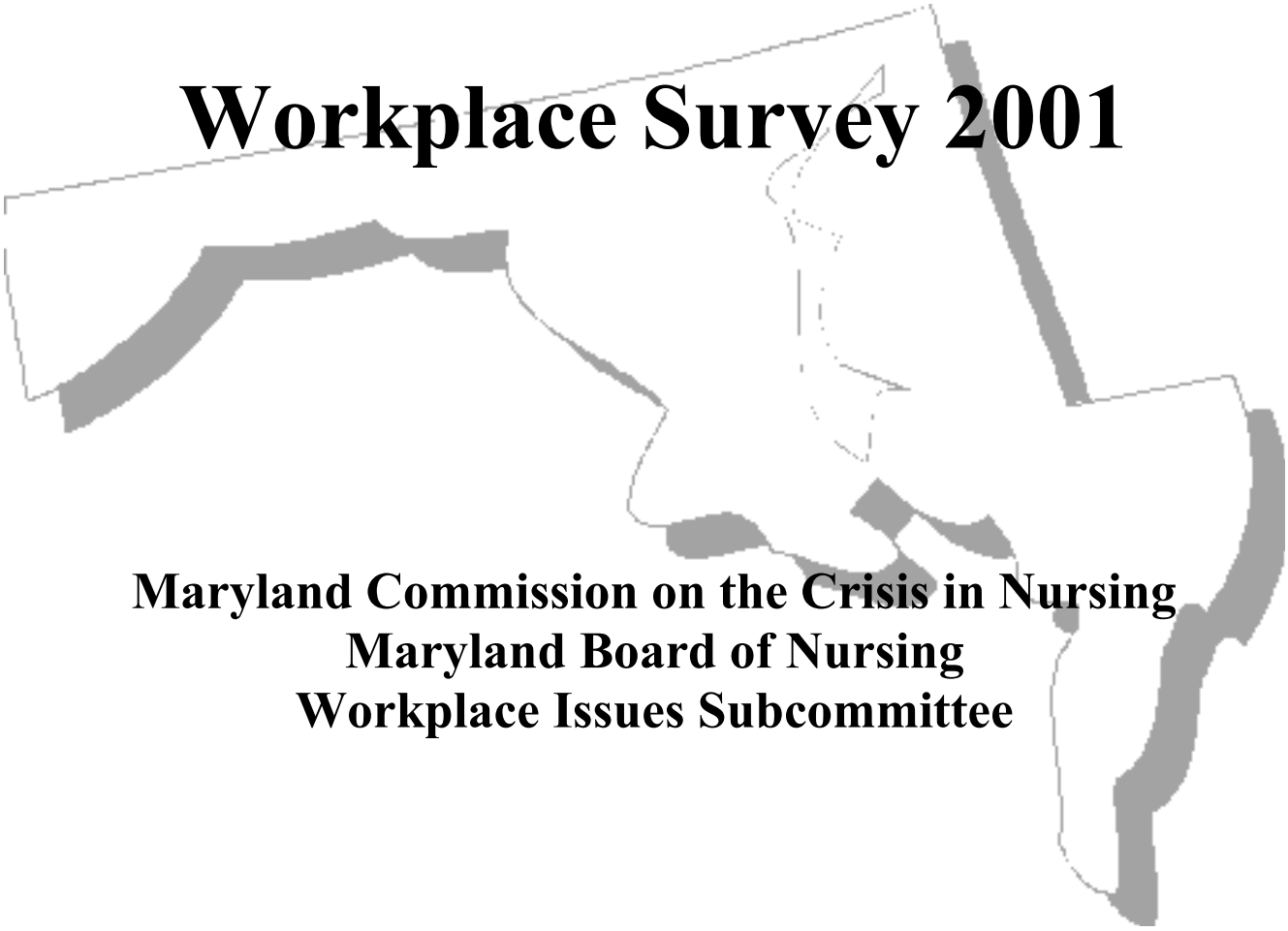
Workplace Survey 2001



Maryland Commission on the Crisis in Nursing
Maryland Board of Nursing
Workplace Issues Subcommittee

Center for Health Program
Development and Management at
University of Maryland, Baltimore County

Workplace Survey 2001

May 2002

Prepared for:
Maryland Commission on the Crisis in Nursing
Maryland Board of Nursing
Workplace Issues Subcommittee

Prepared by:
Center for Health Program
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The Workplace Survey 2001 was conducted by the UMBC Center for Health Program Development and Management (Center), under the auspices of the Maryland Board of Nursing, for the Workplace Issues Subcommittee of the Maryland Statewide Commission on the Crisis in Nursing. It was conducted from November 2001 to March 2002. The purpose of the survey was stated as "[to] obtain factual information regarding issues raised by nurses at the Summit held [June 6, 2001] and at the Commission meeting December 2000."

Selected from the Board of Nursing (BON) database for participation were 2,925 nurses (registered and licensed practical nurses) who reported on their most recent license renewal application that they work full-time in a Maryland hospital, long-term care facility, or home health/hospice. The total number of surveys used in the final data analysis was 1,531, representing a 52.3 percent response rate.

The survey instrument was developed in consultation with the Workplace Issue Subcommittee and the Commission at-large. The Commission determined that the survey should closely reflect the areas researched in the Workplace Issues working paper, "Nurses' Workplace Issues, Patient Safety, and the Quality of Patient Care" (October 2001), which was researched and written by the Center for the Commission. The issues addressed were: scheduling and staffing, mandatory overtime, mandatory on-call, re-assignment, dependent care, functionally appropriate work assignments, and professional recognition in the workplace.

Findings

Scheduling and Staffing. Most nurses (55 percent) work traditional 8-hour shifts; twenty-seven percent rotate shifts. Seniority and physical limitations are not usually considered in scheduling. Although more than half of nurses report that staffing quantity and skill-mix are usually or always adequate, 45 percent report that staffing and 42 percent report that skill-mix are "never," " rarely," or "sometimes" adequate/appropriate.

Extra hours. Eighty-seven percent of nurses have worked extra hours outside of their regular schedule in the last 12 months, and 47 percent say that some portion of it has been mandatory. More than half say that their voluntary extra hours were "coerced" due to peer commitment or concerns for patient safety. Respondents report inadequate staffing and unfilled positions as "frequently" the cause for extra hours being needed.

On-Call. Thirty-four percent of respondents take call as part of their jobs. Of these, the following reasons are reported: as a routine process (55 percent), staff absence (31 percent), and census changes (20 percent). Although 46 percent are compensated when on-call even if they do not have to report to work, more than half of nurses report that they are not compensated if not called. Fifty-three percent report that on-call is an initial condition of employment.

Re-Assignment. Of the 53 percent who report being re-assigned away from their usual work area, 10 percent say it is "often or very often." Seventy-one percent feel competent in the re-assigned area and half are oriented to the new work area.

Documentation. Thirty-eight percent of nurses spend more than half of their shift doing paperwork. Sixty-seven percent feel that paperwork keeps them from spending as much time with patients as needed.

Compensation and Benefits. Twenty-six (regarding the leave benefit) to 69 (retirement health benefits and bonus) percent of all respondents report not having or not being satisfied with the ten benefits addressed in the survey. Respondents are nearly equally satisfied and dissatisfied with their compensation, but more are "very dissatisfied" (19 percent) than "very satisfied" (13 percent).

Dependent Care. More than half of the 392 nurses who respond to dependent care questions say that child care is very important (52 percent), and 39 percent say that adult care is very important. Nearly half say that sick-child care is very important (48 percent). While respondents report that a modest amount of child care is provided by employers (17 percent), very little sick-child care (4 percent) or adult dependent care (10 percent) is reported.

Satisfaction with the Nursing Profession. Forty-nine percent of respondents say that they would leave nursing if they left their current job, though only 25 percent would leave health care altogether. Sixty-four percent are satisfied with their supervisor's skills but most do not feel that their supervisor has adequate administrative support. The primary issues for wanting to leave their current jobs or nursing are: inability to give quality care, mandatory overtime, "other" scheduling issues, mandatory on-call, re-assignment, compensation, and quantity of staffing.

I. Introduction

A survey of Maryland nurses was requested by the Workplace Issues Subcommittee of the Maryland Commission on the Crisis in Nursing under the aegis of the Maryland Board of Nursing (BON). The Commission was established as "an emergency measure" during the 2000 legislative sessions to, among other charges, "Determine the current extent and long-term implications…[and] Develop recommendations on and facilitate implementation of, strategies to reverse the growing shortage of qualified nursing personnel…" (House Bill 363, Legislative Session 2000).

The purpose of the survey was to "obtain factual information regarding issues raised by nurses at the Summit held [June 6, 2001] and at the Commission meeting December 2000." Many perceptions exist as to the presence and extent of some of the issues. The Commission decided that it needed firm data on which to base its actions and recommendations. The survey helps delineate the attitudes, perceptions and experiences of Maryland nurses.

The major issues identified at the June 6, 2001 Summit that are addressed in the survey are:

- Scheduling and staffing
- Mandatory overtime
- Mandatory on-call
- Re-assignment
- Dependent care
- Functionally appropriate work assignments
- Professional recognition in the workplace

Some aspects of compensation are reported in this survey as a further exploration of the major issues.

Prior to implementing the survey, an in-depth literature review was conducted and a working paper produced, outlining for the Commissioners the national scope of the issues. "Working Paper: Nurses' Workplace Issues, Patient Safety, and the Quality of Patient Care" was presented to the Commission in October 2001. The survey was designed to highlight issues as they pertained to Maryland nurses. That is, to what extent these factors mitigate nurse satisfaction, which may contribute to the current and future shortage of nurses. The survey documents how the selected factors contribute to nurses' dissatisfaction (how "important" they are to them) in particular kinds of facilities, and ascertains if these factors might contribute to the nurse either leaving that workplace or leaving the nursing profession altogether.

In addition to submitting their completed surveys, a number of nurses wrote comments on their surveys or enclosed letters expressing their concerns on the issues. These unedited comments are included in this report in Appendix 1. Nurses' comments are consistent with findings of the survey and mirror concerns raised by nurses at the June 2000 summit.

II. Methodology

A. Sample

The sampling frame included registered nurses (RNs) and licensed practical nurses (LPNs) who provide direct patient care in four facility types in Maryland as determined by their most recent licensure application. The facility types are hospitals, long-term care facilities, hospice, and home health.[1] Advance practice nurses, military personnel, and nurses who work in settings that are primarily daytime only (such as school nurses) were not included in this survey. The stratified random sample was drawn representing the two levels of nursing and the location of practice.

Sample Selection

According to the BON database, the total number of RNs who work full-time in the four designated types of health facilities is 18,916, and the total number of LPNs is 3,363. In order to create a balance that would allow group sizes to be sufficient for comparisons, the two levels of nursing and the four facility types were assigned percentages for sampling. The selected percentages provided latitude to accommodate lower response rates, though response rates were adequate without this adjustment.

To be selected, a nurse who was licensed in Maryland had to report that she worked in one of the selected facility types located in Maryland. (A number of nurses live in Maryland but work in surrounding states, or conversely, live in other states but work in Maryland.) (Figures 1a and 1b). Over-sampling was performed for LPNs in hospitals and home health/hospice facilities to accomplish an adequate response rate and adequate balance between groups for analysis (fewer LPNs are employed in these settings). The final sample of nurses selected to participate in the survey was 7 percent of hospital-based RNs and 31percent of hospital-based LPNs; 23 percent of long-term care RNs and 24 percent of long-term care LPNs; and 34 percent of home health/hospice RNs and 62 percent of home health/hospice LPNs (Table 1).

Table 1: Sampling Frame and Final Sample Selection

	Registered Nurse		Licensed Practical Nurse	
Type of Facility	**Database**	**Sample**	**Database**	**Sample**
Hospital	15,323	999 (7%)	1,303	400 (31%)
Long-Term Care	2,250	496 (23%)	1,808	431 (24%)
Home Health Care/Hospice	1,343	448 (34%)	252	151 (62%)
Total	**18,916**	**1,943 (10%)**	**3,363**	**982 (30%)**
Sample Total = 2,925				

[1] Home Health and Hospice categories were collapsed in the analysis due to the relatively small number of nurses in these areas and the similarity of the work that is performed.

Note: The sample of 2,925 nurses was drawn from the BON database of 22,281. These nurses indicated on their most recent license application that they work full-time in one of the designated Maryland facility types. The entire BON database houses approximately 58,000 nurses (LPNs and RNs).

Figure 1a: Distribution* of the Sample of the Workplace Survey 2001
Maryland Statewide Commission on the Crisis in Nursing

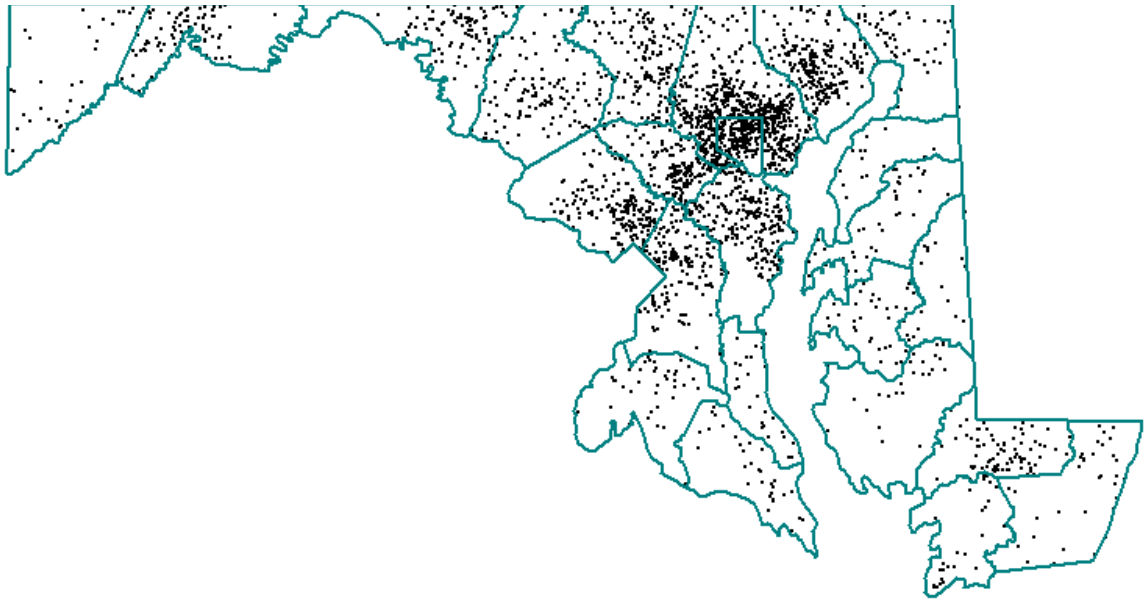
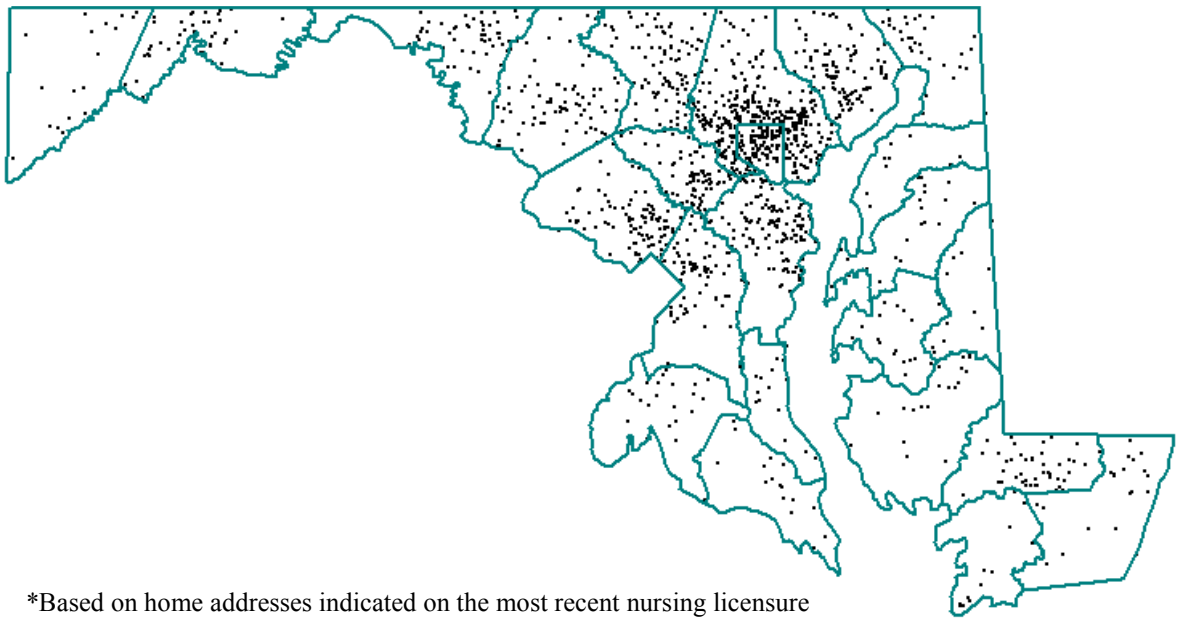


Figure 1b: Distribution* of the Respondents of the Workplace Survey 2001
Maryland Statewide Commission on the Crisis in Nursing



*Based on home addresses indicated on the most recent nursing licensure application at the time of the study.

Note: Figures are illustrative of the relative representation of nurses in the sample and respondent groups. Each dot does not necessarily represent an individual.

B. Survey Design

The survey instrument (Appendix 2) was created using the draft survey developed by the Workplace Issues Subcommittee, input from other Commission Committees as appropriate, and from recent surveys about nursing issues (professional organizations, states, etc.). The Commission stipulated that the survey closely adhere to the content areas that were presented in the working paper on workplace issues. The content areas addressed in the survey are:

- Scheduling and Staffing
- Extra Hours
- On-Call
- Re-Assignment
- Documentation
- Dependent Care
- Compensation
- Satisfaction with Nursing as a Profession

The instrument was pilot tested with nurses in a hospital setting (Johns Hopkins Bayview Medical Center and the Wilmer Eye Institute) and in a long-term care setting (Longview Nursing Facility) to insure content validity and reliability. A total of 30 LPNS/RNs participated in the pilot tests. Based on their comments, modifications and additions were made to the survey instrument and the survey cover letter prior to implementation.

C. Survey Implementation: Data Collection and Analysis

Surveys were assigned unique identifiers by a contracted vendor to protect the identity of individual respondents. Only the researchers at UMBC were able to match returned surveys with individuals, for the purpose of tracking responses and facilitating follow-ups. Surveys were mailed with a cover letter and a postage-paid return envelope to facilitate the return of the survey.

Once returned, surveys were logged-in at UMBC, organized into batches, and sent to the BON for scanning. Scanned data were reviewed by the UMBC researchers by manually matching observations in the database for a sample of returned surveys, and were found to be consistently correct.[2]

The surveys were distributed in November 2001. Prior to survey distribution, the members of the sample were notified of being selected to participate in the survey and informed of the purpose and importance of the survey. Three weeks following the mailing of the survey, non-respondents were sent a reminder postcard encouraging the return of the survey. This follow-up postcard included a contact name and phone number. As a result, many calls were received from nurses who were interested in the survey but had either misplaced or, in some cases, not received their survey.[3]

In addition to the follow-up postcard, approximately 1,600 non-respondents received phone calls from research staff. This again prompted requests for replacement surveys. The total

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[2] An exception is question 52, part 2, which was not "read" by the scanner from any of the surveys.

[3] It is thought that the post September 11th anthrax mail concerns may have impacted the delivery of some surveys.

number of returned surveys was 1,576 (response rate of 54 percent), though 45 of these surveys were excluded.[4] The number of surveys used in the analysis was 1,531, representing 52 percent of the survey sample. Fifty percent of the LPNs and 53 percent of the RNs responded, providing an acceptable response and balance for between-group comparison.

After all follow-up contacts were completed, a space delimited ASCII file was transmitted to UMBC from the BON for analysis. The data were imported into an Excel spreadsheet and ultimately into SPSS (Statistical Package for the Social Sciences).

Statistical analysis was performed on all variables and selected cross-tabulations. Percentages presented in this report may not add to100 percent due to rounding and because multiple responses were allowed in some cases. Analysis was conducted on unweighted data since a weighting analysis[5] showed that there was little difference in standard deviation of selected variables between the weighted and unweighted samples.

D. Code of Ethics

All aspects of this survey were guided by the highest ethical standards of research. The study protocol was reviewed and approved by the UMBC Institutional Review Board. The survey team was committed to upholding the following standards in conducting this study:

- Meeting obligations to the study sponsors
- Protecting the anonymity of respondents, including respondents' identities and/or any information that could compromise confidentiality
- Exercising due diligence in development of the survey instrument and the sampling design to assure the validity of the results
- Taking care in data collection, processing, and analysis to assure the reliability of the findings

[4] Forty-five surveys were excluded because: 1) they were incomplete (particularly if no demographic/ professional status information was given); or 2) the respondents identified themselves as not being an 'appropriate' respondents (due to issues such as retirement, not working for other reasons, or working in administrative or other capacity that made them unable to respond to the questions).

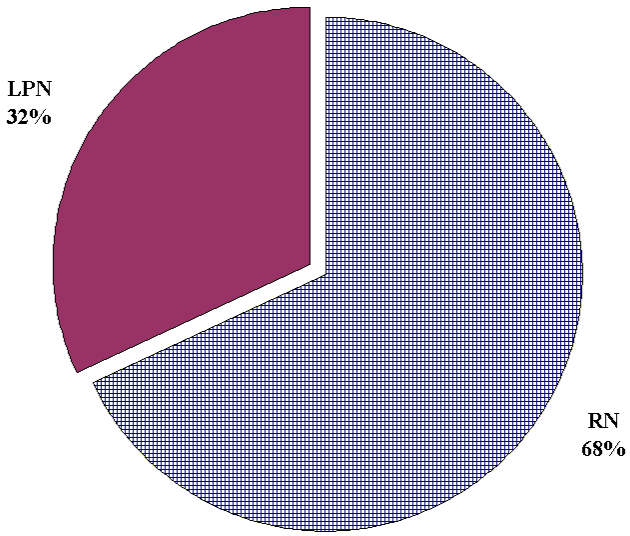
[5] The weighting analysis was performed because of the oversampling of the small categories of nurses in some of the facility types, especially LPNs in hospitals and home health/hospice, and RNs in long-term care.

III. Findings

A. Respondents' Characteristics

The final survey sample, that was used for this analysis, is composed of 1,033 RNs (68 percent) and 489 LPNs (32 percent) (Figure 2). This represents 5 percent of the RNs and 15 percent of the LPNs of the sampling frame. LPNs were purposefully oversampled (See Section II, page 4).

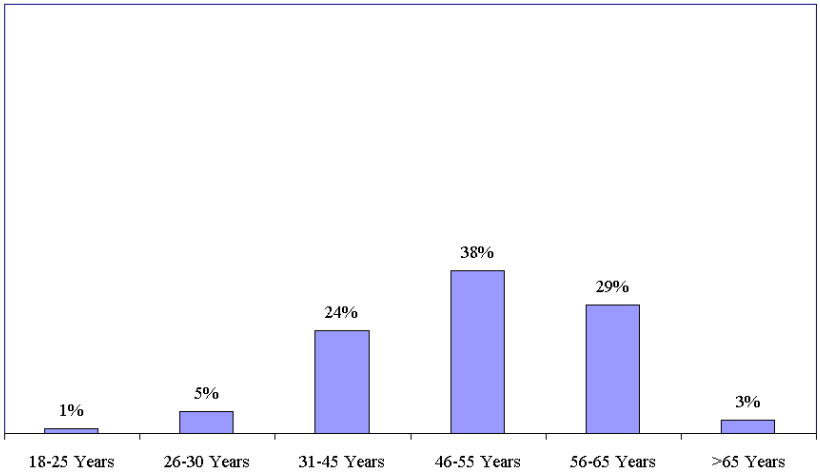
Figure 2: Respondents' Level of Nursing Practice



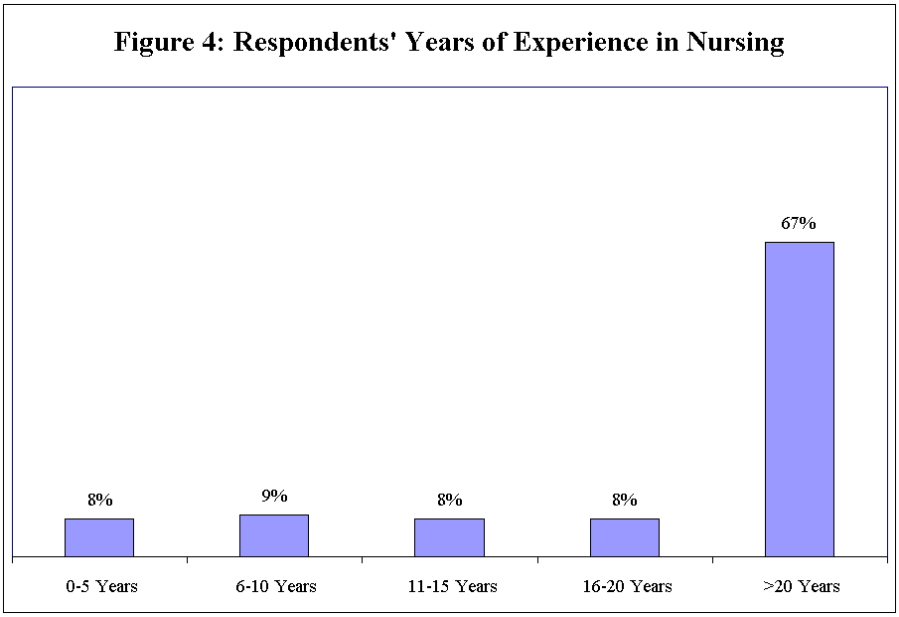
The largest group of respondents is employed in hospitals (42 percent), followed by long-term care (29 percent). Fifty percent of the RN respondents work in a hospital setting; 21 percent in long-term care; 14 percent in home health/hospice; and 15 percent in other settings. The LPN respondents work primarily in long-term care (47 percent) and settings other than hospitals. Only 24 percent of the LPN respondents work in hospitals.

As might be expected from national trends, the largest group of respondents is in the 46-55 year old age range (Figure 3). The second largest group of respondents is in the 56-65 year old group. With the 3 percent of respondents greater than age 65 years, the vast majority of respondents (70 percent) are over age 45 years.

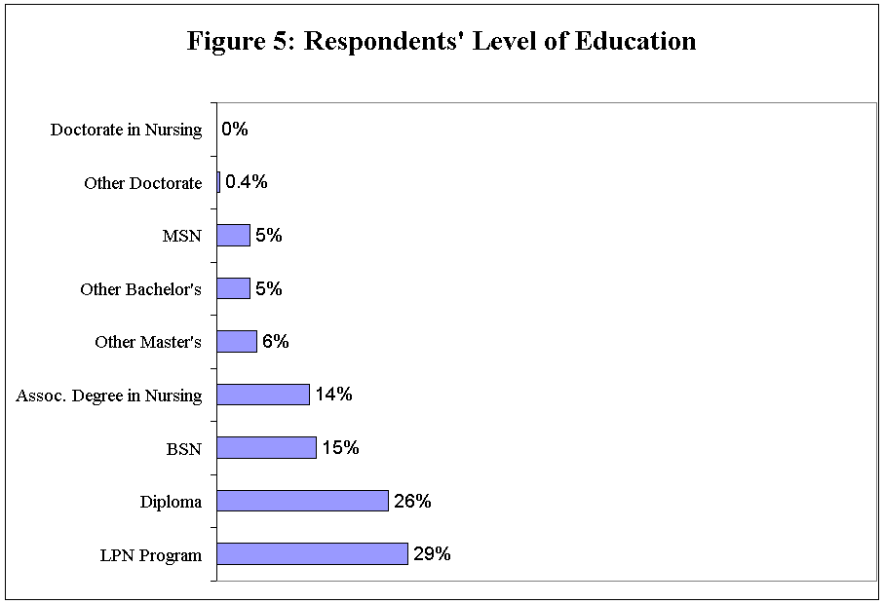
Figure 3: Ages of Respondents



Years of experience are similar to the age dispersion of the sample. Sixty-seven percent of respondents have more than 20 years of experience in nursing (Figure 4).



Thirty-six percent of RN respondents are diploma graduates, possibly a reflection of the predominant mode of education for the average-aged respondent (Figure 5).



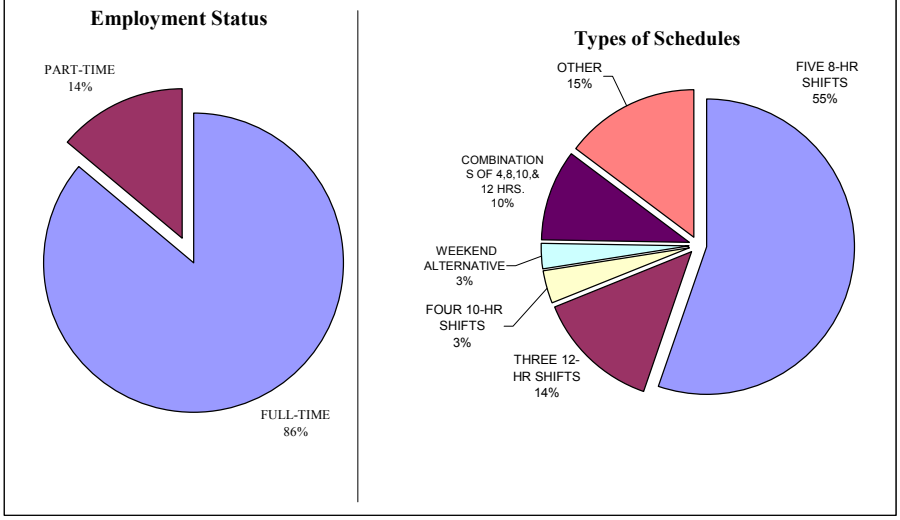
Respondents are primarily female (96 percent) and White (84 percent). Fifty-six men (4 percent) are among the respondents. Respondents include Blacks (13 percent), Asians, (2 percent), Native Americans (1 percent), and other. Less than 1 percent of respondents say that they are Hispanic.

Of those who identify a work area, 33 are ER nurses, 41 from intensive care (ICU), 3 from pediatric intensive care (PICU), 66 from pediatrics, 113 from medical-surgical units, 27 from labor and delivery, 60 from the operating room, and 616 from "other" areas. (Thirty-seven percent do not identify a primary work area.)

B. Scheduling and Staffing

The majority of respondents (86 percent) work full-time, an intended effect of the sample design. Forty-five percent of the full-time nurses work non-traditional shifts (as opposed to five 8-hour shifts) (Figure 6).

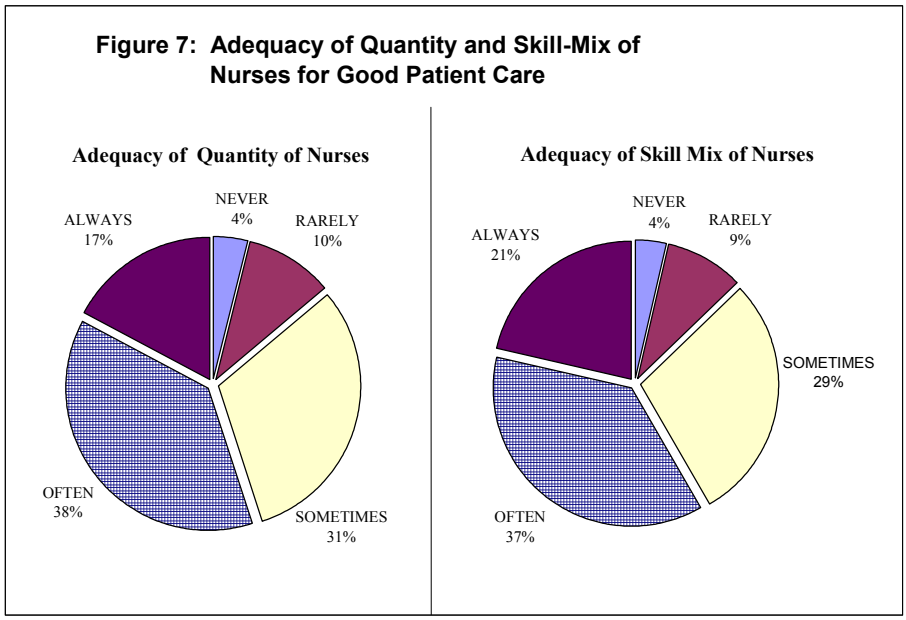
Figure 6: Respondents' Employment Status and Types of Schedules Worked



Among the 541 respondents reporting physical limitations, more than 60 percent state that their physical limitations are not accommodated by scheduling or assignment changes. Substantial variability exists in nurses' experiences with scheduling processes.

Seventy-one percent of respondents report that their preferences are considered in scheduling. Although 67 percent of respondents report more than 20 years of experience, only 27 percent report consideration of seniority in scheduling.

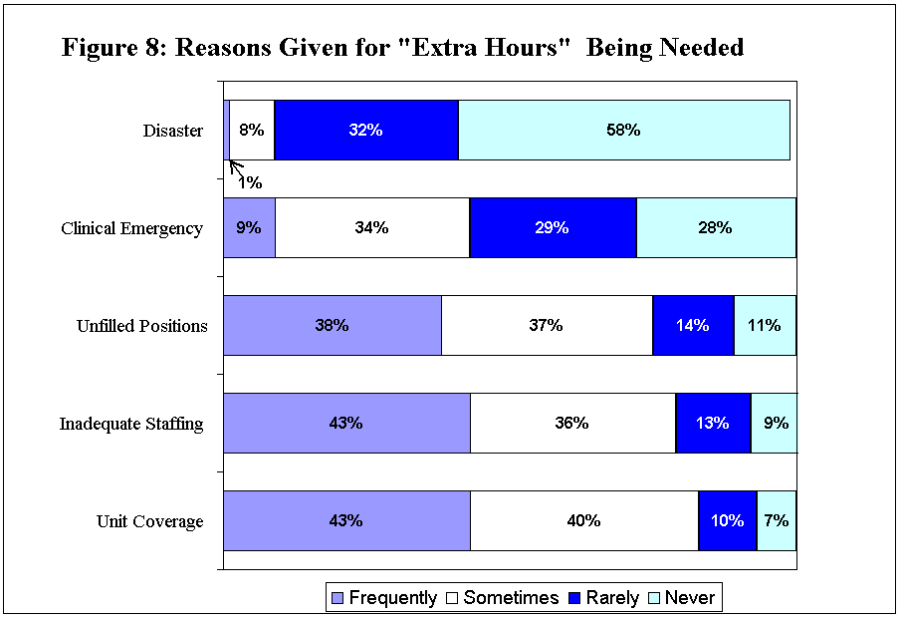
Twenty-seven percent of respondents rotate shifts. Responses on adequacy of quantity of staff (the number of RNs and LPNs) and skill-mix (proportions of RNs, LPNs, Assistants, and ancillary staff) are similar in each response category. Fifty-five percent respond that staffing is "always" or "often" adequate. Forty-five percent respond that staffing is "never," "rarely," or "sometimes" of an adequate quantity. Fifty-eight percent respond that skill-mix is "always" or "often" adequate. Forty-two percent respond that staffing is "never," "rarely," or "sometimes" of an adequate skill-mix (Figure 7).



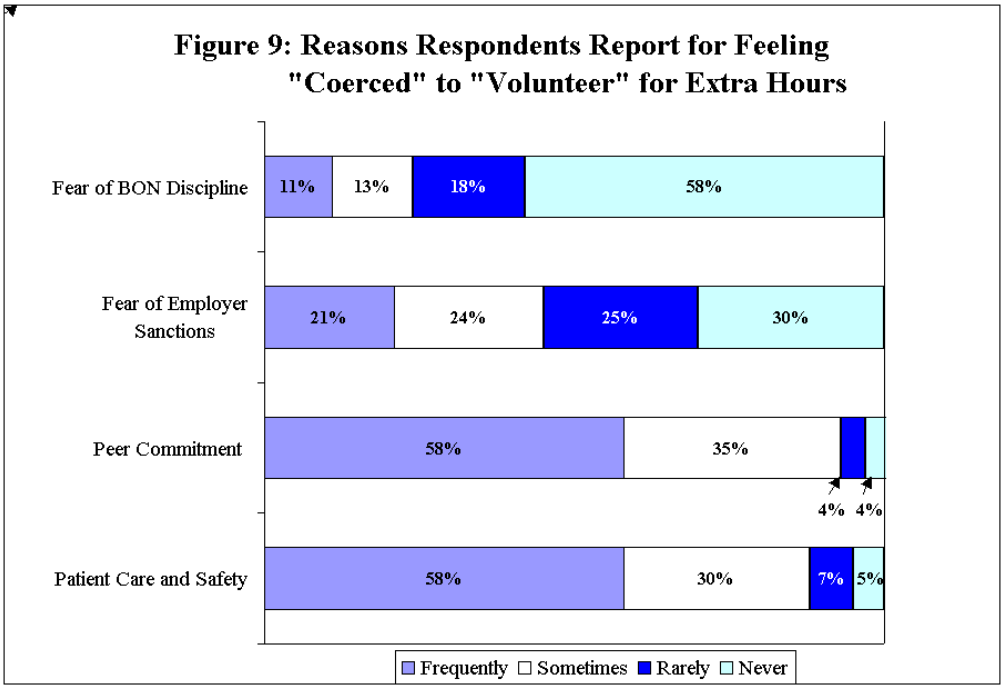
C. Extra Hours

Eighty-seven percent of respondents report having worked extra hours (time outside of regularly scheduled hours) in the past 12 months. Of those working extra hours, 47 percent indicate that their extra hours were "mandatory," (8 percent mandatory only and an additional 39 percent state that their extra hours were of both mandatory and voluntary types).

Respondents report unit coverage (43 percent), inadequate staffing (43 percent), and unfilled positions (38 percent) as being "frequently" the cause for extra hours (Figure 8).



Fifty-one percent of respondents report that they feel "coerced" into volunteering to work extra hours. Patient care and safety (58 percent) and peer commitment (58 percent) are the primary reasons given for feeling "coerced" to volunteer for extra hours (Figure 9).

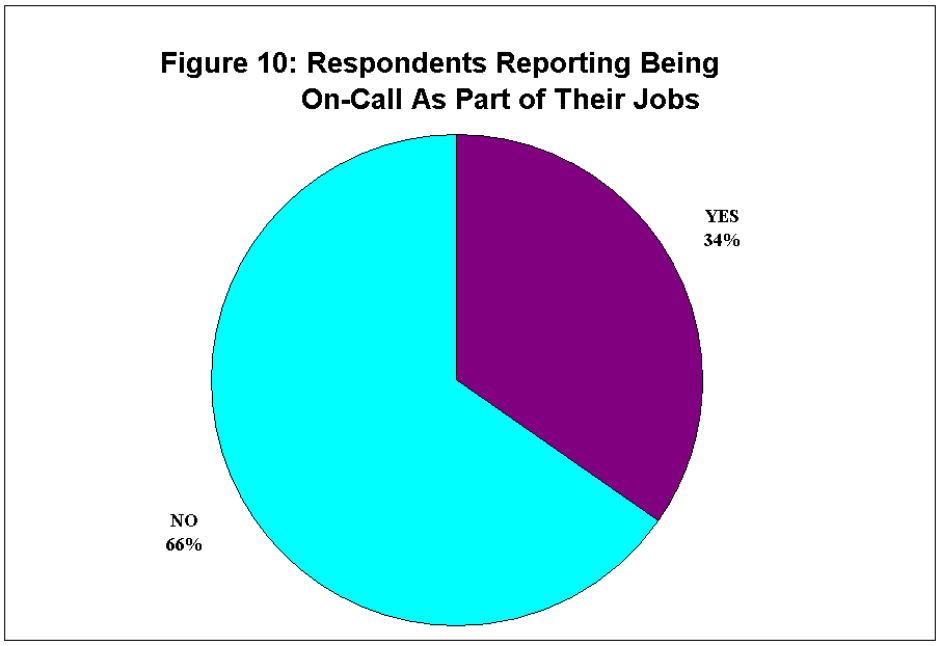


Respondents also report that they work extra hours for extra pay (33 percent) and because of professional commitment (5 percent). Thirty-three percent receive pay if they work extra hours in a day. Sixty-two percent report additional compensation if they work extra hours in a week.

Fifty percent of respondents report that they feel so tired that they feel their own safety is compromised (8 percent "always" or "usually," and 42 percent "sometimes"). Three percent report patient safety as being "always" or "usually" compromised because they are tired. Twenty-seven percent report that this is "sometimes" the case. When asked how many hours they could work in a day before patient or nurse safety would be compromised by their physical or mental fatigue, 69 percent respond 12 hours or less in regard to patient safety, and 75 percent said 12 hours or less in regard to nurses' safety.

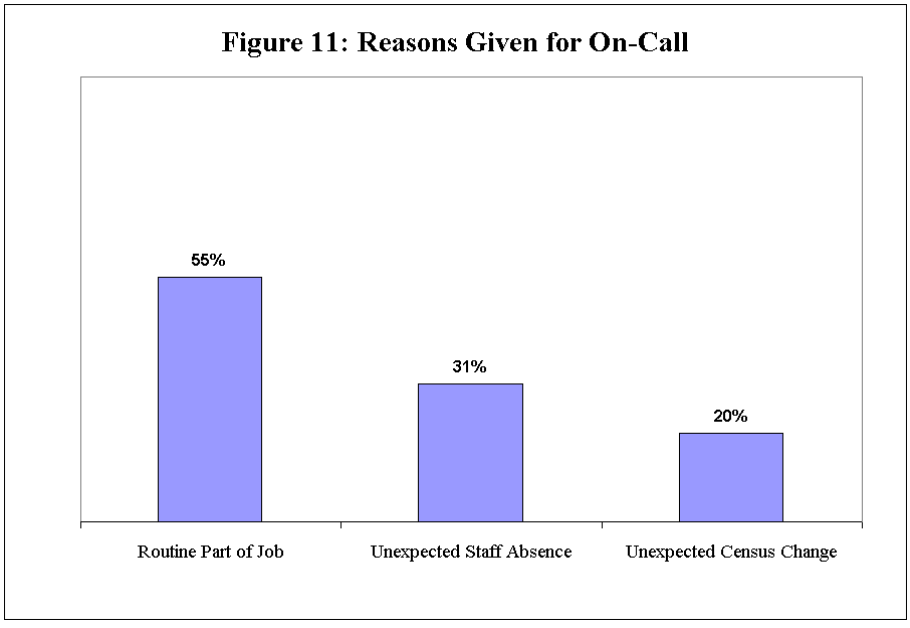
D. On -Call

Thirty-four percent of respondents report that being on-call is part of their job (Figure 10).



Fifty-three percent of respondents report that being on-call was an initial condition of employment, while 61 percent of nurses report that on-call responsibility was a condition of continued employment. Forty-six percent of nurses report that they receive compensation even if they do not have to report to work during their on-call hours; fifty-four percent are not compensated.

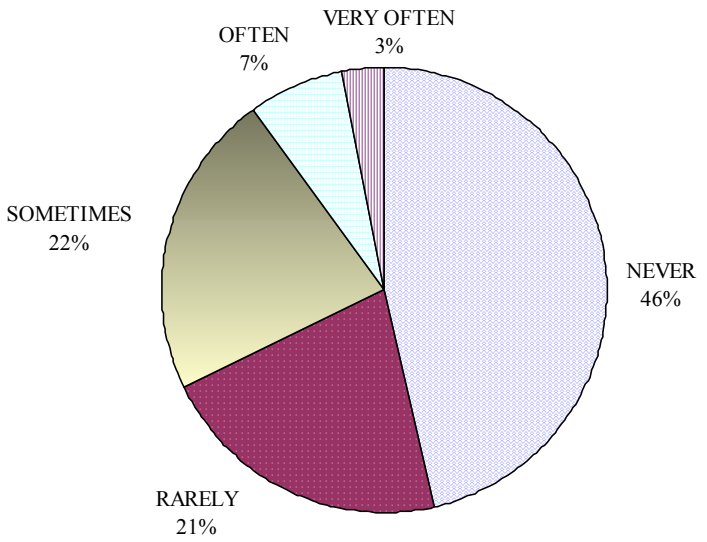
Among respondents who report being on-call, the most common reason (55 percent) is that it is a routine part of their job. Thirty-one percent report having on-call responsibilities due to unexpected staff absence and 20 percent due to unexpected census changes (number or acuity of patients) (Figure 11).



E. Re-Assignment

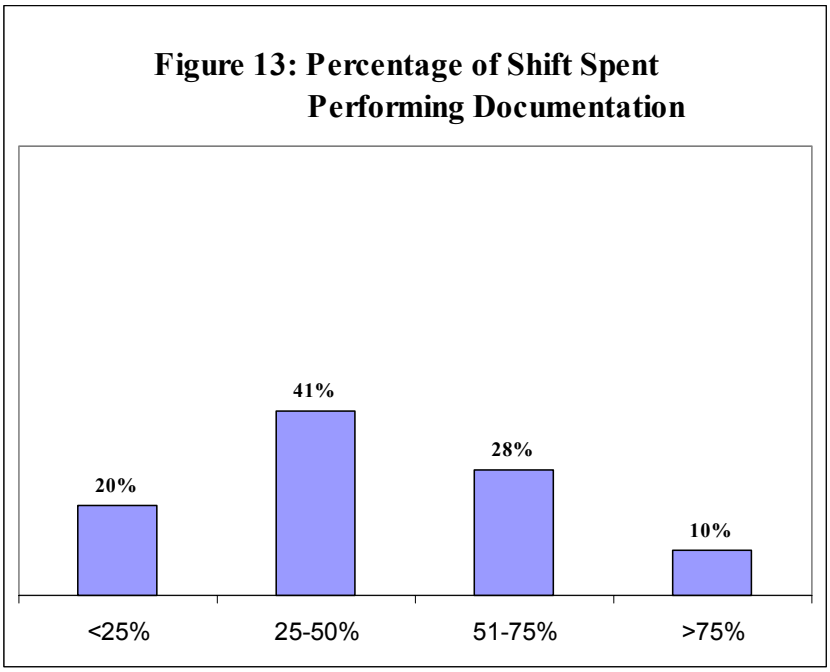
Forty-six percent of respondents report that they are "never" re-assigned. Ten percent report being re-assigned "often" or "very often" (Figure 12). Of those 796 who are re-assigned, 72 percent feel competent to work in the re-assigned area. Three percent of nurses receive additional compensation when re-assigned. Half of those responding report being oriented to their re-assigned unit. Re-assignment occurs "often" or "very often" among 9 percent of respondents who work in hospitals and among 14 percent of those in long-term care.

Figure 12: Frequency of Re-Assignment



F. Documentation

Thirty-eight percent of respondents report that they spend more than 50 percent of their shift performing documentation (Figure 13).



Sixty-nine percent of respondents report that they "sometimes," "often," or "very often" need to work beyond scheduled work hours to complete documentation. Sixty-seven percent of nurses report that they "sometimes," "often," or "very often" feel that documentation keeps them from spending as much time with patients as needed.

G. Compensation and Benefits

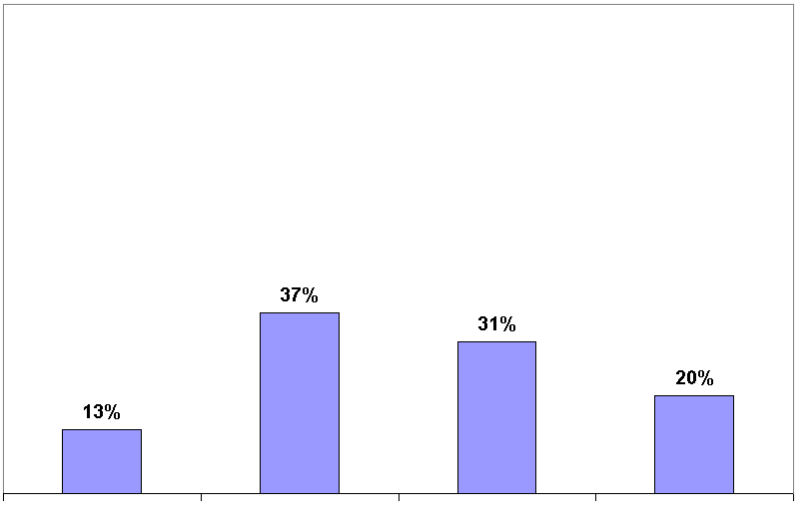
Fifty-one percent of respondents report being "somewhat dissatisfied" or "very dissatisfied" with the selected benefits mentioned in this survey. Many respondents report not having the selected benefits at all. Most either do not have or are not satisfied with retirement health benefits (68 percent), receiving a bonus (69 percent), or compensation for on-call (80 percent) (Table 2).

Table 2: Satisfaction with Selected Benefits

	Don't Have (%)	Very Satisfied (%)	Somewhat Satisfied (%)	Not Satisfied (%)
Leave	8	31	42	18
Tuition	28	23	31	19
Continuing Education	19	24	37	20
Compensation for Extra Hours	17	22	38	22
Insurance	15	25	36	24
Compensation for On-Call	56	6	14	24
Retirement/Pension	17	17	40	27
Bonus	39	12	20	30
Retirement Health Benefits	36	9	23	31

Presumably to avoid compensation for unused staff resources, 28 percent of respondents are required to use leave during low census periods. Respondents are nearly equally satisfied and dissatisfied with their compensation, though more are "very dissatisfied" (19 percent) than are "very satisfied" (13 percent) (Figure 14).

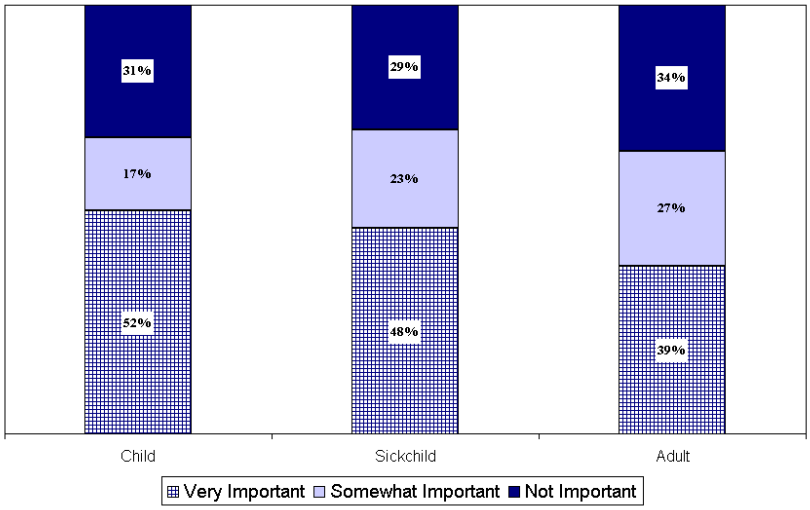
Figure 14: Satisfaction with Compensation



H. Dependent Care

Among the 392 nurses who identify dependent care as an issue relevant to them, more than half say that child care is very important (52 percent), and 39 percent say that adult care is very important. Nearly half state that sick child care is very important (48 percent). While respondents report that a modest amount of child care is provided by employers (17 percent), very little sick child care (4 percent) or adult dependent care (10 percent) is reported (Figure 15).

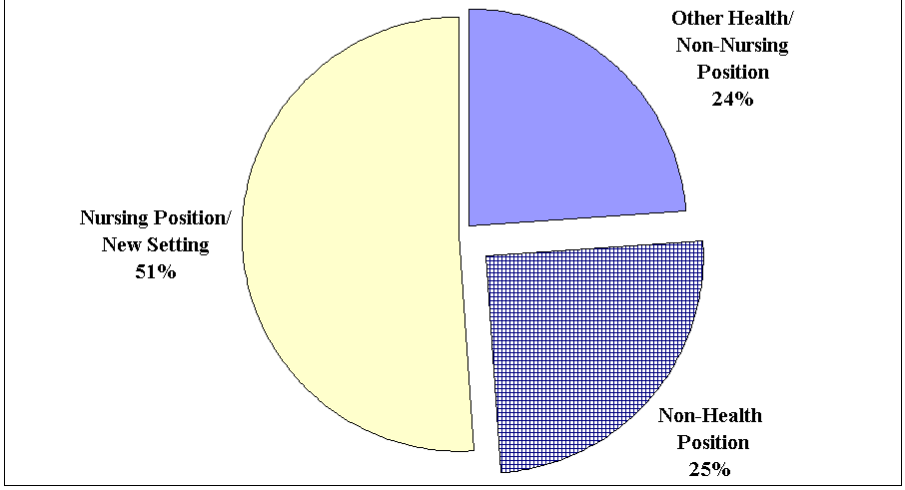
Figure 15: Reported Importance of Dependent Care



I. Satisfaction with the Nursing Profession

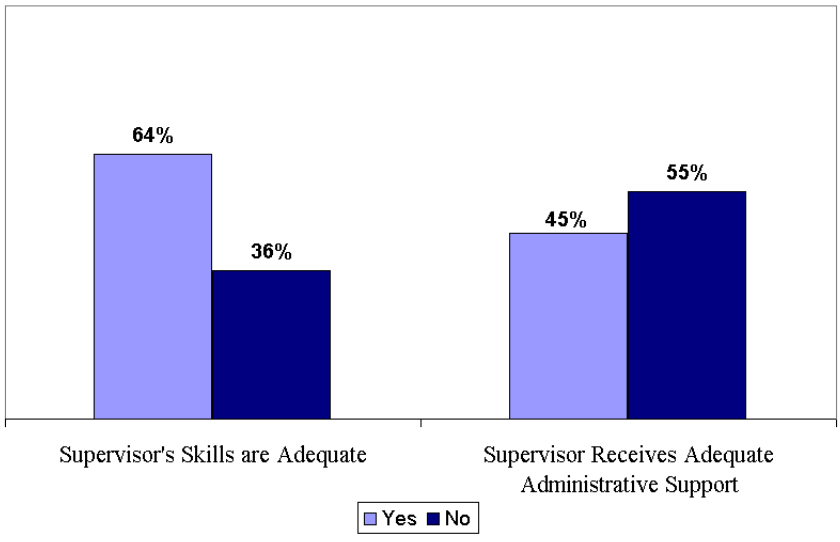
Forty-nine percent of those responding say that they would leave nursing if they left their current position, though only 25 percent would leave healthcare altogether (Figure 16).

Figure 16: Type of Work Respondents Would Consider If They Left their Current Position



Most respondents (64 percent) are satisfied with the skills of their immediate supervisor. However, most (55 percent) do not feel that their organizations' administration gives their supervisors adequate support to respond positively to respondents' work life concerns, such as scheduling and staffing (Figure 17).

Figure 17: Adequacy of Supervisor's Skills and Administrative Support



Among 774 nurses responding that inability to give quality of care is an issue at their place of employment, 54 percent report that this factor makes them want to leave their job. Other

factors contributing to nurses reporting that they want to leave their jobs, as shown in Table 3, are:

- Mandatory extra hours (45 percent, or 254 out of 567 responding)
- Other scheduling issues (44 percent, or 253 out of 574 responding)
- Mandatory on-call (43 percent, or 211 out of 493 responding)
- Re-assignment compensation (41 percent, or 135 out of 326 responding)
- Quantity of staffing (34 percent, or 298 out of 877 responding)

Table 3: Factors Most Associated With Desire to Leave Current Job or the Nursing Profession

Factor	Number Responding	Leave Job		Leave Nursing	
		Number	Percent	Number	Percent
(In)ability to Give Quality Care	774	418	54	247	32
Mandatory Extra Hours	567	254	45	124	22
Re-Assignment	573	234	41	108	19
Compensation for Re-Assignment	326	135	41	60	18
Quantity of Staffing	877	298	34	158	18
Scheduling Issues (other)	574	253	44	98	17
Mandatory On-Call	493	211	47	81	16
Staffing Skill-Mix	795	203	26	103	13
Relationships with Administration	953	278	29	118	12
Compensation for On-Call	438	117	27	46	11
Compensation for Experience (lack of or inadequate)	554	111	20	62	11
(In)adequate Support Services	789	211	27	81	10
Relationships with Managers	988	245	25	86	9
Compensation for Attained Education	378	70	19	34	9
Employer Sponsored Adult Dependent Care (lack of)	112	28	25	9	8
(In)adequate Supplies and Equipment	941	184	20	62	7
(Un)Availability of Clinical Ladder	673	130	19	49	7
Relationships with Subordinates	854	132	15	52	6

The top reasons hospital-based nurses want to leave their jobs are scheduling (44 percent), re-assignment (44 percent), mandatory extra hours (43 percent), mandatory on-call (39 percent), administrative relationships (33 percent), and staffing quantity (32 percent). The top reasons long-term care nurses want to leave their jobs are mandatory extra hours (45 percent), other scheduling issues (44 percent), mandatory on-call (43 percent), staffing quantity (40 percent), and re-assignment (38 percent). Home health and hospice nurses respond that inability to give quality care and scheduling issues (mandatory extra hours, mandatory on-call, and "other scheduling issues") are their top reasons for wanting to leave their jobs.

As shown in Table 3, factors contributing to nurses reporting that they would want to leave the profession of nursing are:

- Inability to give quality care (32 percent, or 247 out of 774 responding)
- Mandatory extra hours (22 percent, or 124 out of 567 responding)
- Other scheduling issues (17 percent, or 98 out of 574 responding)
- Reassignment (19 percent, or 108 out of 573 responding)
- Mandatory on-call (16 percent, or 81 out of 493 responding)

Among hospital-based nurses, the primary reasons reported for wanting to leave nursing are (Table 4): inability to give quality patient care (33 percent, or 110 out of 335 responding), mandatory extra hours (22 percent, or 54 out of 243 responding), and re-assignment (19 percent, or 55 out of 295 responding). Among long-term care nurses, the primary reasons given for wanting to leave nursing are: inability to give quality care (33 percent, or 85 out of 259 responding) staffing quantity (26 percent, or 67 out of 261 responding) and mandatory extra hours (23 percent, or 35 out of 155 responding). Home health/hospice nurses' top concerns are inability to give quality care (33 percent), scheduling issues other than flexible and self (21 percent), and mandatory extra hours (18 percent).

Table 4: Reasons for Leaving Nursing by Facility Type

Reason for Leaving Nursing	Hospital	Long-Term Care	Home Health/ Hospice	Other
Inability to Give Quality Care	33%	33%	33%	26%
Mandatory Extra-Hours	22%	23%	18%	19%
Re-Assignment	19%	19%	13%	21%
Compensation (Re-Assignment)	18%	20%	11%	14%
Mandatory On-Call	16%	17%	13%	15%
Staffing-Quantity	15%	26%	12%	16%
Relationships with Administration	14%	12%	6%	13%
Scheduling Issues-Not Flex or Self	13%	21%	21%	18%
Staffing- Skill-Mix	11%	19%	6%	11%
Adequate Support Services	11%	13%	3%	8%
Compensation (Experience)	10%	13%	6%	14%
Compensation (On-call)	8%	17%	7%	13%
Relationships with Managers	8%	10%	6%	10%
Support Services	8%	9%	3%	7%
Compensation (Attained Education)	7%	15%	2%	11%
Adequate Supplies and Equipment	7%	9%	2%	5%
Professional Independence	7%	8%	6%	10%
Relationships with Physicians	7%	5%	6%	8%
Breaks	6%	5%	3%	2%
Employer Sponsored Dependent Adult Care	6%	16%	0%	0%
Availability of Clinical Ladder	6%	11%	3%	11%
Access Clinical Ladder	5%	9%	4%	14%
Compensation-Extra Hours	5%	10%	9%	13%
Employer Sponsored Child Care	5%	14%	0%	0%
Relationships with Subordinates	4%	10%	2%	7%
Relationships with Peers	4%	5%	2%	5%
Relationships with Patients	4%	3%	1%	4%
Scheduling Issues-Flexible Scheduling	3%	4%	4%	8%
Scheduling Issues-Self-Scheduling	2%	6%	3%	7%

Note: Percentages in Table 4 are based on the number of nurses responding that the particular factor is an issue in their workplace as the denominator; denominators are specific for each cell in the table. The numerators are based on those nurses responding that the issue makes them consider leaving nursing.

IV. Summary of Findings

Many opinions and experiences have contributed to our understanding for why Maryland and the nation are experiencing a shortage of professional nurses. This survey has attempted to quantify the existence and extent of issues and concerns that have been cited in the literature as nurse dissatisfiers in the workplace, as they occur in Maryland.

This survey's findings show that substantial numbers of Maryland nurses are working mandatory extra hours and/or feeling coerced to volunteer to work extra hours. There is an overriding concern with the quality of patient care, and also for nurse and patient safety. Nurses are working when they are too tired, and they are being re-assigned to areas where they do not usually work and have not received orientation, and where they are not (or do not feel) competent to work. Nurses often feel that there is either not enough staff or the right skill-mix to provide high quality patient care. A great deal of time is spent on documentation, which takes away from time spent on patient care. Supervisors' skills and administrative support is a big concern, as are the availability of adequate and operational equipment and supplies.

Appendix 1

Appendix 1

Nurses' Additional Comments from Workplace Survey 2001
Maryland Commission on the Crisis in Nursing

Themes of Comments	Nurse's Comment(s)
Respect-for nurses from patients and families	I feel that the respect for nurses is gone from patients; but especially from family members and visitors. You didn't address this issue.
Staffing Self-Scheduling Compensation LPN displacement with RN staff Staying over to finish assignment Re-assignment without orientation/safety	I have been an LPN for 28 years. I have variety of experience in nursing. The crisis is coming because of the way nurses are treated. I love taking care of my patient(s). But you use to be able to go (to) one place and stay there for (a) year, going from floor to floor, getting different experiences, but now, depending on census and years you are there (not always true), and depending on your evaluation score, you may lose that position. After working a Telemetry floor my position was upgraded to RN, so I have to leave, this has happened to other LPNs also over the year - being taking off cardiac heart floor (after completing) special classes for that; then they decide they want only RNs. You don't mind working with other people, but they should do their job the way it's defined. In the way of staffing, I like self-scheduling, but at times the manager changes it around without consulting you. I don't mind working overtime but a lot of times I have to stay over work to finish up assignments because I don't have time to sit and chat with doing patient care. Having adequate staff is another problem. Before they cut back on patients on our floor, we didn't always have appropriate staffing. You are put between a rock and a hard place because if you leave you get threatened with abandonment. You can't give good care; you do what you can. One day I was told we couldn't have an extra staff member because they may get an admission in the hospital. I work at TUC in the hospital. That day I had another RN and myself whom had never worked the unit before. She took 10 patients and I had 11 patients myself. I didn't feel safe but couldn't do anything about it. You don't always get along with every patient, and in my evaluation it was put that I give less then excellent care. So, when I take care of patient, I tell them to let the manager know when they enjoy me taking care of them and if there's a problem I try to solve it.

	The hospital doesn't always give good raises. It's said that they give base minimum of like 2.0%. I think if they gave better raises people would work that much harder. It's said that the manager and administration get bonuses at the end of the year depending on if they keep to their budget and give minimal raises. To me raises should not be included in that. The patients are getting more complex because they use to go by acuity of patient care, but now they go by how many patients are on the floor instead.
Survey not applicable/survey nurses not working in institutional care and find out why	Although your survey might capture information about nurses who are giving direct patient care in institutional settings you are neglecting to gain important information about the thousands of Maryland nurses not involved in the care of "sick" and institutionalized individuals --- many questions were N/A. But you failed to capture the reasons why many others, and I, (do not work) in those settings.
Diploma grad does not feel advanced education makes better nurses Need for more "regular" RNs	No comments were solicited but I would like to comment on nursing education. I was educated in a 3-year diploma hospital program. We went 11 months of the year and provided work to the hospital while in training. I was only compensated with a diploma even with mandatory college courses. One of the pitfalls of nursing was in closing these nursing schools. Secondly, I have been bombarded by both ads and employers to get a degree. What for? It was not a necessity for my job --- more regular RN's are needed --- too much emphasis on degrees. Believe me. I have worked with 2 and 4 yr. Nurses who do not want to do floor, hospital nursing. They refuse the conditions and keep going to school to go into administration. LPNs, on the other hand, are not constantly encouraged to become RN's.
Survey not applicable-likes her current job, but previously worked LTC where "conditions were always less than desirable"	I am a home care nurse, some questions do not apply to me. Enclosed is the survey I completed as requested. It was very difficult for me to be honest with my answers because for only the last two years have it had a nursing job that I really enjoy. I previously worked in long-term care, in several different facilities where conditions were always less than desirable. I felt that answering the survey with my current job conditions might somehow convince someone that conditions in the long-term care facilities aren't so bad. But my conscience got the best of me. If you want answers on the conditions

	of LTC facilities, just reverse all of my answers.
Multiple jobs with different problems.	The questions apply only to a primary job. Most/many of us work more than one and problems are different in each.
Nursing leadership issues	Thank you for your interest in this problem. Recently, I watched an interview with a Nursing Director. She gave political, canned, non-answers. She is an obvious part of the problem with the nursing shortage. Most graduates of BSN university programs are smart and motivated people. They take employment in hospital settings and find they are a mostly blue-color cog in the hospital business machine. Why would they want to stay there? Patients, and patient care, bow to the goals of hospital administrators (which often involve ego, turf, and money). Nursing administrators feel privileged to join that camp. The patients get over worked, stressed nurses at their bedsides-but they do not have choices.
Professionalism and autonomy Dissatisfaction Complaints not heeded	I have completed your survey but I feel I really need to speak with you to fully express to you the problems with nursing, at least where I work. I cannot fully do that on this survey, although it is helpful. The main problem with my unit is that they DO NOT treat you as professional. They treat you more like a 3-year-old. There is no autonomy, even though they make it look as if you have a voice – you don't. If you complain about something they will refer to you to the Employee Assistance Program, making YOU the one with the problem. If a physician verbally abuses a nurse, in front of a family member who complains to the nurse about it, nothing is done about it. If you write a letter complaining about this behavior the managers pretend they are interested but they want to reword it and then it is never sent out. I feel like I can write a decent letter. I have 2 Bachelor's Degrees and a Masters, none in nursing. Anyway, I am digressing. Please call me if you are interested in hearing more about my wonderful work environment. I can't wait to retire in 3 years.
Survey not applicable with comments re BON Complaints not heeded	There were no questions about the Board of Nursing. We had a nurse leave home health and went to a hospital. While there, she had a difficult situation arise. She turned to the "Board" for help and advice and it gave her neither. That made all of us step back and think. Isn't the "Board" there for us? That would make me want to leave nursing. We can't depend on the "Board." All these years in nursing and I thought the "Board" was for us.

	Next survey - add some "Board" questions. You might be surprised by the answers. I am not employed at the present time so survey does not apply to me.
Inadequate compensation Professionalism UPN issues Complaints not heeded Safety Unfair treatment/favoritism On-call	The pay does not adequately compensate for the responsibility accepted. The status of nurses is down, in part because non-professional people are allowed to present themselves as nurses. The growing feeling that accurate information and good health care practices are secondary to appearance. Integrity is compromised and knowledge is not valued in that climate. There is growing discontent because non-professionals carry increasing weight and make mistakes on the RN's license. The non-professionals are encouraged to make decisions rather than ask for guidance. They chart their own work on the computer but do not give the RN team leader a report. The RN complains and the fault becomes hers. The non-professional gain power and now becomes insolent equal, and begins to tell RN what to do. The good RN leaves. I wonder if the racial prejudice issue that so divides our culture has a voice here also. The increasing pressure to say and do the politically correct thing outweighs the forces of morality itself. Perhaps this is pervasive in our society. However, in a profession built on knowledge, trust, and integrity, a great dissatisfaction creates unrest. It should because the alternative I see is stagnation and decay. The hospital policies sometimes written in response to credentialing agencies' requirements pushes the RN to practice self—survival over the professional oath. I believe our employers must take responsibility to help professional growth and to protect character. Example: RN must chart within one hour the effect of pain intervention. Reality-This strict adherence to one hour not one and five minutes increases risk of less accurate documentation, and of actually decreasing the quality of care. We do not expect most pain

	medications to be dissolved from the stomach in less than one—half-hour. When too much emphasis must be given to any one element of documentation, then we run the risk that paper documentation becomes more important than the actual care rendered. There is a lack of appreciation and sincere recognition by management. Favoritism allows the best compensation for the favored. Poor communication of the policy keeps us unaware of some of the available resources, which would help us. Example: How to have compensation for required education hours? Costing out the service of nurses has not happened. However, Cost cutting stretches the nurse beyond safe practice. The good nurse cannot continue to allow herself to be misused and leaves the field. Frequently people who did not do the work make the decisions as to what equipment we will have to practice with. Often it is inefficient. The would-be savings costs more in time wasted and more supplies used. The hours worked and on-call and call-back policies, when properly administered are not an issue for many of us until work requires us to place our families in second place. The reason most of us work is to have things for our families and ourselves. Employers must recognize that most nurses do not have the capability to make last minute arrangements for their dependents. This is not a frequent problem in my environment. If I sat down and edited these thoughts, I would probably not send them. I know these problems color the day to day work place of the nurse.
Job change/dissatisfaction→ leave nursing	Answered questions in response to position held over last 3 years. Have resigned position to return to staff ICU position (3-13 shifts) for balance. If this is also so dissatisfying, will leave profession.
Survey not applicable	This survey was completed according to my present position (non-hospital based). If I were still employed through the hospital my responses would have been very different. I sincerely hope the analysis helps the nursing population in Maryland.
Survey not applicable Administration issues	This survey was apparently meant for hospital nurses and did not take into account nurses that work in other areas such as home care or administration maybe this is part of the problem!
Agency issues	I am writing to inform of the following: Myself, as well as other nurses to whom I have talked with, like giving care to patients in a clean working environment and in a facility that show staff they care

Compensation inadequate to recruit/retain Respect for nurses from clients Workload	about their staff. Ways a facility can do that is by retention bonuses and an income complementary of what agency staff is paid. I work with a lot of agency staff and the care that most agency staff provides is about 50% good. I don't understand why facilities don't pay their staff well so people will stay on staff, or at least come there for employment. Also nurses want a facility to back them up when they are right and don't allow families to talk to staff any kind of way. I think everyone forget nurses have feelings too. Lastly, I feel another way facilities can keep their won staff on board instead of a whole lot of agency is to be realistic when making patient assignments. The workload of a nurse, especially in a long-tern care setting, is not realistic and too much to complete in an 8-hour and sometimes 12 hour shift.
Survey not applicable with comment	Very important – please note: I work <u>only</u> agency so I don't have to endure the usual (expletive) your questions refer to.
Survey not applicable	I am a nurse practitioner and most circumstances do not apply to my working environment.
New grad issues (preference 9-5, clinical skills low)	There is a shortage of nurses in hospitals because the new graduates do not want to work the off shifts and do not want to work weekends or holidays. They are looking for 9-5 jobs Mondays through Fridays. Also they are not prepared to handle more than 1 or 2 patients. I think the nursing schools need to increase the clinical hours in nursing schools. Because they are not prepared, they leave the hospital after getting off orientation to go to work in a doctor's office or outpatient clinic or home health.

Appendix 2