to assess current levels of staff wellness as perceived by Registered Nurses (RNs), Registered Psychiatric Nurses (RPNs) and Licensed Practical Nurses (LPNs) in a Southern Alberta hospital. Staff wellness, for the purpose of this study, was defined as a reflection of the physical and psycho-social well being of the individual staff nurse. Facilitators and barriers to staff wellness were addressed, including psychological, individual, environmental and organizational factors.

This study also attempted to identify interventions that are currently used by individuals and the institution to maintain wellness. Recommendations for future interventions to improve staff wellness were included.

The Question

What is the current level of staff wellness among Registered Nurses, Registered Psychiatric Nurses and Licensed Practical Nurses at a Southern Alberta Regional Hospital?

Background to the Study

Nursing is a profession that is demanding, both mentally and physically. Health professionals are exposed to numerous psycho-social, physical, biological, reproductive and chemical hazards. Nursing is recognized as an occupation that ranks near the top in

terms of high stress. Physical demands also lead to frequent injuries in nursing. Registered nurses (RNs) and Licensed Practical Nurses (LPNs) report higher than expected numbers of back injuries, and back injuries which are more serious than those reported from other professions.

The health care system in Alberta has undergone significant restructuring since regionalization occurred in 1995. As a result of restructuring and the "cost-containment" environment, the potential is present for occupational injuries and illness to rise. Nurse workloads have increased as a result of patient acuity levels being higher, and earlier discharges being mandated. At the same time, nurses are struggling to maintain the same high quality of patient care.

At the southern Alberta hospital being studied, the direct cost to the institution in 1998 from lost/sick days at work averaged approximately $92,000 per month. Among an estimated 900 full time and part time hospital personnel, there was an average of 230 staff members sick per month and there were over 135 claims made to the Worker's Compensation Board (WCB) in 1998. The average number of sick days per employee in 1988 was just over 8 ½ days per year, an increase from six days per year in 1995. A Statistics Canada Study released in March of 1998 reported on by Howell (1998), also found that the number of sick days per person was on the rise.

Staffing shortages for nurses are predicted for the future. A study commissioned by the Canadian Nurses Association (CNA, 1988) predicts that Canada could experience a shortage of 59,000 to 113,000 registered nurses by 2011. Staffing shortages could result in nursing staff bearing additional responsibilities and working extended hours.

Businesses are realizing the effectiveness of workplace wellness programs in reducing the amounts of sick time lost due to illness, injury and absenteeism. Health promotion has become the new direction for health care. Health promotion in the workplace, or workplace wellness, is becoming a new focus for institutions and businesses. Health care institutions are among those realizing the importance of caring for their patients and their staff.

Rationale

For interventions on workplace wellness to be effective, there needs to be support from both the employees and management. Staff wellness is the responsibility of the individual staff member as well as the employer. Nurses need to identify actual and potential risks to their health, both physical and psycho-social. The importance of their own personal health needs to be reinforced. Nurses are taught to care for their patients' health and well being. However, they need to learn to direct some of their energies to maintaining their own personal health and well- being. Mentally and physically healthy employees are more productive. In the hospital setting, this means in part that quality of patient care is then better.

Successful and unsuccessful coping strategies of staff members need to be identified together with interventions that could be implemented by both the individual and institution to improve workplace conditions and lifestyle factors. Awareness of health promotion behaviors is a necessary initial step in encouraging people to take action. Employees and employers must be made more aware that they share a role in improving

staff wellness.

Research Design

The Survey Instrument

This was a qualitative study conducted by means of a five part survey questionnaire. There were 129 questions consisting predominantly of five point Likert-scale questions and closed ended/fixed alternative questions. The content areas of the survey focused on demographics, stress, job satisfaction, morale and empowerment, and the overall physical and psycho-social well-being of the individual staff nurse.

The questionnaire was adapted primarily from a study conducted by Murray and Smith in 1988 on nursing morale in Toronto with a study sample of 1229 nurses representing a population of 16,000 Toronto area staff nurses. The survey was entitled "The Professional Life of Hospital Nurses". Other questions were adapted from studies conducted by Fletcher (1991) on work stress, as well as Cole (1992) and Bailey, Steffan, and Grout (1980) on stress in nursing. The final section of the survey was developed by the researcher.

Data Collection

The survey questionnaire was distributed to RNs, RPNs and LPNs who are employed on a part-time, full-time or casual basis on the acute care wards of a southern Alberta hospital. These acute care wards include medicine, surgery, pediatrics, maternity, labor and delivery, emergency, intensive care, neonatal intensive care, ambulatory care, mental health, and the operating room/recovery room. The survey was distributed to 75

staff members who were randomly selected from a total of 372 RNs, RPNs, and LPNs employed at the hospital. A consent form accompanied each survey questionnaire. Each staff member who received a questionnaire was given one month to complete the questionnaire and return it to the researcher.

Data Analysis

Results from the study are displayed in graphs and tables to illustrate perceived levels of wellness, barriers and facilitators to wellness, and suggestions that are perceived to be beneficial to maintain or improve current levels of wellness. Data from RNs, RPNs and LPNs were compared to identify differences in responses.

All responses are documented in summary form only. All names, locations and other identifying information were not included in the discussion of the results in order to maintain anonymity of the research participants.

Limitations

Staff wellness is a broad topic. Any effort to include all areas of wellness results in a wide scope of study. Many previous studies identified in the literature review have chosen to focus on one particular area, such as morale or stress. The intention of this study was to determine the overall levels of staff wellness, including as many aspects as possible relating to health. Accordingly, it has resulted in a broad accumulation of relevant data.

The use of a survey questionnaire provides more superficial information than might have been gathered through interviews. The complexity of human behavior cannot be

dealt with adequately in a questionnaire. Cause and effect relationships cannot be inferred with as much confidence from a survey questionnaire as responses from personal interviews. Also, the questionnaire does not allow for control over independent variables.

The questionnaire does provide a large amount of information in a timely fashion. There is no interviewer bias and the anonymity of the respondent can be maintained. The reliability of the questionnaire used in this study has not been tested, however, so the results of the study will lack validity.

A random sampling of acute care RNs, RPNs and LPNs was used, making the results somewhat more generalizable to the entire population of acute care nurses in Alberta. The problems being faced in this hospital appear to be similar to those experienced across Alberta, across Canada, and even internationally. The sample size was small, preventing comparison of responses according to age, gender, experience and between different nursing units.

Definition of Terms

Burn-out: A syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment that can occur among individuals who do "people work" of some kind. It is a response to the chronic emotional strain of dealing extensively with other human beings, particularly when they are troubled or having problems (Maslach, 1981, p. 3)

Empowerment: A social action process that promotes participation of people, organizations, and communities towards the goals of increased individual and community control, political efficacy and improved quality of community life and social justice (Wallerstein, 1992, p. 198).

Health: The state of complete physical, mental and social well-being and not merely the absence of disease and infirmity. It is a positive concept emphasizing social and personal resources as well as physical capabilities (WHO, 1986, p.1).

Health Promotion: The process of enabling people to increase control over, and to improve, their health (WHO, 1986, p. 1).

Job Satisfaction: The perception that one's job fulfills or allows the fulfillment of one's important values, providing and to the degree that those values are congruent with one's needs (Bush, 1988, p.718).

Licensed Practical Nurse: A person trained in basic nursing techniques and direct patient care who practices under the supervision of a registered nurse. The course of training usually lasts one year (Mosby's, 1983).

Morale: A mental condition with respect to courage, discipline, confidence, enthusiasm,

and willingness to endure hardship within a group of individuals (Davidhizar, 1994, p.34).

Positive Work Environment: A work unit that has an intuitive reputation of being a good place to work according to subjective and/or objective criteria described by the director of nursing (McGirr & Bakker, 1995, p.93).

Registered Nurse (RN): A professional nurse who has completed a course of study at an approved school of nursing and who has taken and passed an examination administered by the Canadian Nurses Association Testing Service. A diploma nurse trains for two-three years. A degree nurse trains for four to five years (Mosby's, 1983)

Registered Psychiatric Nurse (RPN): A professional nurse who has completed a course of study concerned with "the prevention and cure of mental disorders and their sequelae" (Mosby's, 1983). The diploma course is two years in length.

Staff Nurse: For the purposes of this paper, staff nurse will be an inclusive term referring to Registered Nurses, Registered Psychiatric Nurses and Licensed Practical Nurses directly involved with patient care at the hospital (the focus group for this study).

Stress: The non-specific response of the body to any demand (Selye, 1976)

Wellness: An integrated method of functioning which is orientated towards maximizing the potential of which the individual is capable, within the environment where he is functioning (Dunn, 1959, p. 477).

Workplace Wellness: The systematic effort by employers to provide various kinds of preventative health care to employees (Kotarba & Bentley, 1988)

CHAPTER TWO

Literature Review

There have been numerous studies conducted on the many different aspects of staff wellness. This review will focus on the occupational hazards of nursing which can be physical, biological, chemical, reproductive and psychological in nature. The potential for occupational health hazards in nursing may increase as a result of increased patient acuity, the threat of a nursing shortage, heavy workloads, health care restructuring and increasing stress. According to Lewy (1987), the National Safety Council in the United States reports the health industry has the fourth highest rate of injury and a hospital staff member is 41% more likely to need time off as a result of a work related injury or illness. As well, psychological illnesses are prevalent in the health professions. Sauter, Murphy and Hurrell (1992) note that health professionals have increased rates of hospital admissions for mental disorders and have higher than expected rates of suicide, alcohol abuse and drug abuse. Downsizing has also been shown to increase the amount of medically certified sick leave. A study in Finland by Vahtera, Kivimaki and Pentti (1997) reported a rate of absenteeism two to three times greater after major downsizing and an increase in musculo-skeletal disorders 5.7 times greater than before the downsizing.

This review will also explore the psychological aspects of stress, burnout, morale, job satisfaction and empowerment because of their dramatic impact on nursing wellness. In conclusion, there will be a review of the literature on workplace wellness programs.

Physical, Chemical, Biological and Reproductive Hazards Related to Hospital Personnel

Physical Hazards

Physical hazards that hospital workers may encounter include noise, poor lighting, slippery floors and inadequate ventilation according to studies documented by Patterson, Craven, Schwartz, Nardell, Kasmer and Noble (1985) and Triolo (1989b). Triolo reports that occupational musculo-skeletal injuries are the second most common occupational health disorder and that back injuries reported by nursing aides, licenced practical nurses and registered nurses were more serious than in other occupations. Nurses lost twice the national average in working days due to back pain. Naish (1996) describes two reports from England. The first report found that one in four nurses had taken time off work as a result of back injury. The second report from a Southampton University found a 60% lifetime prevalence of back pain reported by nurses and a 40% annual prevalence.

An American Hospital's one year record identified back and leg injuries as the most serious of those sustained by health care workers, accounting for 86% of all lost time due to injury, according to a study conducted by Hefferin and Hill (1976). Hignett (1996) found that more frequent handling of patients appears to correlate with the increased incidence of back pain. Geriatrics, medicine and surgery were some of the areas reporting the highest incidence of onset of back pain. Hignett also identified in her research that the training in lifting and handling techniques showed little or no long term benefit in decreasing the incidence of back pain.

Violent patients can also pose a risk to a nurse's physical health according to

Patterson et al.(1985). Nurses on psychiatric and emergency units are at greatest risk, but the risk is present in all nursing units. A Swedish study by Arnetz, Arnetz and Soderman (1998) showed that 19/100 registered nurses and 31/100 practical nurses in a general hospital were exposed to violence at work in one year. Nurses on any hospital unit can be exposed to violent behavior resulting from patient alcohol intoxication, drug use, an adverse reaction to a prescribed medication, dementia or brain tumors, to name a few. It was only recently that violence towards health care workers was actually identified as a workplace health hazard, according to Love and Hunter (1996). These researchers found that psychiatric technicians, male staff, and on-unit supervisory personnel had an alarmingly high rate of injuries from patient violence. Whitley, Jacobsen and Gawrys (1996) report that violence affecting nurses continues to escalate.

Chemical Hazards

A National Occupational Hazards survey reported by Triolo (1989b) identified 179 known skin and eye irritants and 135 carcinogenic (cancer causing), mutagenic (causing genetic mutation) or teratogenic (causing fetal abnormalities) agents in hospitals. Patterson et al. (1985) list anesthetic gases, mercury, formaldehyde, ethylene oxide and radiation as chemical and radiation hazards to which hospital personnel are exposed. The handling of antineoplastic drugs used for cancer treatment or exposure to excreta of patients receiving antineoplastic agents provides another health risk to nurses causing carcinogenic, mutagenic and teratogenic effects as identified above.

Latex allergies are becoming increasingly common among health care workers. A

study by Johns Hopkins Medical Institution (1998) reports that 12.5 % of health care workers are affected by allergies to rubber. Allergic responses can range from minor skin irritation to anaphylactic reactions. Steps are being taken to reduce exposure to latex in sensitized employees by supplying special latex free gloves or cotton liners to reduce irritation.

Biological Hazards

Health care workers care for the sick. As a result, they are exposed to a myriad of infectious diseases. Contact with these infectious diseases may pose a risk to the worker, the worker's family members or other employees of the hospital. The Occupational Safety and Health Administration in the United States estimated that 18,000 health care workers with occupational exposure to blood born pathogens will become infected yearly with hepatitis B virus and 250 will die of related complications (DiBenedatto, 1995).

Patterson et al.(1985) have compiled a list of infectious diseases encountered by hospital employees including Hepatitis B, Hepatitis A, Rubella (German measles), Rubeola (measles), mumps, influenza, Varicella-zoster (chickenpox), herpes simplex, acquired immunodeficiency syndrome (AIDS), tuberculosis, meningococcal meningitis, salmonella, scabies and staphylococcus aureus. Other diseases gaining attention in the media are Creutzfeldt-Jacob (mad cow disease) and necrotizing fascitis (flesh eating disease) which may also put the health care worker at risk.

Needle stick injuries, which are often preventable, put nurses at a great risk for contracting infectious diseases. Needleless systems and retractable needles are now being

introduced into hospital settings to reduce the risk of needle stick injuries.

Reproductive Hazards

Anesthetic gases, such as the commonly used nitrous oxide, are now being considered as possible reproductive toxins according to a report by Shortridge-McCauley (1995). She also reported that ethylene oxide, used for sterilizing medical supplies has been shown to have a possible link to increased amounts of spontaneous abortions and chromosomal abnormalities. This scientist also lists studies that found chromosomal aberrations in nurses handling antineoplastic drugs. Other identified reproductive hazards in the report include ionizing radiation (x-rays, fluoroscopies), non-ionizing radiation (ultrasound, lasers), antiviral drugs (Ribavirin) and biological hazards (rubella, cytomegalovirus, herpes simplex, human parvovirus).

Recommendations

Triola (1989) argues for the implementation of occupational health programs that focus on health promotion rather that disease prevention. Lewy (1987) has identified some essentials of workplace health programs such as the protection of workers from risks resulting from circumstances at the workplace, the promotion and maintenance of the highest degree of physical, mental and social well-being of the staff member, routine immunization, and easy access to care for illness and injury at work. Triola emphasizes that education is the key to success in these programs. Education about potential risks is a preventive measure and, as the saying goes - *"an ounce of prevention is worth a pound of cure"*.

Stress and Burn-out

Definition

There are both positive and negative forms of stress. A certain amount of stress in our daily lives is healthy. Good stress, or eustress, for example, occurs when we are anticipating a pleasant event. However, chronic stress, or poor adaptation skills in dealing with stress, can have negative effects on health.

According to the Health Education Authority in the United Kingdom, nursing is recognized as one of four high stress occupations (Wilkinson, 1994; Seymour, 1995). The other three high stress occupations include police work, social work and teaching. The National Institute for Occupational Safety and Health included RNs and LPNs as belonging to a group of occupations found to have a higher than expected rate of stress related disorders. The occupations included in this group were characterized by a high demand environment with low control as well as a fast paced environment with little relief as reported by Seago and Faucett (1997).

Hans Selye (1976) is noted for his research on the physiological effects that stress has on the body. He defines stress as *"the non-specific response of the body to any demand"*. Selye describes the body's adaptation to stress as the General Adaptation Syndrome. It consists of three stages:

1 - the alarm reaction

2 - the stage of resistance

3 - the stage of exhaustion

Selye identifies that a general stress reaction involves *"virtually every organ and every chemical constituent"*.

Lazarus (1966) has also done extensive research on stress reactions and the coping process. He contends that perception is the key to an individual's response to a threat. People will react differently to a stressor depending on their belief systems about transactions with the environment. The autonomic and behavioral patterns of reaction to a stressor will vary according to the coping mechanisms used by the individual.

Maslach (1981) has focused his research on burnout. He defines burnout as :

> a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do 'people work' of some kind. It is a response to the chronic emotional strain of dealing extensively with other human beings, particularly when they are troubled or having problems" (p. 3).

The initial stage of burnout - emotional exhaustion - appears quite similar to Selye's final stage of stress adaptation as identified above.

Another definition by Greenberg and Valletutti (1980) describes burnout as a result of *"reduced job satisfaction or lack of recognition and reward for successful accomplishment of assigned tasks"* as well as the result of time consuming routine tasks combined with self doubt.

Stressors

Edelwich and Brodsky (1980) believe that burnout will occur whenever people are helping people. Within the helping professions, there are built in sources of frustration that contribute to disillusionment. Some of these sources of frustration begin with the

noble aspirations and high initial enthusiasm of beginning practitioners; the lack of criteria for measuring accomplishment; low pay at all levels of education; skill and responsibility; sexism, inadequate funding; inefficient use of resources; and high public visibility along with popular misunderstanding and suspicion.

Numerous stressors have been identified through studies of health care professionals. A Canadian study of public health nurses and hospital nurses by Hache-Faulkner and MacKay (1985) reported that heavy workload and shortage of staff were the most frequently identified sources of stress. Other sources included the administration of nursing units, interpersonal relationships and patient care.

Greenberg and Valletutti (1980) suggest that stress in the helping professions may be caused by lack of support services, excessive or irregular work hours, lack of cooperation from a patient/client or student, lack of decision-making authority, constant exposure to human grief, role overload, role ambiguity, role conflict, and an attempt to live up to an image idealized and glamorized by media.

Farrington (1997) conducted a small scale research study to identify events that were perceived by nurses as distressing. Responses included inappropriate advice by junior or younger staff with less experience and understanding, inadequacies of nursing care by others delivered at a less than ideal level, delivery of care conflicts in the multi-disciplinary team, bureaucracy of the organization, and verbal abuse from patients and relatives.

Bailey, Steffan and Grout (1980) identified stressors in Intensive Care Nursing (ICU). The most frequent source of stress was personality conflicts with staff physicians,

administration, and residents, followed by inadequate staffing. Other sources included caring for a critically unstable patient, admissions, transfers and lack of work space. It is interesting to note that patient care and interpersonal relationships were cited as the greatest source of stress as well as the greatest source of satisfaction in this study.

Another study of ICU nurses by Fromant (1988) revealed that sources of stress included high levels of concentration for long periods of time, continuous and close contact with distressed families, and sudden death. This study also reported that under-staffing was sending staff morale to an all-time low.

Foxall, Zimmerman, Standley and Captain (1990) compared sources of stress of ICU, hospital and medical-surgical nurses. The study reported that nursing was stressful, regardless of the unit on which nurses were working. ICU nurses cited death and dying and "floating" to other nursing units as most stressful. Hospice nurses also cited death and dying as a major source of stress. Medical-surgical nurses identified work overload, staffing, and floating as stressful.

Nurses in an England hospital identified pressure as a significant theme in the workplace, leading to high levels of stress. The volume of work and under-staffing were cited as the major source of this pressure. Nurses perceived that they were barely able to provide an adequate level of care despite physical fatigue and constant psychological pressure, resulting in feelings of guilt, according to Hockey (1987).

Cole (1992) reported on a survey conducted by Nursing Times in which 65% of nurses identified the major cause of stress at work to be excessive workload, 61% reported management related issues, and 54% reported lack of resources.

"Helper secrets" is a term used by Larson (1987) to describe invisible, internal stressors experienced by nurses. These "helper secrets" are thoughts and feelings that nurses have about themselves and their work that can affect health and job performance. Some of these thoughts and feelings include emotional and physical distancing, feelings of inadequacy, anger, feelings of being in over one's head, and fear of making an error.

Shain (1997) lists ten of the most important stressors at work as reported by employees. These stressors include work overload(time pressure), lack of influence over day-to-day work, ambiguities over job responsibilities, conflicts between job responsibilities, lack of preparation or training, discrimination, harassment, poor communication/poor management, human rights abuse, and neglect of legal health and safety obligations.

Risk factors of burnout have been addressed by Sauter, Murphy, and Hurrell (1992). They report that the amount of control an employee has over workload is more significant than the actual amount of the workload itself. This coincides with the report by the National Institute for Occupational Health and Safety that described high stress occupations as having high demands and low control (Seago & Faucett, 1997). Other sources of burnout, according to Sauter et al. (1992) include rotating shifts, permanent night work, role ambiguity, role conflict, career security factors, interpersonal relations, job content, and situational and personal variables outside of work.

The Impact of Stress and Burnout on the Individual

The result of these stressors can be linked to numerous physiological and

psychological symptoms. Selye (1976) has listed several indices of stress. They include:

1. general irritability, hyper-excitation, or depression 2. pounding of the heart (an indicator of high blood pressure) 3. dryness of throat or mouth 4. impulsive behavior, emotional instability 5. overpowering urge to cry, or run and hide 6. inability to concentrate 7. feeling of unreality, weakness, dizziness 8. fatigue 9. floating anxiety 10. emotional tension and alertness 11. insomnia 12. diarrhea and stomach upset 13. migraine headaches 14. pain in neck or lower back 15. increased smoking 16. increased use of prescription drugs 17. alcohol and drug addiction

Lazarus (1966) describes the nature of the stress reaction in four categories. There can be disturbance in affect (fear, anxiety, anger, depression and guilt), motor behaviors (tremor, increased muscle tension, speech disturbances), cognitive function changes (facilitation or impairment of skill performance and cognitive activity), and physiological changes (skin response, blood pressure, heart rate, respirations and skin temperature).

Psychological disorders commonly investigated by the National Institute of Occupational Health and Safety under the category of "job stress" include affective disturbances such as anxiety, depression, and job satisfaction; maladaptive behavioral and lifestyle patterns; and chemical dependencies and alcohol abuse (Sauter, Murphy, & Hurrell, 1992).

Stress affects the cardiovascular, digestive and musculo-skeletal systems. It has been identified as the primary cause of headaches, ulcers, colitis, constipation, diarrhea,

diabetes, allergies and arthritis. There is also a relationship between stress and psychosomatic illness such as alcoholism and anorexia nervosa according to Greenberg and Valletutti (1980). Selye (1976) associated many diseases with stress. These include diseases of the kidney, heart and blood vessels, arthritis and other rheumatoid diseases, inflammation of the skin and eyes and allergies. High levels of stress are also linked with diseases of the nervous system, sexual disorders and metabolic diseases.

Shain (1997) describes stress as contributing to anxiety, depression, and chronic hostility. It can increase the likelihood of alcohol consumption and the overuse of medications (including sleeping pills, pain killers, tranquilizers and antidepressants). Chronic fatigue, chronic pain, asthma and dermatitis can be brought on or worsened by stress. Shain describes the results of stress at the workplace as including decreased productivity, absenteeism, deteriorated relationships, and short or long term disability. These products of stress affect the individual, family, organization and society.

Dolan (1987) lists some of the common features of burnout. Among these features are reduced energy shown by an inability to keep up with the working pace, reduced self esteem manifested in a sense of personal failure related to work, output exceeding input, a sense of helplessness/hopelessness, being unable to perceive alternative ways of functioning, cynicism, and a feeling of negativism in relation to self, others, the job, and the organization.

Members of the human service professions are more vulnerable to the negative effects of stress. This is a result of the humanistic elements required such as dedication, assumption of responsibility for others combined with long hours, limited pay and poor

career advancement opportunities as described by Greenberg and Valletutti. It is not surprising, then, to note that nurses and other health care professionals have high rates of hospital admissions for mental disorders or that health professionals have higher than expected rates of suicide, alcohol and drug abuse as reported by Sauter et al. (1992).

In a Nursing Times survey, Cole (1992) reported that 93% of nurses considered themselves stressed at work; eight of ten were more stressed at the time of the survey in 1992 than three years prior; four of ten said things were worse than they were the year prior. Physical and psychological symptoms of stress were experienced by the nurses. Some of the most frequently cited symptoms were as follows: 82% experienced tiredness; 67% were moody or irritable; 64% experienced headaches; 62% had sleep problems; 58% were frustrated; 49% experienced anxiety; 49% had poor concentration; 38% experienced depression; 31% had loss of libido; 30% reported stomach or bowel problems; and 30% reported weight gain.

Stress-related illness results in financial cost to the individual, to institutions and, ultimately, to society. Buchan (1995) explains that the employee can develop a work-related illness or injury resulting in loss of earnings. Hospitals are left with the cost of sick pay, arranging cover for absent staff, staff replacement costs, and the impact this has on continuity of care. Ironically, the loss of earnings for the individual from a stress-related illness may ultimately induce more stress.

Predictors of Burnout

There are certain factors that are predictors of burnout. According to Robinson,

Roth, Keim, Levenson, Flentje and Bashor (1991), high work pressure with low work involvement and supervisor support are predictors of emotional exhaustion. They reported that younger nurses experienced more depersonalization than their more experienced colleagues. This last factor is supported by Matrunola (1996) who found burnout to be most prevalent in the first few years on one's career and by Cameron, Horsburgh, and Armstrong-Stassen (1994) who found that RNs with more years of work experience reported the lowest levels of burnout and the highest levels of job satisfaction.

Hare (1988) found that peer cohesion, supervisor support and work involvement were strong interpersonal variables that negatively predicted emotional exhaustion and depersonalization. Intrapersonal variables that were predictors of coping included tension-releasing coping (crying, overeating) and problem-focused coping (talking with others). Individuals using problem-focused coping skills had less signs of burnout. Ceslowitz (1989) reported similar findings. She stated that nurses experiencing reduced levels of burnout use the coping strategies of planful problem-solving, positive reappraisal, seeking social support, and self-control. Nurses experiencing higher levels of burnout used escape/avoidance and confrontation as coping strategies.

Characteristics of the work environment can also contribute to burnout. According to Dolan (1987), the rapid turnover of patients leads to heavier workload resulting in too many patients to treat in too short a time. The inability to meet patient demands leads to feelings of guilt and resentment as nurses find they can not aspire to their own professional standards.

McCranie, Lambert and Lambert Jr (1987) indicate that personality hardiness and

the perceived levels of high job stress are significant predictors of burnout. Personality hardiness refers to an individual's commitment, control and challenge. Commitment was defined by the authors as being "a generalized sense of purpose and meaningfulness expressed as a tendency to become actively involved in ongoing life events". Control is defined as "the tendency to believe and act as if one can influence the course of events". Challenge refers to "the belief that change rather than stability is normal in life and that change can be a stimulus to growth".

Coping Strategies

Many coping strategies are used by nursing staff in dealing with stress. Farrington (1997) lists commonly used coping strategies, both positive and negative. They include problem-solving, cognitive restructuring, tension reduction, social skills, self-disclosure, stress monitoring, seeking information, avoidance/withdrawal, suppression/denial, self-medication, social support, and self-esteem.

In a 1992 Nursing Times survey, Cole reported that 77% of nursing staff talked to colleagues to help them to cope with stress while 54% relied on relaxation and physical exercise to help them to cope.

Chiroboga, Jenkins, and Bailey (1983) found that nurses who dealt most effectively with work stress employed a professional orientation as a coping style. These nurses used more cognitive or rational coping strategies and expressed their emotional responses to job related stress. Nurses also managed better if they had the support of spouses and fellow staff (1983). The importance of supportive friends and colleagues is

also identified by Gillespie (1987). Gillespie recommends increasing confidence and self-esteem by increasing the amount of positive feedback.

Recommendations

Interventions aimed at reducing stress are the responsibility of the individual as well as the organization. Hare (1988) suggests that the most effective intervention is to improve the quality of the work environment. This would include focusing on supervisory support and peer relationships as well as staff training and work-related counseling to assist staff to use problem- focused coping strategies.

Veatch, Loisel, Marshall and Sivesand (1985) discussed the importance of a supportive environment. These authors believe the nurse manager has a role in creating an environment that allows expression of feelings as well as joint problem-solving. Supervisor support in the form of respect and empathy was successful in reducing signs of burnout according to Firth, McIntee, McKeown and Britton (1986). Veatch et al. identified other steps a manager can take to reduce stress such as clarifying the values of the unit, setting priorities and offering guidance in achieving desired outcomes.

Other suggestions made by McCranie, Lambert and Lambert Jr. (1987) to improve the work environment encourage the organization to focus on providing adequate staffing, flexible scheduling, improving the flow of communication among nurses, physicians, administration and other hospital staff, and implementing conflict management strategies.

Supervisors should be provided with leadership and communications training in order to provide the appropriate support to staff members, according to Robinson et al.

(1991). These authors also suggested restructuring the work environment to increase task efficiency and encouraging innovation to make the nursing unit more effective and efficient. This will help to reduce nursing workloads, a recommendation echoed by Hache-Faulkner and MacKay (1985) and Foxall et al. (1990).

Bailey, Steffen and Grout (1980) agreed that training procedures for nurses to help them deal more effectively with stress may be important, but encouraging nursing administration to consider individual differences when planning such programs is necessary for success. Flexible stress management programs allowing for individuality are also supported by Foxall, Zimmerman, Standley and Captain (1990). These authors recommended the implementation of special programs, such as how to deal with the stress of caring for terminally ill patients, support programs, and self-help groups. In addition, they agreed that individual health care workers must also take some responsibility by setting flexible and realistic goals in both their work and home life.

Fromant (1988) described changes made to an ICU nursing unit in order to develop an early warning system against stress. The changes included lengthening the shift by 15 minutes so that staff could take their breaks together and allowing for time to release tension which helped to boost morale. A monthly study day was also incorporated which allowed for clinical update sessions.

In England, a counseling, advice and information service was set up for nurses, consisting of three trained counsellors and one advisor. Trevelyan (1988) described the program called CHAT, which stands for counselling, help and advice together. This program allows nurses to help themselves to tools in order to sort out problems in a way

they choose, away from the hospital setting.

A study in England by Owen (1989) identified some organizational coping strategies. Owen listed some of the suggestions put forward from the study including that all trained nurses should be regularly supervised by someone who can facilitate their learning and development, the use of support groups for both charge nurses and staff nurses, encouragement to attend in-service days, and a clinical career ladder with increasing levels of autonomy.

Greenberg and Valletutti (1980) listed possible activities that an organization could incorporate to help staff deal with stress. These activities include administration education, mid-management education, staff and field service education, career development alternatives, counseling services, programs of prevention, and educational enhancement programs. Greenberg and Vallettuti identified the benefits to individuals who participate in these programs as increased job satisfaction, improved relations with peers and supervisors, reduced stress and its effects carried over to the home environment, and improved health. The agency benefits through increased output and productivity of its staff, reduced staff turnover, reduced absenteeism, and improved employee morale.

Shain (1997)describes the three avenues to health according to Health Canada's Workplace Health System (WHS). These avenues are:

- the physical and psychological environment of the workplace

- personal resources (coping skills, sense of personal efficacy, accessibility of social support)

- personal health practices (exercise, smoking, drinking, eating)

The WHS also recommends identifying the factors that lead to excessive stress at the worksite, and suggests that small changes often work best (1997).

Individuals must take the responsibility for preventing stress at work. Atkinson (1988) identified some measures to help prevent stress at the worksite:

- ensure a good person-job fit or make necessary adjustments
- develop sensible rational beliefs for yourself, your performance, and your job
- change your behavior in line with your new attitudes, including reviewing priorities
- develop the right skills and behaviors to enable you to do your job to the best of your ability
- develop a good social support network, both at work and with family and friends
- keep as physically healthy as you can through sensible diet, sleep, exercise and so forth
- learn to relax
- learn to use leisure time sensibly

The psychological, physiological and economical effects of stress and burnout are overwhelming. It becomes the responsibility of the employee and the employer to make an effort to identify stressors that can be eliminated and focus on effective coping strategies to deal with the stressors that will always be present.

Morale

Definition

According to Davidhizar (1994), negative effects on health and feelings of unhappiness and discontent can be the result of poor morale. Davidhizar has defined morale as a " *mental condition with respect to courage, discipline, confidence, enthusiasm, willingness to endure hardship, etc., within a group or individual*" (p. 34). *Espirit de corps,* the common spirit existing in the members of a group (Merriam-Webster, 1974) is also used to describe morale.

Davidhizar (1994) noted that three components of high morale include a feeling of togetherness, agreement on goals, and specific and meaningful tasks for each member.

Factors Influencing Morale

Several studies have been conducted to determine which factors increase morale. A study by Robinson, Roth and Brown (1992) concluded that supervisor support, satisfaction with co-workers, recognition from others, and peer cohesion were factors influencing staff morale positively. Jones (1988) discovered that a differing management approach, encouraging a dynamic, high stimulation workplace was successful in raising morale and attitudes in nursing staff.

The level of education and position in the hospital also have an influence on morale. In a study by MacRobert, Schmele and Henson (1993), nurses with advanced educational preparation and higher level positions were found to have increased morale. Morale was also found to be better if there was a match between a nurse's skills and the

requirements of the nursing position according to Robinson et al. (1992)

Several factors have been found to contribute to low morale. A report by Haw, Claus, Durbin-Lafferty and Iverson (1984a) making recommendations on how to improve morale states that "work overload may emerge as the single greatest contributor to low morale". This prediction was supported by a study from Wales by Nolan, Nolan and Grant (1995) which found workload to be the most prevalent factor related to low morale.

Studies have shown that cuts to health care funding and restructuring have had a dramatic effect on nursing morale. A survey by Deloitte and Touche cited reasons for Registered Nurse (RN) despondency including layoffs, changes in job duties, lack of communication and uncertainty about health care reform (AJNNewline, 1996). Shindul-Rothschild (1994) concluded the rationing and discontinuity of patient care has also had a significant effect on morale.

The nursing profession in the United Kingdom (UK) has experienced similar problems as a result of reforms. A survey conducted by Bowman, Martin and Stone in 1992, and repeated in 1994 and 1996 identified a decline in RN morale caused by increased anxiety about job security, nursing views being ignored, and a feeling of greater distance from managers. Other UK studies, such as that done by MacAlister and Chiam (1995) revealed that job insecurity, lack of opportunity for career advancement and prevention from providing high quality nursing care were causes of low morale and dissatisfaction. Dix (1996) concluded that job insecurity, restructuring, and stress caused by cuts sent morale plummeting. Ineffective communication and exclusion of nurses from decision-making as a result of reforms in the UK were reported by Bradshaw (1995) as

having a profound negative impact on morale. As a result of these reform changes, Taylor (1996) voiced her concern that we have yet to see how low nursing morale can go.

Other factors found by MacRobert et al. (1993) to contribute to low morale include increased years of service and experience, working conditions, relations with supervisors, effectiveness of administration and identification with the organization.

Patient death can have a significant impact on staff morale. According to O'Hara, Harper, Chartrand and Johnston (1996), nurses who have worked longer or have experienced personal loss may be more negatively affected. Some nursing units deal with patient death on a regular basis. Heavy workload can prevent nursing staff from taking the time to deal with their own emotions that result from circumstances of pain and grief.

Haw et al (1984a) identified factors that would have an anticipated effect on morale. They include workload, amount of responsibility, nurse-patient relationships, use of skills, learning opportunities, career advancement opportunities and opportunities to participate in decision- making. These authors predicted that even with heavier workloads nurses would assume greater responsibility for care of acutely ill patients without formal or legal authority to make even minor modifications to the medical treatment. They also predicted that there would be less staff development, less opportunity for career advancement and less reward as a result of cost containment and other health care reforms. Professional support services were expected to be decreased, especially on evenings, nights, and weekends, with nurses picking up these added tasks, further diluting the use of nursing skills. The effects that were predicted by these authors have become reality for many hospitals in many parts of the world and are having devastating effects on

morale.

Nurses take pride in the quality of care they provide to their patients. If nurses are prevented from maintaining a high level of care, intrinsic needs such as the personal rewards of giving high quality of care, are not being met. A study by Cole (1997) reported that 87% of nurses reported an increase in their workload, 59% reported an increase in the number of patients treated, and nearly half stated that patients were receiving less care as a result of this.

Some studies have shown that productivity and quality of nursing care improved even though patient length of stay decreased, and patient acuity increased (Helt & Jelinek, 1988; Shindul-Rothschild, 1994). These results were credited to the commitment of the direct care nurses and managers' efforts to maintain quality care. This highlights a concern that is at the heart of this study; namely, how long can nurses continue to give of themselves before it has a significant impact on their own mental and physical health?

In recent years, nursing has been given recognition as a high stress profession. High stress leaves are no longer uncommon among staff nurses as they struggle to cope with increased demands, both personally and professionally. An editorial in the Nursing Times concluded that nurses are at the top of the list for female suicides (Dying for Support, 1995). This must be the result, in part, of the emotional demands and stresses that nurses encounter on a daily basis.

Recommendations

A program to improve nursing morale developed by Haw et al. (1984b) was made

up of four central elements. These elements included redefining nursing care priorities, increasing non-professional support services, initiation of more cost effective nursing care approaches and, lastly, the creation of new learning opportunities.

Haw et al. (1984b) have recommended ideas for new learning opportunities such as allowing nurses to act as discharge planning consultants, nurse educators and patient classification system consultants. Learning and practice sessions similar to the pilot study conducted by Hinton (1997) including topics on emotions, interpersonal health and alternative therapies were found to be successful. Providing staff development education in social support activities was identified as a strategy by Gaynor, Verdin, and Bucko (1995).

Coulter (1991) identified lack of recognition as a source of low morale. He supports a professional recognition system in which staff members have access to professional activities, staff who participate in activities are identified, and achievement is rewarded. Nurses are recognized for quality of work rather that just years of service. Keyes (1994) described a recognition and reward program which recognized nurses for excellence in patient care and created role models. Elements of the program included nurses' involvement in the design, as well as peer assessment. Team involvement in a recognition program was also supported by Hurst, Croker and Bell (1994).

SHARE, described by Parsons (1988) is a program designed to boost morale by asking employees to "share a compliment" or "share a suggestion". Hayes (1991) found that positive comments made to nursing staff from nurse managers were good motivators. However, encouragement that sounds trite may have the opposite effect (Davidhizar,

1994; Shearer & Davidhizar, 1994).

Opportunities to participate in learning activities need to be provided during working hours. Expectations of commitment during off duty hours can be an added source of stress as nurses try to balance work, family and social commitments.

The Role of Managers

A large role is placed on the manager or supervisor to maintain high morale on the nursing units. This role includes improving communication and involving staff in decision making processes as suggested by Schulmerich (1993) and Haw et al. (1984b). Davidhizar and Wehlage (1988) suggested managers should act as cheerleaders for the staff by communicating respect, maintaining work visibility, and acknowledging good performance.

Nurse managers should be provided with training in areas such as team building, communications and leadership development according to Robinson, Roth and Brown (1992). Sessions can also be organized for nursing staff. Supervision session discussions including topics on conflict within nursing teams, communication between nurses and doctors, and stress caused by patient problems were found to raise morale as reported by Wittich, Murjahn, and Hartmann (1995).

Loomer, Jacoby, & Schader (1993) reported on the success of using a nurse advocate to improve morale. The purpose of an advocate is to stimulate a positive atmosphere for nurses by facilitating communications between departments and disciplines.

Davidhizar (1994) also emphasizes that it is more than just the responsibility of management to maintain good morale on a nursing unit. Davidhizar (1994) and Shearer and Davidhizar (1994) suggest that everyone on the unit has the function of maintaining a positive attitude, giving recognition to others, putting forth extra effort when needed, and doing work of which they are proud. The nurse manager's role is to make sure that it is not the same few individuals making the extra effort all of the time. If individuals are working harder to make up for a coworker's lack of commitment, morale will go down. Morale is a team effort.

Job Satisfaction and Positive Work Environments

Definition

Job satisfaction and a positive work environment have an impact on staff wellness as a result of their direct relationship with stress, morale, and absenteeism.

Job satisfaction has been defined by Locke (1983) as the "*pleasurable or positive emotional state resulting from the appraisal of one's own job experience*" (p. 1297). It has also been defined by Bush (1988) as:

"*the perception that one's job fulfills or allows the fulfillment of one's important job values, providing and to the degree that those values are congruent with one's needs*" (p. 718).

Traynor and Wade (1992) described three categories of components of job satisfaction. They include the characteristics of the worker (values, experience, motivation, expectations); the nature of the work (task or client-orientated, repetitive or

varied, working with products or people, type of clients); and the work environment (organizational system, resources, opportunities for career advancement).

A positive work environment is often included in the discussions of job satisfaction. McGirr and Bakker (1995) defined a positive work environment as "*a work unit that has an intuitive reputation of being a good place to work according to subjective and/or objective criteria described by the director of nursing" (p. 93).*

Determinants of Job Satisfaction

Job satisfaction appears to be determined by intrinsic factors such as the internal rewards of delivering high quality care and interpersonal relations, whereas job dissatisfaction appears to be determined by extrinsic factors such as pay and employee benefits, as reported in studies by Parahoo & Barr (1994), Wade (1993), and Frisina, Murray & Aird (1988). Studies conducted in the UK (Wade, 1993), revealed that nurses "derive satisfaction from doing a worthwhile job" in interaction with their patients (intrinsic factors) "but that satisfaction may be seriously compromised by poor working conditions and heavy workloads" (extrinsic factors). According to Nolan, Nolan and Grant (1995) job satisfaction and morale can be maintained if nurses perceive that the level of patient care is being maintained.

Several factors contribute to job satisfaction. A meta-analysis by Blegen (1993) identified that stress and commitment were the two variables that had the strongest relationship with job satisfaction. Another major determinant identified by Blegen (1993) and Cavanagh (1992) is communication and interpersonal relationships on the nursing

unit. Examples of communication include multi-disciplinary team work, as noted by Parahoo and Barr (1994), the relationship with nursing supervisors as identified by Murray & Smith (1988) as well as other interpersonal relations with doctors and peers. McGirr and Bakker (1995) found that staff members can contribute to a positive work environment by maintaining a positive and cheerful attitude while nurse managers can facilitate through effective communication and organization. Mutual respect and demonstrating maturity and understanding between staff nurses and managers through praise and positive feedback also fosters a nurturing work environment, according to Mills & Pennoni (1986).

Authors such as Frisina, Murray and Aird (1988) and Townsend (1991) found that increased opportunities for professional growth and development, increased participation in decision making, and more opportunity to influence decisions regarding the work environment contributed to nurses job satisfaction. Other studies have identified autonomy and recognition to be important contributing factors (Parahoo & Barr, 1994; Blegen, 1993; Frisina et al., 1988; Kramer & Hafner, 1989). Respect from coworkers (Murray and Smith, 1988) and opportunity for advancement (Cavanagh, 1992) can also positively affect nurses' job satisfaction.

A study of intensive care unit (ICU) nurses by Bailey, Steffan and Grout (1980) indicated that patient improvement, progress and recovery provided the greatest source of satisfaction. Other sources were opportunities for learning, intellectual challenge, excitement, pace and variety.

In support of the above study, Parahoo and Barr (1994) reported that nurses found

variation in work aspects to be important. In contrast to these findings, routinization was identified by authors such as Blegen (1993), Cavanagh (1992) and Cavanagh and Coffin (1992) as a positive factor related to job satisfaction. The difference in opinion may have been influenced by the number of changes encountered as a result of restructuring in different hospitals. Nurses who have had to adjust to numerous changes may be more interested in developing a routine to gain a sense of control over the work situation. Nurses may be more open to change if they have some involvement in the decision-making that precedes the change. Unfortunately for the nurses who take comfort in routinization, nursing is a profession that is always changing. Working with people, especially sick people, makes every day a challenge.

The organizational climate is yet another factor that has a bearing on nurse satisfaction. Factors related to organizational climate, identified in studies by Kramer and Hafner (1989), Gillies, Franklin and Child (1990) and Blegen and Mueller (1987) include working with competent nurses, not having to float, flexible work schedules, a climate high in responsibility, support and identity, fair distribution of rewards, and appropriate workload. Rewards from the work itself such as involvement with clients, progress of clients and appreciation of clients were also identified by Parahoo and Barr (1994) as factors related to job satisfaction.

Findings from a study in 1976 by Everly II and Falcione reported findings similar to the studies that were conducted more recently. These researchers found relationships with co-workers, immediate supervisors other supervisory personnel to be important. Intrinsic rewards such as the internal rewards gained from the work itself and the

development and use of new skills were also reported as being of the utmost importance to nursing staff. If the factors to increase job satisfaction are relatively unchanged for over 20 years, why isn't more being done to make improvements in the workplace?

Determinants of Job Dissatisfaction

Benefits and pay were less important than the other intrinsic factors listed, according to some authors such as Everly II and Falcione (1976) and Frisina et al. (1988). However they do become an issue when job dissatisfaction is being discussed. Pay was identified as the greatest source of dissatisfaction by nurses in the Metropolitan Toronto area in a survey by Murray and Smith (1988). The second most frequent source of dissatisfaction according to Murray and Smith was inservice education opportunities, followed by lack of recognition.

Job dissatisfaction has been identified as the single most important reason for nurses to leave their jobs in the research done by Frisina, Murray and Aird (1988). Parahoo and Barr (1994) identified six factors that were most frequently cited as resulting in job dissatisfaction. They include heavy caseload, administrative work, lack of resources, lack of communication, lack of recognition from other staff and lack of support from management.

A national overview of nursing issues in Canada conducted by the Canadian Nurses' Association (CNA) and the Canadian Hospital Association (CHA) in 1990 concluded that the "lack of adequate staffing, too many non-nursing tasks, lack of involvement in organizational decision-making, lack of educational opportunities and

inflexible working schedules" resulted in nurses being dissatisfied with their work situations.

A Job Context Index reported by Mansfield, McCool, Vicary and Packard (1989) was developed to help match staff with their work environment. These authors believe that nurses who are not properly matched to the job environment will have lower morale, increased stress and dissatisfaction with their work.

Staff behavior can also have a great effect on dissatisfaction. Mills & Pennoni (1986) found that lack of cooperation, lack of communication and territoriality can create a poor work environment.

Recommendations

Gillies et al. (1990) suggested that for nurse managers to improve job satisfaction amongst staff nurses they need to increase the staff nurses' autonomy, generate "espirit de corps" among staff, and encourage social activity amongst the nurses. In an era of cost containment, it has also been recommended by Kramer and Hafner (1989),that managers should find out what is really important to the staff prior to making budgetary decisions.

In 1990, both the Canadian Nurses' Association (CNA) and the Canadian Hospital Association (CHA) recommended promoting collegiality among nurses, other health care professionals and administration, recognition and respect for nurses, facilitation of professional growth and continued learning, and nurse involvement in decision-making.

An agenda for change was also promoted by Murray and Smith (1988) to help hospitals address staff morale issues and improve job satisfaction. Points of the agenda

included pay equity for experience and expertise, administration support for nurses and attention to nursing care issues, opportunities for clinical education, development of competent supervisors, and increased autonomy for nurses.

Magnet hospitals are a group of hospitals in the United States that have been recognized as being good places in which to work. They focus on maintaining a high level of satisfaction for patients and staff. Kramer and Schmalenberg (1988 a, b) have identified characteristics of these magnet hospitals that make them successful at maintaining a reputation as institutions in which nurses want to be employed. These characteristics include:

- increasing the amount and quality of the nursing staff
- accessibility and approachability of nursing leadership
- an atmosphere of informality and spontaneity
- encouraging communication, growth, identification and solution of problems, and the development of a pro-active stance.
- planned, comprehensive care and the continuity of care
- everyone shares the blame for failures; individuals are singled out for achievements
- phenomenal push for education from top administration to staff nurses
- employees are trained to feel empowered
- autonomy encouraged - staff are allowed the freedom to act on what they know
- people orientation- an overall sense of caring; staff kept informed of

institutional issues

- leaders implement visions and behave persistently simply by being visible
- decentralized structure with few people at the corporate level
- decentralized decision making
- the coexistence of firm central direction and optimum individual autonomy

If an effort is made by nursing management and staff to improve the work environment, job satisfaction will improve. This should ultimately lead to happier, healthier staff and more productive workers. The overall outcome should be improved patient care, which in turn increases nurses' satisfaction with their work.

Empowerment

Definitions

Empowerment has been shown to be associated with positive health outcomes in the workplace. Wallerstein (1992) described how lack of control over one's destiny, or powerlessness, has emerged as a risk factor for disease.

The definition of empowerment provided by Wallerstein (1992) is *"a social action process that promotes participation of people, organizations, and communities towards the goals of increased individual and community control, political efficacy, improved quality of community life, and social justice"* (p.198).

Effects of Powerlessness

Being poor, low in the hierarchy, without control and living in hardship, "being

powerless", has been associated with increased morbidity and mortality rates according to studies done on occupational health, socioeconomic status and stress, as reported by Wallerstein (1992). McDermott, Laschinger and Shamian (1996) described low ambition, lack of motivation and low commitment as being the result of poor opportunities in the workplace.

Recommendations to Promote Empowerment at the Workplace

According to Wallerstein (1992), for employees who have jobs that are considered high demand and low control, increased social support at the workplace has been effective in producing positive health outcomes such as reducing cardiovascular risk factors. She described activities such as participation in decision-making, developing a sense of community and gaining control over one's destiny to be health enhancing.

Several recommendations have been made by McDermott et al (1996). Some of these recommendations include recognition programs to reward achievement at all levels, non-traditional career moves and options, such as cross-functional programs, project teams and special task forces to allow for new relationships and new skills. They also suggest role modeling by clinical experts to increase the nurses' resources and to increase the nurses' effectiveness in teaching and counseling patients as well as in their communications with physicians and other coworkers.

Hiscott and Sharrat (1995) promoted active participation on key decision-making committees as a means for nurses to develop a sense of empowerment. This type of participation can increase nurses' confidence by assuring them that they have a voice in

the institution and that they are making a meaningful contribution. In the words of Paulo Freire *"to alineate men from their own decision making is to change them into objects"* (1970, p. 115).

Other recommendations from Wallerstein (1992), have suggested that health educators utilize empowerment programs by engaging people in group dialogues to problem-solve and develop action strategies. This may be a new concept to the health professions, yet Friere (1970) has always advocated critical thinking and dialogue as a key for the oppressed to gain control.

Many nurses feel they have little control over their work situations. Decisions are made that directly affect them without their having any input. Developing a sense of empowerment in the workplace may make nurses aware that they can also demonstrate control over their health and personal lives.

Workplace Wellness

Definition

According to Health and Welfare Canada (1990/1991), two thirds of Canadians over the age of 15 are employees who spend 60% of their waking hours at work. When surveyed, most of these employees agreed that the workplace is an appropriate place to promote health.

Health has been defined in 1947 by the World Health Organization (WHO) as *"a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."* (Potter and Perry, 1985, p. 38). In 1986, WHO further defined

health as " *a positive concept emphasizing social and personal resources as well as physical capacities"* (p. 1).

Wellness, according to Dunn (1959), involves the total person - body, mind and spirit. He defines it as *"an integrated method of functioning which is orientated towards maximizing the potential of which the individual is capable, within the environment where he is functioning"*(p. 477).

Health promotion is defined by WHO as:

> the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment (p. 1).

Workplace wellness programs are becoming a priority for many small and large businesses. Workplace wellness is also referred to as workplace health promotion. It is the "systematic effort by employers to provide various kinds of preventative health care to employees," as defined by Kotarba and Bentley (1988).

The British Columbia (BC) Ministry of Health and Ministry Responsible for Seniors (1991)defines health promotion as :

> - the process of enabling individuals and communities to increase control over - and thus improve - their health. In the workplace, this translates into a combination of educational, physical, recreational, social and environmental policies, activities and processes designed to promote and

support the health of employees and their families. (p. 4)

These BC Ministries also stress that health includes emotional, social, intellectual and spiritual elements.

Workplace Wellness Programs

Workplace wellness programs vary greatly. Kotarba and Bentley (1988)observed that most programs included at least one of four different types of intervention:

- education strategies - providing information on diet, lifestyle, health care
- evaluation screening - to identify past, current and potential health problems
- prescription programs - individual instruction on how to correct a current health problem or prevent a potential one
- behavior change support services - exercise equipment, aerobics classes

The BC Ministry of Health and Ministry Responsible for Seniors (1991) described a wide range of health promotion options available, including programs that look at the physical environment and the organizational structure as it affects employee health, programs that provide opportunities for employee growth, programs that address specific health practices such as smoking or drinking, programs that focus on the employee or family or retiree, and programs in which participants receive economic incentives versus fees by participants.

Eakin and Weir (1995) described two different approaches to workplace health in Canada. The first is lifestyle health promotion which focuses on non-work behavioral

determinants of health, but ignores the workplace as being a determinant. Secondly, occupational health and safety promotion addresses workplace issues, but not the non-work issues. Eakin and Weir defined the two approaches as being segmented and not holistic when considered individually. They suggested a more holistic, integrated approach needs to be considered. This type of comprehensive approach was supported by Walsh, Jennings, Mangione and Merrigan (1991) who concluded from the analysis of workplace wellness programs that the programs would be more effective if they integrated environmental protection activities with lifestyle risk management activities (health promotion plus health protection). The Ottawa Charter further addressed this issue. The Charter, as described by Anderson (1990/1991), states that workplace health promotion should not only include actions aimed at changing the work environment, but also changes that enable individuals to improve their health.

Weinstein (1986) described the two types of approaches addressed above according to their backgrounds. He noted that Europeans tended to focus on structural and legislative changes such as toxic chemicals and work design, often initiated by the unions. In comparison, North America has focused on personal health practices such as smoking, nutrition and exercise, usually initiated by senior management. Weinstein expected the distinction between these two approaches to blur as comprehensive health promotion programs began to surface.

Participation in Workplace Wellness Programs

Unfortunately, workplace wellness programs usually have low participation rates,

and many of the participants who do not enroll are considered to be the ones who could benefit the most, according to Kotarba and Bentley (1988). These researchers indicated that encouragement from peers, perceived pressure from management to participate and an effective instructor can help alleviate anxiety for new participants in a program. Their study also revealed that four types of experiences influenced the decision of an employee to join a wellness program. These included life cycle events, such as the aging process, perceptions of imminent risk to personal health, traumatic life events, and boredom at work.

Employee ownership and empowerment is a key factor in acceptance of a wellness program. As well, all levels of management must be supportive of the program, according to the BC Ministry of Health and Ministry Responsible for Seniors (1991). A pilot study by Stevens, Paine-Andrews and Francisco(1996) also noted employee involvement in the design of the program, with upper management being in support of the program, as a strength.

A participatory action research project conducted by Israel, Schurman, Hugentobler and House (1992) found that verbal commitment and support by top management in a program to reduce occupational stress was not enough. Direct involvement from management from the onset was necessary.

In reviewing international studies on workplace wellness, Dudgill and Springett (1994) found the most effective programs were comprehensive in nature, focusing on personal health behaviors and the workplace environment. They had high levels of participation of both management and employees, they were based on expressed needs,

and they offered a variety of interventions, especially social support.

Eakin and Weir (1995) have identified factors contributing to and impeding program effectiveness. Contributing factors, ranked in order of importance, include personal or face to face contact, low cost, provider sensitivity to employee needs, establishing a good reputation, skills and qualities of the program and its staff, employer/union/employee support, and maintaining confidentiality. Impeding factors include lack of money and resources, lack of time, and health and safety not being a priority for management.

The Impact of Workplace Wellness Programs

Employers are interested in workplace wellness programs for economic reasons such as containing health care costs and increasing worker productivity as well as for employee benefit, according to Kotarba and Bentley (1988). The BC Ministry of Health and Ministry Responsible for Seniors (1991) identified expectations of management from workplace wellness programs. These expectations include improved employee morale, reduction in costs (e.g. reduced sick time, fewer injury claims, and less absenteeism), increased productivity, decreased turnover, stronger corporate image, reduced back injuries, and improved labor relations.

The BC Ministry of Health and the Ministry Responsible for Seniors have listed results documented from BC businesses illustrating the effectiveness of workplace wellness programs. Results ranged from improvements in general health, reduction in job stress, decline in absenteeism to weight loss and smoking cessation, to relief from back

problems.

A review of American and Canadian research studies by Lusk (1997) on worksite health promotion and disease prevention programs from 1990 to 1994 reported that 68 out of 73 studies obtained positive results in terms of benefitting health or reducing costs.

A study by Bulaclac (1996) of a Work Site Wellness Program in a Michigan hospital found that 67% of the employees participating improved their health status. Indicators of improvement included elimination of back injury, consistent use of seat belts, non-smoking behaviors, and reduction in blood pressure, cholesterol and percentage of body fat. Unfortunately, many of the businesses using workplace wellness programs have not performed evaluations to determine the cost effectiveness resulting from such things as reduced staff illness.

Recommendations

Health and Welfare Canada (1990/1991) has compiled a list of actions that employees would like to see their employers incorporate at the workplace to improve health. These include supervisor training to increase sensitivity to employee concerns, providing recreational exercise facilities and resources, ensuring more employee input on the design and organization of work and encouraging employees to improve their health habits.

Fritz (1984) compiled a list of healthy strategies that organizations can use to make the environment more humane and productive. These include assessing the physical environment to determine the physical and chemical stressors that could be eliminated,

formalized support systems of three to five people to help with stress elimination and management, comprehensive worksite wellness programs, involving staff in planning or decision making that immediately affects them and providing educational opportunities.

Four strategies have been identified by Dooner (1990-1991) as being key to achieving a healthy organization. First, clear policy direction is necessary to convey to employees that their health and the health of the organization are one and the same. Secondly, individual and organizational self-efficacy or empowerment needs to be built. This refers to a sense of control and self-esteem on the part of employees. Thirdly, unnecessary organizational stress should be eliminated. Lastly, there needs to be a commitment to a healthier organizational culture rather than just a healthy climate, which is considered more short term.

Having a sense of efficacy was also addressed by Shain (1990/1991). He observed that employees who have little control or influence over their work are less likely to enjoy good health. He claimed this efficacy can be increased by allowing employees to participate in key aspects related to their work.

Health Canada has developed a system to help Canadian companies put health programs into place. It is called the Workplace Health System (WHS) and is based on the following five principles. The company needs to :

-meet the needs of all employees, regardless of their current level of health

-recognize the needs, preferences and attitudes of different groups of participants

-recognize that an individual's lifestyle is made up of an independent set of

habits

-adapt to the special features of each workplace environment

-support the development of a strong overall health policy

(Health Canada, 1998)

Summary

The literature on all aspects of workplace wellness is abundant. In particular, numerous recommendations have been made to reduce stress and burnout, improve morale, provide for a positive work environment and to encourage empowerment of individual staff members.

Responsibility for staff wellness belongs to both the individual and the institution. Some of the most noted recommendations include the development of a workplace wellness program, providing educational opportunities for staff and managers, finding ways to reduce workloads, increasing autonomy, increasing decision making opportunities for the staff member on issues that directly reflect on patient care, improving the channels of communication between all health care professionals, incorporating recognition programs, and promoting empowerment at the workplace.

A healthy health care worker, employed in a healthy environment, is happier and more productive. This ultimately results in improved health care to the client and economic benefits to the institution.

CHAPTER THREE

Survey Results

The data collected from the surveys was separated into five sections (A, B, C, D, E) according to demographics, stress, job satisfaction, morale and empowerment, and general workplace wellness issues. These were the categories used when the survey was first presented and they remain most appropriate for assessing the question that formed the focus of this study.

Section A- Demographics

This initial section of the survey provided the essential demographic information about study participants.

Response Rate

Table 1

Response Rate

	LPN	RN/RPN
Total # respondents	11	34
Sample size	16	58
Population	91	281

Note. LPN = Licensed Practical Nurse; RN = Registered Nurse; RPN = Registered Psychiatric Nurse

The response rate represents 69% of the LPNs randomly selected, and 59% of the RN/RPNs randomly selected. This represents 61 % of the sample population of 74 staff

nurses. One staff nurse had moved from the region before receiving her survey. The sample comprised 20% of the entire nursing population (372) at the hospital being studied .

Education and Continuing Education

Eleven of the 45 respondents were trained as LPNs. Twenty-nine of the respondents were diploma RNs or RPNs, and five were degree RNs. Four of the LPNs (36%) were enrolled in continuing education, and two of the RN/RPNs were enrolled (6%).

Nature of Employment and Work Rotation

RN/RPNs and LPNs from the following nursing units responded to the nursing survey:

- medicine	- operating room/recovery room	- floats
- maternal child	- mental health	- pediatrics
- ambulatory care	- emergency	- surgery
- intensive care	- intensive care nursery	

Twenty percent of respondents work on a casual basis. Forty-nine percent of respondents work on a part time basis. Thirty-one percent of respondents work on a full time basis.

Thirty-five percent of RN/RPN respondents work day/night rotations. Twenty-three percent work only day shifts. Fifteen percent work day/evening rotations. Twelve percent work day/evening/night rotations. Nine percent work only night shifts and 3% of

RN/RPNs work only evening shifts.

Fifty-five percent of LPN respondents work day/night rotations. Thirty-six percent work day/evening rotations and 9% work day shifts.

Seventy-six percent of the staff responding work eight hour shifts. Twenty percent work 12 hour shifts. Four percent work shorter shifts or the shifts vary if they are employed on a casual basis.

Age and Nursing Experience

Forty-five percent of respondents have been employed for 20 years or more. Twenty-nine percent of respondents have been employed for 11-19 years. Thirteen percent of respondents have been employed for six to ten years. Thirteen percent of respondents have been employed for five years or less.

Thirty-six percent of respondents were 46 years of age or older. Thirty-six percent of respondents were 36-45 years of age. Twenty-six percent of respondents were 26-35 years of age. Two percent of respondents were 25 years of age or younger.

Marital and Family Status

Eighty-seven percent of the respondents are married or in a common-law relationship. Eighty-two percent of the respondents have children. Thirty-eight percent have children under the age of 13.

Section B- Stress

This section of the survey provided information relating to staff nurses perceptions of stress, including what they perceive as the stressors, the effect stress has on individual staff nurses and their coping abilities.

Stress at Work

Forty-six percent of RN/RPNs reported they were fairly stressed. Thirty-nine percent reported they were not very stressed. Fifteen percent reported they were somewhere in between the above two categories.

Nine percent of LPNs reported they were very stressed. Fifty-five percent reported they were fairly stressed. Thirty-six percent of LPNs reported they were not very stressed.

Stress Now Compared to Past Years

Fifty percent of RN/RPNs felt they were more stressed now than they were 3 ½ years ago, however, fifty-five percent felt they were not more stressed now than one year ago.

Seventy-three percent of LPNs felt they were more stressed now than they were 3 ½ years ago and 64% felt they were more stressed now than one year ago.

Symptoms of Stress as Perceived by RNs, RPNs, and LPNs

Physical Symptoms of Stress

As shown in Figure 1, the most frequently reported physical symptom of stress was headaches (64%), followed by sleep problems (49%), stomach or bowel problems (36%), weight gain (24%), loss of libido (16%) and hypertension (9%). Less frequently reported symptoms included frequent infections (4%), weight loss and chest pain (2%).

Psychological Symptoms of Stress

As illustrated in Figure 2, the most frequently reported psychological symptom of stress was tiredness (82%), followed by frustration (62%), moodiness (56%), anxiety (27%), poor concentration (20%), apathy (16%), indecision (13%) and guilt (13%). Less frequently reported symptoms include depression (7%) and forgetfulness (4%).

Behavioral Symptoms of Stress

Avoidance (27%) was the most frequently reported behavioral symptom of stress, as illustrated in Figure 3, followed by relationship difficulties (20%), aggressiveness (18%), and being accident prone (9%). Less frequently reported symptoms include increased alcohol consumption (7%), increased use of prescription and non-prescription drugs (7%), and reduced socialization (4%).

Figure 1. The physical symptoms of stress experienced by RNs, RPNs and LPNs, according to their own personal perceptions.

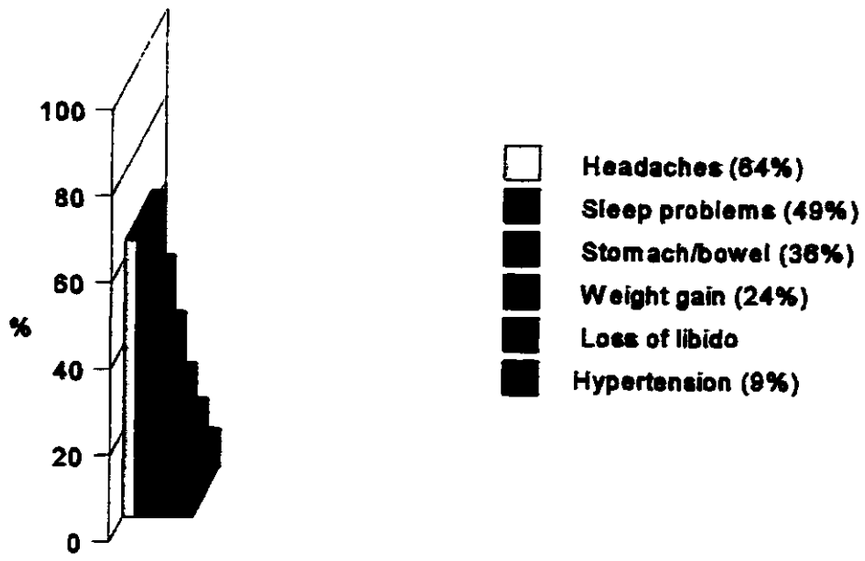


Figure 2. The psychological symptoms of stress experienced by RNs, RPNs and LPNs, according to their own personal perception.

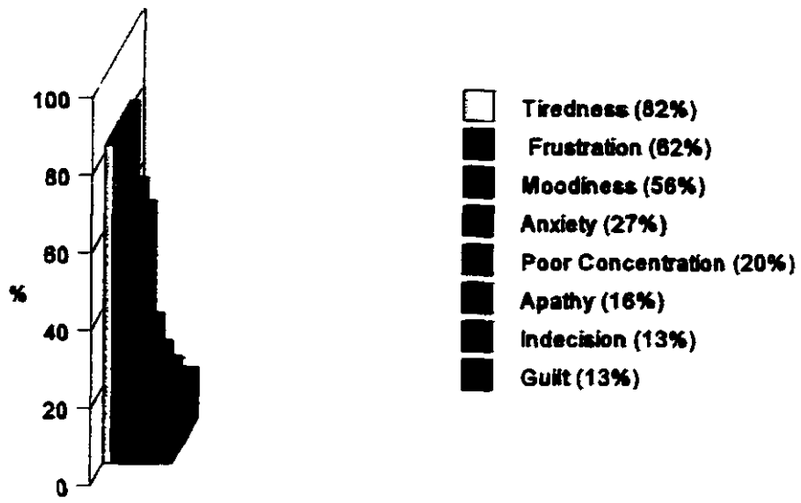
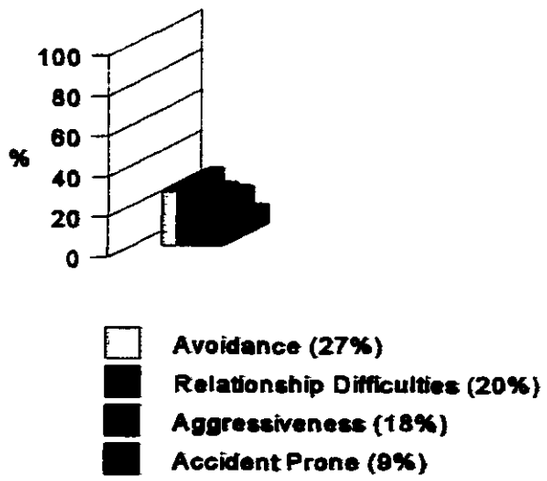


Figure 3. The behavioral symptoms of stress experienced by RNs, RPNs, and LPNs, according to their own personal perceptions.



The Effect of Staff Nurses' Personal Life on Work

Fifty-nine percent of respondents reported that their personal life had little effect on their work. Twenty-two percent of respondents reported that their personal life did not affect their work at all. Nineteen percent of respondents reported that work was affected quite a lot by their personal life.

The Effect of Work on Staff Nurses' Personal Life

Fifty-two percent of respondents reported that work affected their personal life a little. Twenty-seven percent of respondents reported that work affected their personal life a lot. Fourteen percent of respondents reported that work had no effect on their personal life. Seven percent of respondents reported that work impacted their personal life very much.

Types of Stressors Perceived by RNs, RPNs, and LPNs

Psychological Factors at Work Identified as Stressors

The most frequently reported psychological factor identified by nursing staff as a stressor was no control over workload (74% RN/RPNs; 82% LPNs). The other identified stressors differed according to RN/RPNs and LPNs (see Figure 4). RN/RPNs identified feeling under-valued and irregular workloads (56%) as the next most frequent stressors, followed by lack of recognition (47%), inconsistent application of management policies (44%), inadequate continuing education (41%), feeling unprepared to care for certain patients (35%), no participation in decision making (29%), inadequate knowledge (21%), pay not reflecting work (15%), lack of job security (15%), skills not fully used

(12%), and ethical judgements (12%).

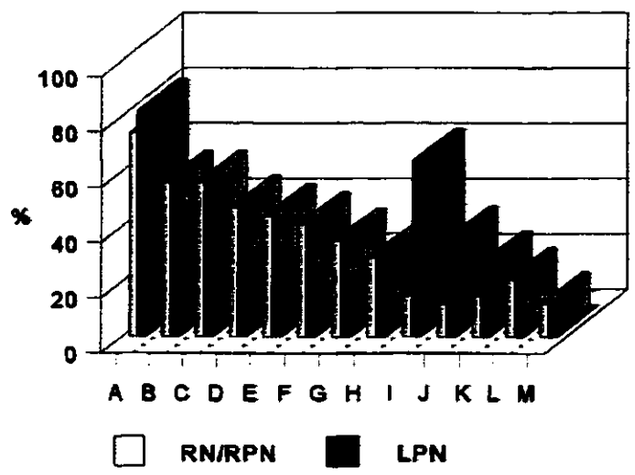
Pay not reflecting work (64%) was the second most frequently reported psychological factor acting as a stressor by LPNs, followed by feeling undervalued (36%), irregular workload (36%), skills not fully used (36%), lack of recognition (27%), lack of job security (27%), inconsistent application of management policies (18%) and feeling unprepared to care for certain patients (18%).

Stressors identified by RN/RPNS and not by LPNs included inadequate continuing education, no participation in decision making, inadequate knowledge, and ethical judgements.

What are the Most Significant Psychological Factors Acting as Stressors at Work?

Table 2 illustrates that both RN/RPNs and LPNs ranked no control over workload as the greatest psychological stressor. The second greatest psychological stressor for RN/RPNs was inconsistent application of management policies. Irregular workload was the second greatest stressor for LPNs.

Figure 4. Psychological factors acting as stressors at work, as perceived by RNs, RPNs, and LPNs



A- No control over work-load
B- Feeling undervalued
C- Irregular workload
D- Lack of recognition
E- Inconsistent application of management policies
F- Inadequate continuing education
G- Unprepared to care for certain patients
H- No participation in decision making
I- Pay doesn't reflect work
J- Skills not fully used
K- Lack of job security
L- Inadequate knowledge
M-Ethical judgements

Table 2

The Most Significant Psychological Stressors at Work

Type of Stressor	Staff Member	#1 Stressor	#2 Stressor
A- No control over workload	RN/RPN	38%	6%
	LPN	45%	18%
B- Feeling undervalued	RN/RPN	3%	15%
	LPN	9%	18%
C- Irregular workload	RN/RPN	9%	18%
	LPN	9%	27%
D- Lack of recognition	RN/RPN	6%	9%
	LPN	—	—
E- Inconsistent application management policies	RN/RPN	21%	9%
	LPN	—	—

What are the Individual Factors Acting as Stressors at Work?

No opportunities to relax (47% RN/RPN; 45% LPN) and working too many hours (35% RN/RPN: 18% LPN) were the most frequently reported individual stressors for RN/RPNs and LPNs as shown in Figure 5. The next most frequently reported stressor by RN/RPNs was no opportunities for learning (26%), followed by little time for family life (24%), too much responsibility (24%), trouble with supervision (15%), and working too few hours (12%).

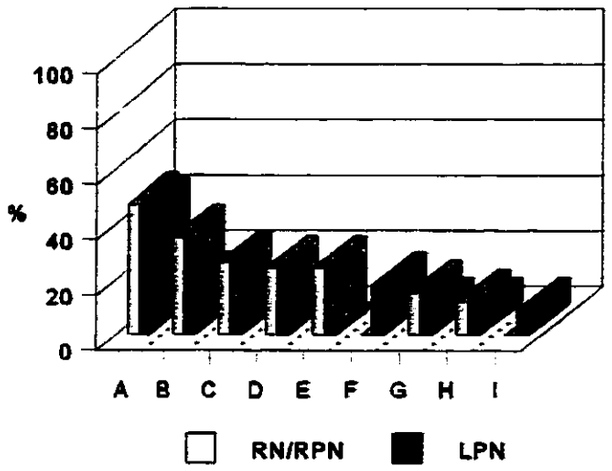
LPNs next most frequently reported stressor was insufficient responsibility (18%), followed by no opportunities for learning, little time for family life, trouble with supervision, working too few hours, and inconsistent hours (9%).

It is interesting to note that RN/RPNs identified too much responsibility as a stressor while LPNs identified insufficient responsibility as a stressor.

What are the Most Significant Individual Factors Acting as Stressors at Work?

As illustrated in Table 3, having no opportunities to relax and working too many hours were rated as the greatest individual stressors by RN/RPNs and LPNs. Insufficient responsibility was ranked as the greatest stressor for 18% of LPNs but was not identified as a stressor by any of the RN/RPNs.

Figure 5. Individual factors acting as stressors at work, as perceived by RNs, RPNS, and LPNs.



A- No opportunities to relax
B- Working too many hours
C- No opportunities for learning
D- Little time for family life
E- Too much responsibility
F- Insufficient responsibility
G-Trouble with supervision
H- Working too few hours
I- Inconsistent hours

Table 3

The Most Significant Individual Stressors at Work

Type of Stressor	Staff Member	#1 Stressor	#2 Stressor
A- No opportunity to relax	RN/RPN	21%	18%
	LPN	—	45%
B- Working too many hours	RN/RPN	26%	6%
	LPN	18%	—
C- Insufficient responsibility	RN/RPN	—	—
	LPN	18%	—
D- Little time for family life	RN/RPN	9%	6%
	LPN	9%	—

What are the Objective Environmental Factors Acting as Stressors at Work?

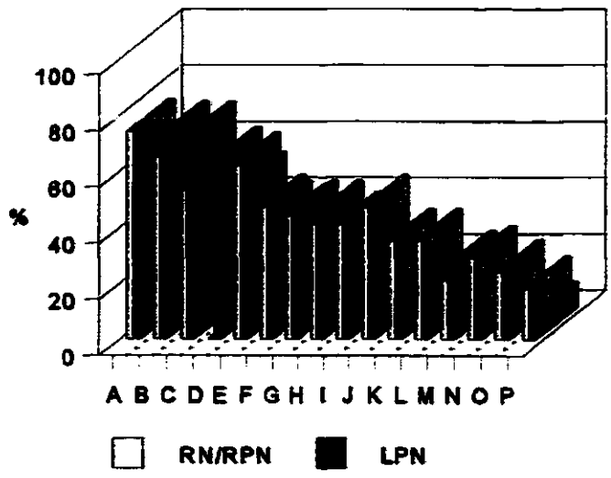
As shown in Figure 6, the most frequently reported objective environmental factor reported by RN/RPNs was inadequate staffing (74%) followed by highly demanding patients/family (65%), emotionally demanding work (62%), work overload (53%), shift work (47%), fast pace of work (47%), uncooperative patients (44%), physically demanding work (41%), lack of encouragement (41%), frequent interruptions (35%), critically ill patients (35%), work requiring quick reaction (29%), patient death (24%), rapid patient turnover (21%), and management policies (18%).

The most frequently reported environmental factors identified by LPNs were highly demanding patients/family and work overload (73%) followed by pay/benefits (64%), inadequate staffing (55%), emotionally demanding work (55%), shift work (45%), uncooperative patients (45%), physically demanding work (45%), rapid patient turnover (27%), lack of encouragement (18%), and frequent interruptions (18%). Less frequently reported stressors by LPNs include the fast pace of work, critically ill patients, work requiring quick reaction and management policies (9%).

What are the Five Most Significant Objective Environmental Factors Acting as Stressors at Work?

Inadequate staffing, as illustrated in Table 4, was identified as the greatest objective environmental stressor for RN/RPNs followed by highly demanding patients/family and work overload. Inadequate staffing was also rated as the greatest objective environmental stressor for LPNs followed by work overload and highly demanding patients/family.

Figure 6. Objective environmental factors acting as stressors at work, as perceived by RNs, RPNs, and LPNs.



A- Inadequate staffing
B- Highly demanding patients/family
C- Work overload
D- Pay/benefits
E- Emotionally demanding work
F- Shift work
G-Uncooperative patients
H-Physically demanding work
I- Lack of encouragement
J- Fast pace of work
K-Frequent interruptions
L-Critically ill patients
M-Rapid patient turnover
N-Work requiring quick reaction
O-Patient death
P-Management policies

Table 4

The Most Significant Objective Environmental Stressors at Work

Type of Stressor	Staff Member	#1 Stressor	#2	#3	#4	#5
Inadequate staffing	RN/RPN	29%	26%	9%	—	—
	LPN	36%	9%	9%		
Highly demanding	RN/RPN	15%	15%	—	15%	6%
patients/family	LPN	9%	8%	9%	—	18%
Work overload	RN/RPN	12%	21%	6%	9%	—
	LPN	18%	9%	27%	9%	9%
Pay/benefits	RN/RPN	—	—	—	—	—
	LPN	9%	—	—	9%	18%
Emotionally	RN/RPN	—	12%	12%	15%	9%
demanding work	LPN	—	—	18%	18%	—

What are the Physical Environmental Factors Acting as Stressors at Work?

The most frequently reported physical environmental stressor for RN/RPNs was poor ventilation (59%) followed by availability of supplies (50%), inadequate rest periods (29%), too much noise (26%), outdated equipment (24%), poor lighting (24%), not enough equipment (18%), and layout of the workplace (18%), as shown in Figure 7.

The most frequently reported physical environmental stressor for LPNs was availability of supplies (73%), followed by poor ventilation (45%), not enough equipment (36%), layout of the workplace (27%), too much noise (18%), outdated equipment (18%), and inadequate rest periods (9%).

What are the Most Significant Physical Environmental Factors Acting as Stressors at Work?

Availability of supplies and poor ventilation were rated as the two most significant physical environmental factors acting as stressors by both RN/RPNs and LPNs, as shown by the data in Table 5.

Figure 7. Physical environmental factors acting as stressors at work, as perceived by

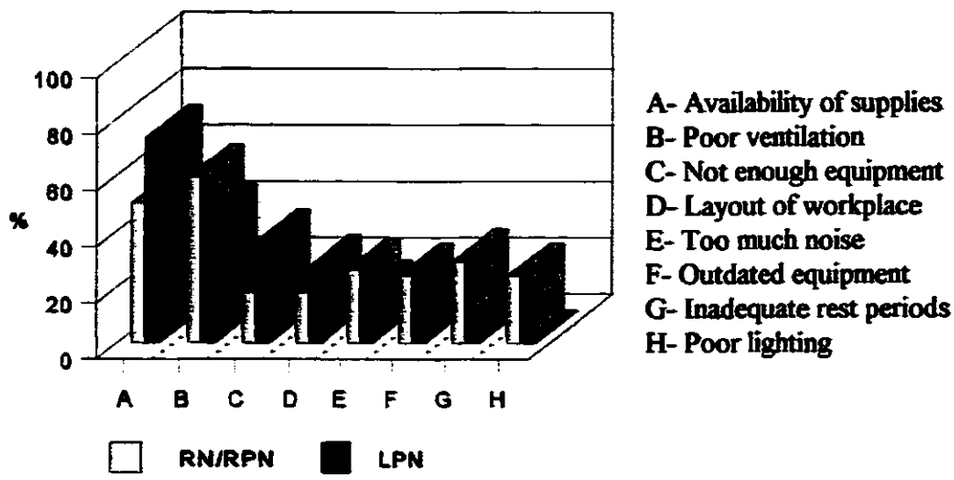


Table 5

The Most Significant Physical Environmental Stressors at Work

Type of Stressor	Staff Member	#1 Stressor	#2 Stressor
Availability of supplies	RN/RPN	12%	26%
	LPN	27%	36%
Poor ventilation	RN/RPN	18%	18%
	LPN	27%	9%
Not enough equipment	RN/RPN	15%	—
	LPN	9%	9%
Layout of workplace	RN/RPN	—	9%
	LPN	18%	9%

What are the Organizational Factors that Act as Stressors at Work?

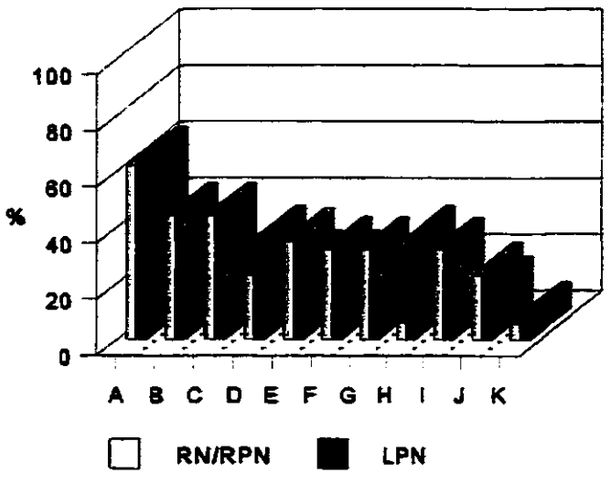
As illustrated in Figure 8, coworkers who don't make an equal contribution at work was the most frequently reported organizational factor acting as a stressor for both RN/RPNs (62%) and LPNs (64%), followed by coworkers in whose skills/judgements you don't have confidence (RN/RPNs 44%; LPNs 36%). The next most frequently reported stressor for RN/RPNs was lack of support from management and the management group (44%), followed by no performance feedback (35%), lack of teamwork with other departments (32%), poor communications/relations with management (32%), conflicts with physicians (32%), lack of appreciation from all levels of staff (23%), and poor communications/relations with coworkers (23%). Less frequently cited organizational stressors by RN/RPNs included poor pay/fringe benefits and little contact with management (6%).

The next most frequently cited organizational factors acting as a stressor for LPNs were lack of appreciation from all levels of staff and poor pay/fringe benefits (36%). These were followed by no performance feedback (27%), lack of teamwork with other departments (27%), lack of support from management and management group (18%), poor communication/relations with management (18%), and poor communications/ relations with coworkers (18%). Less frequently cited stressors by the LPNs included conflicts with physicians and little contact with management (9%).

What are the Most Significant Organizational Factors that Act as Stressors at Work?

Coworkers who don't make an equal contribution at work was the organizational factor rated as the most significant stressor for RN/RPNs and LPNs (refer to Table 6).

Figure 8. Organizational factors acting as stressors at work, as perceived by RNs, RPNs, and LPNs.



A- Coworkers who don't make equal contribution at work (don't carry their load)
B- Coworkers in whose skills/ judgements you don't have confidence
C- Lack of support from management and management group
D- Lack of appreciation from all levels of staff
E- No performance feedback
F- Lack of teamwork with other departments
G- Poor communication/ relations with management
H- Poor pay/fringe benefits
I- Conflicts with physicians
J- Poor communication/relations with coworkers
K- Little contact with management

Table 6

The Most Significant Organizational Stressors

Type of Stressor	Staff Member	#1 Stressor	#2 Stressor
Coworkers who don't make equal contribution at work	RN/RPN	29%	9%
	LPN	55%	9%
Coworkers in whose skills/ judgements you don't have confidence	RN/RPN	12%	18%
	LPN	—	27%
Lack of support from management and management group	RN/RPN	12%	3%
	LPN	9%	9%
Lack of appreciation from all levels of staff	RN/RPN	3%	6%
	LPN	9%	18%

Coping Skills

What are the Strategies Staff Nurses Use to Cope with Stress?

Talking with colleagues was the most frequently reported coping strategy by RN/RPNs (88%) and by LPNs (73%). The second coping strategy most frequently reported by RN/RPNs was talking with friends and family (82%), followed by relaxation and physical exercise (74%), not bringing work home (44%), taking a break from work (38%), massage (26%), crying or anger (21%), problem solving (18%), and avoidance (15%). Less frequently reported coping strategies for RN/RPNS included having a drink after work and smoking (refer to Figure 9).

LPNs identified similar coping strategies, citing relaxation and physical exercise (55%) and not bringing work home (55%) as the next most frequent coping strategy. These were followed by talking with friends and family (45%), taking a break from work (27%), massage (18%), avoidance (18%), and problem solving (18%). Less frequently reported coping strategies included having a drink after work, hobbies and prayer.

How do Staff Nurses Rate Their Own Ability to Cope with Stress?

None of the respondents considered themselves to have poor coping abilities. RN/RPNs ranked their coping ability slightly higher than LPNs. 20% of RN/RPNs believed that their coping ability was very good, 34% felt they were better than average, and 46% felt that their coping abilities were average (refer to Figure 10).

Only 9% of the LPNs reported their coping skills as very good, 27% reported they were better than average, and the largest percentage (64%) reported their coping skills as average (refer to Figure 11).

Figure 9. Methods identified by staff nurses as personal coping strategies.

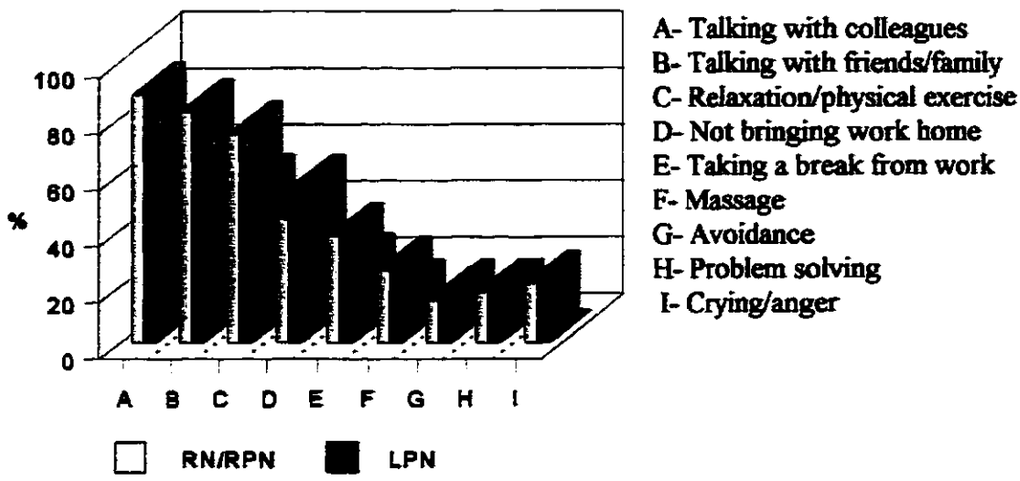


Figure 10. Personal Coping Skills as Rated Rated By RN/RPNs

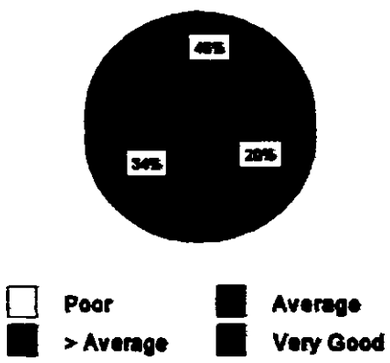
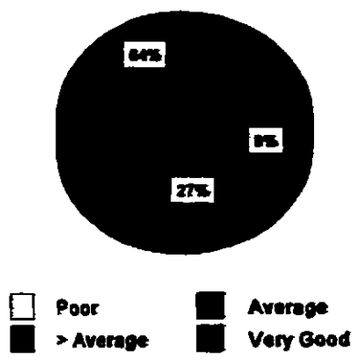


Figure 11. Personal Coping Skills as By LPNs



What Would Staff Nurses Consider to be Beneficial to Cope with Stress?

Forty-two percent of staff nurses completing the survey felt that 15-30 minute inservices on stress management would be beneficial. Thirty-one percent of staff nurses felt peer support groups would be beneficial. Twenty-seven percent felt that full day inservices would bebeneficial. Individual counselling, group counselling, and problem solving related to specific frustrations were less frequently reported.

Are Staff Nurses Satisfied with the Facilities Provided at the Workplace to Cope with Stress?

RN/RPNs - Fifty-three percent were not satisfied with the facilities provided. Thirty-five percent were satisfied. Twelve percent were undecided or reported being unaware of what facilities are available at work.

LPNs - Fifty-five percent were satisfied with the facilities provided. Eighteen percent were not satisfied. Twenty-seven percent were undecided or reported being unaware of what facilities are available at work.

Section C- Job Satisfaction and Physical Environment

This section of the survey provided information on job satisfaction related to the institution, nursing roles, quality of care, responsibility, leadership, communication, and opportunities for advancement.

Are Staff Nurses Satisfied with the Hospital as a Place of Employment?

As shown in Table 7, the majority of RN/RPNS (56%) and LPNs (55%) were satisfied with the hospital as a place of employment. Thirty-two percent of RN/RPNs and 45% of LPNs were just as satisfied as dissatisfied. Twelve percent of RN/RPNs reported being dissatisfied with the hospital as a place of employment.

Are Staff Nurses Satisfied with their Nursing Jobs?

The majority of RN/RPNs (50%) and LPNs (64%) reported being satisfied with their jobs, as shown in Table 7. Eighteen percent of RN/RPNs reported being completely satisfied.

How Satisfied are Staff Nurses with the Physical Condition of the Workplace?

As shown in Table 7, the largest percentage of RN/RPNs (38%) and LPNs (55%) were satisfied with the physical condition of the workplace. The next most frequent response fell under the category of just as satisfied as dissatisfied, with 32% of the RN/RPNs and 36% of the LPNs so reporting.

Table 7

Employment Satisfaction

		Completely Satisfied	Satisfied	Just as Satisfied as Dissatisfied	Dissatisfied	Completely Dissatisfied
Place of employment	RN/RPN	6%	56%	32%	12%	0
	LPN	0	55%	45%	0	0
Nursing Job	RN/RPN	18%	50%	24%	6%	0
	LPN	0	64%	36%	0	0
Physical condition of workplace	RN/RPN	6%	38%	32%	24%	0
	LPN	0	55%	36%	9%	0

How Satisfied are Staff Nurses with Shift Rotations?

RN/RPNs: Forty-five percent were satisfied with their shift rotation. Thirty-six percent were just as satisfied as dissatisfied. Nine percent were dissatisfied and 9% were completely satisfied.

LPNs: Fifty-five percent were just as satisfied as dissatisfied. Forty-five percent were satisfied. Nine percent were completely satisfied.

Forty-six percent of staff nurses were satisfied with the flexibility of their shift rotation. Fifty-four were not satisfied with the flexibility.

Job Satisfaction Pertaining to Specific Roles and Responsibilities

How often do Staff Nurses have to do Things with Which they are not Morally or Ethically in Agreement?

RN/RPNs - Fifty-three percent reported they rarely have to do things with which they are not morally or ethically in agreement. Twenty-six percent reported this never happens. Eighteen percent reported that this sometimes happens while 3% reported this often happens.

LPNs - Twenty-seven percent reported that they never have to do things with which they are morally or ethically in conflict. Forty-six percent reported that they rarely have to do this. Twenty-seven percent reported that they sometimes have to do this.

How Stressful is it for Staff Nurses when they have to do Something with Which they are not Morally or Ethically in Agreement?

RN/RPNs - Thirty percent reported that having to do something with which they are not morally or ethically in agreement causes some stress. Twenty-six percent reported that it is a little stressful. Fifteen percent reported that it causes a lot of stress. Three percent reported that they experience no stress as a result of this situation.

LPNs - Twenty-seven percent reported that having to do something with which they are not morally or ethically in agreement causes some stress. Twenty-seven percent reported that it causes a little stress. Nine percent reported that it results in no stress. Nine percent reported that it causes a lot of stress.

How Often are Staff Nurses Asked to do Non-Nursing Tasks?

RN/RPNs - Thirty-eight percent report that they are sometimes asked to do non-

nursing tasks. Another 38% reported that they are often asked. Nine percent reported that they are always asked to perform non-nursing tasks. Nine percent reported that they are never asked. Six percent reported that they are rarely asked.

LPNs - Forty-six percent reported they are often asked to perform non-nursing tasks. Eighteen percent reported that they are rarely asked and 36% reported that they are sometimes asked.

How Stressful Does the Staff Nurse Perceive it to be when Asked to Perform Non-Nursing Tasks?

RN/RPNs - Thirty-eight percent reported that being asked to perform non-nursing tasks causes them no stress. Twenty-nine percent reported that it causes a little stress. Twenty-one percent reported that it causes some stress and 3% reported that it causes a lot of stress.

LPNs - Forty-five percent reported that performing non-nursing tasks causes no stress. Twenty-seven percent reported a little stress and 18% reported some stress as a result.

How Frequently is the Workload so Heavy that Staff Nurses Lack the Energy for Free Time?

RN/RPNs - Fifty percent reported that sometimes the workload is so heavy that they lack the energy for free time. Twenty-nine percent reported that this often occurs. Twelve percent reported that this will rarely occur and 9% reported that the workload is never so heavy that they lack the energy for free time.

LPNs - Forty-six percent reported that they often lack the energy for free time as a

result of the workload being so heavy. Thirty-six percent reported that this sometimes happens. Nine percent reported that this rarely happens while another 9% reported that the workload is never so heavy that they lack the energy for free time.

How Satisfied are Staff Nurses with the Quality of Care Provided on the Nursing Unit?

Table 8.

Satisfaction with Quality of Care

	Completely Satisfied	Satisfied	Just as Satisfied as Dissatisfied	Dissatisfied	Completely Dissatisfied
RN/RPN	0	79%	18%	3%	0
LPN	10%	65%	25%	0	0

The majority of RN/RPNs (79%) and LPNs (65%) were satisfied with the quality of care provided on the nursing units, as shown in Table 8.

How Satisfied are Staff Nurses with the Ability to Fully Use Their Skills in Their Job?

The majority of RN/RPNs (70%) were satisfied with the ability to fully use their skills, whereas 64% of the LPNs were just as satisfied as dissatisfied with the ability to fully use their skills in their job. Nine percent of LPNs were dissatisfied with the ability to fully use their skills, while another 9% were completely dissatisfied.

Staff Nurses' Autonomy, Roles and Responsibility, and Participation in Decision Making

The information collected in the following paragraphs was gathered from a series of questions pertaining to nurses' autonomy, responsibility, and participation in decision making (refer to Table 9).

Table 9
Nurses' Autonomy, Roles and Responsibilities, and Participation in Decision Making

Statement	Staff Member	SA	A	Neither	D	SD
Nurses on this unit have a great deal of freedom and few rules and procedures to follow.	RN/RPN	0	15%	50%	3%	12%
	LPN	9%	9%	36%	46%	0
Nurses have to ask the NUS* before doing most anything.	RN/RPN	0	0	9%	53%	38%
	LPN	0	9%	27%	27%	36%
Nurses frequently participate in decisions to change or adopt new nursing techniques on this unit.	RN/RPN	9%	42%	27%	15%	6%
	LPN	36%	45%	9%	0	9%
Nurses have a great deal of freedom in deciding nursing interventions for patients without asking physicians.	RN/RPN	6%	33%	30%	30%	0
	LPN	0	18%	55%	27%	0
Most nurses on this unit follow their own ideas in implementing care.	RN/RPN	9%	36%	33%	15%	6%
	LPN	0	27%	27%	45%	0
Nursing staff are quickly discouraged about making their own decisions on nursing care.	RN/RPN	0	9%	36%	39%	15%
	LPN	0	0	45%	36%	18%
There are very precise definitions of nurses' duties on this unit.	RN/RPN	3%	33%	36%	21%	6%
	LPN	0	27%	36%	27%	9%
Responsibility and authority are emphasized on this unit.	RN/RPN	0	36%	48%	15%	0
	LPN	0	36%	36%	18%	9%
Nurses frequently participate in decisions regarding what nursing care will be given to individual patients.	RN/RPN	15%	70%	5%	0	0
	LPN	0	90%	0	9%	0

Note. SA = strongly agree; A = agree; Neither = Neither agree nor disagree; D = disagree; SD = strongly disagree; *NUS= nursing unit supervisor

Autonomy

Fifty percent of RN/RPNs indicated that they neither agreed nor disagreed with the statement that on their nursing unit, nurses have a great deal of freedom and few rules and procedures to follow. Another 35% disagreed or strongly disagreed with this statement. The largest percentage of LPNs (46%) actually disagreed with the statement, while another 36% neither agreed nor disagreed.

The majority of RN/RPNS (91%) and LPNs (63%) disagreed or strongly disagreed with the statement that they have to ask the Nursing Unit Supervisor before doing almost anything. However, staff nurses did feel less freedom in deciding nursing interventions for patients without asking physicians. Thirty percent of RN/RPNS and 27% of LPNs felt they did not have this freedom. Thirty percent of RN/RPNs and 55% of LPNs neither agreed nor disagreed with the statement. Thirty-three percent of RN/RPNS and 18% of LPNs agreed with the statement.

In regards to being able to follow their own ideas is implementing care, 45% of RN/RPNs agreed or strongly agreed with this statement, whereas 45% of LPNs disagreed with this statement. Fifty-four percent of both RN/RPNs and LPNs disagreed or strongly disagreed with the statement that they were discouraged from making their own decisions about nursing care.

Roles and Responsibility

Thirty-six percent of RN/RPNs and LPNs neither agreed nor disagreed with the statement that there are very precise definitions of nursing duties on their unit. Thirty-

three percent of RN/RPNs agreed that there were precise definitions while 21% disagreed. Twenty-seven percent of LPNs agreed that there were precise definitions while another 27% disagreed.

A large percentage of RN/RPNs (48%) and LPNs (36%) neither agreed nor disagreed with the statement that responsibilities and authorities were emphasized on their nursing units. Another 36% of RN/RPNs and LPNs agreed with the statement.

Participation in Decision Making

The majority of RN/RPNs (51%) and LPNs (81%) agreed or strongly agreed that they participate in decisions to change or adopt new nursing techniques on the nursing unit. However, 23% of RN/RPNs did disagree or strongly disagree with this statement. The majority of RN/RPNs (70%) and LPNs (90%) agreed that they did participate in decisions regarding the nursing care given to individual patients on the unit.

Leadership and Communication

Are Staff Nurses Satisfied with the Leadership and Communication Provided by the Nursing Unit Supervisor (NUS)?

Forty-four percent of RN/RPNs were satisfied or completely satisfied with the leadership provided by their NUS. Sixty-four percent of LPNs were satisfied. Thirty-eight percent of RN/RPNs and 27% of LPNs reported being just as satisfied as dissatisfied. A small percentage (18% RN/RPNs; 9% LPNs) reported being dissatisfied.

Forty-three percent of respondents reported that communication with their NUS is very adequate. Thirty-two percent of respondents reported communication as fairly

adequate. Eleven percent of respondents reported the communication as not very adequate. Nine percent of respondents reported the communication with their NUS as completely adequate, while 5%of respondents reported the communication as not at all adequate.

How Satisfied are Staff Nurses with Working Relationships and Communication on the Unit?

RN/RPNs - Sixty-seven percent were satisfied with the working relationships on their unit. Thirty percent were just as satisfied as dissatisfied. Three percent were completely satisfied.

LPNs - Thirty-six percent were just as satisfied as dissatisfied with the working relationships on their unit. Eighteen percent were completely satisfied, 18% were satisfied while 18% were not very satisfied.

Fifty percent of respondents felt nurses on their unit freely exchanged opinions and ideas. Forty-five percent felt nurses sometimes exchanged opinions and ideas. Five percent felt there was not a free exchange of ideas.

Seventy percent of respondents felt that their unit sometimes planned together and coordinated its efforts. Twenty-six percent of respondents felt that their unit always planned together and 4% felt that this never happened.

Sixty-four percent of respondents reported information sharing about important events and situations as sometimes adequate. Thirty-one percent were always satisfied with information sharing. Five percent felt that information sharing was not adequate.

Seventy-seven percent of respondents had mixed feelings as to the effectiveness of

staff meetings on the nursing units.

Satisfaction With Opportunities for Education and Advancement

How Satisfied are Nurses With Opportunities Provided by Hospital for Continuing Education and Updating Skills and Knowledge?

RN/RPNs: Twenty-seven percent were satisfied with the opportunities provided by the hospital for continuing education and updating knowledge and skills. Twenty-seven percent were just as satisfied as dissatisfied. Thirty-six percent were dissatisfied. Nine percent were completely dissatisfied.

LPNs: Forty-five percent were satisfied with the opportunities provided by the hospital for continuing education and updating knowledge and skills. Forty-five percent were just as satisfied as dissatisfied. Nine percent were dissatisfied.

How Might the Hospital Better Support Continuing Education?

Increased funding for continuing education was suggested most frequently as a method which the hospital could incorporate to better support continuing education. This included such things as paid time to attend inservices and staff replacement on the nursing units to attend inservices. Other suggestions were specific to the inservices themselves and inlcuded an increase in the amount of inservices, inservices offered at a variety of times to accommodate shift work, inservices that are specific to certain areas of care, and better advertising of upcoming events.

What are the Promotion Prospects in Nursing?

RN/RPNs: Forty-four percent felt their promotion prospects in nursing were poor.

Twenty-six percent felt their promotion prospects were fair. Twenty-one percent felt they were very poor. Six percent felt they were good. Three percent felt they were very good.

LPNs: Forty-six percent felt their promotion aspects were very poor. Thirty-six percent felt they were poor. Eighteen percent felt they were fair.

How Satisfied are RN/RPNs with Opportunities for Advancement into Nursing Unit Management Levels, Education or Research Positions, or Within the Staff Nurse Role?

Seventy percent of RN/RPNs felt they were just as satisfied as dissatisfied with the opportunities for advancement into Nursing Unit Management levels, education or research. Twelve percent were satisfied with the opportunities. Twelve percent were dissatisfied. Three percent were completely satisfied and 3% were completely dissatisfied.

Fifty-three percent of RN/RPNs were just as satisfied as dissatisfied with the opportunities for advancement within the staff nurse role (preceptor role, charge nurse, resource person). Twenty-six percent were satisfied. Nine percent were dissatisfied. Six percent were completely satisfied and 6% were completely dissatisfied.

Satisfaction with Salary and Benefits

Do Pay and Benefits Reflect Responsibilities, Years of Experience, and Expertise?

RN/RPN: Forty-one percent felt that the wages were average considering the responsibilities of a nurse. Thirty-two percent felt that the wages were good. Twenty-one percent felt the wages were poor. Six percent felt the wages were very good.

Fifty-nine percent felt years of experience were somewhat reflected in the pay. Thirty-five percent felt that years of experience were not reflected in pay. Six percent felt

they were reflected.

Seventy-one percent felt that special expertise was not reflected in pay. Twenty-nine percent felt it was somewhat reflected in pay.

LPNs: Forty-four percent felt the wages were poor considering the responsibilities. Forty-four percent felt the wages were average. Eleven percent felt the wages were good.

Sixty percent felt years of experience were not reflected in the pay. Forty percent felt they were somewhat reflected.

Forty-five percent felt expertise was not reflected in pay. Forty-five percent felt it was somewhat reflected. Nine percent felt it was reflected.

Perceptions of Job Satisfaction in Relation to Recognition, Teamwork and Communication, Roles and Responsibilities

Recognition

RN/RPNs are more satisfied with their present salary than LPNs. Thirty-seven percent of RN/RPNs agreed or strongly agreed that their present salary was satisfactory. Only 18% of LPNs agreed that their present salary was satisfactory, while 72% disagreed or strongly disagreed.

Seventy percent of RN/RPNs feel that the importance of nursing care to hospital patients is not sufficiently appreciated by most people. Fifty-four percent of LPNs felt the same, while another 36% neither agreed nor disagreed with this statement.

Thirty-eight percent of RN/RPNs indicated that physicians understand and appreciate what nursing staff do, while another 38% disagreed or strongly disagreed with

this statement. Forty-five percent of LPNs also did not feel that physicians understand and appreciate what they do.

Fortunately, almost all respondents identified their job as being very important and disagreed with the statement that their work does not add up to anything significant.

Teamwork and Communication

The majority of RN/RPNs (82%) agreed or strongly agreed that nursing personnel pitched in to help when things were in a rush. Fifty-four percent of LPNs agreed or strongly agreed, while another 27% neither agreed nor disagreed.

Many RN/RPNs (76%) and LPNs (63%) did not agree that a "rank consciousness" existed on the nursing unit.

The majority of RN/RPNs (77%) and LPNs (60%) believed the physicians do cooperate with nursing staff on the unit. Fifty-four percent of respondents also felt there was teamwork and cooperation between various levels of nursing personnel on the unit.

Most RN/RPNs (82%) and LPNs (81%) identified a gap between administration and the daily problems of the nursing service. Sixty-five percent of respondents also did not feel that nursing administrators consulted with staff on daily problems.

Roles and Responsibilities

Responses varied in relation to roles and responsibilities. Most RN/RPNs (62%) and LPNs (73%) disagreed or strongly disagreed with the statement that they have ample opportunity to participate in the administrative decision-making process.

A large portion of RN/RPNs (62%) and LPNs (73%) disagreed with the statement

that they had little control over their work. RN/RPNs in particular (56%) also felt that independence was permitted, if not required of them. However, only 23% of RN/RPNs and 18% of LPNs actually agreed with the statement that they had the freedom in work to make important decisions and be backed by the supervisor.

The responses to the statement of having too much responsibility and not enough authority were less definitive. Seventy percent of LPNs neither agreed nor agreed with the statement. RN/RPNs were equally divided in their responses.

Over 50% of respondents disagreed or strongly disagreed with the statement that there is plenty of time and opportunity to discuss patient care problems with other nursing personnel. Few agreed with the statement. Only 27% of RN/RPNs and 9% of LPNs agreed that there was sufficient time for direct patient care.

The above information on perceptions of job satisfaction is further illustrated in Table 10.

Table 10

Perceptions of Job Satisfaction

Statement	Staff Member	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
Present salary satisfactory	RN/RPN	12%	35%	19%	30%	3%
	LPN	0	18%	9%	45%	27%
Importance of nursing care to hospital patients not sufficiently appreciated by most people	RN/RPN	20%	50%	15%	15%	0
	LPN	9%	45%	36%	9%	0
Nursing personnel pitch in and help when things in a rush	RN/RPN	32%	50%	9%	6%	3%
	LPN	36%	18%	27%	18%	0
Physicians cooperate with nursing staff on the unit	RN/RPN	9%	68%	15%	6%	3%
	LPN	0	60%	40%	0	0
Gap between administration and daily problems of nursing service	RN/RPN	32%	50%	12%	3%	3%
	LPN	45%	36%	0	9%	9%
Sufficient input into patient's program of care	RN/RPN	6%	56%	23%	15%	0
	LPN	27%	36%	27%	9%	0
My job is really important	RN/RPN	47%	44%	9%	0	0
	LPN	55%	36%	9%	0	0
There is teamwork and cooperation between various levels of nursing personnel on unit	RN/RPN	9%	48%	27%	15%	0
	LPN	18%	36%	27%	18%	0
Too much responsibility and not enough authority	RN/RPN	6%	23%	38%	29%	3%
	LPN	0	10%	70%	20%	0
Supervisors make all the decisions. Little control over my own work.	RN/RPN	3%	12%	23%	56%	6%
	LPN	0	27%	9%	45%	18%
Satisfied with the types of activities done in job	RN/RPN	9%	52%	27%	12%	0
	LPN	0	82%	9%	9%	0

Table 10 (cont.)

Statement	Staff Member	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
Plenty of time and opportunity to discuss patient care problems with other nursing personnel	RN/RPN	0	21%	26%	41%	12%
	LPN	0	18%	27%	45%	9%
Ample opportunity to participate in administrative decision making process	RN/RPN	0	12%	26%	47%	15%
	LPN	0	9%	18%	64%	9%
Independence permitted, if not required	RN/RPN	15%	41%	23%	21%	0
	LPN	18%	9%	55%	9%	0
Work does not add up to anything significant	RN/RPN	0	3%	9%	53%	35%
	LPN	0	0	9%	73%	18%
"Rank consciousness" on unit.	RN/RPN	3%	6%	15%	47%	29%
	LPN	0	9%	27%	45%	18%
Sufficient time for direct patient care.	RN/RPN	6%	21%	32%	35%	6%
	LPN	0	9%	27%	55%	9%
Physicians understand and appreciate what nursing staff does	RN/RPN	0	38%	23%	32%	6%
	LPN	0	18%	27%	45%	0
I have the voice in planning policies and procedures that I want	RN/RPN	0	29%	29%	29%	12%
	LPN	9%	27%	9%	36%	9%
Nursing administrators consult with staff on daily problems	RN/RPN	0	6%	29%	41%	24%
	LPN	0	9%	27%	55%	9%
Freedom in work to make important decisions, and supervisors will back me	RN/RPN	3%	20%	50%	20%	6%
	LPN	0	18%	27%	45%	0

Section D- Recognition

The following information relates to morale and empowerment. Respondents were asked to reply to questions pertaining to recognition and respect they receive from patients, co-workers, supervisors and other members of the health care team.

How Important is it for Staff Nurses to Receive Recognition for Their Work from the Highest Level of Management?

Forty-two percent of respondents reported it was somewhat important to receive recognition from the highest level of management. Twenty percent felt it was very important, while another 20% felt it was not very important. A small percentage, as shown in Figure 12, felt it was extremely important or not at all important.

How Often do Staff Nurses Receive Recognition for Their Work from the Highest Level of Management?

Fifty-eight percent of respondents reported they rarely receive recognition from the highest level of management. No respondents indicated they often or always receive recognition (refer to Figure 13).

Figure 12. The importance of recognition from the highest level of management, as perceived by RNs, RPNs, and LPNs.

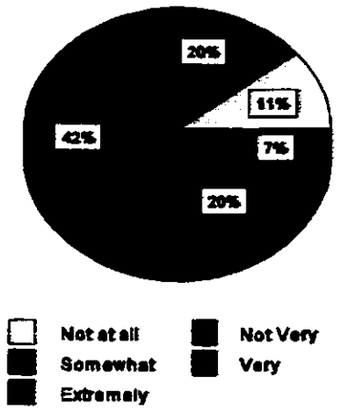
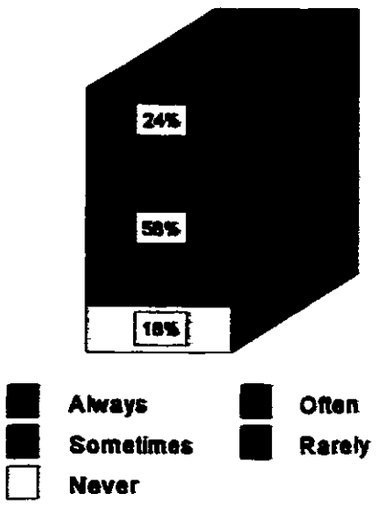


Figure 13. The frequency of recognition from the highest level of management, as perceived by RNs, RPNs, and LPNs.



How Important is it for Staff Nurses to Receive Recognition for Their Work from Nursing Administration?

Respondents perceived recognition from nursing administration to be more important than recognition from the highest level of management. Seventy-five percent of respondents felt it was somewhat or very important to receive recognition from nursing administration (refer to Figure 14).

How Often do Staff Nurses Receive Recognition for Their Work from Nursing Administration?

The frequency of recognition of work from nursing administration was perceived to be almost identical to the perceived frequency of recognition from the highest level of management, as shown in Figure 15. Seventy-six percent of respondents felt that they rarely or never received recognition from nursing administration.

Figure 14. The importance of recognition from nursing administration, as perceived by RNs, RPNs, and LPNs.

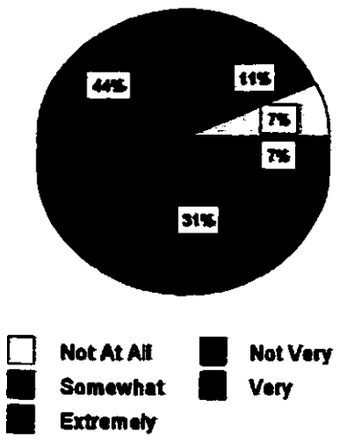
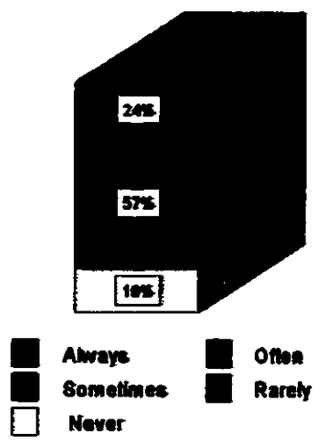


Figure 15. The frequency of recognition from nursing administration, as perceived by RNs, RPNs and LPNs.



How Important is it for Staff Nurses to Receive Recognition for Their Work from the Immediate Supervisor?

Staff nurses perceived recognition from the immediate supervisor as more important than recognition from nursing administration or the highest level of management. Thirteen percent felt it was extremely important, 36% felt it was very important, and 40% felt it was somewhat important. Very few staff felt that recognition from this level was not important, as shown in Figure 16.

How Often do Nurses Receive Recognition for Their Work from the Immediate Supervisor?

Nurses perceived that they received recognition more frequently from their immediate supervisor than from other levels of management. Twenty-two percent of respondents felt they always or often received recognition for their work from their immediate supervisor. A large percentage (49%) felt they sometimes received recognition, as shown in Figure 17.

Figure 16. The importance of recognition from the immediate supervisor, as perceived by RNs, RPNs, and LPNs.

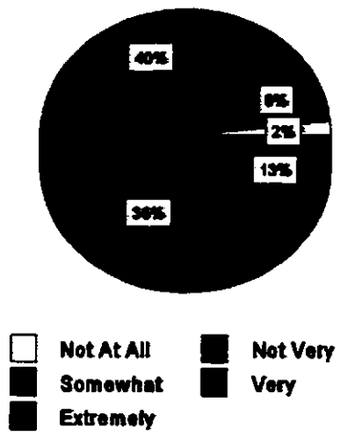
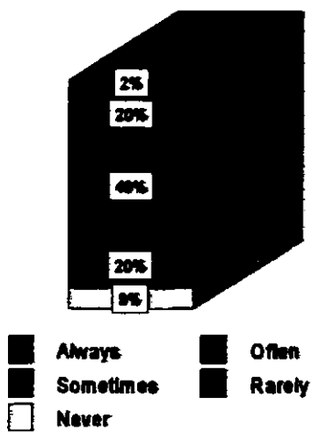


Figure 17. The frequency of recognition from the immediate supervisor, as perceived by RNs, RPNs, and LPNs.



Do Staff Nurses Perceive Themselves to be Respected by Other Members of the Health Care Team, Physicians, Patients and Family ?

Forty-six percent of respondents reported they felt the nurses on their unit were often respected by other members of the health care team. Forty-two percent felt that they were sometimes respected. Nine percent felt that they were always respected, while 2% felt that they were rarely respected.

Forty-four percent of respondents felt that physicians sometimes treat nurses with the respect they deserve. Forty-two percent felt the physicians often treat them with the respect they deserve. Eleven percent felt they were rarely treated with the respect they deserve. Two percent felt they were always treated with the respect they deserve.

Fifty-three percent of respondents were satisfied with the respect they received from patients and family. Twenty-nine percent were just as satisfied as dissatisfied. Eighteen percent were dissatisfied with the respect that they received.

How Often Do Patients and Family Show Appreciation for Nursing Work?

Fifty-six percent of nursing staff felt that patients and family sometimes showed appreciation for nursing work. Forty-two percent felt that appreciation was often shown. Two percent felt that it was rarely shown.

How Often Do Staff Nurses Perceive Themselves Being Regarded as a Service Rather than a Care-Giver by Patients or Family?

Fifty-one percent of nursing staff felt they were sometimes regarded as a service. Thirty-three percent felt they were often regarded as a service. Twelve percent felt they were rarely regarded as a service and 3% felt this never happened.

How Much Conflict do Staff Nurses Perceive they have with Physicians?

RN/RPNs: Sixty-five percent felt they experienced a little conflict with physicians. Twenty percent felt they experienced some conflict. Fifteen percent felt they experienced no conflict.

LPNs: Sixty-four percent felt they experienced no conflict with physicians. Eighteen percent experienced a little conflict. Nine percent experienced some conflict.

Do LPNs Perceive Being Treated with the Respect they are Entitled to by RN/RPNs?

Fifty-five percent felt they were often treated with the respect they are entitled to by RN/RPNs. Twenty-seven percent felt they were sometimes treated with this respect. Eighteen percent felt they were always treated with the respect they are entitled to.

How much Conflict Do LPNs Perceive they have with RN/RPNs?

Forty-five percent felt they experience no conflict with RN/RPNs. Thirty-six percent felt they experience some conflict. Eighteen percent felt they experience a little conflict.

Section E- Wellness

The following data pertains to healthy lifestyle, musculo-skeletal injuries, stress and wellness education.

What Activities do Staff Nurses Regularly Partake in to Maintain a Healthy Lifestyle?

Following a healthy diet was the most frequently cited activity, followed by regular exercise, relaxation techniques, and spiritual growth. Ninety-six percent of staff responding to the questionnaire were non-smokers.

How Many Staff Nurses have Experienced Back Pain?

As shown in Table 11, 56% of RN/RPNs and 27% of LPNs have experienced back pain in the last six months.

Table 11

Back Pain Experienced by Nursing Staff

Time Period	RN/RPN	LPN
In the last 6 months	56%	27%
In the last year	29%	27%
In the last 3 years	35%	18%
During career	50%	36%

How Many Staff Nurses have Experienced Muscular Injuries Resulting in Lost Time at Work?

As shown in Table 12, 6% of RN/RPNs and 27% of LPNs have had a lost time

injury at work in the last 6 months as a result of a muscular injury.

Table 12

Lost Time From Muscular Injuries

Time Period	RN/RPN	LPN
In the last 6 months	6%	27%
In the last year	9%	18%
In the last 3 years	15%	9%
During career	15%	18%

How Many Staff Nurses have had Lost Time at Work as a Result of Stress or Patient Violence?

Two percent of respondents reported having to be off work as a result of an injury from patient violence or aggression.

Seven percent of respondents reported that they were off work as a result of a stress leave. Sixteen percent of respondents reported being off work from a stress-related illness.

How Many Staff Nurses Would be Interested in Information Sessions Related to Wellness?

Sixty-seven percent of respondents expressed an interest in stress management information sessions. Fifty-seven percent of respondents expressed an interest in lifestyle management classes. Sixty-six percent of respondents indicated they would be interested in participating in a fitness program organized through the hospital.

How Many Staff Nurses Would be Interested in Recognition Programs

Sixty percent of respondents were interested in a recognition program that would recognize individual nurses for their excellence in nursing care.

Sixty-six percent of nursing staff were interested in a recognition program for absence from sick time.

What Activities do Staff Nurses Identify as Important That They Could Personally Partake in to Improve Their Own Level of Wellness?

The most frequently reported personal activity that staff identified as important to partake in to improve wellness was exercise. Eating a healthier diet was also commonly identified as being important, followed by engaging in relaxation techniques, participating in educational activities, and getting adequate rest. Less frequently cited activities included reducing or eliminating shift work, focusing on personal relationships, and participating in stress management classes.

What Activities do Staff Nurses Identify as Important That the Institution Could Incorporate to Improve the Level of Staff Wellness?

The responses for this question have been divided into the following categories:

Valuing - The most frequently cited suggestion was to implement recognition programs at the hospital, including recognition for good service, staff appreciation, and rewards for not taking sick time. More respect from physicians was also noted.

Working Conditions - Staffing was another major concern for staff. An increase in staffing was recommended to reduce workload, to increase the nurse:patient ratio, and reduce the amount of call-backs of regular staff members. Reducing the amount of off-

service patients was also suggested as a way to make the work easier.

Wellness - Several staff would like to have access to exercise facilities, either in the hospital or at reduced rates in an exercise facility that would include some exercise instruction.

Communication - Several areas were identified where communication could be improved. Regular staff evaluations were recommended to allow for positive feedback and to assess whether all staff were contributing equally to the workload.

- Improving communication with management also appears to be an important issue. Suggestions include management being more aware of day-to-day bedside nursing, dealing with problems promptly, and communication on a more personal level.

- More regular staff meetings were suggested as a way to improve communication between coworkers and identify current issues on the ward.

- Improving communication between different departments was also identified.

Support - Backing from management, peer support groups and easy access to debriefing or other support groups were recommended.

Education - Paid time to attend inservices, and inservices on lifestyle, wellness and the promotion of staff health were suggestions for teaching opportunities.

Empowerment/Morale - Some staff indicated that they would like more input into decision-making, input into their nursing rotations, and involvement in team activities. A system for recognizing nurses for their expertise was another suggestion.

Physical environment - Providing quiet and comfortable areas in which nurses could take their breaks, maintaining equipment in good working condition, maintaining adequate amounts of supplies/equipment, and better ventilation (windows that open) were other recommendations that the hospital could do to improve staff wellness.

CHAPTER FOUR

Analysis of Results

Response Rate

The response rate for the survey was very satisfactory. Some staff voiced concerns about confidentiality and anonymity because their name accompanied the survey on the consent form. Some surveys were not completed for this reason. Others completed the survey but commented that they may not have been as honest as they could have been because of the concern with anonymity and the relatively small size of the hospital. Confidentiality may have been a concern with the men responding to the survey because there are only 11 employed in acute care. The response rate was noted to be greater on the nursing units that have personal or professional connections to the researcher.

Some staff commented that they do not like to complete questionnaires. Some staff may feel that the survey brings out interesting information but doubt if it will have any effect in the "system". Some staff were very honest about how they felt about certain issues, possibly because they were issues of great concern to them, but also because the researcher holds an education position at the hospital. An educator is in close contact with both staff and management, yet does not hold a management position. This may allow staff to be forthcoming with information, without being identified by management, and expect that something may result from the research.

Some of the issues identified as being stressors for the staff may have had an effect on the number of people completing the questionnaire. Workload is heavy, preventing

many from being able to complete the questionnaire at work. Those who had time to complete it at work may have felt uncomfortable doing so because of the personal nature of many questions. Many people try to leave work at work, and may not have wanted to take time out of their personal lives to complete it at home.

The survey required a lot of time and thought on the part of staff members and the timing of the survey may have been more appropriate earlier in the fall and not so close to Christmas season.

Also, another international survey similar in nature was distributed shortly before this survey. Some people may have felt that completing one survey was enough. It may also speak to the morale of nurses. This survey may have been seen as more work, and since it does not directly relate to patient care, it may not have been seen as a high priority. Some nurses are reluctant to take on additional tasks other than what they perceive to be their specified nursing duties. This attitude may have resulted from the constant heavy workloads nurses have had to deal with. With all of these factors to consider, the response rate was certainly acceptable.

Differences in Responses Between RN/RPNs and LPNs

There were some differences in responses between RN/RPNs and LPNs. Some of the differences may be a result of job descriptions and roles. LPNs over the last three years have been required to take additional courses before being allowed to register with their professional association in 1999. For some of the LPNs, this was a very stressful experience and may explain why a larger percentage (73%) of LPNs reported being more

stressed than 3 ½ years ago. This may also help to explain the larger percentage of LPNs compared to RN/RPNs enrolled in continuing education. LPNs' perception of less conflict with physicians may be because it is usually the RN/RPN who has the most frequent contact and makes rounds with the physicians.

Poor pay and benefits, job insecurity, and not being able to use skills to the fullest were factors that LPNs identified as stressors more frequently than RN/RPNs. The LPN wage is not significantly greater than that of the nursing aides, who require no training. The additional course requirements of the LPN association for registration had raised several concerns in this hospital about whether some staff were going to be able to work in 1999. Some of the courses the LPNs were required to take cannot be put into practice because the hospital does not allow them to perform the duties associated with the courses, particularly in the acute care wing of the hospital. Robinson, Roth and Brown (1992) reported that morale was better if there was a match between the nurse's skills and the requirements of the nurse's practice.

Stress

The level of stress reported by staff members was lower than expected. Only 46% of RN/RPNs and 64% of LPNs reported they were fairly stressed or very stressed. This is low in comparison to the results of a study performed in England by Cole (1992) that reported 93% of nurses considered themselves stressed at work. The cutbacks in England may have been greater than at the hospital in this study. Some of the larger nursing centres in Alberta are having a more difficult time with health care restructuring than the

hospital surveyed. Many staff at this hospital consider themselves fortunate when they hear of the working conditions in nearby hospitals. Alternately, experiencing stress may be perceived as a weakness by some staff members and, therefore, they do not want to admit to it. As well, stress may be experienced for a long period of time before individuals are even aware of the effects it is having on them personally. It is much easier to observe the effects of stress on coworkers than it is to see it in oneself.

Even though the level of stress was not reported as high as anticipated, several symptoms of stress were reported. 82% of the staff reported feeling tired, 66% experienced headaches, 64% experienced frustration, 55% experienced moodiness or irritability, 50% reported sleep disturbances and 34% reported stomach or bowel problems. These results can be compared to Cole's findings (1992) which found 82% reporting tiredness, 67% being moody or irritable, 64% experiencing headaches, 62% with sleep problems, 58% frustrated, and 30% reporting stomach or bowel problems.

Staff did find that work had a greater effect on their personal life than their personal life had on work. The findings from this survey question may have been underestimated because some staff are unaware of the effects that their work life or personal life have on the other aspects of their lives.

Numerous stressors were identified in the workplace. The large number of stressors identified may indicate that staff underestimated their level of stress or it may show they are coping well with many stressors. The huge increase in the amount of sick time over the last three years suggests that the former assumption may be more correct rather than the latter, and that stress levels may continue to increase unless changes are

made within the working environment.

The most frequently reported stressors were objective environmental and psychological factors including inadequate staffing, highly demanding patients and family, work overload, no control over workload, emotionally demanding work, and lack of recognition. This supports several studies from the literature review. Shortage of staff was identified as a major stressor by Bailey, Steffan and Grout (1980), Foxall, Zimmerman, Standley and Captain (1990), and Hockey (1987). It was also identified as a factor sending morale to an all-time low by Fromant (1988). The Canadian Nurses' Association (CNA) and the Canadian Hospital Association (CHA) (1990) listed lack of adequate staffing as a source of job dissatisfaction. The respondents in this study ranked it highest as an environmental stressor.

Working with highly demanding patients and family was a not a major stressor addressed in previous studies. Patient care was cited as a both a great source of stress and a great source of satisfaction in a study by Bailey, Steffan and Grout (1980). This factor may be becoming more prevalent within the health care system today as patients and family become more knowledgeable about their own health and may have greater expectations from the health care system.

A report by Haw, Claus, Durbin-Lafferty and Iverson (1984a) stated that "work overload may emerge as the single greatest contributor to low morale" and was supported by a study in Wales by Nolan, Nolan, and Grant (1995). Studies by Hache-Faulkner and MacKay (1985), Foxall et al (1990), Cole (1992), and Shain (1997) all supported workload as a top stressor for nursing staff. Wade (1993) reported that job satisfaction

can be seriously compromised by heavy workloads. Many of the nursing staff (79%) responding to this survey felt they sometimes or often lacked the energy for free time as a result of heavy workloads.

No control over workload was reported as being more significant than the amount of the workload itself by Sauter, Murphy, and Hurrell (1992). This conclusion was supported by the National Institute for Occupational Health and Safety (Seago and Faucett, 1997) that described high stress occupations as being high demand with no control. Approximately 78% of the respondents in this study felt that lack of control over workload was a major stressor.

Lack of recognition as a stressor was supported by several studies in the literature review. Coulter (1991) identified it as a source for low morale. Conversely, recognition has been identified as a source of job satisfaction by Parahoo and Barr (1994), Blegen (1993), Frisina, Murray and Aird (1988), and Kramer and Hafner (1989). In this study, lack of recognition was identified as a stressor by 47% of RN/RPNs. Respondents to this study also identified the importance of recognition from the different levels of management. Eighty-nine percent felt that recognition from their immediate supervisor was from somewhat to extremely important.

Death and dying was cited as a significant stressor in the literature review but was ranked #15 amongst other objective environmental factors by the respondents in the study. Staffing and workload issues seem to have overshadowed patient death as a stress factor for members of this staff.

The coping strategies that staff identified as being most frequently used include,

firstly, talking with colleagues (84%), followed by talking with family and friends (71%), relaxation and exercise (69%), and not bringing work home (47%). These correspond with the findings in the study done by Coles (1992) in which 77% of the staff talked to colleagues to help them cope with stress and 54% relied on relaxation and physical exercise to help them cope. Avoidance was identified by 17% of the respondents as a coping mechanism. Avoidance was identified by Ceslowitz (1989) as a coping mechanism used by nurses experiencing higher levels of burnout.

Many of the RN/RPNs were satisfied with the facilities provided by the hospital for coping with stress. The LPNs were not as satisfied, and they also rated their coping ability lower than the RN/RPNs. Several factors may play a role in this, including the results that many LPNs disagreed with the statement that they have a great deal of freedom and few rules and procedures to follow while RN/RPN response was more indifferent to this question. RN/RPNS also reported being more satisfied with their working relationships than the LPNs. LPNs were more dissatisfied with pay and benefits, and most felt that promotion prospects were very poor. Despite that, however, none of the LPNs reported being dissatisfied with the hospital as a place to work and none reported being dissatisfied with their job.

Nurses indicated the physical symptoms of stress they experience and the variety of stressors that exist in the workplace, yet they rated their level of stress as fairly high rather than very high. Effective coping skills may help to explain how nurses are rating their own level of stress, or it may be that nurses need to be taught to better evaluate their own levels of stress, as compared to evaluating the stress level in other people. Nursing

training has taught nurses that their priority is the patient. In order to best care for the patient, nurses must also learn to care for themselves.

Job Satisfaction

Communication was a primary concern for the nursing staff in this survey. The majority of nursing staff felt there was a communication gap between administration and the daily problems of the nursing service. Communication with the Nursing Unit Supervisors, however, was mostly rated as very adequate or fairly adequate, with some of the responses varying according to nursing units or to a specific Nursing Unit Supervisors (NUS). Satisfaction with the leadership shown by the NUS was lower, especially for the RN/RPNs. In this hospital, the supervisors are not routinely given any training in leadership skills when they take on such positions. Also, workload has increased for the NUS as well as the staff members. A lot of this extra work is paper work or meetings, making them less visible on the nursing units - the opposite of what the nursing staff may need to maintain a supportive environment. Murray and Smith (1988) concluded from their study findings that the nurses' relationships with the NUS were important for job satisfaction. This was also supported in the literature review by Everly II and Falcione (1976) who reported on the importance of the relationship with immediate supervisors.

Interpersonal relations with coworkers play an important role in stress and job satisfaction. The majority of RN/RPNs (70%) were satisfied with their working relationships. Some of the LPNs (18%) reported that they were dissatisfied with the

working relationships, while another 18% were just as satisfied as dissatisfied. Working with coworkers who don't carry their load was the most frequently reported organizational stressor (63%), followed by staff not having confidence in the skills or judgements of their coworkers (40%). The relationship with coworkers is extremely important. Trust and respect need to be present. Talking with colleagues is also identified in the research results as the most common coping mechanism for stress by the staff members. Maintaining these strong, productive interpersonal relationships must be a priority in any effective organization.

Conflict with physicians was rated as one of the two most significant organizational stressors for some of the RN/RPNs (15%). Several respondents commented that it was only in regards to a certain few physicians. In this study, conflict with physicians appears to be greater for RN/RPNs (32%) than LPNs (9%). RN/RPNs have more contact with physicians. The majority of staff felt that physicians cooperated with nursing staff on the units, yet a considerable percentage (42%) did not feel that physicians understand and appreciate what nursing staff does. For example, 44% of RNs felt they were sometimes treated with the professional respect they deserve by physicians. Bailey et al. (1980) reported personality conflicts with physicians as a frequent source of stress in their study of intensive care nurses. The majority of RN/RPNs (65%) in this study indicated that such conflicts were not so frequent and 64% of the LPNs reported having no conflict with physicians.

Lack of participation in decision making was another important stressor. While many nurses felt that they participated in decisions regarding the nursing care given to

individual patients and did not feel the Nursing Unit Supervisor made all the decisions, some (29%) did not report having a great deal of freedom in deciding nursing interventions for the patients without consulting with the doctor. Sixty-five percent also disagreed with the statement that they have ample opportunity to participate in the administrative decision process. As well, most staff disagreed with the statement that nursing administration consult with staff on daily problems. Perhaps more disturbing was the response that 45% of LPNs and 26% of RN/RPNs did not feel they had the freedom in work to make important decisions and be backed by their supervisors. These findings support the results of numerous studies from the literature review, which found that increased participation in decision-making contributed to job satisfaction (see, for example, Frisina, Murray & Aird, 1988; Townsend, 1991; Wallerstein, 1992; Hiscott & Sharrat, 1995).

A large percentage of RN/RPNs (45%) were dissatisfied with the opportunities provided by the hospital for continuing education. LPNs were more satisfied, but perhaps that was because they have been required to enroll in courses over the last couple of years. Most of the staff (73%) agreed that the hospital did sponsor continuing education programs. Funding was identified as an issue for continuing education, however. Staff would like paid time so they can attend inservices, as well as staff replacement so that they do not have to use vacation time or attend on their days off. The CNA and CHA (1990) listed lack of educational opportunities as a source of job dissatisfaction. An agenda developed by Murray and Smith (1988) to help hospitals address staff morale issues and improve job satisfaction included opportunities for clinical

education. A key characteristic of magnet hospitals is the phenomenal push for education for all levels of staff (Kramer & Schmalenberg, 1988b). Education has to become the responsibility of both the employee and the employer. Nurses have the professional responsibility to keep current in their skills, and the hospital has to provide and support these educational opportunities. The findings of this study suggest there are some important disincentives acting against staff participation in their own continuing professional development.

Promotional prospects were rated poor to very poor by 74% of the nursing staff. LPNs rated their opportunities lower than did the RNs. However, 70% of all staff were just as satisfied as dissatisfied with the opportunities for advancement and many are clearly not interested in leaving the staff nurse role. Management positions are generally viewed as "high stress", with little recognition and little increase in wage. Management positions are also out of scope and, therefore, a staff nurse must give up her seniority and the security of a union job to move into such a position. There are few opportunities for nursing advancement within the hospital other than management, so it is possible the responses to this question were influenced to some degree by this institutional reality.

Satisfaction with wages varied. Several RN/RPNs (47%) were satisfied with their wages, whereas the majority of LPNs (72%) were not satisfied with their present salary. Greenberg and Valletutti (1980) describe members of the human service professions as being more vulnerable to the negative effects of stress partly as a result of limited pay and poor career advancement opportunities. Other studies from the literature review citing lack of opportunities for career advancement as a source of job dissatisfaction were

authored by MacAlister and Chiam (1995) and Cavanaugh (1992). The respondents to this survey have offered partial concurrence with these other study results.

It is extremely important to note that a large percentage of nursing staff (77%) in this study were satisfied with the quality of care they provided. This may help to explain why so many nursing staff report they are satisfied with their jobs. Nolan, Nolan and Grant (1995) believe that job satisfaction and morale can be maintained if nurses perceive that the level of patient care is being maintained. This one statement may help to explain many of the responses to the survey. There appear to be numerous stressors at work in this hospital, including gaps in communication, gaps in continuing education, and lack of recognition, but the quality of patient care is still perceived to be good. The intrinsic factors of satisfaction still appear to be far outweighing the extrinsic factors. Unfortunately, if the level of care is suddenly perceived to be deteriorating, which could well happen if the staff members become unable to maintain their own health and workloads remain unchanged, the perceptions of job satisfaction and stress levels and effectiveness of coping may change radically.

Empowerment and Morale

The importance of recognition from different levels of management as well as the frequency of recognition from different levels of management is an important matter to the nurses in this study. The results from the survey indicate an incongruence between the importance of recognition and the frequency that it occurs. Sixty-two percent of nursing staff said it was somewhat or very important to receive recognition from the highest level

of management, yet 76% reported it rarely or never occurs. 75% find it somewhat or very important to receive recognition from nursing administration, yet 76% reported it rarely or never occurs. 89% of staff felt it was important to receive recognition from the immediate nursing supervisor. Fortunately, the most important person from whom to receive recognition is reported to provide recognition the most frequently (69% reported they received recognition sometimes or often).

While most staff (98%) reported they sometimes or often received recognition from patients and family, many (62%) felt that the importance of nursing care was not appreciated by most people. Some nurses (42%) also felt that physicians don't understand and appreciate what nursing staff does.

Generally, the factors that isolate magnet hospitals in the United States, as described by Kramer and Schmalenberg (1988a + b), that give them the reputation as good places to work, are many of the same factors that have been identified as concerns by the nursing staff in this survey. These include increased amount of nursing care, accessibility and approachability of nursing leadership, an atmosphere of informality and spontaneity, encouraging communication, a strong push for education, and decentralized decision-making.

Staff Wellness and Lifestyle

Fifty-six percent of RN/RPNs and 27% of LPNs had experienced back pain in the last 6 months. Twenty-seven percent of LPNs reported having lost time at work as a result of a muscle injury in the last 6 months. These results are similar to study findings

reported from England by Naish (1996) in which 1 in 4 nurses had been off work with a back injury and 40% of nurses reported an annual prevalence of back pain. The high incidence of back pain is not uncommon to the nursing profession but, in some ways, the increasing amount may be attributable in part to the effects of health care restructuring. A significant association was shown between downsizing and the increase in the amount of back injuries by Vahtera, Kivimaki, and Pentti (1997). The results of this study suggest a similar connection may well exist in the hospital that was the focus of this study.

Few staff reported a lost-time injury as a result of violence, but it is still possible the results may have been different if the nursing staff had been asked about the frequency of violent encounters. Many staff do not report these types of incidents or do not require time off work because of them. However, they can be extremely stressful. There has probably been an increase in the number of violent encounters at this hospital in recent years, but the evidence of that would need to be collected in some more systematic ways.

Tables 13, 14 and 15 compare the total number of sick days, the number of sick days per employee and the direct cost for sick time for 1995 (when regionalization occurred) and 1998 for staff in the hospital that was the focus of this study. Note that these tables include the information for all hospital staff, and not just nursing staff. The total number of staff is approximately 900. The information was obtained from annual records from the staff health nurse and the payroll department. The data from these tables show that the average number of sick days for all hospital employees has increased by 220 days per month in the last three years. The average number of sick days per employee has risen by .2 days per month in the last three years. The direct cost of replacement for sick

time has increased by approximately $33,000 per month since 1995. These findings may be attributable to the numerous stressors identified by the nurses in this study and should prove to be an incentive for administration to take further action as quickly as possible to address staff wellness issues.

Table 13

Total Number of Sick Days

Year	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE
1995	410	452	566	429	411	534
1998	605	601	708	858	790	700

Year	JULY	AUGUST	SEPT	OCT	NOV	DEC	AVERAGE
1995	394	391	400	416	545	402	**445**
1998	588	458	694	702	652	627	**665**

Note. Total number of staff = 900(approximately); The number of staff includes all staff at the hospital and is not exclusive to nurses.

Table 14

Average Number of Sick Days Per Employee

Year	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE
1995	.45	.49	.66	.50	.48	.62
1998	.66	.66	.77	.93	.86	.76

Year	JULY	AUGUST	SEPT	OCT	NOV	DEC	**AVERAGE**
1995	.46	.45	.46	.47	.63	.46	**.51**
1998	.64	.49	.74	.76	.71	.68	**.72**

Note. Total number of staff = 900 (approximately). This represents the entire hospital staff, and is not exclusive to nurses.

Table 15

Direct Cost for Sick Time

Year	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE
1995	$54,009	$55,352	$69,752	$51,436	$59,319	$71,112
1998	$85,059	~ $83,000	~$101,000	$120,329	$101,358	$100,451

Year	JULY	AUGUST	SEPT	OCT	NOV	DEC	**AVERAGE**
1995	$46,388	~$44,000	$57,482	~$45,000	$74,038	$57,914	**$58,158**
1998	$73,941	$72,460	$95,035	$96,413	$88,763	$89,523	**~$92,278**

Note. Direct cost only includes the cost for an individual to be on sick leave. It does not include replacement costs. Total number of staff = 900. This represents the entire hospital staff, and is not exclusive to nurses.

Recommendations for Improving Staff Wellness

Personal activities that nursing staff identified as important to improving their own wellness included lifestyle changes such as improving diet, increasing physical activity, more relaxation activities and focusing on spiritual growth. These are some of the activities that Atkinson (1988) describes as being part of the employee's responsibility to help prevent stress at the worksite.

Staff made numerous suggestions describing the activities that the institution could incorporate to improve staff wellness. The responses to this question were perhaps the richest part of the survey. The need for recognition programs was the most frequently cited request. Recommendations included recognition for absence from sick time, recognition for quality nursing care and general staff appreciation. This is supported in the literature review by Coulter (1991) and Keyes (1994) who promote recognition programs for excellence in patient care rather than just years of service.

Improved working conditions was an anticipated response that covered a broad range of suggestions. Nursing staff would like more staff to help lessen the workload, more staff to reduce the number of call-backs, and a reduction in the number of off-service patients on the units. This is supported in the literature review by authors such as McCranie, Lambert and Lambert Jr. (1987) as a recommendation to improve the work environment. In the case of this hospital, it is apparent to nursing staff that a great many issues relating to wellness are also directly related to decisions about staffing.

Nursing staff also indicated that they would like to see the hospital provide access to exercise facilities, either within the hospital or at a reduced rate at another fitness

centre, along with instruction for exercise. This is one key portion of what is usually included in effective workplace wellness programs. With 66% of respondents supporting this recommendation, it is clear it would need to be part of any such program in this hospital.

67% of staff expressed interest in information sessions on stress management, agreeing with conclusions reached by authors such as Hare (1988), who suggests staff training and work-related counselling to assist staff with better coping strategies.

Regular evaluations was an unanticipated recommendation. It was suggested that staff members be involved in regular evaluations to receive positive feedback related to work performance. As well, some want evaluations used as a mechanism to ensure that everyone is carrying an equal workload. Staff not carrying their own share of the work was identified as a major stressor by 63% of respondents. This factor is probably closely related to interpersonal relations with coworkers.

Recommendations for Further Study

Recommendations for further study include using a larger sample which would be more representative. In addition, a sample drawn from several hospitals, either provincially or nationally, would probably provide more generalizable information. In any subsequent study, associations among stress, job satisfaction and morale could be analyzed in relation to age, gender, years of experience, and nursing units.

A future survey could focus more on the biological, chemical and physical hazards of the workplace rather than on psychological hazards to the extent this survey did. Moreover, input related to job satisfaction rather than job dissatisfaction might be more helpful in making decisions to improve or maintain staff wellness. Finally, a survey of nursing management and their current levels of wellness, and the types of stressors they encounter, may greatly assist all nursing staff to appreciate the different roles in nursing and the elements of interdependence they have in common.

Summary

Overall, a large proportion of staff identified themselves as being fairly stressed, as compared to highly stressed. However, staff nurses did identify several symptoms of stress which they have experienced as well as numerous stressors in the workplace. The most frequently reported stress-related symptoms experienced by staff nurses include headaches, sleep disturbances, tiredness, frustration, moodiness, anxiety and weight gain. The most significant stressors in the workplace reported by nursing staff include no control over workload, feeling undervalued, inadequate staffing, highly demanding patients/family, work overload and coworkers who don't make an equal contribution.

Staff rated their coping abilities as average or above average. The level of stress, as rated by nursing staff, and the ability to cope with stress, as rated by nursing staff, do not help to explain the considerable increase in sick time noted in the data drawn from annual reports. Some staff may be unaware of the effects of stress on their own health as a result of focusing their time and energy on the health of those around them. Others may be underestimating the negative effects of stress, or overestimating their abilities to cope with stress. Another possibility is that biological, chemical and physical hazards are responsible for some of the large increase in sick time. Yet another reasonable assumption is that stress has lowered the immune response and the general physical health of staff, making them more susceptible to viruses, infections and musculo-skeletal injuries.

Most nursing staff reported that they were satisfied with their nursing jobs and with the hospital as a place of employment. Most nursing staff also reported being satisfied with the quality of care given to the patients, possibly the single greatest indicator

for job satisfaction for nurses. The intrinsic rewards, such as providing quality care and realizing the importance of the nursing role, appeared to play a significant role in the job satisfaction of respondents in this study. The extrinsic rewards such as pay and recognition are greater determinants of job dissatisfaction. Other identified sources of dissatisfaction include the gap in communication with administration, the need for additional support for continuing education, and promotional prospects. Nurses also identified a difference in the importance of recognition received from the different levels of management and the actual frequency of recognition received.

According to the records, the actual amount of sick time per employee has increased appreciably (by approximately 40%) over the last four years. This will predictably take its toll on the delivery of patient care. Clearly, it is time for employees to take more of the initiative and begin addressing their own health issues but, just as certainly, the institution must take its fair share of responsibility for looking after the wellness of its employees.

This survey has provided several recommendations, identified by the nursing staff, as methods to improve staff wellness. These recommendations include staff members having a role in maintaining wellness through proper diet, exercise and relaxation. Suggestions for the hospital to aid in improving staff wellness include recognition programs, reducing workloads, an exercise facility, improving communication with management, support groups, and increased educational support.

Sick time has increased an average of 225 days per month over the last four years. It is abundantly clear that more institutional attention needs to be given to caring for the

care-givers. Judging by the continual rise in sick time, the time to act is now. Staff health must be a priority for both individual staff members and the health care institution in which they work.

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APPENDIX

Survey Questionnaire

REGISTERED NURSE,

REGISTERED PSYCHIATRIC NURSE

AND LICENSED PRACTICAL NURSE

PERCEPTIONS OF STAFF WELLNESS

CONSENT FORM

Dear research participant:

For my Masters of Education thesis at the University of Lethbridge, I am conducting a study of staff wellness at the Medicine Hat Regional Hospital. The purpose of the study is to determine the current levels of Registered Nurse (RN), Registered Psychiatric Nurse (RPN), and Licensed Practical Nurse (LPN) wellness as perceived by the staff members themselves. The study will also identify the positive and negative influences on staff wellness. I anticipate that staff from the hospital will benefit from the findings of the study by helping to identify the greatest barriers and facilitators to wellness. These results are intended to assist in discovering potential solutions to improving or maintaining the health of the staff, both physically and emotionally.

Your name has been randomly chosen to participate in the study. I would like your consent to cooperate in this study. As a part of this research, you will be asked to complete a survey questionnaire on staff wellness. All information will be handled in a confidential and professional manner. When responses are released, they will be reported in summary form only. All names, locations and any other identifying information will not be included in the discussion of the results. You have the right to withdraw from the study without prejudice at any time.

If you choose to participate, please indicate your willingness by signing this letter in the space provided below and return the letter with the completed survey in the envelope provided to the Education Department (Attention: Monique Fernquist) - 3rd floor of the old hospital. If you choose not to participate, please return this package to the Education Department.

I very much appreciate your assistance in this study. If you have any questions, please feel free to call me at 528-3983 (home) or 528-8174 (work). Also, feel free to contact the supervisor of my study, Dr. David Townsend at 329-2731 and/or any member of the Faculty of Education Human Subject Research Committee if you wish additional information. The chairperson of the committee is Richard Butt at 329-2434.

Yours sincerely,

Monique Fernquist, University of Lethbridge, 528-3983.

RN, RPN, AND LPN PERCEPTIONS OF STAFF WELLNESS

I, _____, agree to participate in this study.
(Name - please print)

_____ _____
(Signature) (Date)

RN, RPN AND LPN PERCEPTIONS OF STAFF WELLNESS

[NOTE: The results obtained from this survey will be used primarily in the completion of my Masters of Education Thesis at the University of Lethbridge.]

A. This first section asks questions related to demographic information.

1. Level of training:
   - __ LPN (licensed practical nurse)
   - __ RPN (registered psychiatric nurse)
   - __ RN - (registered nurse) -diploma level
   - __ RN - degree level
   - __ RN - masters level

2. Are you currently enrolled in a continuing education program:
   __ yes __ no

3. The area of nursing which I am currently employed in is:
   __ medicine __ maternal child
   __ surgery __ emergency
   __ intensive care __ labor/delivery
   __ pediatrics __ float
   __ operating room __ ambulatory care
   __ mental health

4. Current employment status:
   __ casual __ part time __ full time

5. Shift most frequently worked:
   __ day __ night __evening __day/evening rotating
   __day/night rotating __day/evening/night rotating other_____

6. Hours usually worked per shift:
   __ 4 hours __ 8 hours __ 12 hours other _____

7. Gender:
   __male __female

8. Age:
   __ 18-25 years __26-35yrs __36-45yrs 46+__yrs

9. Years employed as an LPN/RN/RPN:
   __1-5 years __6-10yrs __11-19yrs __20+years

10. Marital status:

__ single __ married/common law __separated/divorced __ widowed

11. Do you have children?

__ yes __ no

If you answered yes, please indicate the age of the youngest child. _____

B. The next section asks questions related to stress.

1. Do you feel stressed at work?

1	2	3	4
Not at all	Not very much	Fairly	Very

2. Do you feel more stressed than 3 1/2 years ago (when regionalization occurred)?

__ yes __ no

3. Do you feel more stressed than one year ago?

__ yes __ no

4. Do you experience any of the following physical symptoms that you think result from stress? Place a checkmark in front of any symptoms which are applicable to you.

__ headaches
__ sleep problems
__ stomach or bowel problems
__ weight gain
__ weight loss
__ loss of libido
__ frequent infections
__ chest pain
__ high blood pressure
__ other _____

5. Do you experience any of the following psychological signs that you think result from stress? Place a checkmark in front of any symptoms which are applicable to you.

__ tiredness
__ moodiness/irritability
__ frustration
__ anxiety
__ poor concentration
__ boredom
__ depression
__ feelings of guilt
__ apathy
__ indecision
__ other_____

6. Do you experience any of the following behavioral signs that you think result from stress? Place a checkmark in front of any symptoms which are applicable to you.

__ relationship difficulties
__ being accident prone
__ aggressiveness
__ absenteeism
__ avoidance/withdrawal
__ increased alcohol consumption
__ increased use of prescription/non-prescription drug
__ other _____

7. How does stress in your personal life affect how you feel at work?

1	2	3	4
Not at all	A little	Quite a lot	Very much

8. How does stress at work affect your personal life?

1	2	3	4
Not at all	A little	Quite a lot	Very much

9. Which, if any, of these psychological factors act as stressors for you at work?

__ feeling undervalued
__ no participation in decision making
__ lack of job security
__ pay does not reflect work
__ irregular work load
__ capabilities/skills not fully used
__ feeling unprepared to care for certain patients (critical patients, for example)
__ no control over workload
__ inadequate knowledge
__ lack of recognition
__ inadequate continuing education (updating skills, inservicing)
__ ethical judgements
__ inconsistent application of management policies
__ other _____

10. In the above question, indicate the two most important factors that affect stress by writing number 1 and 2 beside the response.

11. Which, if any, of these individual factors act as stressors at work?

__ working too many hours
__ working too few hours
__ no opportunities for learning
__ no opportunities to relax
__ little time for family life
__ insufficient responsibility
__ too much responsibility
__ trouble with supervision
__ other _____

12. In the above question, indicate the two most important factors that affect stress by writing number 1 and 2 beside the response.

13. Which, if any, of these objective environmental factors act as stressors at work?

__ pay/benefits
__ management policies
__ shift work
__ work requiring quick reaction
__ dirty work
__ physically demanding work
__ emotionally demanding work
__ fast pace of work
__ work overload
__ inadequate staffing
__ rapid patient turnover
__ frequent interruptions
__ critically ill patients
__ uncooperative patients
__ highly demanding patients/family
__ patient death
__ lack of encouragement
__ other _____

14. In the above question, indicate the top 5 stressors by writing the numbers 1, 2, 3, 4 and 5 beside the responses, with number 1 being the most significant factor affecting stress.

15. Which, if any, of these physical environmental factors act as stressors at work?

__ poor ventilation
__ layout of workplace
__ inadequate rest periods
__ too much noise
__ poor lighting
__ not enough equipment
__ availability of supplies
__ outdated equipment
__ other _____

16. In the above question, indicate the top 2 factors affecting stress at work by writing number 1 and 2 beside the response.

17. Which, if any, of the following organizational factors act as stressors at work?

__ poor pay/fringe benefits
__ poor communication/relations with coworkers
__ poor communication/relations with management
__ no performance feedback
__ little contact with management
__ conflicts with physicians
__ conflicts with immediate supervisor
__ lack of teamwork with other departments
__ coworkers who don't make equal contribution at work (don't carry their load)
__ coworkers in whose skills/judgement you don't have confidence
__ lack of support from management and management group
__ lack of appreciation from all levels of staff
__ other _____

18. In the above question, indicate the two most significant factors which act as stressors at work by writing number 1 and 2 beside the response.

19. What strategies do you use to cope with stress?

__ talking with colleagues
__ talking with family and friends outside of work
__ relaxation/ physical exercise
__ massage
__ taking a break from work
__ not bringing work home
__ having a drink after getting home from work
__ smoking
__ taking medications to help you relax
__ problem solving
__ avoidance
__ crying/anger
__ other

20. How do you rate your ability to cope with stress?

1	2	3	4
Poor	Average	Better than Average	Very Good

21. Are you satisfied with the facilities provided at work to help you cope with stress?

__ yes __ no

22. Would any of the following be beneficial to help you cope with stress?

__ stress management workshops (full day)
__ stress management inservices (15-30) minutes
__ individual counselling
__ group counselling
__ peer support groups
__ other _____

C. This next section asks questions related to job satisfaction.

1. In general, how satisfied or dissatisfied are you with this hospital as a place to work? Circle the number which comes closest to how you feel.

1	2	3	4	5
Completely Satisfied	Satisfied	Just as Satisfied As Dissatisfied	Dissatisfied	Completely Dissatisfied

2. In general, how satisfied or dissatisfied are you with your nursing job? Circle the number which comes closest to how you feel.

1	2	3	4	5
Completely Satisfied	Satisfied	Just as Satisfied as Dissatisfied	Dissatisfied	Completely Dissatisfied

3. a. In your job, how often do you do things with which you are not morally or ethically in agreement?

__ never
__ rarely
__ sometimes
__ often
__ always

b. How stressful is this to you if it occurs?

__ not applicable - (never happens)
__ no stress
__ a little stress
__ some stress
__ a lot of stress

4. a. How often are you asked to perform non-nursing tasks?

__ never
__ rarely
__ sometimes
__ often
__ always

b. How stressful is this to you if it occurs?

__ not applicable (never happens)
__ no stress
__ a little stress
__ some stress
__ a lot of stress

5. How satisfied are you with the physical condition of the workplace?

1	2	3	4	5
Completely Satisfied	Satisfied	Just as Satisfied as Dissatisfied	Dissatisfied	Completely Dissatisfied

6. a. Is your workload ever so consistently heavy that you lack energy for free time?

__ never
__ rarely
__ sometimes
__ often
__ always

b. How stressful is this to you if it occurs?

__ not applicable (never happens)
__ no stress
__ a little stress
__ some stress
__ a lot of stress

7. How satisfied are you with the quality of care provided on your unit?

1	2	3	4	5
Completely Satisfied	Satisfied	Just as Satisfied as Dissatisfied	Dissatisfied	Completely Dissatisfied

8. How satisfied are you with the opportunity in your job to use your skills to their fullest?

1	2	3	4	5
Completely Satisfied	Satisfied	Just as Satisfied as Dissatisfied	Dissatisfied	Completely Dissatisfied

Beside each of the following statements listed below, please circle a number to the right of the question according to the following scale.

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
1	2	3	4	5

	Agree				Disagree
9. On this unit, nurses have a great deal of freedom and few rules and procedures to follow.	1	2	3	4	5
10. Nurses have to ask the Nursing Unit Supervisor before doing almost anything.	1	2	3	4	5
11. Nurses frequently participate in decisions to change or adopt new nursing techniques on this unit.	1	2	3	4	5
12. Nurses on this unit have a great deal of freedom in deciding nursing interventions for patients without asking physicians.	1	2	3	4	5
13. Most nurses on this unit follow their own ideas in implementing nursing care.	1	2	3	4	5
14. If the nursing staff want to make their own decisions about nursing care, they are quickly discouraged here	1	2	3	4	5
15. There are very precise definitions of nurses' duties on this unit.	1	2	3	4	5
16. Responsibilities and authority are emphasized on this unit.	1	2	3	4	5
17. Nurses frequently participate in decisions regarding what nursing care will be given to individual patients on the unit.	1	2	3	4	5

18. How satisfied are you with the leadership provided by your Nursing Unit Supervisor?

1	2	3	4	5
Completely Satisfied	Satisfied	Just as Satisfied as Dissatisfied	Dissatisfied	Completely Dissatisfied

19. Is your Nursing Unit Supervisor (NUS) interested and sympathetic when listening to nurses's problems?

__Yes, always __ Yes, sometimes __ No

20. Does your NUS offer new ideas for solving job related problems?

__ Yes, always __ Yes, sometimes __ No

21. In general, how do you feel about the kind of communication you have with your NUS?

Would you say that it is :

__completely adequate
__ very adequate
__ fairly adequate
__ not very adequate
__ not at all adequate

22. How satisfied or dissatisfied are you with the working relationships among staff nurses on your unit?

1	2	3	4	5
Completely Satisfied	Satisfied	Just as Satisfied as Dissatisfied	Dissatisfied	Completely Dissatisfied

23. Do nurses on your unit provide enough help to you so that you can plan, organize, and schedule your work?

__ Yes, always
__ Yes, sometimes
__ No

24. Do nurses on your unit freely exchange opinions and ideas?

__ Yes, always
__ Yes, sometimes
__ No

25. Does your unit plan together and coordinate its efforts?

__ Yes, always
__ Yes, sometimes
__ No

26. Is information-sharing about important events and situations within the nursing department adequate?

__ Yes, always
__ Yes, sometimes
__ No

27. Does your supervisor schedule regular staff meetings to discuss problems and changes in your work?

__ Yes, always
__ Yes, sometimes
__ No

28. How effective do you feel staff meetings are?

__ Very worthwhile
__ Mixed feelings
__ Waste of time
__ Other _____

29. Do you feel that staff nurses on your unit are respected by the other members of the health care team?

__ Always
__ Often
__ Sometimes
__ Rarely
__ Never

30. How satisfied or dissatisfied are you with the opportunities provided by the hospital for training and updating your clinical skills and knowledge?

1	2	3	4	5
Completely Satisfied	Satisfied	Just as Satisfied as Dissatisfied	Dissatisfied	Completely Dissatisfied

31. Does the hospital provide the support you need to attend continuing education programs outside the hospital?

__ Yes __ No

32. Does the hospital sponsor continuing education programs within the hospital itself?

__ Yes __ No

33. How might the hospital better support your attempts to get this education?

_____

_____

_____

34. What are the promotion aspects in nursing for someone like yourself?

__ Very good
__ Good
__ Fair
__ Poor
__ Very poor

35. LPNs can skip to question 37. As an RN/RPN, how satisfied are you with the opportunities available for advancement to nursing unit management levels or to education or research positions?

1	2	3	4	5
Completely Satisfied	Satisfied	Just as Satisfied as Dissatisfied	Dissatisfied	Completely Dissatisfied

36. As an RN/RPN, how satisfied or dissatisfied are you with opportunities available to you for advancement within the staff nurse role (e.g. preceptor role, charge nurse, resource nurse) at your hospital?

1	2	3	4	5
Completely Satisfied	Satisfied	Just as Satisfied as Dissatisfied	Dissatisfied	Completely Dissatisfied

37. Considering the responsibility that you have as a nurse, how good are your pay and benefits?

1	2	3	4	5
Very Good	Good	Average	Poor	Very Poor

38. Do you feel that years of experience in nursing are adequately reflected in nurses' pay ranges?

__ Yes, completely
__ Yes, somewhat
__ No, not at all

39. Do you feel that special expertise in nursing is adequately reflected in nurses' pay ranges?

__ Yes, completely
__ Yes, somewhat
__ No, not at all

Please circle the number for each of the following statements that reflects the extent of your agreement or disagreement according to the scale.

Strongly Agree 1	Agree 2	Neither 3	Disagree 4	Strongly Disagree 5

	Agree				Disagree
40. My present salary is satisfactory.	1	2	3	4	5
41. Most people do not sufficiently appreciate the importance of nursing care to hospital patients.	1	2	3	4	5
42. The nursing personnel on my service do not hesitate to pitch in and help one another whe things get in a rush.	1	2	3	4	5
43. Physicians in general cooperate with nursing staff on my unit.	1	2	3	4	5
44. I feel that I am supervised more closely than is necessary.	1	2	3	4	5
45. I think I could do a better job if I did not have so much to do all the time.	1	2	3	4	5
46. There is a great gap between the administration of this hospital and the daily problems of the nursing service.	1	2	3	4	5
47. I feel I have sufficient input into the program of care for each of my patients.	1	2	3	4	5
48. There is no doubt whatever in my mind that what I do on my job is really important.	1	2	3	4	5

	Agree				Disagree
49. There is a good deal of teamwork and cooperation between various levels of nursing personnel on my service.	1	2	3	4	5
50. I have too much responsibility and not enough authority	1	2	3	4	5
51. On my service, my supervisors make all the decisions. I have little direct control over my own work.	1	2	3	4	5
52. I am satisfied with the types of activities that I do on my job.	1	2	3	4	5
53. I have plenty of time and opportunity to discuss patient care problems with other nursing service personnel.	1	2	3	4	5
54. There is ample opportunity for nursing staff to participate in the administrative decision-making process.	1	2	3	4	5
55. A great deal of independence is permitted, if not required of me.	1	2	3	4	5
56. What I do on my job does not add up to anything really significant.	1	2	3	4	5
57. There is a lot of "rank consciousness" on my unit. Nursing personnel seldom mingle with others of different ranks.	1	2	3	4	5
58. I have sufficient time for direct patient care.	1	2	3	4	5
59. I am sometimes frustrated because all of my activities are scheduled for me.	1	2	3	4	5
60. I am sometimes required to do things on my job that are against my professional nursing judgement.	1	2	3	4	5

	Agree				Disagree
61. Physicians at this hospital generally understand and appreciate what the nursing staff does.	1	2	3	4	5
62. The physicians at this hospital look down too much on the nursing staff.	1	2	3	4	5
63. I have all the voice in planning policies and procedures for this hospital and my unit that I want.	1	2	3	4	5
64. The nursing administrators generally consult with the staff on daily problems and procedures.	1	2	3	4	5
65. I have the freedom in my work to make important decisions as I see fit, and can count on my supervisors to back me up.	1	2	3	4	5

66. How satisfied or dissatisfied are you with your shift rotation?

1	2	3	4	5
Completely Satisfied	Satisfied	Just as Satisfied as Dissatisfied	Dissatisfied	Completely Dissatisfied

67. Does your shift rotation allow for flexibility in scheduling?

__ Yes __ No

D. This next section asks questions related to morale and empowerment.

1. How important is it that you receive recognition for your work from the highest level of management of this hospital?

a) not at all important
b) not very important
c) somewhat important
d) very important
e) extremely important

2. How often do you get recognition for you work from upper levels of management at this hospital?

1	2	3	4	5
Never	Rarely	Sometimes	Often	Always

3. How important is it to you that you receive recognition for your work from nursing administration at this hospital?

a) not at all important
b) not very important
c) somewhat important
d) very important
e) extremely important

4. How often do you get recognition for your work from nursing administration at this hospital?

1	2	3	4	5
Never	Rarely	Sometimes	Often	Always

5. How important is it to you that you receive recognition for your work from your immediate supervisor?

a) not at all important
b) not very important
c) somewhat important
d) very important
e) extremely important

6. How often do you get recognition from your immediate supervisor?

1	2	3	4	5
Never	Rarely	Sometimes	Often	Always

7. How often do patients and their families show their appreciation to you for your nursing work?

1	2	3	4	5
Never	Rarely	Sometimes	Often	Always

8. How often do patients and family regard you as a service rather than a care-giver?

1	2	3	4	5
Never	Rarely	Sometimes	Often	Always

9. Do your job and workload permit you enough involvement or contact with individual patients?

a) yes, always
b) yes, sometimes
c) no

10. How satisfied or dissatisfied are you with the respect you receive from patients and family?

1	2	3	4	5
Completely Satisfied	Satisfied	Just as Satisfied As Dissatisfied	Dissatisfied	Completely Dissatisfied

11. Do the physicians at your hospital treat you with the professional respect to which you are entitled?

a) always
b) often
c) sometimes
d) rarely
e) never

12. Overall, how much conflict do you have with physicians?

a) none
b) a little
c) some
d) a lot

13. RN/RPNs can skip to Section E. As an LPN, do you think that the RN/RPNs at your hospital treat you with the respect to which you feel entitled?

a) always
b) often
c) sometimes
d) rarely
e) never

14. Overall, as an LPN, how much conflict do you have with RN/RPNs?

a) none
b) a little
c) some
d) a lot

E. This last section will ask questions related to your overall level of wellness.

1. What activities are you regularly involved in to maintain a healthy lifestyle?
   a) healthy eating
   b) regular exercise
   c) relaxation techniques
   d) spiritual growth
   e) stress management activities
   f) other _____

2. Do you smoke?
   _____ Yes ____ No

3. If you responded no to the above question, skip to the question 4. If you responded yes, has the no smoking policy encouraged you to become a non-smoker?
   ____ Yes ____ No

4. Have you experienced back pain - in the last 6 months? _____ Yes ____ No
   - in the last year? _____ Yes ____ No
   - in the last three years? _____ Yes ____ No
   - during your career? _____ Yes ____ No

5. Have you been off work with a muscular injury (back, neck or shoulder for example)
   - in the last six months? ____ Yes ____ No
   - in the last year? ____ Yes ____ No
   - in the least three years? ____ Yes ____ No
   - during your career? ____ Yes ____ No

6. Have you ever been off work as a result of an injury from patient violence/aggression?
   ____ Yes ____ No

7. Have you had to take a stress leave from work?
   ____ Yes ____ No

8. Have you been off work as the result of a stress related illness such as high blood pressure, depression, anxiety, headaches, or chest pain for example?
   ____ Yes ____ No

9. Do you feel that information sessions on stress management would be beneficial if offered by the hospital?
   ____ Yes ____ No

10. Would you like to see lifestyle management classes with topics such as nutrition and exercise offered at the hospital?

____ Yes ____ No

11. Would you be interested in participating in a fitness program organized through the hospital?

____ Yes ____ No

12. Would you like to see recognition programs for excellence in nursing care initiated that would recognize individual nurses for their work?

____ Yes ____ No

13. Would you like to see recognition programs for absence of sick time initiated?

____ Yes ____ No

14. What do you identify to be the most important activity or practice that you could participate in personally to improve your current level of wellness?

_____

_____

_____

15. What do you identify to be the most important activity or practice that the institution could incorporate to improve the current levels of staff wellness?

_____

_____

_____

Thank you very much for your help in completing this survey.