Considering the Employee Point of View: Perceptions of Job Satisfaction and Stress Among Nursing Staff in Nursing Homes

Kate L. Lapane, PhD, and Carmel M. Hughes, PhD

Objective: To document job satisfaction and sources of stress among nursing staff working in nursing homes and to evaluate the extent to which the reasons of stress differ by type of nursing staff.

Design: Cross-sectional study.

Setting: Twenty-five nursing homes in North Carolina participating in a demonstration project of a new model of long-term care pharmacy.

Participants: Nurses and nursing assistants employed at the time of the survey in the spring and summer of 2002 (n = 1283).

Measurements: Health Professional Stress Inventory modified for use in the nursing home setting and ratings of job satisfaction.

Results: The situations most stressful for nurses were not having enough staff, having too much work to do, interruptions, having non–health professionals determine how to do their job, poor pay, and ultimately being responsible for patient outcomes. The top most stressful situations for nursing assistants included poor pay, not enough staff, and too much work to do. Nursing assistants were more likely than nurses to report stress because they do not have adequate information regarding a patient’s condition. Nurses were more likely than nursing assistants to report stress because non–health professionals (eg, surveyors) determine how they must do their job.

Conclusions: The findings of this study support the need to improve recognition for nursing, improve staffing, and provide competitive compensation in nursing homes. (J Am Med Dir Assoc 2007; 8: 8–13)
members of the pharmacy team. The current study report describes measures of job satisfaction and stress among members of the nursing team prior to the implementation of the demonstration project.

METHODS

The protocol for this study was approved by the Brown Medical School Institutional Review Board. Twenty-five nursing facilities participating in the Fleetwood Phase III demonstration project provided the research team with an enumeration of the target survey respondents by staff type (nurses or nursing assistants), as well as a preference for distribution method (either directly to staff members at their home address or mailed to the nursing facility for distribution at work). The survey process consisted of up to 4 mailings each spaced 2 weeks apart: 2 copies of the survey and 2 reminder postcards. The survey packets consisted of a cover letter explaining the survey and including the elements of informed consent, as well as the procedures necessary to receive the incentive for survey completion, the survey with the unique identifier included on the survey (but not the respondent’s name), and a postage-paid return envelope. Return envelopes were addressed to the research team at Brown Medical School. The respondents were asked not to complete the survey at work. Mailings began in spring 2002 and continued throughout the fall of 2002, before the initiation of the demonstration project. We mailed $15 incentive checks to respondents. Data were de-identified at this point.

Four sections comprised the questionnaire. The sections were the following: sociodemographic items (shown in Table 1), the modification of the Health Profession Stress Inventory (HPSI; Tables 2 and 3), and a modified version of a communication-effectiveness instrument. This report summarizes our findings from the first 2 sections of the study and excludes the data on communication effectiveness. Developed by Wolfgang et al., the HPSI questionnaire asks participants to rate 30 situations on a 5-point scale (responses ranging from 1 = Never stressed to 5 = Frequently stressed). The instrument evaluates 30 stressful situations in the following domains: patient responsibility, job conflicts, professional uncertainty, and professional recognition. Because this instrument was not designed for use in nursing home settings, we evaluated the extent to which the questions were understood among nurses and nursing assistants working in nursing homes in North Carolina using cognitive interviews. The interviews were conducted with employees and took approximately 1 hour to complete. The cognitive interviews revealed that some questions were confusing within the nursing home context. These questions were modified for clarity and content. In

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Nurses n = 378 (%)</th>
<th>CNAs n = 805 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (% women)</td>
<td>364 (96)</td>
<td>746 (93)</td>
</tr>
<tr>
<td>Race/ethnicity (% white)</td>
<td>279 (74)</td>
<td>347 (44)</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>4 (1)</td>
<td>102 (13)</td>
</tr>
<tr>
<td>High school or GED</td>
<td>5 (1)</td>
<td>234 (29)</td>
</tr>
<tr>
<td>Vocational/trade school</td>
<td>64 (17)</td>
<td>97 (12)</td>
</tr>
<tr>
<td>Some college</td>
<td>100 (26)</td>
<td>312 (39)</td>
</tr>
<tr>
<td>Associate degree</td>
<td>143 (38)</td>
<td>37 (5)</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>51 (13)</td>
<td>18 (2)</td>
</tr>
<tr>
<td>Postgraduate degree</td>
<td>9 (2)</td>
<td>5 (1)</td>
</tr>
<tr>
<td>Years worked for nursing home</td>
<td>5.5 (6.2)</td>
<td>5.0 (5.6)</td>
</tr>
<tr>
<td>years worked in present position</td>
<td>6.1 (7.8)</td>
<td>6.0 (6.7)</td>
</tr>
</tbody>
</table>

Table 1. Sociodemographic Information Relating to the Respondents in this Study

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Nurses (n = 378)</th>
<th>Nursing Assistants (n = 805)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care responsibility: How often do you feel stressed . . .</td>
<td></td>
<td></td>
</tr>
<tr>
<td>because you are ultimately responsible for patient outcomes?</td>
<td>2.21 ± 0.95</td>
<td>1.48 ± 1.09</td>
</tr>
<tr>
<td>because you disagree with other health professionals concerning the treatment of a patient?</td>
<td>1.73 ± 0.80</td>
<td>1.61 ± 1.14</td>
</tr>
<tr>
<td>keeping up with new developments to do your job well?</td>
<td>1.55 ± 0.86</td>
<td>1.06 ± 1.01</td>
</tr>
<tr>
<td>because you care for the emotional needs of patients?</td>
<td>1.92 ± 0.90</td>
<td>1.96 ± 1.21</td>
</tr>
<tr>
<td>dealing with “difficult” patients (for example, behavior problems)?</td>
<td>1.98 ± 0.86</td>
<td>1.83 ± 1.03</td>
</tr>
<tr>
<td>trying to meet society’s expectations for high-quality medical care?</td>
<td>2.04 ± 1.08</td>
<td>1.64 ± 1.16</td>
</tr>
<tr>
<td>How often does caring for terminally ill patients make you overwhelmed?</td>
<td>1.48 ± 0.93</td>
<td>1.50 ± 1.05</td>
</tr>
<tr>
<td>Job conflicts: How often do you feel stressed . . .</td>
<td></td>
<td></td>
</tr>
<tr>
<td>because you have so much work to do that everything cannot be done well?</td>
<td>2.60 ± 0.92</td>
<td>2.37 ± 1.05</td>
</tr>
<tr>
<td>because there aren’t enough people working to get the work done well?</td>
<td>2.83 ± 0.97</td>
<td>2.84 ± 1.11</td>
</tr>
<tr>
<td>being interrupted by phone calls or people while doing your job?</td>
<td>2.40 ± 1.08</td>
<td>1.04 ± 1.01</td>
</tr>
<tr>
<td>because you experience conflicts with supervisors and/or managers?</td>
<td>1.48 ± 1.01</td>
<td>1.43 ± 1.15</td>
</tr>
<tr>
<td>because you experience conflicts with coworkers?</td>
<td>1.51 ± 0.94</td>
<td>1.19 ± 1.06</td>
</tr>
<tr>
<td>because you have job difficulties that conflict with your personal life?</td>
<td>1.25 ± 1.00</td>
<td>0.88 ± 1.02</td>
</tr>
<tr>
<td>supervising the performance of coworkers and students?</td>
<td>2.00 ± 0.99</td>
<td>1.03 ± 1.06</td>
</tr>
<tr>
<td>because non–health professionals determine how you must do your job?</td>
<td>2.38 ± 1.12</td>
<td>1.79 ± 1.24</td>
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</tbody>
</table>

Table 2. Stress at Work Relating to Patient Responsibility and Job Conflicts by Nursing Type, Mean ± SD
addition, this process revealed that the structure of the questions and responses required modification for this population. We modified the instrument to accommodate a lower reading level, and reworded the items to appear as questions, rather than statements. The revised questions are provided in Appendix 1. After revising the instrument, we piloted it in 1 to 2 people per employee type. The psychometric properties of the HPSI tool have been demonstrated in pharmacists13 and nurses.14,15

Descriptive analyses were performed by nursing staff type: nurses and nursing assistants. We used t tests to compare the average scores of nurses and nursing assistants.

RESULTS

Facility-specific response rates ranged from 11% to 70%, with the overall response rate being 49% among nursing staff. The overall nursing assistant response rate was 50% with facility-specific response rates ranging from 18% to 69%. Regardless of nursing staff type, over 90% of respondents were women and the average length of employment at the nursing facility was approximately 5 years. Compared to 26% of nurses, 56% of nursing assistants reported being an ethnic/racial minority. Sociodemographic information relating to the respondents is summarized in Table 1.

Tables 2 and 3 show that the situations most stressful for nurses were not having enough staff, having too much work to do, interruptions, having non–health professionals determine how to do their job, poor pay, and ultimately being responsible for patient outcomes. The top most stressful situations for nursing assistants included poor pay, not enough staff, and too much work to do. Nurses were more likely than nursing assistants to report feeling stressed because of their ultimate responsibility for patient outcomes, trying to meet society’s expectations for high-quality medical care, and keeping up with new developments to do their job well. With respect to job conflict items, nurses were more likely than nursing assistants to report stress because of conflicts with coworkers, supervisory responsibilities, and interruptions.

For items under the professional uncertainty domain, nursing assistants were more likely than nurses to report stress owing to not being accepted as a true health professional. While nurses were more likely than nursing assistants to report stress over fear that a mistake would be made, nursing assistants were more likely than nurses to report stress because they had inadequate information to deliver care to the patient (Table 3).

DISCUSSION

In our study, for both nurses and nursing assistants, a major source of stress was not having enough staff to get everything done well. Nurses reported that frequent interruptions by people and phone calls often caused stress. For nursing assistants, lack of recognition (feedback on job performance, no voice in decisions, no respect from families of patients and other health professionals) was often a source of stress. Poor pay was frequently reported as a source of stress for both nurses and nursing assistants. Despite these reports of job stressors, the overall job satisfaction was high, but less so for nursing assistants. Nursing assistants in 24 nursing homes in the US Midwest16 reported that the assistants were most concerned with the security of their jobs and the potential for growth and development.

Our study highlights that a major source of stress experienced by nursing staff is a result of not having enough people to perform duties well. Indeed, an astounding 92%
of nursing homes do not have sufficient staff to provide levels care to meet the federal regulation and practice guidelines. Recent federal requirements dictating that on a daily basis for each shift, skilled nursing facilities and nursing facilities must post nurse staffing data for the licensed and unlicensed staff directly responsible for resident care in the facility underscores the importance of staffing in the provision of quality care. While the impact of increasing staffing in the nursing home sector on patient outcomes has been documented, the additional benefits on job satisfaction and employee stress must be considered. Such factors may increase satisfaction and lower turnover. Australian researchers found that dissatisfaction in long-term care of older people arose because of working with unskilled or inappropriately trained staff and inadequate staffing levels. Dissatisfaction was also compounded by laborious tasks such as documentation and tensions within role expectations. Nevertheless, the extent to which improvements in staffing levels and mix can be implemented in the face of a nursing shortage is unknown.

An improvement in the quality of care can only be forthcoming by matching staff resources and training to the care needs of residents. In the face of registered nurse shortages, some have suggested that key services provided by registered nurses to prevent poor patient outcomes in this setting must be determined and then others should be trained to provide the services. In the current survey, 1 in 5 nurses and nursing assistants report often experiencing stress because they are unable to use all of their skills on the job. If a substitution model of care is embraced, nursing homes must provide the organizational support to permit employees to use their skills to their fullest potential. We urge caution in considering the use of nontraditional staff to provide care. Previously, we evaluated the role of medication technicians as an example of a nontraditional staffing strategy in nursing homes. Not only did we observe marked variation across states in terms of the use of these employees, their training, supervision, and regulation requirements, but also facilities that employed medication technicians had more deficiency citations for activities relating to medication errors and pharmaceutical services (which include administration of medications) than those facilities who did not employ medication technicians.

Recent reports have called for the inclusion of incentives such as higher wages and/or training subsidies to increase quality of care. While implementing higher wages may prove difficult to achieve, improved training of nursing staff for specific duties required in the nursing home settings may be a more feasible approach to improving job satisfaction and lessen the stressors experienced by nursing staff. Research has shown that there is a need to strengthen geriatric nursing as an area of specialization. Furthermore, some training strategies have been tested in terms of their impact on stress reduction in the nursing home setting. Proctor et al assessed the impact of a training program for developing skills in individual care planning for care staff on symptoms of stress and work-related pressure. Those in receipt of the program demonstrated no increase in psychological stress compared to staff who had not been exposed to the training. This approach complements that of the Institute of Medicine’s recommendations for the education of health care professionals, which would encompass the training of nursing staff in nursing home settings. These recommendations include providing patient-centered care, working in interdisciplinary teams, employing evidence-based practice, applying quality improvement, and using informatics. We are currently evaluating the extent to which an innovative clinical tool to improve the medication monitoring in nursing homes by providing training and standard monitoring reports to nursing assistants improves both patient outcomes and job satisfaction, as well as reduction of stress.

Our data should be interpreted with some caution. The original survey instrument reported on has good psychometric properties among pharmacists and geriatric nurses. Changes to factors have been called for. Despite these reports, the HPSI was not designed and tested for use among members of the nursing home team. Yet, the Cronbach’s alphas found in this study ranged from 0.78 to 0.82 revealing good internal consistency of the factors. Future research of the psychometric properties of this tool among both nurses and nursing assistants will be completed before using factors as summary scores in research. The role of response bias must be considered. Despite our inclusion of a survey incentive and multiple mailings, our response rate was not optimal. However, the sociodemographic characteristics do compare favorably to other surveys conducted in nursing home staff.

In addition, given the dynamic nature of staffing in the nursing home setting, our data provide a mere snapshot of the perceptions of nursing staff and are merely descriptive in nature. Future research will further explore any relationships between these findings and the sociodemographic variables of the sample. Finally, the extent to which the reports of the nursing staff in North Carolina reflect the perceptions of nursing staff nationwide is unknown. Although these limitations are real, we believe that these findings are necessary to begin understanding the role of the employee in the provision of quality health care in the nursing home arena. However, a review on workplace stress in nursing concluded that, generally, the main stressors that were most frequently reported by the profession (irrespective of practice setting) were workload, inadequate staff, and time pressure, which are reflected in these present findings.

CONCLUSION

Concerns regarding the quality of care delivered to approximately 1.6 million nursing home residents remain despite extensive legislative and quality improvement programs. To provide care prescribed in federal regulation and practice guidelines is a labor-intensive effort and efforts should be made to ensure that staff, particularly nursing staff, are supported in order to deliver care to a standard that is acceptable to government, the public, and of course, residents and their families.
ACKNOWLEDGMENTS

We thank Jenifer Allsworth, PhD, for her work overseeing the survey process and providing preliminary data analyses. We are indebted to our research partners and innovators of the Fleetwood Model, Janice Feinberg, PharmD, JD, and Kathleen Cameron, RPh, MPH. We acknowledge the incredible support of the membership of the American Society of Consultant Pharmacists whose donations and insight provided the momentum to bring the Fleetwood Model to fruition. We also acknowledge the committed members of our consultant pharmacy partners, Neil Medical Group. The management team working on the Fleetwood Project includes Randy Angell, Ross Brickley, Todd King, Mike List, Jim Rouk, and Danny Yates.

REFERENCES


APPENDIX 1

Stress at Work

Below, we have listed a series of job situations that health professionals may experience from time to time in doing their job. Please let us know how often you find these situations stressful in doing your job. (To each, a 5-point scale was provided for responses (Never, Rarely, Sometimes, Often, and Frequently.)

How often do you feel stressed because you have so much work to do that everything cannot be done well?
How often do you feel stressed because you experience conflicts with coworkers?
How often do you feel stressed because you do not get the respect or recognition you deserve from the families of the patients?
How often do you feel stressed because you are uncertain what to tell a patient or a family about the patient’s condition and/or treatment?
How often do you feel stressed because you care for the emotional needs of patients?
How often do you feel stressed because you disagree with other health professionals concerning the treatment of a patient?
How often do you feel stressed because you do not have the chance to share feelings and experiences about work with coworkers?
How often do you feel stressed because you experience conflicts with coworkers?
How often do you feel stressed because you have job difficulties that conflict with your personal life?
How often do you feel stressed because you allow personal feelings and emotions to interfere with the care of patients?
How often do you feel stressed keeping up with new developments to do your job well?
How often do you feel stressed because there are few opportunities for better positions at work?
How often do you feel overwhelmed trying to meet society’s expectations for high-quality medical care?
How often do you feel stressed supervising the performance of coworkers and students?
How often do you feel stressed dealing with “difficult” patients (for example, behavior problems)?
How often do you get stressed because you are not accepted as a true health professional by other health professionals?
How often do you get stressed because you are not prepared to meet the needs of patients?
How often do you get stressed because you do not have adequate information regarding a patient’s condition?
How often do you feel stressed because no one gives you feedback on your job performance?
How often do you get stressed because there aren’t enough people working to get the work done well?
How often do you feel stressed because non-health professionals (e.g., the surveyors) determine how you must do your job?
How often do you feel stressed because no one tells you what is expected to do your job?
How often do you feel stressed being interrupted by phone calls or people while doing your job?
How often do you feel stressed because no one asks for your opinion when making decisions about your job?
How often does not being challenged at work make you feel stressed?
How often does feeling that you are not paid enough make you stressed?
How often does caring for terminally ill patients make you overwhelmed?
How often do you feel stressed because you are not able to use all of your skills on the job?
How often do you feel stressed because you are afraid a mistake will be made in the treatment of a patient?