WORKING PAPER:
NURSES' WORKPLACE ISSUES, PATIENT SAFETY, AND THE QUALITY OF PATIENT CARE

Revised October 2001

Maryland Statewide Commission on the Crisis in Nursing
Workplace Issues Subcommittee

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EXECUTIVE SUMMARY OF THE WORKPLACE ISSUES SUBCOMMITTEE EFFORTS

The Maryland Statewide Commission on the Crisis in Nursing (Commission) holds the provision of quality healthcare and patient safety as the central tenet of all its endeavors. To this end, ***A STATEMENT ON PATIENT SAFETY AND THE QUALITY OF PATIENT CARE*** has been written as the guiding principles upon which this document and all other work of the Commission is based. (ADDENDUM)

In March 2001, the Board of Nursing contracted the Center for Health Program Development and Management (Center) at the University of Maryland, Baltimore County to develop a paper consisting of a problem statement and review of the literature, integrated with the deliberations of the Workplace Issues Subcommittee. This paper seeks to explore the seven priority areas related to lifestyle and scheduling identified through nurses' testimonies at the June 6, 2000 Nursing Summit, deliberations of the Maryland Statewide Commission on the Crisis in Nursing, and the Subcommittee's own extensive discussions. The seven issue areas are:

- Scheduling and Staffing
- Mandatory Overtime
- Mandatory On-Call
- Re-Assignment
- Dependent Care
- Functionally Appropriate Work Assignments
- Professional Recognition in the Workplace

In addition to the above areas of concern, compensation was also discussed as a prominent feature of nurses' work life issues. The Retention Subcommittee will explore the issue of compensation more fully.

The Center was also asked to conduct a survey mailed to a sample of Maryland nurses to gather information about their perspectives and experiences in regard to scheduling and lifestyle issues. A survey report will be available January 2002.

Statement of the Problem and Definition

SCHEDULING AND STAFFING. Nurses ranked staffing and scheduling among the leading reasons for dissatisfaction and for leaving their jobs (The Advisory Board, *"Reversing…",* 2000). Adequate staffing consists of an appropriate number of nursing hours to care for patients with a specified level of medical need (acuity). The shortage of nurses has sometimes meant assigning too high a caseload for the acuity of the patients cared for, or, for some nurses, unwanted extra hours.

MANDATORY OVERTIME, OR "EXTRA HOURS." In this paper, hours worked outside of the usual, expected, and agreed-upon timeframe are termed "extra hours." Overtime is a more commonly used term, but it specifically relates to the experience of non-exempt, full-time workers governed by the Fair Labor Standards Act, and is variably applied to nurses. Several states and national professional organizations have forwarded legislation, advisories, and guidelines to limit the use of mandatory extra

hours/overtime. This issue is important to the work life of nurses with implications for patient care and the future supply of nurses.

For most nurses, ***ON-CALL*** consists of being available if and when additional staff are needed. Like mandatory overtime/required extra hours, this practice is variably applied in terms of process and compensation.

RE-ASSIGNMENT is when nurses are directed to provide care in a location that is different from their usual work location. Re-assignment is problematic when the nurse is not adequately oriented to the new work location and may not have the competencies required to practice safely.

Balancing employment with responsibilities for dependents (children, older adults) can be demanding and unpredictable, as nursing itself can be, and is a challenge for nurses whose work positions involve 24-hours a day, 7 days a week (24/7) scheduling. Addressing nurses' needs for ***DEPENDENT CARE*** will help nurses remain in the workforce.

FUNCTIONALLY LIMITED NURSES. Nurses who have functional limitations through injury or illness that occurs either early during the career or later in life (due to the accrual of chronic health conditions) need places where they can work despite their limitations.

Impact on Nurses

In our current system, the nurse alone bears the full consequences of accepting or rejecting an assignment, which could include sanctions that may be imposed by the employer or the Board of Nursing for acts of commission or omission consequent to the accepted/rejected assignment. The Maryland Nurse Practice Act places the responsibility of accepting and fulfilling assignments directly on the nurse.

The issues addressed in this paper cause both economic or psychological burden for nurses. Often, patient safety/quality of care or the nurse's own safety or professionalism are compromised. Providing care to patients who require care outside of the nurse's knowledge base or in unfamiliar surroundings, as can be the case when a nurse is re-assigned, can be demoralizing and a major cause of dissatisfaction. Nurses fatigued from working too many hours due to mandatory extra hours or other demands, such as too large a workload, may make errors that injure patients or themselves. Mandatory on-call or extra hours require personal adjustments and create uncertainties and stress. Opportunities to rest or to attend to family or personal needs may be lost.

Examples of impositions placed on nurses include: working through uncompensated breaks, staying late to finish paperwork that could not be completed during the scheduled time due to too heavy a patient load, and having to adjust personal plans during uncompensated time-off in order to be available for duty.
Since the average age of nurses is the mid-forties, and most nurses are women (and therefore largely responsible for the care of dependents), many are part of what is being called the "sandwich generation" – caring for both children and their aging parents.

Caring for dependents, especially children, may be a reason that nurses leave the workforce, either temporarily or permanently. Concerns about dependent care can be very stressful and contribute to lost work time.

Finally, an overarching theme, discussed briefly toward the end of the paper, is the lack of professional recognition of nurses, which includes issues of autonomy, respect, and acknowledgement.

Impact on Patients

Patients have the right to expect unhindered care, without needing to consider if an adequate number of competent staff is available. The Institute of Medicine's report, *Crossing the Quality Chasm:A New Health System for the 21st Century*, explains that Americans are not getting the care that they should receive, and that the missing quality is not just a "gap," but a "chasm." The report names nursing staffing shortfalls as being among the factors contributing to the chasm in quality (IOM, 2001). There is a potential for reduced quality of care when extra hours, voluntary or required, results in care being rendered by a nurse who is physically or mentally fatigued, distracted by dependent care concerns, or when a nurse's functional limitations are not accommodated. An earlier IOM report, *To Err is Human* (2000), focuses specifically on the impact of system restructuring and systemic deficits that need to be corrected to ensure patient safety.

At a societal level, the unnecessary loss of nurses from the workforce due to any of these remediable factors exacerbates the "natural" shortage of available nurses (due to aging of the nursing workforce), whose valuable experience would otherwise contribute to the knowledge pool that promotes an environment of high quality patient care and good patient outcomes. Already, the public is being affected by the shortage of nurses through limited access to care. Delayed surgeries, closed hospital beds and limited emergency room availability, and patients in hospitals experiencing delayed nurse response times are all reported issues. Media sources have even suggested that patients ask questions about nursing turnover and staffing ratios, or even consider hiring private duty nurses to ensure the availability of nursing care (Parker-Pope, 2001).

(See also, **A STATEMENT ON PATIENT SAFETY AND THE QUALITY OF PATIENT CARE**, prepared by the Maryland Statewide Commission on the Crisis in Nursing, September 2001, in the Addendum to this document.)

Strategies from the Subcommittee and the Literature

Scheduling, Staffing, and Extra Hours (Overtime). The concept of "self-scheduling" is highly supported by the Subcommittee and is well documented in the literature as an effective strategy to the growing nursing shortage. Success of self-scheduling requires institutional support and nursing leadership to structure guidelines to facilitate this process. Misapplied self-scheduling can fail, leading to increased costs and friction between colleagues.

The Subcommittee suggested strategies that include autonomous scheduling (flexible, creative, self-scheduling), shared governance approaches (including nurses' involvement in admission decisions), regulatory approaches to decrease the amount of required documentation, and appropriate support staffing to relieve nurses of tasks not requiring their expertise. Staffing patterns, including chronic understaffing due to unfilled vacancies and high turnover, contribute to the issues of increased workload and inadequate skill-mix that can lead to nurse dissatisfaction.

The Subcommittee does not support the substitution of unlicensed assistive personnel[1] (UAPs) in lieu of an appropriate contingent of licensed nurses. The use of UAPs has been shown to have a mixed effect on patient care. In Maryland, the Nurse Practice Act and recent regulatory requirements for certification of persons providing care to patients under the delegatory authority of nurses have made this less of an issue than it is in other parts of the country.

Mandatory On-Call. Strategies consist primarily of avoiding the need for on-call as a staffing supplement. The Subcommittee strategies include anticipating the need for staff and encouraging "voluntary" nurse participation with adequate compensation.

Re-Assignment, or Floating. The Subcommittee specifically endorses proactive nurse involvement in re-assignment, including educating nurses on how to accept or reject assignments; the development of policies that include the need to ensure nurse competency[2] in re-assignment; mechanisms to document nurses' concerns; and differential pay. Nurses may find participation in a variable assignment arrangement to be acceptable when they are appropriately oriented and cross-trained. Professional interest, enhanced compensation/recognition, advanced, equitable planning, and agreed-to patterns of re-assignment can fix this problem.

Dependent Care. Nursing is a 24/7 commitment, as are dependent care responsibilities.
The Subcommittee suggests that institutions consider: (1) onsite dependent care facilities, (2) subsidies through vouchers or cash assistance, (3) scheduling flexibility to facilitate shared caring arrangements, and (4) employer-sponsored assistance programs or other services that assist with placement of dependents. Special dependent care needs, such as inclement weather, holidays, sick children, and other occasions that might disrupt usual caring arrangements, should be considered as well.

Functional Limitations. Use of ergonomic approaches, such as appropriate and sufficient staff or technology that help in lifting patients, can reduce injuries to nurses as well as provide a safer approach to patient care (e.g., fewer patient falls and back injuries for nurses), as well as allow nurses with functional limitations to continue to work. Re-assignment of nurses to positions that will utilize the nurse's competence within his or her limitations can also be considered.

[1] The terminology UAP is used as a global designation for the non-licensed patient care provider (*not* a registered or licensed practical nurse).
[2] Competency is used here to include physical and psychological capacity, as well as skill and knowledge.

PREFACE

On behalf of the Workplace Issues Subcommittee of the Maryland Commission on the Crisis in Nursing, the Maryland Board of Nursing engaged the Center for Health Program Development and Management (Center) at the University of Maryland, Baltimore County to write a working paper on scheduling and lifestyle issues facing nurses in Maryland who are engaged in the direct care of patients in hospitals, nursing homes, home healthcare, and the like. In an analysis such as this, it is difficult to identify a single problem. While the focus of this paper is to explore options that limit satisfaction in the work life of nurses, there are underlying and antecedent issues that also need to be explored and resolved so that the ostensible nurse "dissatisfiers" are not inadvertently perpetuated.

Performing this time-limited and focused review required the Center to identify key articles, testimony, and findings in published literature to assure that the principal issues are addressed in this document. The nursing shortage is a problem for employers because they are concerned about the economic impact of staffing decisions and about having an appropriate contingent of nurses to carry out the care needs of patients. From the nurses' perspective, working extra hours and working without adequate compensation and support (material or human resources, and support from management and medical colleagues) can be cause to leave the profession. It can also be a reason for young people choosing a career not to consider nursing. Nurses leaving the profession lead to shortages; shortages create working conditions that nurses find untenable, so they leave their jobs and possibly the profession; and dissatisfaction among nurses may discourage enrollment into nursing school, leading back to shortages. According to Georges C. Benjamin, M.D., FACP, Secretary of the Maryland Department of Health and Mental Hygiene, "Health policy makers need to work with nursing leaders to devise dramatic, creative mechanisms to increase the number of well-educated, properly trained nurses throughout the healthcare industry nationwide" (Benjamin, 2000).

This paper will consider the situation from the perspective that certain issues cause dissatisfaction among nurses, and it will present some of the options to resolve these issues.

The Center was also asked to conduct a survey mailed to a sample of Maryland nurses to gather information about their perspectives and experiences in regard to scheduling and lifestyle issues. A survey report will be available January 2002.

I. BACKGROUND

While there have been other nursing shortages during the past century, experts have determined that the current one is of unique import since it is driven by both supply and demand dynamics, and is expected to last longer and be more severe than others. The current nursing shortage, apparent on both a national and local level, was first recognized as a severe healthcare problem in Maryland in 1999. The shortage is composed of a broad range of contributory factors, including:

- An aging of the nurse workforce and nursing faculty
- An inadequate supply of young adults selecting nursing as a career, due to competing and more attractive career opportunities in other fields more lucrative and less challenging
- Growing concerns over unsafe and/or stressful working conditions for nurses, leading to concern for nurse and patient safety
- Increasing demand for nursing care because of the aging of the general population and a consequent increase in chronic healthcare needs, and a greater need for community-based care (which takes nurses away from institutional settings) (NCSBN responds, 2001)
- The use of nurses in non-direct patient care areas, such as utilization management, quality assurance, case management, and nursing informatics
- Overall population growth (515,000 during the 90's), which will create a need for more health services

It is a notable trend that nurses are widely dispersed in areas of healthcare outside of direct patient care, such as the insurance industry and pharmaceutical sales. As the healthcare delivery system changes, nurses may not see their roles as clearly defined as in the past. In response, some nurses may decide to develop alternate careers that are outside of healthcare. Nurses have left nursing to go into real estate, sales of non-healthcare products, private business/consultation, and many other "second careers."[3] Just as young adults who are selecting career options for a variety of reasons (economic concerns, better compensation in other fields, personal interest, opportunities for recognition and advancement, etc.) so too, do persons currently practicing nursing consider their career options based on these factors. Some have found nursing an excellent platform from which to launch alternative careers. Anecdotal commentaries have suggested that some who choose nursing education do not actually intend to practice nursing, but rather desire the clinical foundation that nursing education provides to augment other career paths. This is an area in which research could yield valuable insight.

To examine the critical issues related to the nursing shortage in Maryland, the Maryland General Assembly passed legislation during the 2000 legislative session, creating the Statewide Commission on the Crisis in Nursing (Commission). Among other responsibilities, the Commission is to determine the extent and long-term implications of

[3] There is a collateral phenomenon of nursing being chosen as a "second career" that could be utilized as a strategy to counter the loss of nurses to other professions.

the growing nursing personnel shortage in the State. The Commission will evaluate mechanisms currently available in the State and elsewhere intended to enhance recruitment, retention, and education, and will develop recommendations and implementation strategies to reverse the growing shortage of qualified nursing personnel (Senate Bill 311/House Bill 363, 2000). With the Secretary of the Department of Health and Mental Hygiene designated as Chairman, the legislation formed the Commission of at least 42 Commissioners representing a broad spectrum of clinical nursing professionals and others from education, healthcare administration, and the public. This commission differs from previous nursing commissions in that the General Assembly established a term length of five years, which allows for the development and perhaps some oversight of implementation and evaluation of identified solutions to the problem.

The legislation also mandated the convening of a statewide nursing summit, which was held on June 6, 2000. More than 600 nurses attended the full-day program hosted by the University of Maryland School of Nursing, Baltimore, Maryland. Following several presentations, the attendees participated in small group discussions, where they determined the topic areas of common interest, established priorities, and explored solutions (White, 2001). The legislation designated three priority areas for the Commission's consideration: recruitment, retention, and education. As other issues emerged during the summit, the need for a fourth area was identified, and "workplace issues" was added to the Commission's agenda. It became apparent that no other remedies to the shortage in nursing would be effective unless fundamental changes were made in nurses' daily work environments.[4]

The first meeting of this subcommittee was held on September 21, 2000, at which the group developed a vision statement, as follows:

> The Workplace Issues Subcommittee of the Statewide Commission on the Crisis in Nursing will develop recommendations to address the issues of increased need for nurses in hospitals, long-term care facilities, and community healthcare settings. The focus of this subcommittee is to reduce turnover rates; to explore alternative care models; and to explore technology options to free nurses for direct patient care.
>
> The Subcommittee will collaborate with the Nursing Commission and subgroups of the Commission, Maryland Hospital Association, and other statewide committees and professional organizations to develop recommendations for long-term solutions.

The group identified many factors that might discourage new entrants into the profession and/or drive experienced nurses out of hospitals and other direct-care venues. The Subcommittee decided to address the following five priority areas:

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[4] "Nurses' work environments" speaks globally to all aspects of the work place, including administratively processes, physical layout and accommodations, technologies to assist in patient care, and so on.

1. Scheduling and Lifestyle Issues
2. Professional Environment
3. Regulatory Issues
4. Clinical Practice Delivery Models/Quality of Care
5. Stress in the Workplace

After reporting to the Commission on December 13, 2000, it was decided that the Subcommittee would concentrate initially on scheduling and lifestyle issues. Discussion and vigorous debate enlivened Subcommittee meetings (held twice a month), defining terminology and focusing the approach for studying the issues. Over the next four months, the group discussed the issues in terms of problem definition, effect on the patient, effect on the nurse, and successful strategies from both the literature and local experience.

The Subcommittee determined that their investigation of scheduling and lifestyle issues would focus on the following seven areas:

- Staffing
- Scheduling
- Mandatory Overtime
- Mandatory On-Call
- Re-Assignment
- Dependent Care
- Functionally Appropriate Assignments

Professional recognition in the workplace developed as an area of significance during the literature review. The discussion here of each topic describes the scope of the problem, reviews research relative to the problem and supported in the literature, describes the impact on and the quality of nursing care, and suggests strategies for addressing the issues. Information to address the topics has been summarized from a review of recent literature and synthesized from information brought forward by the Workplace Issues Subcommittee through discussion and documents presented by members, as well as direct experiences of Subcommittee experts.

It was decided that the Center for Health Program Development and Management at the University of Maryland, Baltimore County would write this working paper, and further, to conduct a study of Maryland nurses to ascertain the extent and impact of these issues on their lives.

II. STATEMENT OF THE PROBLEM

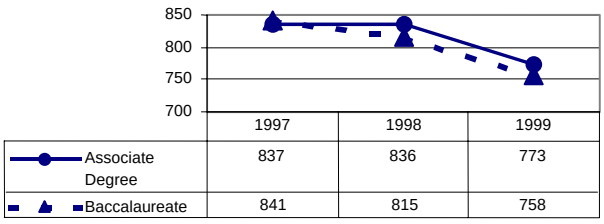
There is an increasingly insufficient number of nurses across the nation. This shortage is the critical outcome of a myriad of factors, which, in a circular fashion, further exacerbate the problem. While it is not possible to quantify, at this point, which factors are most critical, it seems logical that the outflow of experienced nurses must be stopped if the goal of increasing the number of qualified nurses is to be achieved. What aspects of the workplace discourage qualified, experienced nurses from continuing in their current job or chosen profession (which conversely may also stop others from entering), and what makes them stay? It is estimated that nearly 500,000 nurses are not providing bedside care because of "grueling work conditions and lack of staff" (Barnard, 2001).

The Changing Demographics of the Nursing Workforce

One factor that leads to attrition is the loss of nurses who, through injury or illness that occurs early during the career or later in life due to the accrual of chronic health conditions, become functionally limited[5] and may no longer be able to perform the required tasks. These nurses may leave their positions or the nursing field altogether. The loss of functionally limited nurses would not only be a loss of numbers, but also a loss of valuable years of experience that would contribute directly to the quality of care, and to the nursing.

Another factor in the nursing shortage, regarding supply, is the aging of the nursing workforce itself. To some extent, the nursing workforce-aging phenomenon is due to the older-aged graduates from associate degree programs (National Advisory Council on Nurse Education and Practice, 1995). Also, the large number of nurses who are baby boomers, the cohort born during and after World War II, will deplete the number of nurses as they retire or leave nursing.

Figure 2: Number of Graduates from Registered Nursing Programs in Maryland 1997-1999



	1997	1998	1999
Associate Degree	837	836	773
Baccalaureate	841	815	758

Source: Adapted from the Maryland Statewide Commission on The Crisis in Nursing Interim Report, September 2000-January 2001.

The number of young nurses entering the field is decreasing. There are lower levels of enrollment in schools of nursing across the country. Nationally, a 2.1 percent fall in enrollment into entry-level Bachelor of Science in nursing programs in the fall of 2000, was the sixth consecutive year of decline (Freudenheim, 2001). This decline may have even been greater since some of the entrants were RNs seeking their baccalaureate degree and

[5] Functional limitations include being unable to perform certain physical tasks typically required of nurses, such as bending, lifting, and reaching. Functional limitations also refers to being unable to comply with the physical and emotional challenges of caring for critically ill individuals and their families (extended shifts, etc.).

therefore not “new” persons who would increase the pool of nurses. In Maryland, there were 3.1 and 6.1 percent declines in 1998 and 1999, respectively. In the 5 years from 1988 to 1993, there was a 14 percent decline among nurses less than 30 years of age, while the general US workforce experienced a decline of only 1 percent in this age cohort (Buerhaus, Staiger, & Auerbach, 2000). There are fewer younger nurses and an increasing numbers of older nurses. Clearly, then, the trend is an overall aging of the nursing workforce.

Compensation is an issue that is sometimes avoided by nurses who feel that their commitment to the profession is somehow lessened by focusing on pay. However, nurse salaries lag behind other health professionals, and salary is a leading issue in surveys. Nursing salaries have changed little (when inflation is factored in) since 1992 (Freudenheim, 2001).

Despite the social adjustment to women working outside of the home, women remain the primary caretakers of their children and aged family members, and therefore require certain accommodations to balance these roles. Dependent care issues (child and adult) are an important factor in the ability of many nurses to participate fully in the workforce.

Economic Issues: Supply and Demand

A shortage of any commodity involves an imbalance of supply and demand. In the case of the nursing shortage in Maryland, both supply and demand must be analyzed to identify the alternatives that will address the problem. Mergers and acquisitions and streamlining the healthcare delivery system are leading to the closing of hospital beds, nursing homes, and even entire hospitals. It is somewhat of a paradox that there is a looming nursing shortage as nursing positions are cut. In Maryland, 8 hospitals have been closed (over approximately 15 years) and the number of licensed beds decreased by 20 percent. Since 1998, 15 nursing facilities in Maryland have closed, which may be due in part to quality of care and nursing availability issues (Office of Healthcare Quality, DHMH, 2001). Factors having to do with business solvency, budgets, and profits are likely to be critical components to the perceived shortage of nurses as the work life issues that will be explored in this paper. Certainly many, if not most, of the issues and their alternatives may have a financial impact on the healthcare system, nurses themselves, and consequently, the public.

In the first part of 2001, Maryland’s 50 general hospitals requested a rate increase from state regulators to cover higher salaries and other incentives to recruit and retain nurses. They stated that their profit margins are narrowing, and without the increase, they would be unable to retain the nurses and therefore endanger quality of patient care. The Health Services Cost Review Commission (HSCRC) approved an increase of .5 percent above inflation, rather than the requested 1.5 percent. The HSCRC staff indicated that a rate increase would raise Maryland’s collective hospital bill by $150 million escalating health premiums. Insurers consider the increase too high (Salganik, 2000). Consumers are likely to bear the burden of the increased cost.

Fagin (2001) frames the problem in terms of "an absence of effective reimbursement incentives for quality care in general, and nursing care in particular." Managed care is often mentioned as the reason for cutbacks and lowered nursing staffing. According to hospitals, lower than adequate rates from Medicaid and Medicare, and other managed care plans, "squeeze" hospital budgets so tightly that there is no room for increasing nursing numbers (i.e., labor costs) (Freudenheim, 2001 and Barnard, 2001). While hospitals say that there are not enough nurses to fill vacant positions, others present that hospitals "won't" hire more nurses but instead rely on nurses' "volunteerism" to fill vacant shifts (Barnard, 2001).

In addition to the supply issues, there are looming demand issues. Nationally, it is estimated that by 2010 there will be a 20 percent shortfall in the number of nurses needed (Buerhaus P, JAMA, June 14, 2000, as cited in the MSCCN Interim Report, January 2001). This will primarily be due to the care needs of an increasingly larger number of older adults with more complex and chronic conditions. The combination of sicker patients (due to technological and medical advances allowing the survival of more seriously ill persons) and shorter hospital stays (some of which are attributed to managed care and hospital reorganization), cause high levels of personal and professional stress for nurses, patients, and their families (Fagin, 2001).

Paradoxically, some of the short-term strategies are successful in increasing the supply of nurses but may be more costly than longer-term and permanent remedies. Use of agency and traveling nurses, incentive programs, and costs of frequent recruiting due to high turnover may be effective in the short-term, but costly.

Shortage, Staffing, and Scheduling

One facet of the shortage/staffing/scheduling dilemma is mandatory overtime. Overtime has been a defined practice since the establishment of the federal Fair Labor Standards Act (FLSA) in 1938. The FLSA delineates under what circumstances and who is eligible for the various provisions of the Act. The FLSA was initially developed in an effort to protect workers. It was assumed that requiring premium pay for overtime would lead employers to hire more workers rather than pay the additional costs incurred by overtime (Fagnoni, 1999). Its purpose was to decrease the standard work week to 40 hours, thereby improving worker quality of life, decreasing worker fatigue, decreasing accidents, and increasing productivity and efficiency. Fatigued nurses are more likely to sustain on-the-job injuries and make mistakes that injure patients. An Institute of Medicine study showed that injury among private industry workers occurred at a rate of 8.5 (per 100), compared to 12 in hospitals and 17.3 in nursing and personal care facilities (Wunderlich, et.al., 1996). Injuries included back sprains and strains and needle sticks. A Florida study of critical care nurses found that

> The requirements of the Fair Labor Standards Act allow employers to calculate healthcare worker's compensation for overtime differently than for other employees.
>
> Source: Kany, 1999.

- ✓ Fair Labor Standards Act does not limit overtime hours for nurses.
- ✓ Federal Aviation Administration regulates work hours for pilots.
- ✓ Department of Transportation regulates the work hours for truckers.

Source: Kany, 1999.

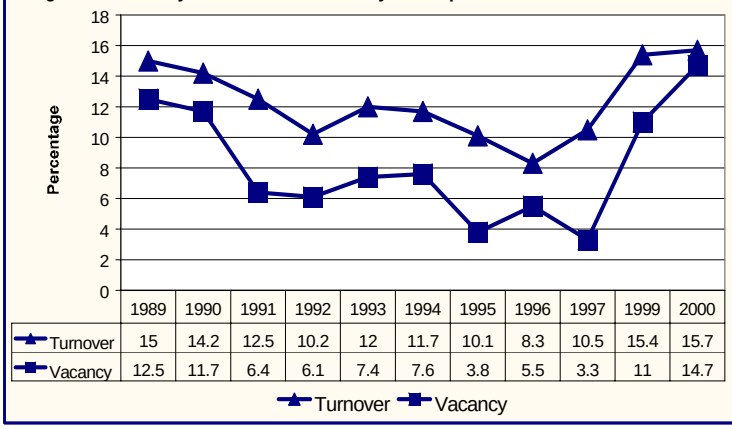
60 percent of nurses reported feeling exhausted and discouraged at the end of their workday. These nurses feel overworked - that they must do more for patients with fewer resources (Galewitz, 2001).

Today, more than 60 years after its enactment, the FLSA inadequately addresses the current workplace due to inflation and changes such as less focus on manufacturing and industrial output than it had been. The FLSA has been both friend and foe to nursing. Despite their exempt status, nurses continue to be managed by most employers like hourly employees, subject to attendance and time. Nurses often do not have the protections of the provisions the FLSA affords non-exempt workers, nor do they receive the benefits afforded to those having an exempt status (higher pay and flexible work hours, etc.).

A study by the Association of Maryland Hospitals and Health Systems showed trends (1989-2000) of high turnover and vacancy rates in nursing positions. A Mercer study found that the primary reason for turnover was dissatisfaction with supervisors, career prospects, or jobs (workload and staffing-skill mix, new role expectations and insufficient training, higher patient acuity, and pressures to increase productivity and reduce costs) (Mercer, 1999).

The number of days to fill a nursing position fell to a low of 30.8 days in 1995, after a high point in 1990 of an average of 63, but has risen each year since, to an average of 49.5 days in 1999. Nursing turnover rates showed a continuous decline from 15 percent in 1989 to a low of 8.3 percent in 1996, but have gradually increased each year since to 15.7 percent in the first quarter of 2000.

Figure 5: RN Vacancy Rates and Turnover in Maryland Hospitals 1989-2000



	1989	1990	1991	1992	1993	1994	1995	1996	1997	1999	2000
Turnover	15	14.2	12.5	10.2	12	11.7	10.1	8.3	10.5	15.4	15.7
Vacancy	12.5	11.7	6.4	6.1	7.4	7.6	3.8	5.5	3.3	11	14.7

Source: Adapted from "AHA News, "Different Looks at the Numbers Illustrated Depth of Nursing Shortage at Hospitals in Maryland", 9/4/2000.

Nursing position vacancy rates show a similar trend with 12.5 percent in 1989, decreasing to 3.3 percent in 1997, but up to 14 percent in 2000 (AHA News, 2000). Vacancy rates may be one of the best measures of the problem even though they do not provide a solution. In New York, rates increased from 5.5 percent in 1999 to a current 8 percent. Some hospitals and hospital units report up to 25 percent vacancy rates. Vacant positions either require current staff to work more hours, or limit institutional capacity, leading to such events as delays in surgeries and closed or by-passed emergency rooms (Freudenheim, 2001).

In a study released April 19, 2001, the Federation of Nurses and Health Professionals (the healthcare division of the American Federation of Teachers) reports that more than half of the nurses surveyed say that they are thinking about leaving nursing in the next five years. Reasons cited include nursing jobs being too stressful or physically demanding, irregular hours, and low morale. Nurses who are considering leaving state that better pay, better staffing levels, better schedules, and more respect could encourage them to remain in their jobs. The president of the Federation calls for a legislative ban on mandatory overtime. Federal standards for staffing levels, congressional support for The Nurse Reinvestment Act of 2001, targeted recruitment of men and minorities and higher salaries and better benefits (especially pensions) (American Federation of Teachers, April 19, 2001).

The conventional wisdoms of needing to work smarter and not harder, and throwing money or bodies (staff) at a problem in the workplace, are not necessarily upheld. Many studies are finding that understaffing and too high a workload are at the root of the problem for much of what is being experienced as a shortage in nursing. The Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) found in its review of nursing home staffing that quality of care was improved with staffing levels of .45 hours (RNs) and 1.0 hour (LPNs) per resident per day. Staffing ratios are being strongly considered. California is the first state to pass legislation mandating establishing such ratios in hospitals, but nursing and hospital groups are far apart on the method for establishing the numerical formulas for doing this.

Maryland Legislative Initiatives

Federal and state legislation has been proposed to amend the FLSA in regard to forced overtime for nurses. In Maryland, Senate Bill 732 and its companion, House Bill 889, were introduced to the Maryland General Assembly on February 2, 2001. Entitled “An Act Concerning Labor and Employment – Nurse – Involuntary Overtime Prohibition,” the legislation seeks to limit employers (particularly hospitals) from requiring nurses to work beyond their routine scheduled hours. The proposed legislation describes the appropriate length of a workday (8-10 hours) and under what circumstances and through what processes an employer can require overtime. The bills also describe the nurse’s recourse if overtime is mandated inappropriately, allowing for civil liability to be incurred by the employer. In a letter to the Chairman of the Finance Committee of the Maryland General Assembly, Dr. Benjamin wrote that, as Chair of the Commission on the Crisis in Nursing, he would like to wait for the findings and recommendations of the Commission to be presented before passing legislation that could obstruct the work of the Commission (2001). As they were presented, the bills would preclude those who choose to work alternate schedules such as 10 or 12-hour shifts from doing so. The bills were defeated in Committee.

These policy alternatives are being proposed in response to concerns for nurse and patient safety, and because many feel that forced overtime exacerbates the underlying problem of a shortfall in the supply of experienced nurses. Forced overtime leads some

nurses to seek jobs in non-acute healthcare venues, or to leave nursing altogether. It may be that for the older nurse (the average age of a nurse in Maryland is 45), forced overtime may lead some to seek early retirement. Nurses are opting for employment opportunities that give them greater flexibility in their personal lives and allow them to practice their profession safely and in a fulfilling manner (i.e., practicing autonomously and utilizing their skills and knowledge as a professional member of the healthcare team).

These observations have prompted action, including the passing of the bills that formed the Maryland Commission on the Crisis in Nursing. According to an interim report released by the Commission in January 2001, enrollments in schools of nursing decreased by six percent, and the number of graduates decreased by nine percent last year. In testimony to the U.S. Senate Subcommittee on Aging, February 2001, Dr. Georges C. Benjamin stated that Maryland nursing license renewals were 2,300 fewer among registered nurses and 300 fewer among licensed practical nurses in 1999, compared to the previous year. He cited mandatory overtime as a negative factor in the recruitment and retention of nurses.

The issue of refusing to work extra hours (hours not previously scheduled or hours required beyond the work agreement or contract), may become a professional decision for the nurse. Governed by the Nurse Practice Act, the individual nurse is responsible to determine that she or he is competent to accept a work assignment. In the case of extra hours, competency would include the physical and mental capacity to provide safe patient care. This competency can be compromised by fatigue if working extra hours means that the nurse goes without needed rest.

The Maryland Nurses Foundation has written guidelines about the responsibilities of the nurse and the employer when they pertain to giving (delegation), accepting, or rejecting work assignments. The Foundation cites instances where the nurse could be sanctioned by the Board of Nursing, including the acceptance of a work assignment that the nurse is not competent to perform, and abandoning a patient. While these guidelines do not specifically tie working extra hours to these issues, it does define abandonment in its glossary as the nurse “terminating the nurse-patient relationship without reasonable notification to the nursing supervisor for the continuation of the patients care” (The Maryland Nurses Foundation, undated). The guidelines recommend a course of action for the nurse to take if faced with the decision to reject an assignment. The nurse is admonished to know the policies of her employer, the Nurse Practice Act, and to carefully document each step taken. In South Dakota, the State Nurses Association promulgated an “advisory opinion” specifically stating that refusal of additional hours does not constitute patient abandonment (South Dakota BON, 2000). There are activities in many states to address this specific aspect of the nursing shortage.

National Legislative Initiatives

Representatives Tom Lantos (D-California) and James McGovern (D-Massachusetts) have introduced HR 5179, an amendment to the Fair Labor Standards Act of 1938 that will limit the number of overtime hours of licensed healthcare employees (not including physicians). Also called "Registered Nurse and Patients Protection Act," HR 5179 acknowledges the impact of mandatory overtime and the risk it poses to the safety and outcomes of care for patients (quality of care) and for the nurses themselves (work-related injuries and stress, as well as professional risk from errors made while fatigued). These issues are substantiated in the literature, including the Institute of Medicine's To Err is Human: Building a Safer Health System (IOM, 2000), which cites a need for research on the impact of maximum work hours and overtime on the likelihood of errors.

In October 1999 California became the first state to pass legislation mandating nurse-patient ratios. This approach, however, is opposed by the American Nurses Association (ANA), which cites that such ratios might become staffing "ceilings" rather than minimums, and could be met by using personnel with inappropriate skill mix. The legislation is scheduled for implementation in January 2002 (ANA, Press Release, October 13, 1999).

Nurses have stated that they have felt pressured and sometimes coerced into accepting mandatory overtime, even when they felt it would cause them to practice unsafely. The American Nurses Association House of Delegates has proposed actions to oppose mandatory overtime but refutes the idea that refusal of overtime by the nurse constitutes patient abandonment. They recommend research to better understand the relationships between hours worked and the provision of safe care (ANA, 2000).

State and federal entities are addressing the issue of mandatory overtime for nurses. Mandatory overtime is symptomatic of a growing nursing shortage that has broad public policy implications: education, employment and wages, and ensuring an adequately trained quantity of nurses to care for an aging population with the more complex care requirements of chronic disease. Solutions to remedy the future dearth of experienced professional nurses will likely require expenditure of public dollars.

Other national legislation includes The Nurse Reinvestment Act (HR 1436/S 706), which was introduced in the 107th Congress to address the issues of the nursing shortage. Among other interventions, the bills include language to support the promotion of the advantages and rewards of nursing (http://thomas.loc.gov).

Nursing Shortage and Public Policy

The correction to the current nursing shortage has been described as a classic scenario of adjustment of supply and demand (Buerhaus et al., 2000). Specifically, Buerhaus et al. state that the shortage of nurses (supply) will increase demand, leading to increased wages and a consequent influx of returning nurses, new graduates, and nurses from other countries, which will lead to eventual market equilibrium at higher wages. While

the market might correct itself naturally in the long run and obviate the need for government intervention, there is still a present danger of risk to patients and their nurse caretakers. The short run costs may be too great without public policy to mediate the competing market forces.

Healthcare, unlike other non-public goods, is not an "optional" commodity that can be left purely to the market forces of "willingness to pay." Passively awaiting market correction to restore the balance in the supply and demand of nurses is not acceptable since lives are at stake. A large portion of the healthcare industry is publicly funded and prone to government intervention. Shortages of health personnel (nurses) will cause delays in care and/or the likelihood of the increased use of less-educated, less-prepared individuals providing care and consequent poor outcomes for patients. As a major payer of healthcare, government holds an interest in health outcomes.

These issues have been addressed at a high level in the case of doctors by the creation of the Council on Graduate Medical Education (COGME). On an ongoing basis, COGME monitors the supply and demand and support of medical education (Sweeney & Rose, 1997). There may be lessons that nursing can learn from the COGME example. Legislation currently in the Senate, S 721 introduced April 5, 2001, seeks to create the National Commission on the Nursing Crisis. However, this National Commission, unlike COGME, has a limited lifespan of 15 months (http://thomas.loc.gov/).

To the extent that recruiting foreign nursing graduates is an alternative to the underlying problem of staffing shortages, government policies on immigration and controls would be required to ensure appropriate levels of education, language competency, and other issues. There may be ethical, economic, cultural, and other quality-related issues involved with increased use of foreign nurses (Buerhaus et al., 2000, Vol. 3).

III. EFFORTS OF WORKPLACE ISSUES SUBCOMMITTEE AND REVIEW OF LITERATURE

Methodology

A selective search of the relevant nursing and allied health literature was performed using relevant criteria to identify issues associated with nursing shortage, scheduling, staffing, mandatory overtime, mandatory on-call, re-assignment, dependent care, magnet hospitals, shared governance, and so on, for 1991-2001. More than 75 articles were reviewed. Additional articles supplied by the Subcommittee were also reviewed and were selected based on their appropriateness. Citations from these articles were chosen to further define topic areas. Human resources and other social science literature were searched for information on dependent care; elder care, childcare, sandwich generation, flexible scheduling, and mandatory overtime.

Workplace Issues Subcommittee minutes were utilized for the Workplace Issues Subcommittee sections. Johns Hopkins Hospital's Department of Nursing provided their guide for "professional nursing." Human resource personnel were consulted via telephone interviews. Local nurse experts were also interviewed.

AMERICAN NURSES ASSOCIATION'S PRINCIPLES FOR NURSE STAFFING

Patient Care Unit Related

- Appropriate staffing levels.
- Question concept of Nursing Hours per Patient Day (HPPD).
- Incorporate in staffing levels all unit functions that support quality of care.

Staff Related

- Specific needs of the patient population should determine the clinical competencies required of the nurse.
- RNs must have nursing management support at the operational and executive level.
- Clinical support from experienced RNs should be available to RNs who are not as proficient.

Institution/Organization Related

- Organizational policy should reflect a climate that values RNs and other employees.
- All institutions should have documented competencies for nurses.
- Organizational policies should recognize the myriad needs of both patients and nurses.

Staffing

Maintenance of adequate staffing levels is the foundation of an organization's functional ability to provide quality patient care. Not only is the number of nurses required an issue, but also that nurses possess the knowledge and skills that are required to care for their patients.

There is a positive correlation between the number of hours of care delivered by an RN and positive patient outcomes (McCloskey, 1998, Kovner & Gergen, 1998, Miller, 1992, Elliott, 1989, Blegin, Goode, & Reed, 1998). A 1997 Department of Health and Human Serivces study by the Harvard School of Public Health found improvement in five medical outcomes when higher numbers of licensed nurses (RNs and LPNs) were utilized. A recent study by Needleman and Buerhaus showed conclusively that nursing staffing makes a positive difference in decreasing what they call "Outcomes Potentially Sensitive to Nursing" (OPSNs). "Strong and consistent relationships" were found between outcomes such as urinary tract infections, length of stay, upper gastero-intestinal

bleeding, shock, and death occurring as a result of complications, with higher ratios of nurses to patients.

Insufficient staffing can be viewed as being analogous to knocking over the first block in a chain of dominos. First to collapse is scheduling - not enough nurses to care for patients, which leads to mandatory overtime, mandatory on-call, and inappropriate unit re-assignments (all methods to cover the patient units). Once this domino effect has been set into motion, it gains momentum as more blocks - quality of care and the morale of nurses - fall. Job satisfaction declines when nurses feel that they cannot provide the care their patients require because of too large a caseload, resulting in high turnover rates and loss of nurses to the profession.

The January 2001 study commissioned by the Service Employees International Union (The SEIU Nurse Alliance, 2001) surveyed 800 nurses in a nationwide representative sample and found the following perception among nurses in regard to adequacy of staffing levels:

- Nurses do not have enough time to meet the basic needs of their patients in regard to teaching and education
- When nurses are overloaded, mistakes happen – and patients suffer
- Most medical errors are caused by insufficient staffing
- There is sometimes insufficient staff for the acuity of patients
- Understaffing is the cause, not the result, of the nursing shortage
- Deteriorating work conditions (stress, chronic fatigue, and work-related injuries cause nurses to seek less demanding jobs, outside of hospitals
- Industry response to the shortage of nurses – excessive mandatory overtime and floating – is exacerbating the shortage by causing nurses to leave

<u>Strategies from the Literature</u>

The American Association of Critical Care Nurses has developed an approach called the Synergy Model that links patient characteristics with nurse competencies in order to gain optimal patient outcomes. This approach can be adapted to other areas of nursing practice, providing standardization while avoiding the cookie-cutter approach of adopting what may not be best for all settings. Patient characteristics include stability, complexity, vulnerability, resiliency, predictability, resource availability, and ability to participate in decision-making and care. Nurse competencies include clinical judgement, advocacy, response to patient uniqueness, collaboration, holistic relationships, response to diversity, clinical inquiry, and facilitation of learning (Critical Care Nurse, April 2000).

Scheduling

Healthcare institutions providing 24/7 patient care traditionally have functioned using three eight-hour shifts: day shift (7 a.m. to 3:30 p.m.); evening shift (3 p.m. to 11:30 p.m.); and night shift (11 p.m. to 7:30 a.m.). There are now many different kinds of schedules. "Flextime," "alternative," and "flexible" are all terms used for scheduling that deviate from the traditional shifts. The purpose of alternative scheduling is to meet the staffing needs of the unit as well as nurses' personal needs. These alternative schedules could be 4, 10, or 12-hour shifts, or any combination of hours. A Nursing Executive Center of the Advisory Board study (Reversing…, 2000) cites scheduling issues as the third highest ranked cause for reason to change hospitals in a nationwide survey of staff nurses performed by the Advisory Board in 1999.

The literature mentions alternative schedules as early as 1969, when General Hospital in Rhode Island first offered ten-hour shifts as an option to nurses. The advantage of 10 and 12-hour shifts is that they overlap the traditional 8-hour shifts, allowing continuity of care of patients. Extended-hour shifts allow nurses to compress their schedules to have blocks of time off, which can facilitate "quality time" for personal endeavors, such as recreation and child/parent care, as well as educational endeavors.

Schedule considerations need to include patient acuity and nurses' competency and skill-mix to ensure adequate and safe nursing care.

<u>Strategies from the Literature</u>

I. Self-Scheduling

Self-Scheduling is a strategy that was highly supported by the Subcommittee, with emphasis on the need for factual information to aid the process, such as understanding skill-mix, patient acuity, and organizational needs as the basis for scheduling.

After implementation of a self-scheduling computer program in an emergency department:

- ✓ 94 percent of the staff believed coverage had improved
- ✓ 88 percent believed conflicts were resolved fairly
- ✓ 100 percent were satisfied with this method of scheduling
- ✓ 90-95 percent were granted their requested work schedules
- ✓ 98 percent of time-off requests were granted

Source: Irvin & Brown, 1999.

Herzberg identifies scheduling as an important component of a "good" job. He maintains that when a person's work schedule is prescribed, the worker feels an obligation to the schedule and not to the work. Workers are more inclined to be concerned with the time they are at work rather than the importance of the work itself. Employees become accountable for their work once they are permitted to determine their own schedules (Herzberg, 1974).

"Self-scheduling" is defined as "a process by which the staff of a unit collectively determine their own monthly work schedule and then implement it. The group establishes criteria that assure that staffing is adequate to provide quality patient care,

but after these criteria are met, the personal needs of the nurses take precedent" (Miller, 1992). Self-scheduling provides nurses with autonomy and control over their schedules, leading to an increase in job satisfaction (Dearholt & Feathers, 1997).

Initiating a successful self-scheduling program requires the commitment of nursing administration and staff nurses to the program's development. Components of the self-scheduling program include the formation of a scheduling committee that defines goals and sets guidelines for scheduling, a trial phase to identify problems, and a consensual agreement from the entire staff regarding the continuance of the program (Miller, 1992, Dearholt et. al., 1997, Elliott, 1989, Beltzhoover, 1994, Miller, 1984, Bischof, 1992, & Manchester, 1987).

Pros	**Cons**
<u>Impact on Patients</u> • Increased quality of nursing care • Increased patient satisfaction <u>Impact on Nurses</u> • Increased job satisfaction • Increased communication between shifts • Increased sense of professionalism • Improved balance between work and personal life <u>Impact on Staffing</u> • Increased retention of staff • Improved staff relationships • Decreased absenteeism • Improved relationsionships with management	• Nurses who sign up first choose the "best" times to work, while those who sign up last have to sign up for the shifts that were left over (Irvin & Brown, 1999; Reversing…Advisory Board, 2000). • Not all nursing staff possess negotiating skills that are required to make changes to schedules (Abbott, 1995).

Other Considerations:

- Hospital administration as well as unit nurses need to accept the program.
- Ensure the success of the program by allowing committee scheduling members to work four hours on each monthly schedule (Manchester, 1987). [Irvin & Brown (2000) found that nurses, staff, and managers spent less time developing the schedule using a computerized version of self-scheduling.]
- Agreed-upon guidelines, including a framework for resolivng conflicts, opportunity for communication, and a format (e.g., a grid) are needed as a foundation (The Advisory Board, 2000).

Self-Scheduling Success Factors

Committee Structure
- Establish a formal committee
- Involve self-directed staff
- Get input from all staff

Provide Staff Education
- Educational staff meetings
- Staff development
- Orient new staff

Negotiation Skills
- Staff development on negotiation skills and conflict resolution

Guidelines
- Establish guidelines for scheduling expectations
- Guidelines are clear and concise
- Review and revise guidelines

Source: Partially adapted from Hoffart, N., & Willdermood, S., Self-Scheduling in Five Med/Surg Units.

Successful Self-Scheduling Approaches:

1. The Nursing Executive Center of The Advisory Board describes an approach to scheduling in its report “Reversing the Flight of Talent: Nursing Retention in an Era of Gathering Shortage” (2000), which includes the following actions:

    - *Measure* and ascertain, through a survey or other means, the range of staff preferences, and compare staff preferences with a plan of the needs of the institution. Look for a win-win strategy that provides the flexibility that nurses need for their personal lifestyles, while fulfilling the institutional requirements for care giving. Have nurses then prioritize their preferences.

    - *Scheduling should be customized* to accommodate all requests that can be accomodated, keeping in mind fairness, flexibility, and the ground rules (institutional needs – a staffing grid that has full-time equivalent needs for each type of staff person based on unit census can proactivley inform staff of anticipated needs). The outcome is a customized schedule, unique to the needs of the staff involved.

    - *“Unit Practice Council”* to establish scheduling policy, review requests, and resolve conflicts. All nurses rotate onto the Council for two years and each must take leadership for six months.

2. The University of Pennsylvania Hospital in Philadelphia has a 23-bed surgery unit that employed 32 nurses. The average nursing tenure was one to two years. The head nurse recommended self-scheduling to the staff. A committee was formed, guidelines were established, and a pilot period was started. Scheduling issues were

identified at this time and alternative guidelines were established. As a result, nurses' tenure increased to about four years after implementation of the self-schedule program (Griesmer, H., 1993).

II. The Use of Unlicensed Assistive Personnel (UAPs)

Maryland has addressed the dilemma of unregulated unlicensed healthcare workers by requiring certification of nursing assistants and special training with certification of other categories (such as Medication Assistant). The Maryland Nurse Practice Act clearly delineates the nurse's responsibility in delegating nursing tasks to others.

Increasingly, acute care hospitals around the country are using or considering the use of unlicensed assistive personnel (UAPs), not only in response to the nursing shortage, but also to cut costs. Other terms that are used to describe the same category of workers are "nurse extenders," "patient care partner," "multi-skilled worker," "patient-care aide," and "technician" (Krainovich-Miller, Sedhom, Bidwell-Cerone, Campbell-Heider, Malinski, Carter, 1997).

Documentation in the literature is divided about the safety and quality of care to patients and cost effectiveness of employing UAPs (Huston, 1996, Barter, 1994, Bostrom & Zimmerman 1993). Empirical data quantifying the effect of UAPs on the quality of patient care is scarce.

Use of UAPs: Pros	Use of UAPs: Cons
• UAPs appear to be performing adequately in their positions, and RNs were satisfied with the performance of UAPs (Badovinac, Wilson, & Woodhouse, 1999, Lengacher, Kent, Mabe, Heinemann, VanCott, & Bowling, 1994).	• RNs felt that UAPs do not receive enough training (Hurley, 2000). • There was inappropriate use of UAPs (given too much or not enough responsibility) (Haddad, 1998, Lengacher et al., 1994). • RNs share liability if a delegated task is partially or incorrectly performed by a UAP (Huston, 1996). • Many RNs have not been trained to delegate assignments (Huston, 1996). • A 1993 study completed by Bostrom indicated that the quality of care was not changed when UAPs were (i.e., increased cost without improvement of quality of care).

Other Considerations:

- More research is needed to demonstrate the UAPs' effectiveness on patient outcomes, UAP and nurse relationships, and cost-effectiveness.
- Education and training of UAPs need to be standardized.[6]
- Titles and job descriptions need to be standardized.

Local Practices

A. The Johns Hopkins Hospital Professional Practice Environment

Unit-based shared governance, participatory decision-making, self-scheduling, peer review, and salaried compensation are the core tenets of the professional practice environment at The Johns Hopkins Hospital. These tenets are applied through unit-level working committees of registered nurses. The compensation program is designed to align the professional role and status of nurses with their level of autonomy in clinical practice and with their responsibility for shared governance (*Creating Professional Nursing Practice Environments*: *A Guide from the JHH Department of Nursing*, 1995). According to the guide, shared governance has led to an increase in nursing job satisfaction.

The Professional Accountability and Clinical Expertise (PACE) Program is a modified salaried approach to compensation that applies to registered nurses working on patient care units. In this program, RNs are paid a base salaried rate that incorporates shift and weekend differential, holiday pay, time for indirect patient care activities, and on-call (when applicable). Also, RNs are eligible for pay in addition to their base salary when they work more than their scheduled hours in a given scheduling period (four or six-week schedule). This method of using the scheduling period as the basis for determining pay in addition to salary provides staff with increased flexibility and control over when and how they work.

B. The Baylor Plan

The Baylor Plan, or Weekend Alternative, is a staffing model that is implemented by the Baylor Health Care System, Inc. in Texas. This model pays employees for 40 hours at their basic hourly rate for working two 12-hour shifts on Saturday and Sunday. Baylor employees receive overtime pay for work in excess of 24 hours on Saturday and Sunday, and in excess of 8 hours on any other day. Nurses in this model are considered full-time employees for all personnel management purposes (i.e., retirement calculation, leave time, etc.) (Baylor Plan, http://ohrm.cc.nih.gov/infocenter/NursAH/baylor.htm).

While different versions of the Baylor model are used in different hospitals, the foundation is based on 12-hour coverage on Saturday and Sunday. At Prince George's Hospital Center, a Human Resource Generalist stated that nurses are paid for 36 hours for 12-hour day/evening shift rotations on Saturday and Sunday, and are paid for 40 hours for 12-hour evening/night shift rotations. He states that this program was initiated

[6] This has been done in Maryland.

in October 2000 at Prince George's Hospital Center in an effort to recruit and retain nurses. In addition to being a recruiting tool, this type of scheduling model boosts the morale of nurses currently working, as they do not have to work many weekends.

Institutions employing this model may need to consider the expense of the model's implementation and maintenance, as well as implications of having more uncovered shifts when a full-time nurse only works two days.

Discussion and Findings of the Workplace Issues Subcommittee

The following suggestions were made during Workplace Issues Subcommittee meetings as strategies to address scheduling issues.

Staff Nurse Involvement:

- Staff nurses should participate in the scheduling process.

Administration involvement:

- Create a staffing plan to drive the scheduling process.
- Schedule should be dynamic and include manpower resources needed for fluctuations in the quantity and acuity of patients without requiring loss of nurses' flexibility and personal time (on-call and re-assignment); the institution should absorb the cost of this requirement.
- Incorporate Authorized Down Time (ADT) into the staffing plan.
  - Assess peak and low activity levels of each shift for each unit so that staffing needs can be better anticipated.
- Experience and competency of the nursing staff is taken into account (assure that the skill-mix is appropriate for unit and patient acuity needs; senior nurses can assist new graduates/new hires).
- Assign an individual (non-nurse) for securing nursing coverage.
- Develop opportunities for continuing education.
- Consider preference of staff member in scheduling.
  - Leave, holidays, shifts, days off.
- Recognize seniority (when scheduling).
- There is a concern that UAP utilization is not consistently applied in all patient care venues in Maryland.

"Required Extra Hours" and Mandatory Overtime

Mandatory overtime is not as straightforward as it may seem. The definition of this phenomenon can vary among and within professions. The Workplace Issues Subcommittee struggled with viewing mandatory overtime as an issue that affects nurses because the problem is not just the technical human resources issue as addressed by the FLSA as 40 hours per week, or 8 hours per day. The Subcommittee chose to adopt the broader concept of "required extra hours" to capture the breadth and depth of the nursing experience, since nurses work alternative schedules (4, 8, 10 or 12-hour shifts) in varying practice settings. The issue of being compelled to continue to work beyond previously agreed-upon hours needs to be addressed for all nurses. Unforeseen events, such as epidemics, disasters, and/or colleagues calling in sick, creating the need for nurses to "cover," is part of working in healthcare and is something that every nurse knows and accepts. However, required extra hours – defined as hours that are required in addition to routinely scheduled hours, in either full or part-time situations – is used increasingly by facilities as a routine method to cover patient units due to the nursing shortage. Nurses often feel coerced by their concern for patient well-being or by administration (threatened with losing their jobs or even their licenses) into complying. ANA President Mary Foley stated "hospitals' increasing use of mandatory overtime puts patients and nurses at risk, and is an inappropriate way of contending with nursing shortages" (Levenson, 2000).

In non-hospital venues (e.g., home healthcare), extra hours become an issue of concern when the nurse must work significant hours beyond those needed for patient care in order to complete required paperwork, often without additional compensation. In another interview, Ms. Foley stated that more research is needed to understand how understaffing might contribute to increased patient care errors. She further explains that increased patient load can be tantamount to rendering the usually competent nursing professional incompetent (Long-Term Care Interface, April 2001).

This section will present legislative approaches found in the literature, suggestions for the empowerment of nurses, and health system changes that can ameliorate the negative effects of mandatory overtime.

<u>Strategies from the Literature Review</u>

Legislation:

- State and national nurses' associations have initiated legislation or are developing regulations to ban or restrict mandatory overtime.
  - In Maryland, the Involuntary Overtime Prohibition bill was defeated in committees in both houses of the legislature. Some of those in opposition stated the need to await the outcomes of the survey of Maryland nurses (which the Workplace Issues Subcommittee is in the process of performing) to guide a response to this issue rather than prematurely adopt legislation that may not fully address the problem.

  - The California Nurses' Association was able to persuade California's Industrial Welfare Commission to issue a ruling that banned forced overtime. However, this only covered healthcare workers in the private sector who work 12-hour shifts and are not represented by a contract (Vernarec, 2000).
  - The New Jersey State Nurses' Association formulated a bill banning mandatory overtime that was approved by both houses of the state legislature. Former New Jersey Governor Christine Todd Whitman, however, vetoed the bill. She stated that the bill spoke only to mandatory and not voluntary overtime. The Governor charged the Commissioner of Health and Senior Services and the Commissioner of Labor to establish maximum daily and weekly working hours for healthcare providers (Vernarec, 2000).
- State nurses' associations and nurses are supporting federal legislation.
  - Nursing associations in California, Massachusetts, Maine, and Pennsylvania convinced U.S. Representatives Tom Lantos (D-Calif) and James McGovern (D-Mass) to introduce the "Registered Nurses and Patients Protection Act," HR 5179, banning mandatory overtime beyond 8 hours in a workday or 80 hours in a 14-day period, except in cases of natural disaster or a state of emergency. Voluntary overtime would be exempted (Vernarec, 2000). To date, this bill has not gone to committee and is not expected to be considered during this congressional session (Levenson, 2000).

Empowering Nurses:

The Healthcare Corporation of St. John's developed a program called the Nursing Peer Support Program to address occupational stress among nurses. Nurses are taught cognitive therapy techniques to assist colleagues who are experiencing work-related stress. The relationships among nursing staff are strengthened through this process (www.acen-cjonl.org, 2001).

Vernarec (2000) and Trossman (2000) state that a collaborative effort between individual nurses, state nurses' associations, and state boards of nursing is required to address the issue of mandatory overtime. Their strategies include:

- Ensuring that nurses are informed about their state nurse practice act and that they are aware of their board of nursing's position on mandatory overtime through workshops and their own initiative.
- Developing a website by the state nurses' association for RNs to report quality of care issues.
- Empowering nurses to assess their own competency and understand how to decline assignments they cannot perform safely.
- Support of nurses by their state board. (The Texas Board of Nursing created a "safe harbor" form that is available at www.bne.state.tx.us/safe.htm for nurses to complete when they refuse an assignment of mandatory overtime.)
- Making mandatory overtime a priority union issue for nurses covered by contracts.

- Submitting formal complaints by nurses to state licensing agencies and accrediting organizations about employers of nurses who require mandatory overtime.
- Empowering nurses to negotiate with management to set up a schedule for anticipated overtime.
- Encouraging nurses to support efforts to pass state and federal legislation.

Healthcare System Changes:

- Healthcare executives and administrators need to make a commitment to provide adequate staff in their facilities (MASS Nurse, 1998, Feb).

<u>Successful Mandatory Overtime Approaches</u>

- Nurses at Quincy Hospital in Massachusetts were able to obtain specific language in their contract to ban mandatory overtime. The hospital did not comply, and the issue became a grievance. The nurses also developed forms for management to complete when a directive for mandatory overtime was issued. Copies of this form were sent to Massachusetts Nurses' Association to provide a mechanism for tracking. The nurses also placed advertisements in their local newspaper warning the public of the compromised patient care. They met with hospital trustees and implemented an internal campaign among the nursing staff. The hospital increased their RN positions, which decreased mandatory overtime and improved RN/patient ratios[7] (MASS Nurse, 1998).

- The nurses at Brigham Hospital came together and presented a large volume of completed forms reporting unsafe staffing to management. When this did not change working conditions, the nurses voiced their concerns with The Boston Globe. Aware that the nurses had spoken to The Globe, hospital administrators still did not respond to the nurses' complaints. The situation finally changed when The Globe printed the story on the front page. Seventy-five positions were added (MASS Nurse, 1998).

- In Washington DC, Howard University Hospital's nurses went on strike for one day and Washington Hospital Center's nurses went on strike for a little over six weeks before they were able to add mandatory overtime restriction language into their contracts (Trossman, 2000).

[7] Fagin (2001) objects to standard nurse-to-patient ratios, stating that ratios make recommendations based on *minimum* rather than *appropriate* numbers based on skill-mix and patient acuity, which could make such an approach "ineffectual."

Workplace Issues Subcommittee Comments

The following are the strategies the Subcommittee discussed that are either currently employed by facilities in Maryland or recommended by the Subcommittee to avoid the need for mandatory overtime:

Autonomous Scheduling:

- Flexible/creative/self-scheduling.
- Utilizing *pre-assigned* mandatory overtime (nurses choose which day(s) out of a two-week period to be available for mandatory overtime).
- Pre-planning for staffing (i.e., the nurse manager reviews the scheduled staffing for the next five to seven days and solicits individuals to work *volunteer* overtime based on absenteeism, projected patient census, etc.).
- The decreased needs of the patient unit (number and acuity of patients) leads the nurse managers to send home nurses who have reported for work. The nurse must then work an alternate schedule or use her/his own leave in order to obtain the usual 40 hours per week.

Staffing:

- Use of agency/traveling nurses.
- Recruitment of foreign nurses.
- Increasing the hiring of UAPs.
- Increasing the number of clerical positions (i.e., ward clerks to transcribe physician orders, thereby extending the nurses' availability for patient care).
- Increasing the number of support personnel positions (i.e., transport personnel, runners, etc.).
- Increased technology to support nursing care (i.e., use of robotics, etc.).

Management Considerations:

- Shared governance/partnership/participatory decision-making.
- Incentives for voluntary overtime (i.e., time off, end-of-shift cash, bonuses, etc.).
- Closing of facility beds.
- Initiating and supporting changes to decrease the amount of documentation required by regulation.
- Self-scheduling, flexible scheduling, or some type of creative scheduling.
- Nurses having input into control of elective admissions based on patient acuity and available staffing.

Mandatory On-Call

On-call practices are as different as the many facilities that employ them. Generally, being on-call for nurses means being on stand-by and available to work if called. Nurses who work in specific areas, such as the operating room or critical care unit, may expect to be on-call for a specified amount of days per schedule. Generally, these nurses are compensated for the additional responsibility and understand being on-call as a routine part of their specialty unit. They are provided with the technological devices (beepers, cell phones, etc.) to allow them to incorporate on-call duties into their personal lives.

In the case of the average nurse working in general patient area, there may be no support or compensation. In some cases, on-call is used similarly to mandatory overtime - it is another way to staff units that have staffing shortages and to ensure adequate staff for fluctuating patient needs. When mandatory on-call is not compensated and/or part of the nurse's routine schedule, it usually requires personal readjustments and creates uncertainties and stress. Opportunities to rest or attend to family or other personal needs may be lost.

Strategies from the Literature

There was little exclusive mention of mandatory on-call in the literature, as it was often grouped with other workplace issues such as mandatory over-time, re-assignments, and/or scheduling. At the Albert Einstein Medical Center in Philadelphia, mandatory on-call for nurses who had been employed for 25 years was eliminated in an attempt to initiate non-monetary perks (Jacobson, 2000).

At the St. Francis Medial Center in New Jersey, implementation of the shared governance model in their operating room eliminated on-call during the week, decreased costs related to overtime, raised staff satisfaction, and attracted new staff (Ledger, 2001). See "Professional Recognition in the Workplace" on page 34 of this report.

Local Practices

Doctors' Community Hospital in Maryland pays RNs a premium salary for volunteering to increase their hours for the 12-week interval during the Thanksgiving/winter holiday season. The nurse recruiter states that this option is less expensive than hiring traveling nurses or agency nurses. In other instances, bonuses are paid for extra weekends, shifts, and for assisting short-staffed units.

Workplace Issues Subcommittee Comments

The following are the strategies discussed by the Subcommittee that are either currently employed by facilities in Maryland or are recommended by a Subcommittee member to avoid the need for mandatory on-call:

Scheduling:

- Flexible/creative/self-scheduling.
- Utilizing *pre-assigned* mandatory on-call (nurses choose which day(s) out of a two-week period to be available for mandatory on-call).
- Pre-planning for staffing (i.e., the nurse manager reviews the scheduled staffing for the next five to seven days and solicits individuals to work *volunteer* on-call based on absenteeism, projected patient census, etc.).

Compensation:

- Compensate the nurse for mandatory on-call.
- Incentives for voluntary on-call (i.e., time off, end-of-shift cash, bonuses, etc.).

Re-Organization of Management Practices:

- Institute a shared governance model of nursing practice.
- Provide initial and ongoing managerial leadership development for the nurse manager.
- Develop an organizational expectation that the nurse manager complete an exit interview of all licensed staff who chooses to leave the unit.
- Develop an organizational expectation that all managers have ongoing involvement with licensed nursing staff.

Re-Assignment

Re-assignment is when nurses are directed to work in a location that is different from their usual work location. Re-assignment is problematic when the nurse is not oriented with the new work location and does not have the competencies required. In this era of medical specialties, nurses are often certified in clinical areas they prefer but in which they also have extensive experience. Several organizations re-assign nurses and expect them to perform within their level of competence and are expected to defer clinical activities outside of their competence level to a nurse assigned to assist them. The philosophy that “a nurse is a nurse is a nurse” is a problematic approach to assignment. Reassigning a neonatal intensive care nurse to an adult medical floor, for instance, invites potential for error.

Nurses commonly call re-assignment “floating” or “being pulled.” Just like mandatory overtime and mandatory on-call, some facilities use floating to accommodate staffing shortage. Providing care to patients in unfamiliar surroundings and who require care outside of the nurses’ knowledge base can be demoralizing and a major dissatisfier to the professional nurse who primarily wants to ensure patient safety and also experience the satisfaction of a job well done. In addition, when reassigned to an area with unfamiliar clinical tasks, the registered nurse is still responsible for her/his actions as a registered nurse, albeit the re-assignment is considered “to help out as an assistant.”

The Maryland Nurse Practice Act places the responsibility of accepting and fulfilling assignments on the nurse. The nurse bears the full burden of her/his response to the employer's requirements (accepting or rejecting an assignment), as well as shouldering subsequent actions that may be taken by the employer or the Board of Nursing.

Strategies from the Literature Review

Strategies focused primarily on ways to empower nurses and on management techniques to proactively develop inclusive approaches to the issue.

Kany (2000) and Kleinpell (2000) recommend the following:

- Document (on an incident report, memo, or some other type of form) unsafe practice concerns about unethical re-assignment.
- Bring issue before collective bargaining agent.
- Negotiate with the nurse manager for an orientation program to that unit.
- Know what the State Nurse Practice Act says about floating.
- Enlist the help and support of staff on the unfamiliar unit.
- Express your preference for patient assignments.
- Validate unfamiliar procedures and/or medications with procedure manuals, drug books, or any other resource materials.

ANA and Nursing Administration (Kany, 2000):

- The ANA is developing policies and guidelines to address the re-assignment issue.
- Nursing administration could create float pools of nurses with multi-skill mixes.

Successful Re-assignment Approaches

In 1993, St. Joseph's, a 250-bed hospital in Michigan, was going through a merger with another facility. During that process, nurses were floated to different units every day as units were also merging. The administration developed a task force of nurse managers and RNs to create a float pool. Orientation guidelines were a by-product of this venture. The administration thought that the time for orientation was excessive, but the nurses prevailed and had strong language placed in their contracts regarding orientation time for float-poolers and staff nurses who occasionally still are floated to other units (Trossman, 1999).

At South Shore Hospital (SSH) in South Weymouth, Maine, the issues of floating and "cross-training" were sources of dissatisfaction among staff nurses. Carole Conley, RN, MS, Director of Project Development, formed groups of nurse managers and RNs. These groups identified assignments that floating nurses would be expected to perform. They also produced resource packets, unique to each unit, containing information about unit routines, resource people, and a written evaluation to be completed by the float nurses about their experience. Since the implementation of this program, the need for

the float pool became obsolete, as nurses were willing to accept re-assignment with the appropriate resources (Farella, 2001).

The Nursing Executive Center (NEC) recommends that health facilities develop systems that monitor re-assignment decisions and processes so that they can then develop practices that capitalize on the advantages re-assignment can bring to staffing, while not impacting nurses negatively.

The following are strategies suggested by the NEC (Practice Brief: A Delicate Balance, undated):

- Offer a variety of float schedule options, allowing for nurse-selected flexibility and matching competency. The point is made that cross-training is not the same as orientation and should be done in a planned manner, not as a response to a crisis. This might include "differentiated compensation" for the broader skill-set required. For example, Good Samaritan Regional Medical Center in Phoenix, Arizona, has a "Nursing Resource Management System" that has five levels of nurse assignments: "primary experts" are core staff assigned to one unit; "clustered" floats regularly cover three to four units; "float pool" and "SWAT team" nurses float 100 percent of their time; and agency or travel nurses cover census fluctuations, seasonal peaks, and vacancies.
- To support the nurse who floats, the NEC recommends the identification of "resource nurses" (to answer questions and to help the re-assigned nurse adjust), kits with information about the re-assignment location (including floor plan, standard procedures, and location of key supplies), and a list of responsibilities and competencies.
- Re-assignment data at the facility, unit, and individual nurse level can help make re-assignment more equitable and provide benchmarking to anticipate unit needs and future staffing strategies.
- Finally, success of a re-assignment policy rests on involvement of staff, including getting feedback and responding to negative evaluation.

<u>Strategies Discussed by the Workplace Issues Subcommittee</u>

Nurse Involvement in Re-Assignment:

- Nurses should have a voice in the re-assignment.
- Educate nurses about how to accept, receive, or reject assignments.
- Educate nurses about how to file a complaint with the State.

Facility Policies and Procedures:

- Require assignments to reflect nurses' credentialed specialty area.

- Develop an “as needed” pool with multiple competencies.
- Hospital quality management and risk management develop policies to allow nurses to document re-assignment issues.

Characteristics of Some Models:

- Credentialing - the method by which RNs prove, by examination, that they have specialized knowledge of a unique clinical area (i.e., critical care, pediatrics, and geriatrics).
- Competency-based float pools (in-house).
- Floating differential pay.
- Developing skilled nursing multi-specialists.
- Certification for specialty skills (i.e., conscious sedation, IV therapy).

Dependent Care

There is copious information in the literature regarding the needs of the “sandwich” generation - those women still caring for children and simultaneously assuming responsibility for aging parents. Individuals (nurses) who are distracted with concerns about their dependents may feel greater stress and lose more time from work (McIntyre, 2000). While the literature was not exclusive to nurses, it can be applied to nursing as a female-dominated profession. The Family Medical Leave Act, while not documented in the literature as a specific remedy to dependent-care issues for nurses, is an important regulation that can assist nurses in particular situations in providing care to dependents. Nurses need to be aware of its provisions.

<u>Strategies from the Literature</u>

This section explores strategies from the literature or discussed by the Workplace Issues Subcommittee and examples of local practices.

Benefits Offered by Non-Healthcare Companies:

- On-site childcare centers (Kohl & McAllister, 1995).
- Discounts at local childcare centers or a voucher system, whereby an employer pays a percentage of expenses (Kohl et al., 1995).
- Flexible spending accounts for pre-taxed deduction of childcare expenses (Kohl et al., 1995).
- Employee referral services (information materials provided about childcare centers) (Kohl et al., 1995).
- “Corporate elder care” provides a long distance search for services (such as housing and medical care) for employees whose parents live in another state (Watt, 1999).

Local Practices

- Johns Hopkins Hospital offers flexible self-scheduling and a child/elder care finder service.
- Mercy Medical Center offers a "flexible spending account" and pre-taxed dollars up to $5,000 for health and dependent care expenses.

Strategies Discussed by the Workplace Issues Subcommittee

Assistance for Child/Adult Care:

- Provide subsidized onsite facilities for sick and well children, adult/elder care, and school closings.
- Provide vouchers/monetary assistance for child/adult care (including before and after school care).
- Nurses should avail themselves of Employee Assistance Programs, if offered by their employers, to help them manage the stress of dependent care issues.

Scheduling:

- Provide job sharing opportunities for nurses to facilitate sharing of child/elder care responsibilities.
- Allow flexible hours and flexible schedules.

Functionally Appropriate Work Assignments

The Workplace Issues Subcommittee defines "functional limitations" as an accrual of chronic health conditions that increases the loss of function (also called functional impairment) brought on by illness or injury at any age. The Subcommittee states that the goal is to "find a place where every [nurse] who wants to work can work, despite physical limitations." The Americans with Disabilities Act (ADA) is "fundamental and a comprehensive civil rights legislation designed to protect disabled individuals from discrimination by public or private employers and to ensure that public facilities, services, and accommodations are accessible to the disabled" (Kellough, 2000). The ADA protects persons with physical or mental impairments and facilitates their employment with or without reasonable accommodation (ADA: A Guide for People with Disabilities Seeking Employment, 2000).

All persons, including nurses, are subject to forces that are unanticipated and beyond their control. Events that modify an individual's physical abilities are not necessarily ones that require a total re-direction of vocational interests. "The combined effects of genetic factors and lifelong exposure to health habits, medical problems, lifestyles, environmental factors, and sociocultural influences intensify the differences between individuals, making it difficult to absolutely predict the effects of 'normal aging'" (Engberg & McDowell, 1991).

If the healthcare system is to prevent the unnecessary loss of valuable, experienced nursing professionals, it will become imperative for healthcare facilities to craft assignments and schedules that accommodate changes in the functional abilities of older nurses and others whose functional capacity may be limited. Use of ergonomic approaches, such as appropriate and sufficient staff and technologies that help with patient lifting, could reduce injuries to nurses (and possible loss from the profession), as well as provide a safer approach to patient care (e.g., fewer patient falls).

Strategies from the Literature

Wyman discusses the physician's relationship with the functionally limited employee and the ADA. He states that when a patient has reached their maximum potential through medical and rehabilitative interventions and is still not able to perform full duties, then the patient's ability to perform "essential duties" needs to be addressed. "Essential duties" are defined by the ADA as those duties that "make up a significant part of the work or are required for safety or contingency" (Wyman, 2000). An employee may ask for "reasonable accommodation," which is defined as "any change or adjustment to a job, the work environment, or the way things are done that would allow a person to perform job functions, or enjoy equal access to benefits available to other individuals in the workplace" (The ADA Guide, 2000).

The ADA's requirement for reasonable accommodation entails changes in the physical environment and/or usual operational procedures to allow the person with functional limitations to equally access job seeking and workplace benefits available to others. This could include accessible written formats for those with visual impairment, TTY adaptation and ramps.

The literature reflects the need to retain senior nurses in the workforce. Senior nurses have the most experience and knowledge. Innovative strategies are the key to keeping them in the nursing workforce. However, studies need to be completed to identify exactly the needs and desires of these nurses. The following strategies are from the literature (Zimmerman, 2000, Krisher, 2001, Buerhaus et al., 2000, No. 3 and No. 6). The limited empirical data found during the review of the literature indicate an opportunity for research in this area.

Scheduling:

- Flexible scheduling and self-scheduling.
- Part-time positions.
- Compensation.
- Economic incentives - nurses may want to supplement Social Security Income if the salary is attractive.
- Flexible benefit plans appropriate to the senior nurse (e.g., instead of offering childcare, offer vision benefits).

Re-Arrangement of Work Responsibilities:

- Work re-engineering - offer senior RNs positions as preceptors/mentors to new graduates, or as in-house consultants to other nurses.
- Improve ergonomic conditions (consider work that requires bending, reaching, lifting, etc.).
- Offer independent work assignments - positions that nurses can perform from home, such as scheduling and some quality assurance activities.

Example from the Literature Review:

- The act of rearranging work activities is retaining some senior emergency department RNs at the Desert Samaritan Medical Center in Mesa, Arizona. Part of their time is spent writing policies or following up on patient complaints. The emergency department's nursing director states that the senior nurses' experience and perspective make them valuable in this role (Zimmerman, 2000).

Workplace Issues Subcommittee Discussion

The nurse who becomes functionally limited has several challenges in the workplace. The nurse may experience a possible loss of confidentiality as accommodations are made to allow the continuation of work. Discord among staff might occur if others feel that the functionally limited nurse is receiving more favorable treatment. The nurse may suffer from loss of esteem due to loss of employment/advancement opportunities and reduced competency. Ultimately, these may be strong enough inducements that the nurse may leave the workforce.

Patients can be affected by decreased quality in care if the nurse's limitations are not accommodated for but she/he remains employed. Decreased response time to patients' needs, or a nurse's inability to perform needed care, could lead to patient dissatisfaction or patient harm.

Strategies Discussed by the Workplace Issues Subcommittee

- Empowerment of the nurse through education and support in utilizing the American Disabilities Act.
- Clearer job descriptions that include the physical requirements for successful job functioning.
- Management and institutional leadership need to address functional limitations prior to hiring based on the requirements of the position.
- Establishment of a corporate culture and policies to support accommodating functional limitations.
- Utilization of technology to accommodate functional limitations of the nurse.
- Education and training opportunities to prepare nurses for alternate job assignments appropriate to their limitations.

Professional Recognition in the Workplace

The practice and recognition of nursing as a profession has painfully evolved over the past century. Since the first nursing theorists attempted to describe the contextual frameworks in which the processes of nursing were developed and practiced, there has been a struggle (within nursing, as well as externally) to foster an appreciation for the critical thinking, decision-making, and unique perspective of nursing. Much of the schism between nursing and healthcare administration and medicine is the difference in the approach to "care." Unfortunately, too often the varying perspectives of these facets of healthcare delivery are, at least seemingly, at odds. Though there are common goals, the health of the patient, the approach, and intervening agenda vary greatly. The result is a struggle for control, exacerbated by the need for professional autonomy and recognition among the various constituents. Following is a conceptual framework within which the perspectives could be brought into alignment (shared governance), and a model (Magnet Health Facility Program of the American Nurses' Credentialing Center). These show promise in revealing to non-nursing healthcare entities and the public the issues confronting nursing and the value of nursing in the patient care process.

Shared Governance

Porter-O'Grady (1991) presents the incongruity between the core values of nurses and healthcare administration. There is an expectation that nurses will act to keep patients safe, to provide the highest standard of service, and to adhere to certain clinical/professional standards.

Healthcare administration maintains a different set of values than nurses maintain. Per Porter-O'Grady, institutions impose their values on nurses. Nurses are viewed as the institution's employees who should only carry out the dictate of the organization. The institution and medical staff dictate the definition of nursing practice. Nurses soon learn their expected role and, in doing so, surrender autonomy (Porter-O'Grady, 1991). Nurses' low moral and job frustration are often attributed to their lack of autonomy.

> "The work of the [nursing] profession frequently is reduced to being just a job."
>
> Source: Porter -O'Grady, 1991.

Shared governance is a professional practice model that reinstates autonomy into nursing practice. Shared governance empowers nurses to incorporate their nursing values into their roles. The term "shared" means that the institution and the nurses enter into a commitment to work as partners to meet the goals of the institution while maintaining the values of nursing practice. "Governance" is defined as control gained by the nursing staff over the management of nursing practice (Smolensky, Zuzak, Adams, Mackaly, 1999, & Porter-O'Grady, 1991).

Implementation of a shared governance system in a healthcare facility requires change in the philosophy of management. Management must now relinquish control of clinical practice areas to nurses. The manager's new role is "to ensure that the necessary

human, material, fiscal, support, and organizational resources are available" (Porter-O'Grady, 1991).

Nurses are accountable for the clinical practices, which include scheduling, quality assurance, professional practice (adhering to clinical pathways/achieving outcome measures/competencies/certification, etc.), and the recruitment and retention of staff. Committees composed of nursing staff are formed to address issues, create policy, and implement operations in each area (Skubak, Earls, & Botos, 1994).

There is not a single model for shared governance: the model must be adjusted to fit the specific requirements of the clinical unit. There is ample evidence, however, that variations of this model are successful in boosting morale, increasing professional growth, and retaining nurses.

Magnet Health Facility Program

In 1990, the American Nurses Association (ANA) re-instituted a program first developed by the American Academy of Nursing (AAN) in 1982. The "magnet hospitals" were deemed attractive to nurses because they exhibited high standards in the recognition and support of professional nursing. In 1998, excellence in nursing services in long-term care facilities was added to the program (Aiken, Havens, & Sloane, 2000).

The current Commission on the Magnet Recognition Program reviews applications from health facilities seeking four-year approval. The program recognizes excellence in the following areas:

- The management philosophy and practices of nursing services.
- Adherence to standards for improving the quality of patient care.
- Leadership of the chief nurse executive in supporting professional practice and continued competence of nursing personnel.
- Attention to the cultural and ethnic diversity of patients and their significant others, as well as the care providers in the system.

A study of the characteristics of magnet facilities revealed "flat organizational structures, unit based decision-making processes, influential nurse executives, and investments in the education and expertise of nurses" (Aiken et al., 2000). The study, which compared current magnet facilities to the original AAN magnet hospitals and non-magnet institutions, showed higher patient satisfaction and lower rates of nurse burnout. More than 50 percent of nurses working in magnet hospitals were baccalaureate-prepared, compared to 34 percent nationally. These magnet hospitals employed 190 full-time equivalent (FTE) registered nurses per 100 patients, compared to 128 FTEs per 100 patients in the original AAN magnet hospitals, and 109 in community-based, non-magnet hospitals. There are currently 26 magnet facilities nationally, but there are none in Maryland.

IV. IMPLICATIONS FROM THE WORKPLACE ISSUES SUBCOMMITTEE FINDINGS AND THE LITERATURE REVIEW REGARDING POLICY AND AN APPROACH TO SCHEDULING AND LIFESTYLE ISSUES

Nurses' concerns of the workplace environment are complicated and complex. There are no quick fixes or silver bullets to address these concerns. The literature review revealed that strategies are intertwined and need to be instituted collectively if they are to be successful in recruiting and retaining nurses.

This paper has identified and documented important issues pertaining to the work life of nurses, according to those issues identified during the Nursing Summit, June 2000, and subsequently by the Maryland Commission on the Crisis in Nursing and its Workplace Issues Subcommittee. This paper is not an attempt to look at the healthcare system or the nursing shortage in an exhaustive fashion, but rather to look within the existing system at work life issues currently faced by nurses. Other subcommittees of the Commission will consider the nursing shortage from the perspective of education, recruitment, and retention. The Workplace Issues Subcommittee will develop additional papers to address other areas impacting the work life of nurses, including professional environment, regulatory issues, clinical practice delivery model/quality of care, and stress in the workplace. Eventually, healthcare delivery models may need to be reformed as societal changes and technological advances lead to improved systems of care.

Next Steps

Management philosophy and nursing values must become aligned and focus on common goals, the provision of high quality care to patients in a safe and supportive work environment for nurses, while enhancing the fiscal viability of the institution. As a first step, addressing workplace concerns must be a top priority so that nurses are enabled to perform their duties in an atmosphere that leaves them free to focus on the care of the patient. Jointly, management and nurses must identify workplace issues, plan a strategy, implement the plan, and evaluate the plan's effectiveness. Nurses are not merely "support" staff or a human resource in a monolithic healthcare delivery system, but integral constituents in the evolution of a system that is re-inventing itself to respond to the changing needs of a changing world. Without full participation of nursing and its unique perspective in healthcare, there will continue to be misunderstanding and consequent periodic ebbs in the supply of this important resource.

Many of the strategies identified by the Subcommittee and in the literature will require the development of management and leadership abilities of nurses, especially young ones. Nurses cannot be asked to simply "pull themselves up by their boot straps" and create systems that will allow, or facilitate, the changes that are alluded to in this paper. Trust between nurses and institutional administration, and nursing autonomy are topics that will be explored in more detail by other Commission subcommittees, but these are factors that are also critical to satisfaction in the work life of nurses. The solutions

suggested here (and others) must be considered, and the best options must be implemented if lasting change is to occur.

One outcome of this process must be that nurses renew and strengthen their commitment to ensure quality of care for patients and to promote professionalism within nursing. There are many and varied interests among nurses dependent upon level of practice, area of specialty, or even the type of institution in which they practice. These differences should not divide nurses in their quest to have nursing professional issues acknowledged as more than a simple “staffing” concern. When nurses are not seen as critical thinkers and decision-makers, they are relegated to numbers on a scheduling sheet. The issues presented in this paper go beyond the concern of numbers: it is the underlying or root causes of why the numbers are not greater that need to be addressed.

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