# Maryland Statewide Commission on the Crisis in Nursing Workplace Survey 2005: Final Report

January 2006

CENTER FOR HEALTH PROGRAM DEVELOPMENT AND MANAGEMENT

# Maryland Statewide Commission on the Crisis in Nursing Workplace Survey 2005: Final Report

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## INTRODUCTION

The Workplace Survey 2005 was conducted as a replication study to determine what changes had occurred in nurses' experiences and perceptions of workplace issues since the original survey in 2001. The Maryland Statewide Commission on the Crisis in Nursing was interested in knowing if the work that had been accomplished had contributed to improvements in nurses' satisfaction and experiences. While the Commission realizes that a myriad of factors could have contributed to change, it feels confident that its actions have, in fact, been an influence. Therefore, the Commission wished to measure differences by conducting this follow-up survey.

In addition to preserving as much of the 2001 survey as possible to allow for testing for significant change between the two time periods, only questions that were deemed important in understanding the impact of the Commission's work were added. Additions to the survey include knowledge of legislative initiatives spearheaded by the Commission (prohibition of mandatory overtime and whistle blower protection); patient safety monitoring roles of the Board of Nursing and the Office of Health Care Quality; and concerns regarding workplace health (influenza vaccine availability, uptake, and knowledge).

As in 2001, a random sample of registered nurses (RNs) and licensed practical nurses (LPNs) were selected to participate in the survey. Since the sample was random, there was no attempt to contact the same nurses who participated in 2001, but some effort was taken to avoid surveying nurses who were selected to participate in another survey that was being conducted simultaneously for the Commission. The 2005 Workplace Survey had 546 participants, achieving a 46 percent response rate and a 4.1 percent margin of error at the 95 percent confidence level.

## METHODOLOGY

### Sampling

As in 2001, the target population for the study consisted of RNs and LPNs who work in one of three venues: hospitals, home health agencies/hospice, and long-term care. A list of nurses who met these criteria was extracted from the Maryland Board of Nursing's licensure database, yielding 19,251 RNs and 2,959 LPNs. To achieve a 95 percent level of confidence with a 5 percent margin of error, a sample of 377 RNs and 341 LPNs was needed. The desired sample size was distributed proportionately according to the percentage of RNs and LPNs in the three work venues. Also, the sample size was increased by 60 percent to accommodate for low response and facilitate achieving the desired confidence level. The final sample size was 1,199 nurses (630 RNs and 569 LPNs). Table 1 details the sampling strategy.

**Table 1: Sampling Strategy**

| Work Venue | RN | Sample * | LPN | Sample* |
|---|---|---|---|---|
| **Hospital** | 16,046 (83%) | 522 | 862 (29%) | 165 |
| **Home Health/Hospice** | 2,012 (11%) | 70 | 1,820 (62%) | 352 |
| **Long-Term Care** | 1,193 (6%) | 38 | 277 (9%) | 52 |
| | Total RNs→ | 630 | Total LPNs→ | 569 |

*Sample size includes the desired return enhance by 60% to accommodate for non-response.

**Instrument Development and Dissemination**

As a replication study, the instrument was based on the 2001 Workplace Survey and kept the original as intact as possible (Appendix 1). Wording or response categories were modified for a few questions and several questions were added. Added questions concerned knowledge of, use of, and satisfaction with legislation enacted through the Commission's actions, and the role of the Board of Nursing (BON) and the Office of Health Care Quality (OHCQ) in monitoring patient safety complaints. Because of these changes, these questions were not included in the 2001 to 2005 comparison analysis. In 2001, the instrument was pilot tested for content and face validity. In 2005, questions that were modified or added received broad review for face validity within the Commission and its subgroups.

As in 2001, the primary categories of the survey are:

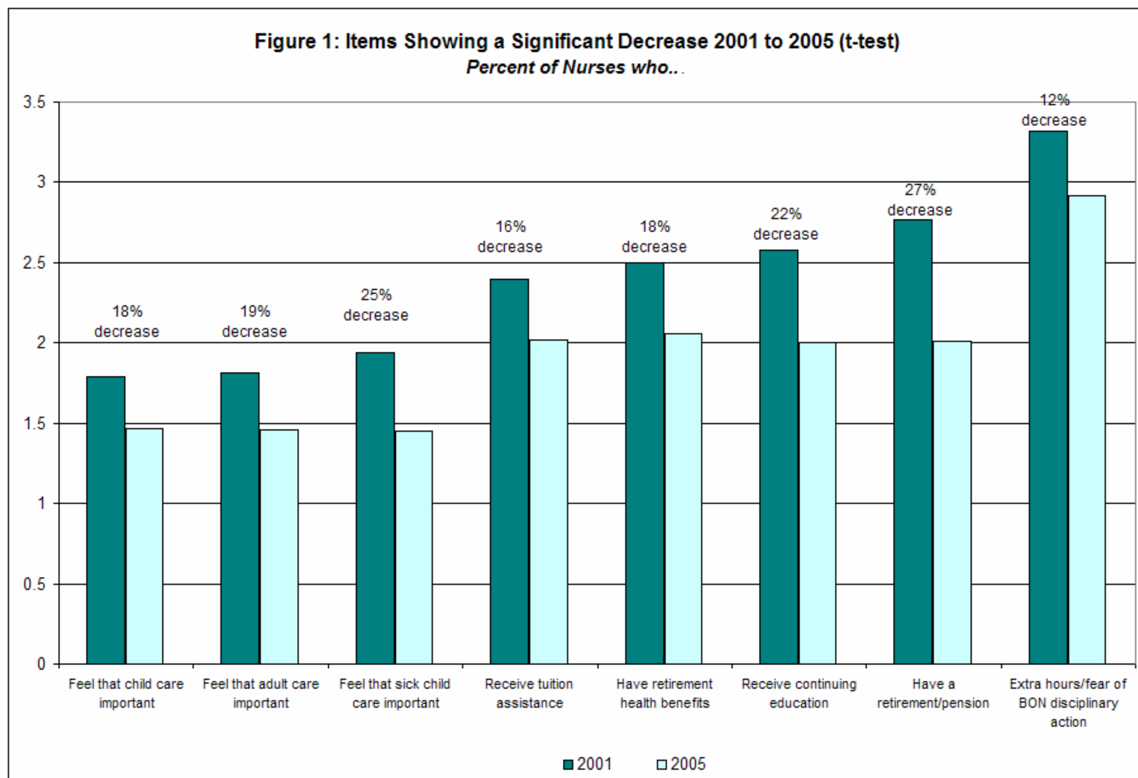
- ***Demographics***: type of facility of the primary position, specialty area, age, highest degree earned, etc.
- ***Scheduling and Staffing:*** type of schedule/shift of work, physical limitations accommodated in scheduling, etc.
- ***Extra Hours:*** type of and reasons for extra-hour work, how much extra-hour work, how often, mandatory or voluntary, patient safety and well-being, personal safety and well-being, etc.
- ***On-Call:*** conditions, reasons
- ***Re-Assignment:*** frequency, competency, orientation, compensation, etc.
- ***Documentation:*** quantity, impact on patient care
- ***Dependent Care:*** types provided by employer, importance
- ***Compensation:*** satisfaction, pay equity, benefits, etc.
- ***Other Professional Issues:*** knowledge and use of resources/laws, attitudes toward, and knowledge and availability of influenza vaccine, support from manager, satisfaction with certain workplace factors

Surveys were mailed to 1,199 Maryland nurses. Prior to receiving the survey, the nurses in the sample received a letter signed by the Secretary of the Maryland Department of Health and Mental Hygiene and the Director of the Board of Nursing. This letter informed the nurses that they would receive the survey and emphasized the importance of completing the survey (See Appendix 2). Follow-up activities consisted of mailing reminder postcards two weeks after the survey was mailed, and phone calls (a week after the reminder postcards) to nurses who had not

returned the survey. In order to maximize the response rate, nurses were also offered an online option to complete the survey; only 13 respondents used this option.

## FINDINGS[1]

Sixty-seven items were found to be appropriate for testing for statistically significant differences between the 2001 and the 2005 surveys. Using Chi Square for nominal responses and the t-test for interval or scaled responses, 18 items were found to have significant decreases and 16 were found to have significant increases. Appendix 3 contains the complete tabulation of the testing for change from 2001 to 2005. Figures 1–4 contain the items that had significant increases and decreases.




[1] Percentages do not always equal 100 due to rounding.

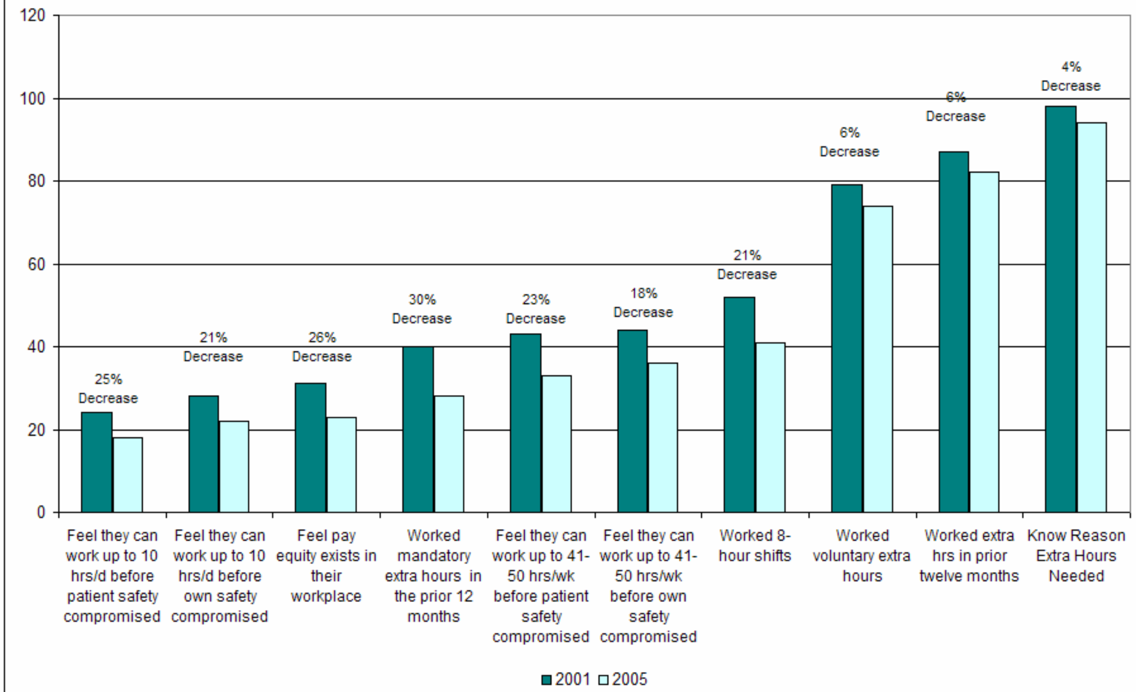


Figure 2: Items Showing Significant Decreases 2001 to 2005 (Chi Square)
120
100
80
60
40
20
0
25% Decrease
21% Decrease
26% Decrease
30% Decrease
23% Decrease
18% Decrease
21% Decrease
6% Decrease
6% Decrease
4% Decrease
Feel they can work up to 10 hrs/d before patient safety compromised
Feel they can work up to 10 hrs/d before own safety compromised
Feel pay equity exists in their workplace
Worked mandatory extra hours in the prior 12 months
Feel they can work up to 41-50 hrs/wk before patient safety compromised
Feel they can work up to 41-50 hrs/wk before own safety compromised
Worked 8-hour shifts
Worked voluntary extra hours
Worked extra hrs in prior twelve months
Know Reason Extra Hours Needed
2001 2005

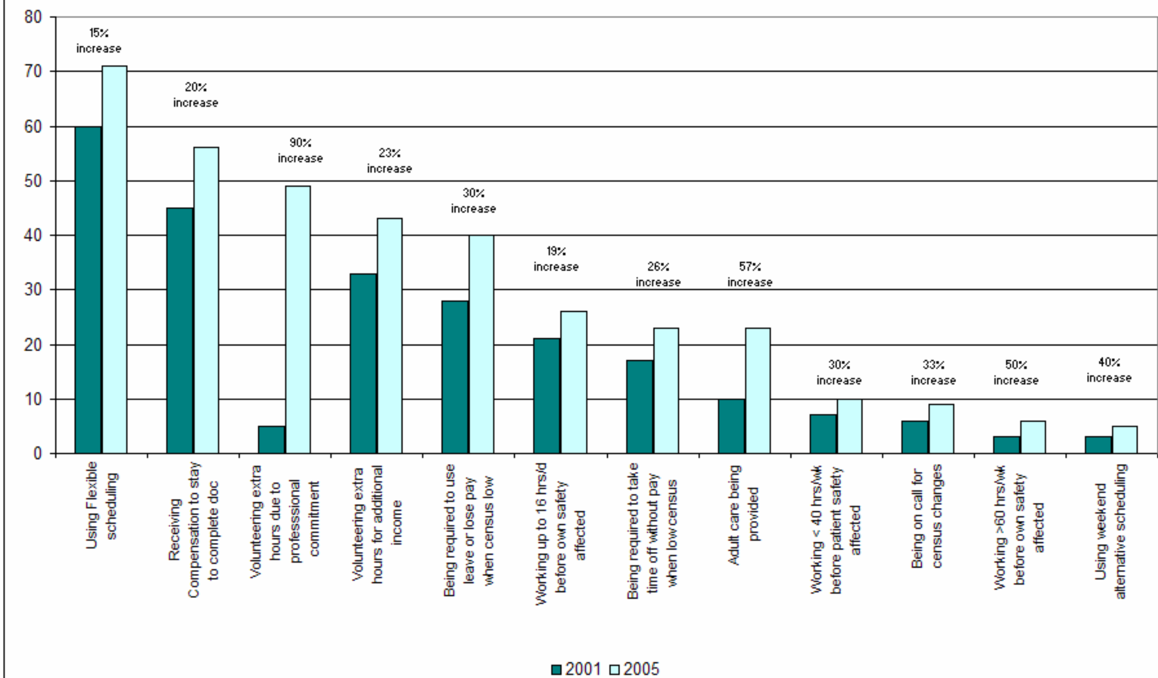
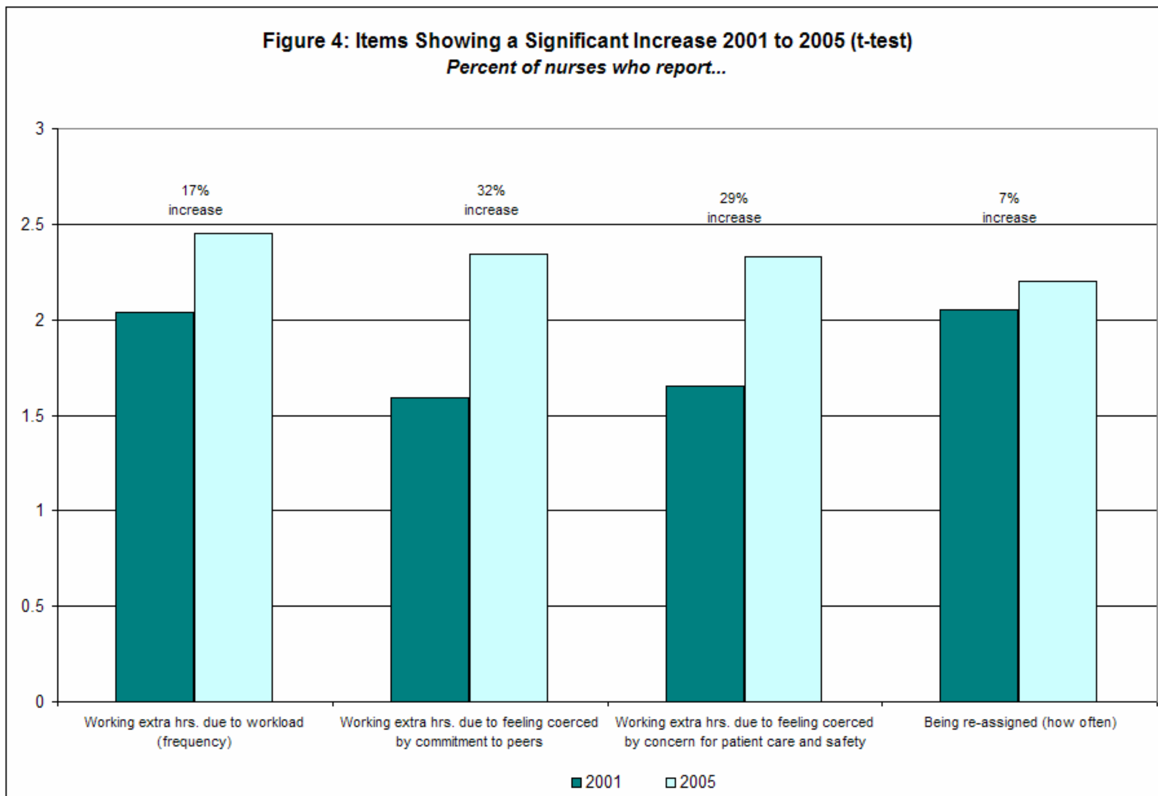


Figure 3: Items Showing Significant Increase 2001 to 2005 with Percent Change (Chi Square)
Percent of nurses who report...
80
70
60
50
40
30
20
10
0
15% increase
20% increase
90% increase
23% increase
30% increase
19% increase
26% increase
57% increase
30% increase
33% increase
50% increase
40% increase
Using Flexible scheduling
Receiving Compensation to stay to complete doc
Volunteering extra hours due to professional commitment
Volunteering extra hours for additional income
Being required to use leave or lose pay when census low
Working up to 16 hrs/d before own safety affected
Being required to take time off without pay when low census
Adult care being provided
Working < 40 hrs/wk before patient safety affected
Being on call for census changes
Working >60 hrs/wk before own safety affected
Using weekend alternative scheduling
2001 2005



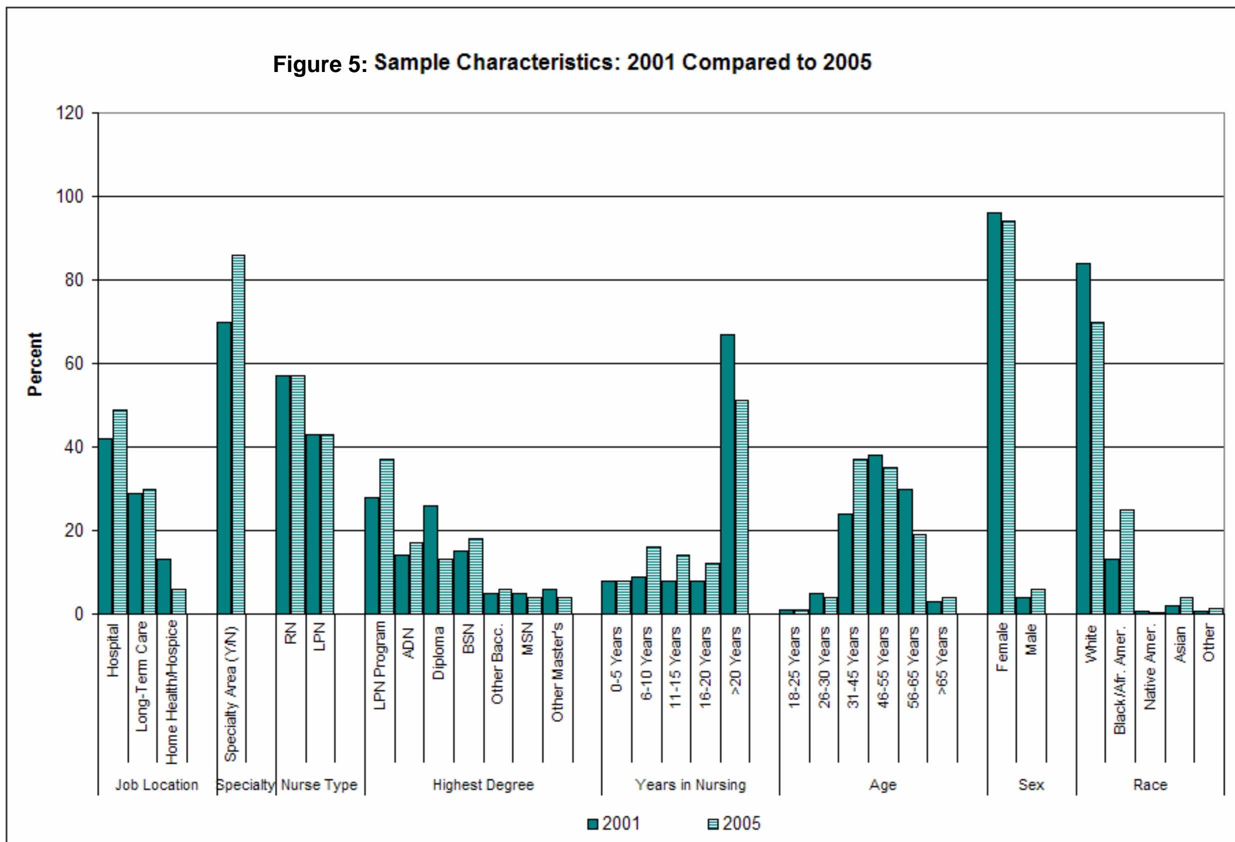

## Demographics

The final sample of respondents included 309 RNs (57 percent) and 237 LPNs (43 percent). This sample represents a more even distribution between RNs and LPNs than in the 2001 survey.

Almost half (49 percent) of the respondents surveyed worked in a hospital setting. The remaining respondents work in specialty areas, primarily "Geriatric/LTC" (30 percent) and "Other" (33 percent). The following additional specialty areas comprised less than 7 percent each: "Critical Care," "OR," "Med-Surg," "ER," "Home-Health," "L&D," "Peds," "ICU," "Hospice," and "PICU."

Approximately one-quarter (24 percent) of the respondents have a bachelor's degree and just fewer than 9 percent have graduate degrees. In 2001, "diploma graduates" was the most represented group of RNs; however, in 2005, there was a higher proportion of associate and bachelor's prepared nurses. A higher proportion of 2005 respondents selected "LPN program" as the highest educational level.

Figure 5 shows a more detailed comparison of 2001 and 2005 demographic characteristics.




Half the respondents (50 percent) have more than 20 years of experience in nursing, possibly reflecting the commitment many nurses have toward their profession. As an indication of the large number of years committed to nursing, few respondents (5 percent) are under age 30. The largest group of respondents (37 percent) is between the ages of 31 and 45, followed closely by the age group of 46–55 years (35 percent). Respondents over the age of 65 represented about 4 percent of the sample.

As in 2001, the vast majority (94 percent) of respondents were female. Male representation rose slightly in 2005 and the proportion of black/African American respondents nearly doubled (13 percent in 2001 and 25 percent in 2005).

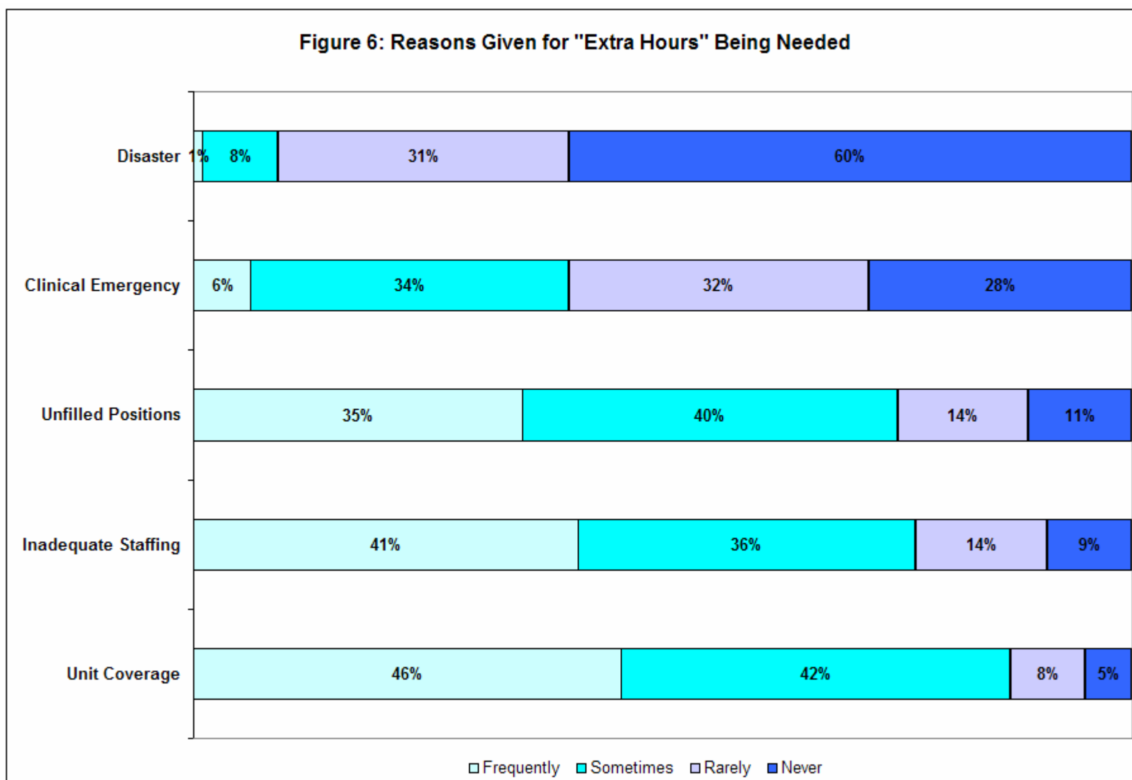
## Scheduling and Staffing

Three items changed significantly in the ***scheduling*** category. Respondents reported working less 8-hour shifts and more weekend shifts in 2005 than in 2001. There was also an increase in the use of flexible scheduling.

## Extra Hours

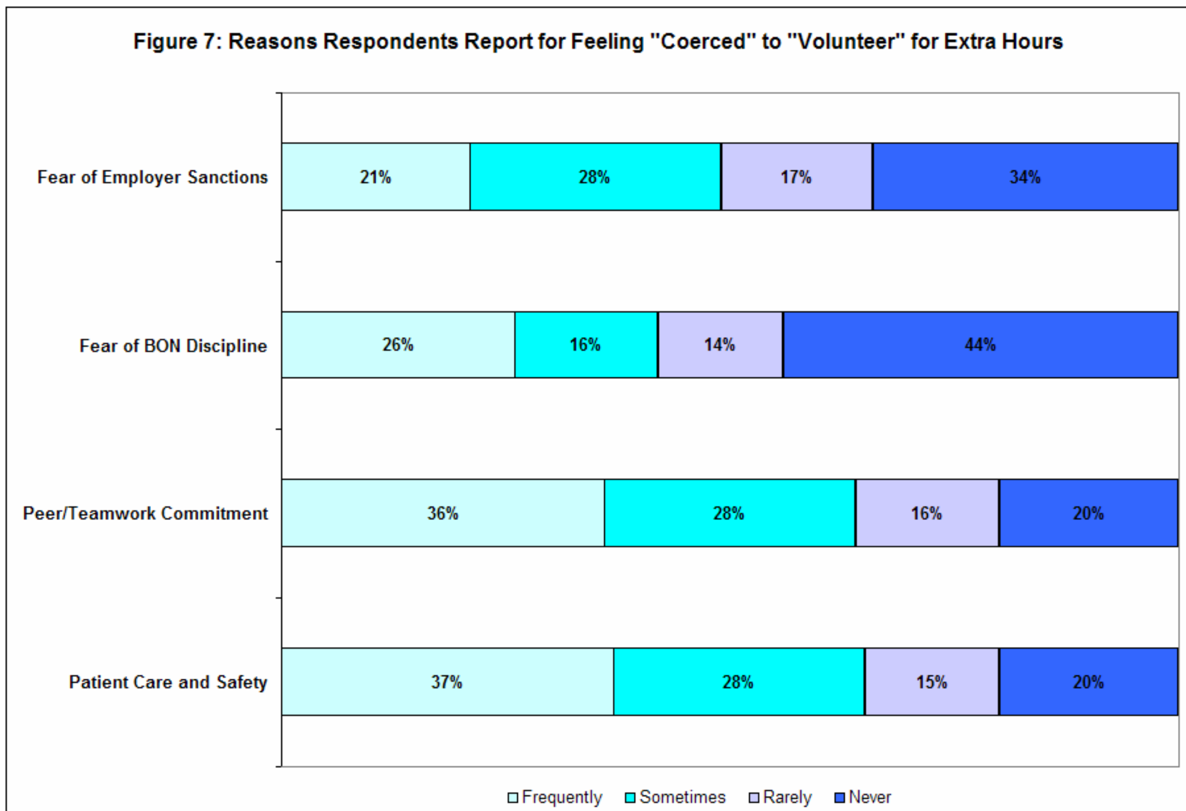
Though significantly decreased from 2001 to 2005, a sound majority of nurses (82 percent) still report working extra hours in the past 12 months. Among the respondents who reported usually ***knowing why*** extra hours are needed (Figure 6), the most frequently reported reason was unit coverage (for situations such as sick call and vacation), followed by inadequate staffing, unfilled

positions, and clinical emergency. Disaster was the least frequently reported reason for working extra hours.




The biggest change from 2001 to 2005 occurred in reports of ***mandatory extra hours***, which dropped by 30 percent. However, 12 percent report that mandatory extra hours were a condition of initial employment and 21 percent report that it is a condition of continued employment, similar to 2001. Voluntary extra hours dropped by 6 percent.

While a large number of nurses continue to report feeling ***"coerced to volunteer"*** to work extra hours, the reasons have changed. A significantly higher number of nurses report feeling coerced to work extra hours due to concerns for patient safety (37 percent) and commitment to their peers (36 percent). Fewer nurses report that they feel coerced to work extra hours due to fear of being disciplined by the Board of Nursing. See Figure 7 for a breakdown of all reasons.




Also, nurses report that ***workload*** contributes to the frequency of extra hours more in 2005 than in 2001 (a 20 percent increase). From 2001 to 2005, volunteering to work extra hours increased 30 percent for extra income and five-fold for professional commitment .

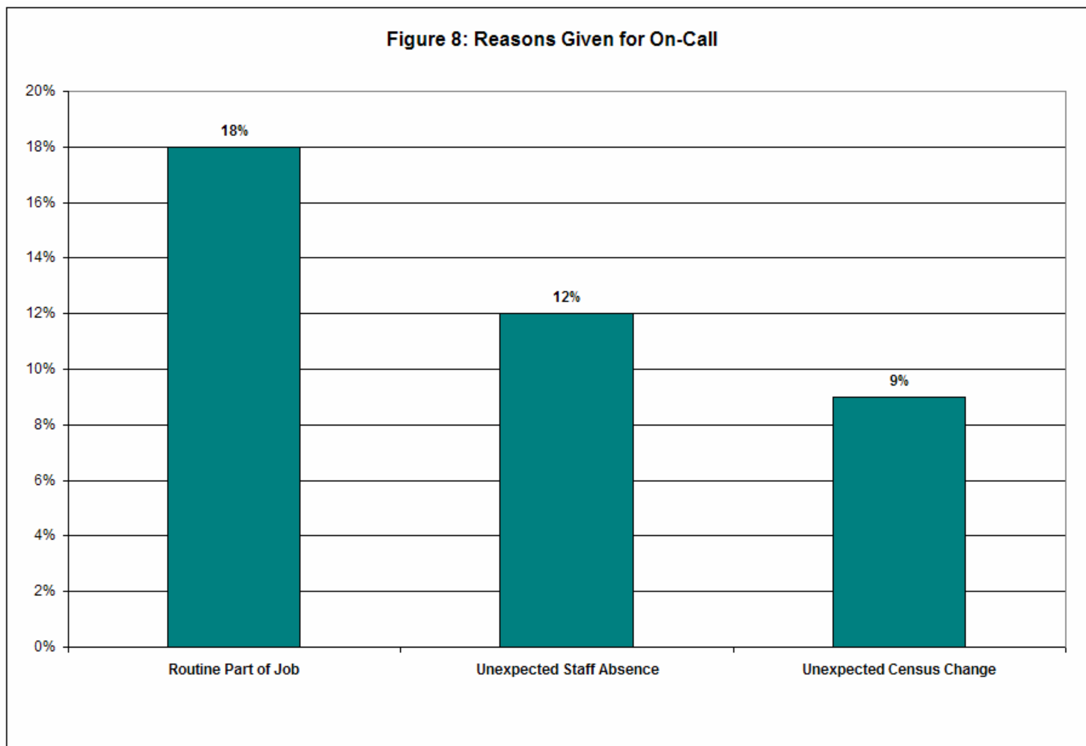
The majority of nurses (76 percent) report ***feeling safe*** working up to 12 hours a day, but the percentage decreases for 16 or more hours in a day. Fewer nurses in 2005 felt that they could work up to 10 hours a day; conversely, more reported being able to work up to 16 hours a day (the "double shift" so familiar to nursing). These findings were similar to the nurses' concern for their own safety and to their concern for patient safety. On average, nurses do not report that they think tiredness from work compromises patient safety, though a higher number feel that their own safety may be compromised, with little change from 2001 to 2005.

Consistent with the 2001 findings, in 2005, more nurses worked extra hours that are not ***planned-in-advance*** than are planned (a margin of more than 2 to 1). Slightly more than a third continue to report that they receive additional ***compensation*** for extra hours and 14 percent report that they are required to take some other time off if they work more than 8 hours in a day to avoid overtime.

An interesting corollary to working extra hours are responses from nurses regarding ***actions taken when the census is low*** and they are not needed to work. In each case (taking time off without pay or having to use their own leave), there were significant increases from 2001 to 2005 (17 to 23 percent in the former case, 28 to 40 percent in the latter).

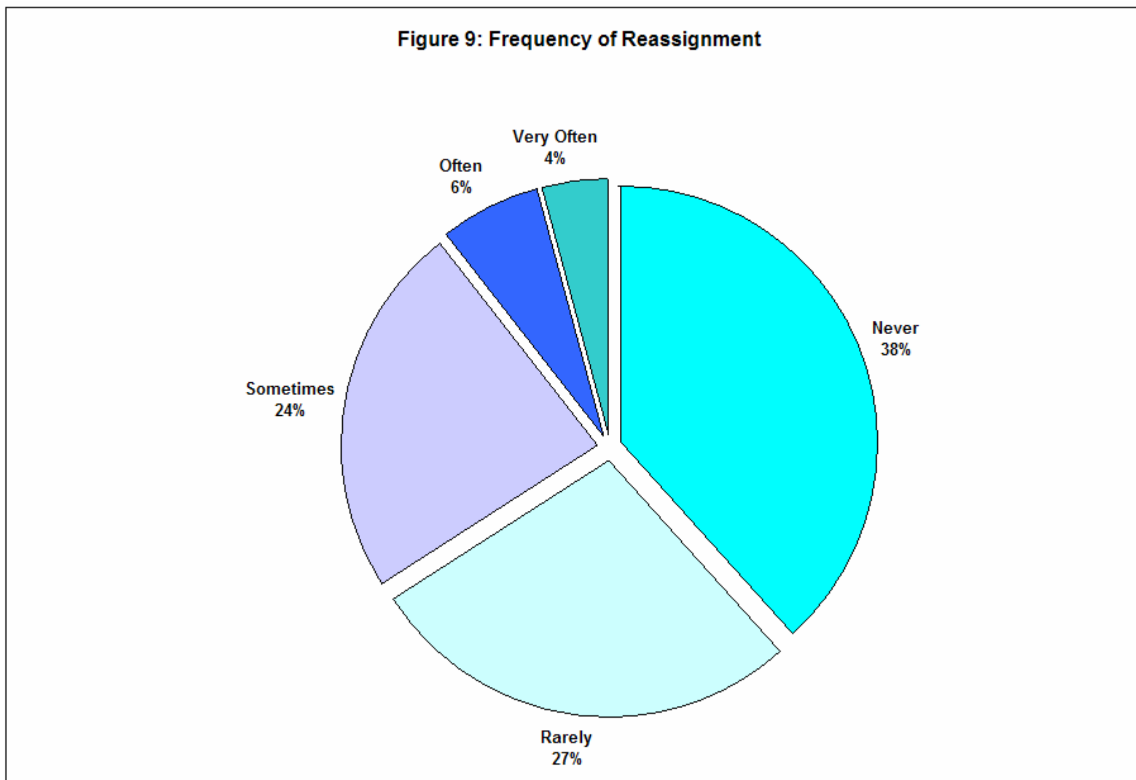
## On-Call

Nearly two-thirds of the respondents (65 percent) reported that being “on-call” was not part of their job. Of those who are on-call, the most frequently reported reason was that it is a “routine part” of the job. “Unexpected staff absences” (12 percent) and “unexpected changes in the census” (9 percent) were also cited reasons for being on-call. There was little change in nurses’ experiences with on-call, except for a significant increase in the need for it due to unexpected changes in the census. See Figure 8.



## Re-Assignment

Re-assignment to another work area continues to affect about 34 percent of the respondents (see Figure 9). While most nurses (72 percent) feel competent to work in the reassigned area, only about half say that they are oriented to the area. Very few (4 percent) receive additional compensation for re-assignment.



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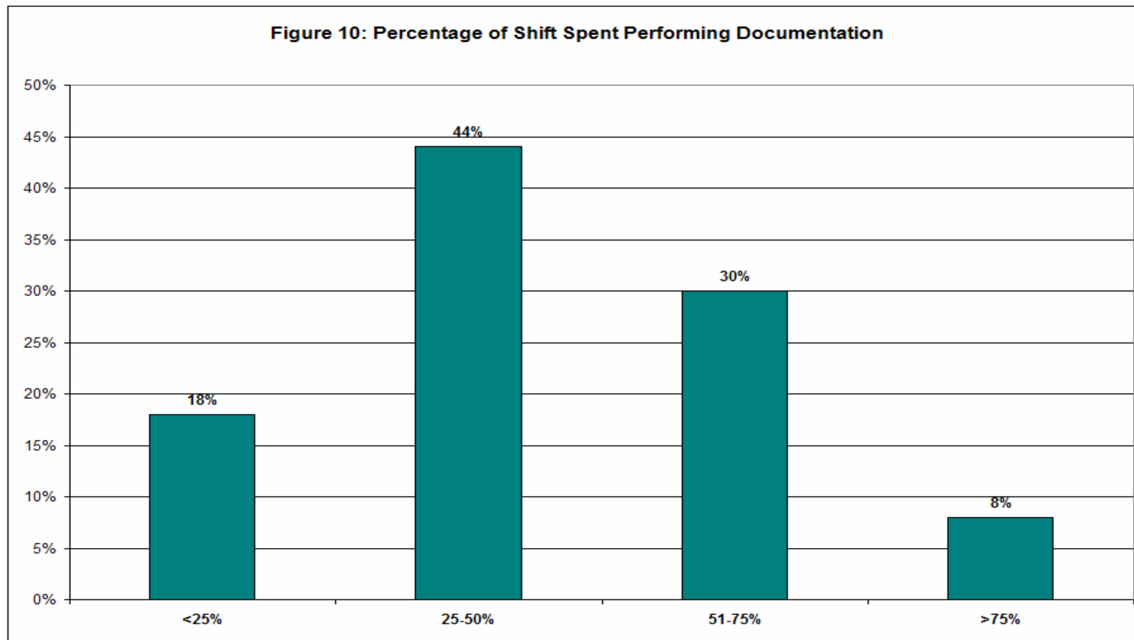
**Documentation**

Though there was no significant change from 2001 to 2005, it is noteworthy that upwards of 80 percent of nurses continue to report that more than 25 percent of their shifts are spent on documentation (Figure 10). Thirty-six percent report that documentation compels them to stay beyond their scheduled hours often or very often, and 38 percent say that documentation often or very often prevents them from spending as much time as needed with patients. More nurses report that they are compensated when they stay over to complete documentation (45 percent in 2001; 56 percent in 2005).



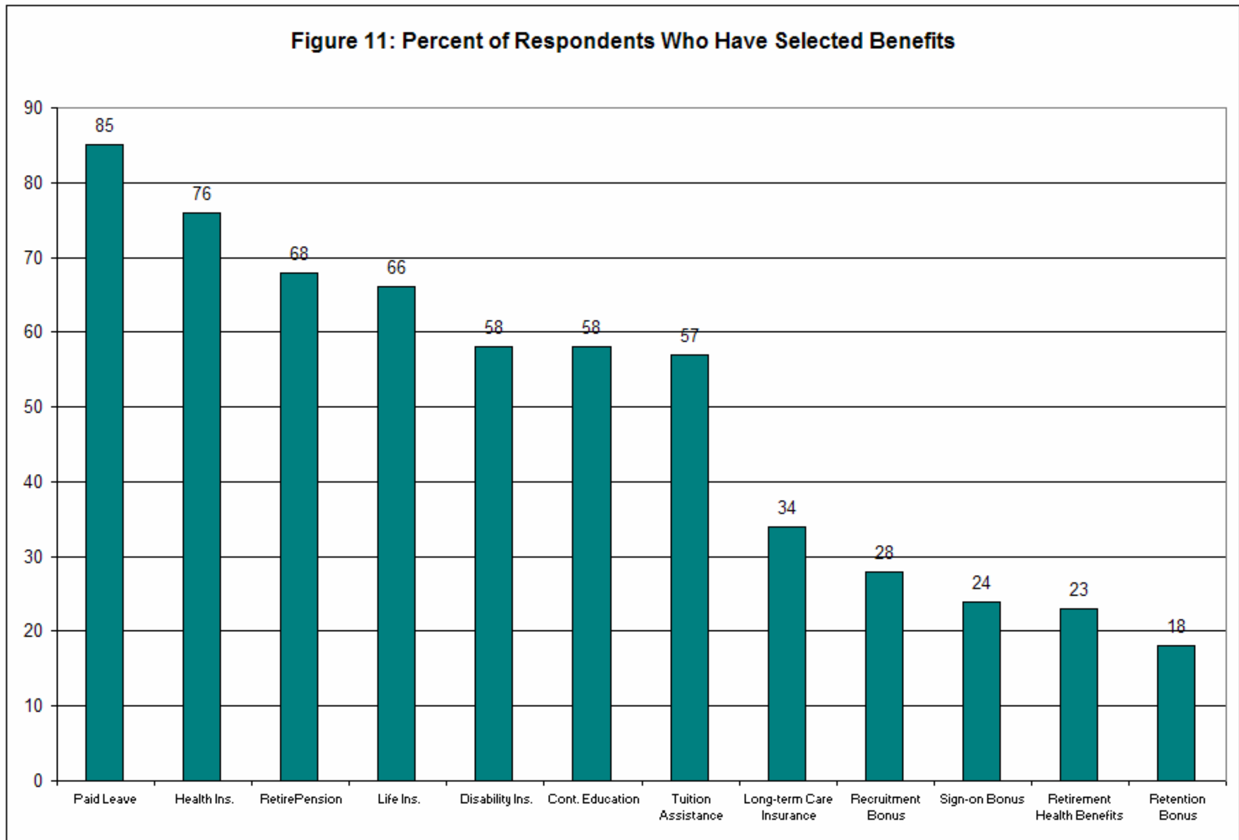

**Dependent Care**

While it is still the exception to the rule, there was a significant increase in the number of employers who offer assistance with adult care. Child care and sick child care services remained steady at 17 and 4-6 percent, respectively, while adult care more than doubled. However, in all categories of dependent care (child, sick child, and adult), respondents reported that this was a less important issue for them in 2005 than in 2001 (mean of 1.46 out of 3).

**Compensation and Benefits**

On a scale of 1 to 4 (where 1 is very dissatisfied and 4 is very satisfied), nurses' satisfaction with compensation averaged 2.4, with no appreciable change from 2001 to 2005. Fifty-one percent were somewhat satisfied to very satisfied, and 48 percent were somewhat dissatisfied to very dissatisfied. Feelings of pay equity in the workplace decreased significantly from 31 percent to 23 percent.

Seventy-five percent or more of respondents reported having two of the twelve benefits listed in the survey; many report having paid leave (85 percent) and health benefits (76 percent). At least 30 percent do not have the other benefits. See Figure 11.




Of those having the selected benefits, most were somewhat satisfied or very satisfied. Respondents who were not satisfied ranged from 17 to 44 percent with most being in the 20-30 percent range. From 2001 to 2005, satisfaction with tuition assistance, continuing education, retirement/pension, and retirement health benefits all decreased significantly, though it still remained slightly above somewhat satisfied.

**Table 2: Satisfaction with Selected Benefits**

| | Percent of those who responded that they have the benefit | | |
|---|---|---|---|
| | **Very Satisfied** | **Somewhat Satisfied** | **Not Satisfied** |
| Paid Leave | 30 | 46 | 24 |
| Health Insurance | 27 | 49 | 24 |
| Retirement/Pension | 25 | 49 | 26 |
| Life Insurance | 25 | 58 | 17 |
| Disability Insurance | 29 | 50 | 21 |
| Continuing Education | 32 | 42 | 27 |
| Tuition Assistance | 26 | 46 | 28 |
| Long-Term Care Insurance | 27 | 48 | 25 |
| Recruitment Bonus | 30 | 38 | 33 |
| Sign-on Bonus | 25 | 37 | 38 |
| Retirement Health Benefits | 31 | 32 | 37 |
| Retention Bonus | 31 | 25 | 44 |

## Other Professional Issues

Respondents were asked to answer a series of questions about their professional lives that were not directly connected to the primary workplace issues. These questions concerned the relationship with their immediate supervisor, plans for leaving or staying in the nursing profession, and satisfaction with certain factors in the workplace. Also, two new areas of questioning were introduced: nurses' knowledge of and experience with influenza vaccine during the 2003 influenza season; nurses' knowledge and experience with legislative changes initiated by the Commission in the period between the two surveys; and knowledge and use of the BON's and OHCQ's roles in monitoring patient safety.

When asked about the adequacy of their ***supervisor's skills***, more than half (66 percent) responded that their supervisor's skills provide them with adequate support in their position. Fewer than half (43 percent) felt that their ***supervisor receives the administrative support*** he or she needs to allow the supervisor to respond well to nurses' work life concerns.

When queried about the likelihood of ***remaining in the nursing profession*** if they left their current position, most (58 percent) responded that they would seek a nursing position in a different setting, while 42 percent said that they would leave the field entirely. Of those who would leave nursing, nearly even proportions said they would seek a non-nursing position in a health care setting or a non-health-related position. Fourteen percent of respondents stated that at some point in the past, they had left nursing with the intention of never returning.

Important accomplishments for the Commission included the passing of legislation to limit mandatory overtime and to provide nurses (and other health care professionals) with protection to report situations in the workplace that created unsafe circumstances for patients (House Bill 329 [2002] ***Whistle Blower Protection Act*** and House Bill 42 [2002] ***Labor and Employment-Nurses-Involuntary Overtime Prohibition***). The majority (51 percent) of nurses remain unaware that mandatory overtime is against the law except during a disaster. Fewer than 45 percent were aware of 2002 whistle blower and mandatory overtime legislation, and very few had used either of them for their own circumstances. Awareness of the ***OHCQ's role in monitoring patient safety*** approached 50 percent, while awareness of the ***BON role*** was 27 percent. Though overall use was low, the OHCQ was used more than twice as often as the BON for reporting safety issues (7 percent compared to 3 percent).

Though most nurses are aware of the Centers for Disease Control and Prevention's (CDC's) recommendations regarding ***influenza vaccine***, fewer than 50 percent of respondents received the vaccine last year, and nearly half reported that their facility had an adequate supply of the vaccine last year. Those who did not receive the vaccine reported the following as reasons:

- Lack of supply (16%)
- Belief that vaccine might precipitate illness (12%)
- Belief that vaccine is ineffective (9%)
- Employer not offering the vaccine (5%)

**Highlights of the 2005 Survey and Comparison of the 2001 to the 2005 Surveys**

- More weekend shifts and use of flexible scheduling; fewer 8-hour shifts
- 30% decrease in mandatory extra hours; increases in feeling “coerced” due to patient safety concerns and peer commitment; diminished fear of BON sanction
- Unplanned extra hours outnumber planned by a margin of more than 2 to 1
- Workload played a larger role in 2005 for the need for extra hours
- As the number of consecutive hours worked or hours worked in a week increase, fewer nurses in 2005 than in 2001 feel that they or their patients are safe; however, more reported feeling safe to work the 16-hour “double-shift”
- On-call continues to be part of the job for about a third of respondents, mostly as a routine part of the job, but with a significant increase in use due to changes in census
- Upward of 80% report spending more than 25% of their shift completing documentation, in 2001 and 2005, causing the need to stay over and interfering with patient care; more are being compensated for this additional time
- Though still comparatively low for all types of dependent care, more adult dependent care is being provided
- Compensation satisfaction remains steady at about 2.4 out of 4; satisfaction with pay equity is lower
- A third or more do not have 10 of the 12 benefits asked about in the survey, including pensions, life or disability insurance, and continuing education or tuition assistance; most of those with benefits are somewhat satisfied or very satisfied
- 42% would leave nursing if they left their current position; half would not seek a health care-related position
- 66% feel their supervisor is supportive; only 43% feel their supervisor gets the support that he/she needs
- Less than 45% were aware of 2002 whistle blower and mandatory overtime legislation
- Reasons nurses did not receive flu vaccine:
  - Lack of supply (16%)
  - Belief that vaccine might precipitate illness (12%)
  - Belief that vaccine is ineffective (9%)
  - Employer not offering the vaccine (5%)

**Summary of Nurses’ Comments**

Appendix 4 contains a transcript of comments that respondents wrote on their surveys and as unsolicited letters. Generally, nurses feel that inadequate staffing and increased patient acuity is leading to stress, a workload that is too heavy, and, ultimately, burnout. All of this is compounded by ineffective management and lack of recognition and/or compensation.

***Workplace quality of life*** issues such as a lack of respect and acknowledgement of nurses’ work from management and other members of the health care team (including peers who have a poor work ethic) fuel nurses’ discontent. ***Management*** (from the nursing supervisor to institutional administration) is seen as having unreasonable expectations (e.g., too heavy a workload) that many respondents felt hinged on the need to save money at the expense of patient care and their

own well-being. Some managers are characterized as not understanding patient care (because they are too far removed from the experience and represent the fiscal interests of administration), or as using unfair management practices (such as having "favorites" among staff).

***Workload*** in terms of high nurse-patient ratios is a frequently mentioned issue. One nurse characterized her choices as: 1) doing less (and not enough) for more patients; 2) leaving some patients unserved; or 3) work over her allotted hours and serve all patients well but risk reprimand and a poor evaluation for being "inefficient."

***Compensation*** concerns included:

- Agency nurses receiving greater remuneration for less work/responsibility
- Experienced staff being released to eliminate higher salaries gained through longevity ("we had to reapply for our jobs…")
- Not being paid for overtime because the scheduled work week (without lunch periods) is less than 40 hours, circumventing overtime pay for 8 hours of extra work
- General perception of being "underpaid" for the work required

Another concern was the impact of work life issues on nurses' ***personal quality of life***. There were mentions of having to miss important family events, and little consideration being given by administrators to nurses' lives outside of work, especially for single parents and parents of young children.

## FINAL COMMENTS

Nurses' workplace experiences vary widely with small but substantial proportions having combinations of issues that would lead as many as 42 percent of the 2005 survey respondents to leave the profession—a significant finding in a time of nursing shortages. Likely to be quite varied, there is no one solution or set of solutions that might make enough difference to enough nurses. However, further research could help to define the critical issues for which the greatest overall improvement could be made. Systematically addressing the long list of multifarious issues may be the best approach and will take time. It may be left to institutionally based assessments and initiatives to improve the work life of their organizations, and then for that knowledge to be shared among similar institutions.

**Appendix 1: Copies of the 2001 and 2005 Surveys**

**COPIES OF 2001 AND 2005 SURVEYS**

## Appendix 2: Sample Correspondence

STATE OF MARYLAND

**Maryland Statewide Commission on the Crisis in Nursing**
4140 Patterson Avenue · Baltimore, Maryland 21215-2254

September, 2005

Merged Name
Merged Address Line 1
Merged Address Line 2
Merged Address Line 3

Dear <Merge Name>:

In the next two weeks, you will receive a survey sent to you on behalf of the Maryland Statewide Commission on the Crisis in Nursing's Workplace Issues Subcommittee. The enclosed survey will help the Commission understand how nurses' experiences have changed since the 2001 Workplace survey. The Commission and the Maryland Board of Nursing strongly urge you to take advantage of this opportunity. It is very important that you complete your survey as soon as possible after receiving it. The "right" solutions for Maryland nurses depend on gaining an understanding of real problems.

Independent researchers at the Center for Health Program Development and Management at the University of Maryland, Baltimore County are administering this survey. Based on your most recent license renewal application, your name was randomly selected from among nurses employed full-time in a hospital, long-term care facility, home health, or hospice care agency. Although your response will be tracked for research purposes, you can be confident that no individual's data will be reported to the Board of Nursing, the Commission on the Crisis in Nursing, or any employer. All responses will be aggregated for analysis.

Thank you in advance for assisting the Commission's identification of approaches that will both make a difference in your professional life, and provide a strong and sufficient nursing workforce for the future health of all Marylanders.

Sincerely,

Donna Dorsey, RN
Director, Maryland Board of Nursing
Vice Chair, Maryland Statewide Commission on the Crisis in Nursing

S. Anthony McCann
Secretary, Maryland Department of Health and Mental Hygiene
Chair, Maryland Statewide Commission on the Crisis in Nursing

# Appendix 2: Sample Correspondence

STATE OF MARYLAND

**Maryland Statewide Commission on the Crisis in Nursing**
4140 Patterson Avenue · Baltimore, Maryland 21215-2254

September, 2005

<Name>
<Address>
<City, State>

Dear <Merged Name>:

The enclosed survey is being sent to you on behalf of the Maryland Statewide Commission on the Crisis in Nursing's Workplace Issues Subcommittee. Since its inception in 2000, the Commission has been working towards effecting change to improve the professional experience of nurses in Maryland. As stated in the letter that you recently received, advising you of your selection to participate in this survey, the "right" solutions for Maryland nurses depend on gaining an understanding of the real problems.

The enclosed survey replicates a survey conducted in 2001 and will help show how things have changed. If you completed the survey in 2001 and have been selected again, it is still very important for you to complete the survey. The Commission and the Maryland Board of Nursing strongly urge you take advantage of this opportunity to present your experiences.

This time, you will have the option of either mailing back the written survey, or completing the survey online. To complete the survey on line, go to www.healthcaresurveys.org/BON2005 and enter the following access code: <this will be a merged data field>. Processes such as this survey provide information that can guide meaningful change.

An independent research organization is administering this survey in order to assure confidentiality. Although your response will be tracked by the researchers, no individual's data will be reported to the Board of Nursing or to the Commission. All responses will be aggregated for analysis and reporting. Questions about the survey can be addressed to Annette Snyder, the Project Director at University of Maryland, Baltimore County, at 410-455-6386, or 1-800-353-8622, and then follow instructions by pressing 3 for the Center for Health Program Development and Management.

Sharing your experiences will allow the Commission to identify approaches that will make a difference in your professional life, as well as provide a strong and sufficient nursing workforce for the future health of all Marylanders.

Please return this survey by ***(date within two weeks of mailing).*** Thank you.

Sincerely,

Donna Dorsey, RN
Director, Maryland Board of Nursing
Vice Chair, Maryland Statewide Commission on the Crisis in Nursing

S. Anthony McCann
Secretary, Maryland Department of Health and Mental Hygiene
Chair, Maryland Statewide Commission on the Crisis in Nursing

**Appendix 3: Comparison of Change between 2001 and 2005 Survey Responses**

| Variable | 2001 | 2005 | P-Value |
|---|---|---|---|
| **Scheduling** | | | |
| 5 8-hour shifts | 52% | 41% | <.0001**** |
| 3 12-hour shifts | 13% | 17% | 0.0070 |
| 4 10-hour shifts | 3% | 3% | 0.8535 |
| Weekend alternative | 3% | 5% | 0.0061** |
| Combinations of 4, 8, 10, and 12-hour shifts | 9% | 10% | 0.7317 |
| Use of flexible scheduling | 60% | 71% | <.0001**** |
| Nurse determines her own schedule | 49% | 47% | 0.6721 |
| Scheduling accommodates physical limitations | 14% | 14% | 0.6548 |
| Assignment accommodates physical limitations | 11% | 12% | 0.6531 |
| Seniority considered in scheduling | 27% | 26% | 0.6065 |
| Preferences accommodated in scheduling | 71% | 66% | 0.0671 |
| Rotate shifts | 27% | 24% | 0.2169 |
| **Staffing** (1=Never, 4=Always) | | | |
| Adequate quantity of nurses | $\bar{x}$ =3.60 | $\bar{x}$ =3.66 | 0.5554 |
| Has the skill-mix needed in their unit | $\bar{x}$ =3.69 | $\bar{x}$ =3.71 | 0.7223 |
| **Extra Hours** | | | |
| Worked extra hours in last 12 months | 87% | 82% | 0.0045** |
| Extra hours: Voluntary | 79% | 74% | 0.0464* |
| Extra hours: Mandatory | 40% | 28% | <.0001**** |
| Usually knows reason extra hours needed | 98% | 94% | <.0001**** |
| Reasons (1=Never, 4=Frequently) | | | |
| Volunteered to work for extra income | 33% | 43% | <.0001**** |
| Volunteered to work due to professional commitment | 5% | 49% | <.0001**** |
| Frequency that workload makes extra hours necessary (1=Never, 4=Frequently) | $\bar{x}$ =2.04 | $\bar{x}$ =2.45 | <.0001*** |
| Disaster | $\bar{x}$ =1.43 | $\bar{x}$ =1.44 | 0.6316 |
| Clinical emergency | $\bar{x}$ =1.66 | $\bar{x}$ =1.71 | 0.3734 |
| Unit coverage | $\bar{x}$ =1.53 | $\bar{x}$ =1.54 | 0.9283 |
| Unfilled position | $\bar{x}$ =1.54 | $\bar{x}$ =1.59 | 0.2484 |
| Inadequate staffing | $\bar{x}$ =1.52 | $\bar{x}$ =1.55 | 0.7229 |
| Ever felt coerced into volunteering to work extra hours | 51% | 48% | 0.3042 |
| Why nurses felt coerced (1=Never, 4=Frequently) | | | |
| Concern for patient care and safety | $\bar{x}$ =1.65 | $\bar{x}$ =2.33 | <.0001**** |
| Commitment to peers | $\bar{x}$ =1.59 | $\bar{x}$ =2.34 | <.0001**** |
| Fear of employer sanctions | $\bar{x}$ =2.72 | $\bar{x}$ =2.80 | 0.9165 |
| Fear of Board of Nursing discipline | $\bar{x}$ =3.32 | $\bar{x}$ =2.92 | <.0001**** |

**Appendix 3: Comparison of Change between 2001 and 2005 Survey Responses**

| Variable | | 2001 | 2005 | P-Value |
|---|---|---|---|---|
| Mandatory extra hours a condition of initial employment | | 14% | 12% | 0.2037 |
| Mandatory extra hours a condition of continued employment | | 25% | 21% | 0.0523 |
| Extra hours a month that are planned | None | 42% | 41% | 0.6639 |
| | 1-4 | 18% | 21% | |
| | 5-12 | 20% | 20% | |
| | 13-16 | 8% | 7% | |
| | 17+ | 12% | 11% | |
| Extra hours a month that are not planned | None | 17% | 18% | 0.7043 |
| | 1-4 | 33% | 35% | |
| | 5-12 | 31% | 31% | |
| | 13-16 | 9% | 9% | |
| | 17+ | 10% | 8% | |
| How often so tired from work that own safety is compromised (1=Never, 5=Always) | | $\bar{x}$ =2.45 | $\bar{x}$ =2.49 | 0.8892 |
| Hours in a day worked before own safety is compromised | 8 or less | 10% | 10% | 0.8875 |
| | Up to 10 | 28% | 22% | 0.0116* |
| | Up to 12 | 36% | 33% | 0.2766 |
| | Up to 16 | 21% | 26% | 0.0119* |
| | More than 16 | 3% | 4% | 0.0588 |
| Hours in a week worked before own safety is compromised | Less than 40 | 9% | 12% | 0.0511 |
| | 40 | 19% | 22% | 0.1776 |
| | 41-50 | 44% | 36% | 0.0013** |
| | 51-60 | 21% | 19% | 0.4081 |
| | More than 60 | 3% | 6% | 0.0093** |
| How often so tired from work that patient safety is compromised (1=Never, 5=Always) | | $\bar{x}$ =2.02 | $\bar{x}$ =2.04 | 0.7992 |
| Hours in a day worked before patient safety is compromised | 8 or less | 9% | 8% | 0.4192 |
| | Up to 10 | 24% | 18% | 0.0021** |
| | Up to 12 | 33% | 34% | 0.7697 |
| | Up to 16 | 24% | 27% | 0.1262 |
| | More than 16 | 6% | 8% | 0.0853 |
| Hours in a week worked before patient safety is compromised | Less than 40 | 7% | 10% | 0.0349* |
| | 40 | 19% | 22% | 0.1850 |
| | 41-50 | 43% | 33% | <.0001**** |
| | 51-60 | 21% | 21% | 0.6970 |
| | More than 60 | 6% | 8% | 0.0545 |
| Receive additional compensation | | 35% | 38% | 0.3793 |
| If work more than 8 hours must take some other time off | | 12% | 14% | 0.4201 |

## Appendix 3: Comparison of Change between 2001 and 2005 Survey Responses

| Variable | 2001 | 2005 | P-Value |
|---|---|---|---|
| **On-call** | | | |
| On call is part of job (all respondents) | 34% | 35% | 0.7101 |
| On-call routine part of job | 53% | 54% | 0.9891 |
| On-call to cover staff absence | 31% | 37% | 0.1430 |
| On-call to cover unexpected changes in census | 20% | 28% | 0.0201* |
| **Re-assignment** | | | |
| How often re-assigned (1=Never, 5=Very Often) | $\bar{x}$ =2.05 | $\bar{x}$ =2.20 | 0.0458* |
| Feels competent to provide care in re-assigned area | 71% | 72% | 0.8004 |
| Oriented to re-assigned area | 50% | 51% | 0.6926 |
| Compensated in addition to regular pay | 3% | 4% | 0.2897 |
| **Documentation** | | | |
| Percent of shift spent completing documentation: Less than 25% | 20% | 18% | 0.2944 |
| 25-50% | 41% | 44% | |
| 51-75% | 28% | 30% | |
| More than 75% | 10% | 8% | |
| How often completing documentation causes staying over (1=Never, 5=Very Often) | $\bar{x}$ =3.13 | $\bar{x}$ =3.11 | 0.7061 |
| Compensated to stay over | 45% | 56% | <.0001**** |
| Documentation keeps nurse from patient care (1=Never, 5=Very Often) | $\bar{x}$ =3.00 | $\bar{x}$ =3.10 | 0.1420 |
| **Dependent Care** | | | |
| Dependent care provided? | | | |
| Child care | 17% | 17% | 0.8529 |
| Sick child care | 4% | 6% | 0.2596 |
| Adult care | 10% | 23% | <.0001**** |
| Dependent care important? (1=Not Important, 3= Very Important) | | | |
| Child care | $\bar{x}$ =1.79 | $\bar{x}$ =1.47 | <.0115* |
| Sick child care | $\bar{x}$ =1.94 | $\bar{x}$ =1.45 | <.0031** |
| Adult Care | $\bar{x}$ =1.81 | $\bar{x}$ =1.46 | <.0096** |
| **Compensation** | | | |
| Current compensation is appropriate (1=Very Dissatisfied, 4=Very Satisfied) | $\bar{x}$ =2.43 | $\bar{x}$ =2.40 | 0.5053 |
| Required to take time off without pay when census is low | 17% | 23% | 0.0006*** |
| Required to use own leave or lose pay when census is low | 28% | 40% | <.0001**** |
| Feels that there is pay equity in current workplace | 31% | 23% | 0.0026** |
| **Satisfaction with Benefits (1=Not Satisfied, 3= Very Satisfied)** | | | |
| Tuition assistance | $\bar{x}$ =2.40 | $\bar{x}$ =2.02 | <.0001**** |
| Continuing education | $\bar{x}$ =2.58 | $\bar{x}$ =2.00 | <.0001**** |
| Retirement/pension | $\bar{x}$ =2.77 | $\bar{x}$ =2.01 | <.0001**** |
| Retirement health benefits | $\bar{x}$ =2.50 | $\bar{x}$ =2.06 | <.0001**** |

***=p-value <.05  **=p-value <.0 1  ***=p-value <.001  ****=p-value <.0001  $\bar{x}$ = t-test mean**

## Appendix 4: Additional Comments Submitted by Respondents

***Nurses wrote comments regarding their thoughts beyond the information requested in the survey. The following quotes were taken directly from the surveys received.***

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***LPN since 1968***

"Working at a Drug and Alcohol Rehab is so much different from hospital work. I wish I had received this survey about 1½ years ago. Working Med/Surg. in a non-teaching hospital was pure Hell! Even the travelers didn't re-up."

***RN – Hospital***

"Also need to address the lack of nursing schools and/or small acceptance rate! I have spoken with many young women who became discouraged because of the long waiting list – after two (2) or three (3) tries, they go on to another career!"

***RN – Hospital***

"Board of Nursing should make it mandatory for Nursing Supervisors and Clinical Managers to work at bedside to better view and realize the quality of patient care. They should work once a week as a staff nurse at bedside. They are dumb nurses. They want to save money to the hospitals but do not care about the quality of patient care. If they will start to work as a clinical nurse once a week at bedside with a full load of patients like the other nurses do, they will start to provide better Nurse Patient Ratio, which will improve quality of care. Nurses now a day are going in business, teaching and computer programming OR sitting home like me. Of course, I miss bedside nursing and my patients, but I do not want to come home very frustrated that I was unable to provide the care to my patients which I wanted to because the floor was not staffed according to the patient's need. The main reason nurses are leaving is: (1) burn out. (2) Lack of understanding of the patient's care needs by the hospital staffing authorities like clinical managers and the nursing supervisors. (3) Employers want to save money by assigning 7-8 patients to one nurse. Patients are more ill with multiple medical problems now a day than ever before. Very sick patients are admitted to the hospitals now a day; most of the treatments are done as an out-patient care. For patient safety and retention of nurses the ratio should be 1:4 and in step down cardiac unit it should be 1:3. I do not need benefits and I do not need money. I work as a volunteer at a school as a school nurse or once in a while I work in a hospital in E.R. OR Pediatric Cardiology as I am ACLC & PAL certified."

***LPN - LTC***

"If I know about a Nursing Home that does have mandatory overtime or at least they did. Also they do not pay employees for mandatory in-services. Should I send you the name of the nursing home? I do not want to get in any kind of trouble for reporting this, but after reading this survey, I am concerned."

## Appendix 4: Additional Comments Submitted by Respondents

***If you ever felt coerced into volunteering to accept extra hours, what made you feel coerced?***

- "Guilt trip by managers."
- "Professional responsibility."
- "Extra money (bonus)."
- "Can't leave until last patient leaves."
- "Part of my hours are as a lactation consultant. Patients are promised in hospital promotional materials that they will see a lactation consultant each day. If I cannot see all of the breast feeding patients in the allotted time, I feel it reflects negatively on me. Patients are upset – 'Why didn't you come to see me? I need help.' The administrative recommendation is that I be more efficient. Still, I can't seem to be efficient enough to squeeze 20 consultations with varying degrees of complications into five to six hours. It seems my only choices are: (1) Provide sub-optimal care and see everyone in the given time period. (2) Prioritize and not see some people. (3) Work over and endure the administrative reprimands regarding my inefficiency."
- "No replacement RN."
- "Fear of bad evaluation by Supervisor."
- "Emergency/mandatory meetings."
- "No alternate option."
- "Understaffing."

***If you did not feel coerced, why did you volunteer to work extra hours?***

- "Enjoyed working with co-workers."
- "Extra contract day."
- "Commitment to peers/team work."
- "It is just expected in academics."
- "Commitment to peers."
- "Mandatory on-call to cover absences."
- "Fulfill extra duty (after school) requirements."
- "To help coworkers; begged by assistant managers."
- "No one else to do it!"
- "Overtime is part of my job; staff has to be flexible. To fulfill job requirements."
- "Concern for colleagues."
- "Commitment to field."

***If you did not feel coerced, why did you volunteer to work extra hours? (- continued)***

- "It is time consuming when patients don't have ID bracelets. No unit secretary, no census sheets and patient's name and room number."
- "Not being able to finish in time due to heavy workload."
- "Give back to profession."
- "I enjoy nursing, co-workers, residents."
- "Giving to community."

## Appendix 4: Additional Comments Submitted by Respondents

***Is working mandatory extra hours a condition of initial employment?***

- "Due to doctor's orders."

***Is working mandatory extra hours a condition of continued employment?***

- "Working mandatory extra hours is not an over condition of continued employment, however, there is enormous pressure to do so."

***In regard to your <u>own</u> safety and well-being:***
***How many continuous hours in a day do you feel that you can work before physical or mental fatigue compromises your own safety and well-being:***

- "8 hours or less – On-going health issue."

***In regard to your <u>patient</u> safety and well-being:***
***How many continuous hours in a day to you feel that you can work before physical or mental fatigue compromises patient safety and well-being:***

- "8 hours or less – On-going health issue."

***Do you receive higher pay for working extra hours?***

- "Sometimes – higher rates of pay for extra hours is administrative discretion."

***Are you compensated when you stay over to complete documentation?***

- "If I were full-time, then the pressure would be enormous to do whatever it takes to carry whatever workload is given in the allotted time. As a part-timer, I do get paid for extra hours because they are not, by law, overtime. With the pay, however, come negative evaluations of my efficiency."

***How satisfied are you that your current compensation package (salary/hourly wage and other benefits) is appropriate for your years of education and experience?***

- "Paying way too much for health benefits – no incentive for long-term employees."

***Are you required to take time off without pay when the census is low?***

- " Not required, but pressured."

***Do you feel that there is pay equity at your place of employment (nurses in similar positions get similar pay)?***

**Appendix 4: Additional Comments Submitted by Respondents**

- "In-house staff RN's are paid a reasonably comparable salary. However, I often work a shift with an in-house or out-of-house agency nurse who makes 1 ½ or more times more money per hour than I do – AND they have fewer responsibilities and less accountability."

- "New nurses making almost the same as me."

***Have you ever left nursing because of professional or workplace issues with the intention of never returning? If yes, why did you leave?***

- "Poor management, lack of support from supervisor, poor wages, and looked down upon because I was an RN = zero respect from other multidisciplinary staff. Nurses should make more than current pay scales."
- "I left ICU because I placed a patient back on a ventilator at previous settings because of respiratory distress affecting her hemodynamically, when respiratory therapist was not able to be found for 1 ½ hours and I was reprimanded for touching the ventilator. The respiratory therapist was hardly counseled for her negligence.

- "I left one job after working for over ten (10) hours, a new program "Spirit" was being implemented and everyone had to reapply for their positions. I firmly believe that seniority in nursing needs a great more need for "Respect" by other co-workers and strongly feel that some people enter the nursing field for money, not the love of caring for the sick."

- "I left because managers or directors were not knowledgeable/trained to handle staff complaints; they were not effective at their job, or because of prejudice experience."

- "I changed specialty areas and went to a new hospital. Although they told me the department was putting together an education program, they did not have this in process. I was not sure who was really mentoring me. I was let go. There seemed to be a political problem with management, educator, and staff nurses. I received letters from staff nurses stating I was treated unfairly."

- "Self-employment, no more politics, poor patient care, lack of respect, downsizing."

- "Unable to be with my family at the necessary times. Had other outside interests."

- "Yes, but my facility has a nurse's union, without which, we would not be nearly as protected or compensated. Administration has made it very clear that they would prefer the union out. And then many people will leave, conditions will not be as protected, compensated."

**Appendix 4: Additional Comments Submitted by Respondents**

- "Low integrity of new manager – nasty and told us lies."

- "I have thought about leaving but "something always pulls me back". There is still lack of respect among nurses for the many contributions of all RNs at all levels of education, from AA to Master's Degrees. This factor has contributed to nurses constantly feeling less loyal to the profession because of this constant push for degrees and not real commitment to nursing. No monetary support for proven experienced nurses that have been tax paying U.S. citizens to obtain degrees; many free educations for non-U.S. nurses. The board of nursing states they have never offered recognition, monetary or otherwise, for many good practitioners, practicing nursing fifteen or more years!!!"

- "I am seriously considering leaving nursing and currently exploring alternatives."

- "Lack of respect from fellow nurses and physicians. Hostile work environment, long hours, poor staffing, no support from nurse managers."

- "Burnout. Placed in difficult situation which, if pursued, would have caused problems with my co-workers (I was a supervisor)."

- "Workload too stressful. Forced to work in different units (unfamiliar)."

- "Two times! (1) Supervisor insensitive to single parent issues and the need for work hours for day and evenings and illness care. (2) When I worked as a worker's comp. nurse when my supervisor, attorney's representing clients, and injured workers, were all yelling due to their anger and trying to get their own way. The stress was bad enough to raise my B/P and cause me to feel physically ill."

- "But thought of it often! Working three (3) 14-16 hour shifts (usually with an approximate 15 minute break for lunch) is too long. We don't get paid for short lunch time, and we only get paid if we work over forty (40) hours a week. Therefore, they can pay us regular time for the 8 extra hours we do in a pay period without overtime. We also don't have enough support staff and we are the only unit in the hospital not allowed to refuse patients, even if nurse to patient ratios are unsafe. Our patients can be visited one-on-one on other units, but we will have another two to three patients that we are looking after. It is just unsafe!"

- "No, but I've thought about it a hundred times!"

- "Nursing shortage placed patient into unsafe environment. Nurses don't have time to take breaks, lunch sometimes. Stress of the job extremely high, but payment not high enough."

- "Frustration and loss of interest in position."

## Appendix 4: Additional Comments Submitted by Respondents

- "My immediate supervisor was rifted due to the facility dumping long time employees to save on salary and benefits. Several nurses reassigned to support our supervision."

- "1985 worked in free standing mental health facility with inpatient care (detox, rehab, mental health) and, due to shortage of money, company dismissed security program. They reduced nurse-patient ratio making it an unsafe environment. I encountered an emergency and tackled a patient with a scalpel."

- "Left nursing for one year because I felt overworked, under-compensated, was made to work in another unit (not just being pulled-out, but transferred to work there) against my will and my supervisor not even discussing the situation with me. Very poor administrative support. We were forced to work overtime if somebody called out.

- "Overworked, under paid, but most important, no respect. Nurses are considered part of the building and operating expenses, just overhead to be minimized. Work them to death and then get new ones."

- "Every day we were working under shortage of staff. It was dangerous for the patients. I did not want to put my R.N. (nursing) license on the spot. As well as patient's safety, so I resigned three times in twenty years. We need better patient nurse ratio.

- "My previous workplace hired an AM that did not believe males should be nurses. I was fired, wrongly accused of stealing supplies and drugs, and voluntary drug tested negative. I vowed never to return to work with idiots again until I found this job as a nurse case manager – long hours, little benefits, but I am my own boss."

- "Because satisfaction among the nursing staff was so poor; poor pay and work hours. Little staffing, no consideration that nurses having any life outside of nursing, such as family needs."

- "Never received pay for extra work to cover inadequate staff. Rarely saw or heard from RN Manager. Inadequate resources to give good patient care and found JAHCO to be a joke!!"

- "This is not related, however, I do feel very strongly that the acuity of patients needs to be addressed in an acute hospital setting. Med-surg. area and staffing should be assigned based on acuity of patients needs for safe and quality of care for patients. Acute hospital settings assignments should <u>not</u> be addressed on census only!"

## Appendix 4: Additional Comments Submitted by Respondents

- "The shift from clinical OR to a support/IT role was prompted by work hours related to family issues (i.e., on call). I will never return to clinical OR nursing. I am into the informatics piece."

- "General "burnout". Although I may get the support I need from admin., my subordinates (GNA's) often feel overworked, etc.. Consequently, I often need to "back delegate" in order to meet my deadlines. This is very frustrating, often creating a no win situation (due to lack of work ethic on part of GNA's).

- "Overwhelmed with young children."

- "Abuse by doctors and no support on these issues by nursing management. At my current hospital, the doctors are more team players and nursing administration takes employee abuse very seriously."

- "Injured at work parking lot during blizzard of '93 (in PA). Unable to work with neonates, where my heart is in nursing. It was in 2001, I began Neonatal Nursing in Maryland – Part-time for health reasons that remain as well as new health issues. Thus part-time I work 8 ½ hour shifts and am paid for 8 hours, as I should take mandatory ½ hr. meal break. I never take the break due to staffing issues, patient delivery loads, and availability of time. I wish I was paid for time worked, not hassled about start/stop times (private hospital)."

- "Hospital staffing poor. No support. So very tired."

- "Having vacation, holiday and sick time accumulated and unable to use, and lost because of staffing, time of year limited or not permitted. Flex staff getting preferred days over permanent staff. Managers also floor nursing, self scheduling themselves over the needs of other permanent staff members or wants of majority staff."

- "Poor staffing conditions. Failure to recognize nurse's needs. Insensitive to personal life issues.

- "Yes, you don't want to know!"

- "I was promoted from staff nurse to Infection Control. In my former facility, Infection Control is under Medical Services. There was a huge difference between the management of these two departments. Nursing management makes it hard for nurses while the medical management accommodated my family and professional work."

- "Long hours, low pay – little staff gratitude – "Hospital parities".

**Appendix 4: Additional Comments Submitted by Respondents**

- “I left the hospital work place for home health work place. I left due to unfair practices of scheduling patterns, rotation of shifts, inadequate staff/patient ratios. Weekend alternative shifts removed, self-scheduling received by seniority or first preferences, approval rate. No overtime or extra hours sign-up for overtime or extra hours, when available.”

- “Asked to work overtime on my unit – pulled somewhere else. Not my turn to be pulled – felt it was unfair – Received three days off without pay.”

- “Racial prejudice, discrimination (and heavy work load) from some of the RN’s. Working short staffed – lots of call outs and having to work with very sick patients.”

- “I get tired of working for the state government and the budget being balanced on state employee’s shoulders. If I had the pay raises that have been denied me (COA) over the past thirty-three years, the post retirement system could have been subsidized and it wouldn’t look so bad at 60.”

- “They don’t have enough staff to properly give good nursing care. I worked at a hospital and left there because of the Nurse Manager. It was because I didn’t fit into ‘the click’ at work and was treated unfairly. She had her favorites and I just wasn’t one of them. I had to get away from a job that I had worked at for twenty-nine years because of one manager who had just received her position, which she liked having power and didn’t care who she hurt to make herself look powerful. I just had enough. I moved on to the Detention Center. I have a great boss now (thank God!).”

- “Co-workers not doing their share of work and manager not able, or unwilling, to correct the situation.”

- “Better benefits.”

- “I couldn’t provide adequate care for patients and felt that my license and integrity were compromised.”

- “The reasons are numerous. This is my second nursing “shortage”, so I’m a survivor now as then it is/was created by nurses. No professionalism remains among us or the patrons we service. Every and anyone can or believes they can perform our duties and they are many. It remains a dominant, demanding, low paying feminine job.”

- "To improve skills and increase salary and benefits."

- "Didn't agree with staffing policy/required mandatory overtime."

**Appendix 4: Additional Comments Submitted by Respondents**

- "Just too much paper work - not enough time spent with patients, meeting personal needs, listening, personal touch, education of patient and family, too many mistakes! Rushing and feeling of leaving each day - unfulfilled - nursing care."

- "Burn out, everyone around me … burn out; burn out people taking lots of anger out on other burned out people because of a broken system no one can fix. Now in LTC, nurses, including DON's, have piled up desks because corporate take overs say no to everything. It looks pretty hopeless."

- "Incompetent manager with a personality disorder; unprofessional and unethical."

- "Thought about it a couple of times but still stayed."

- "Administration changes – with no respect from new administration for nurses employed at facility for a long time."

- "I will say, the place I worked last year in Sykesville, Maryland was managed very poorly. They had an LPN as a DON, who sought out one nurse at a time to basically harass and demean the nurses into tears. I know most of the nurses and nursing assistants I worked with are gone, mostly due to the management, and this person I am speaking of, I hear, is still a DON there."

- "Staff shortage – Too many hours required to complete nursing assignment. Day shift did not transcribe orders and they did not stay overtime. Plus, 3-11 admissions, in addition to 7-3 carryover work. 11-7 nurses did not know to admit patients."

- "Staffing issues (under staffed)."

- "Freeze on raises for over six months. New employed LPN with less than one year experience was hired at a higher pay then I was getting (I had 14 years experience as a LPN). I went and applied with another company."

- "Burn out due to inadequate support and lack of human and material resources."

- "Nurse/patient ratio was unsafe. Work load was not focused on safety but rather the corporate 'bottom line'."

- "Two small children at home to care for. Thought about returning to mental health employment."

- "Working short staffed. Unable to provide quality care, working sick, having to discourage others from not coming in sick."

**Appendix 4: Additional Comments Submitted by Respondents**

- "At that time, was overworked and understaffed and felt paperwork more important then resident care."

- "In 2003 while working at [name deleted] nursing home, the DON hired several foreign nurses that had difficulty speaking English. There were several occasion mistakes were made to harm the patients. The DON threatened to fire me and have my license if I continued to report the serious incidents to her or the administrator. I left that job for that reason. I felt very threatened; 50% of all staff also left the facility during the 1 ½ years she was DON."

- "Staffing, money, nepotism."

- "Burned-out; too heavy work load, no team work, too much favoritism among friends that are not qualified for the positions given to them."

- "Staffing and safety issues."

- "For personal reasons between me and another co-worker involving harassment that my boss did nothing about."

- "Administrative decision to convert LPN positions from salaried employees with benefits to contract employees without benefits."