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IDENTIFICATION AND RANKING OF STRESSORS SPECIFIC TO THE ACUTE CARE HEAD NURSE

by

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B.S.N. Old Dominion University, 1980

A Thesis Submitted to the Faculty of
Old Dominion University in Partial Fulfillment of the
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MASTER OF SCIENCE

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APRIL, 1991

Approved by:

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ABSTRACT

IDENTIFICATION AND RANKING OF STRESSORS SPECIFIC TO THE ACUTE CARE HEAD NURSE

Joan A. Breen
Old Dominion University, 1991
Director: Dr. Gregory H. Frazer

The purpose of this study was to identify the most significant stressors specific to the head nurse role. A random sample of 85 head nurses was used to generate a list of 63 stressors specific to the head nurse role. Sixty - three randomly selected head nurses responded to a questionnaire which asked the head nurse to rate the relative stressfulness of each of the 63 items on a scale from 0 - 1000. Data from the responses indicated that demands of paperwork/meetings/ task forces/projects, nurses performing too many non - nursing functions, unrealistic expectations of nursing, unrealistic workload of staff nurses, and inadequate budgeted FTEs were the most significant stressors encountered by head nurses. The reliability of the ranking questionnaire was .98 as determined by Cronbach's alpha. Pooled variance t-tests and its representative subgroups indicated differences on the individual scales but not on the composite instrument. Results of this study may be used by hospital administrators, nursing administrators, nursing directors, and head nurses to identify stressors specific to the head nurse role. Once

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CHAPTER ONE

INTRODUCTION

According to Selye (1956), stress is a specific state which comprises a variety of induced changes in the human biological system. Stress was seen as a syndrome with its own characteristic form and composition. Stress is an accepted part of everyday life, it produces both positive and negative responses. In Selye's General Adaptation Syndrome Theory, the body adapts to the stresses of everyday life through a series of neural and hormonal changes in an attempt to maintain homeostasis, a "healthy" balance of structure and function (Selye, 1956). When the stimulation or stress exceeds the body's ability to adapt, both psychological and physiological illness may occur (Polworth, 1985). Some examples of stress induced diseases and or illnesses may include colitis, ulcers, stomach pains, nausea, coronary heart disease, hypertension, arrhythmias, alcoholism, drug abuse, sexual dysfunction, depression, anxiety, insomnia and suicide. (Cooper & Marshall, 1976; Elek, 1977; Numerof, 1983; Umiker, 1985; Leppanen & Okinuora, 1977).

Lazarus (1976) looked at the stress phenomenon in terms of interaction between a person and his environment. Lazarus saw the person with all his attributes both inherited and acquired, interacting with the environment.

While recognizing environmental stimuli, and the effect upon the reacting individual, he emphasized that it is the nature of the relationship of that interaction that is crucial. He felt that in the final analysis stress depends upon the perception of the individual and upon the appropriateness of their physical and cognitive coping abilities. The intensity of the stress experience is determined by the degree of perceived threat, i.e. how well the person feels he can deal with the danger he has identified. Lazarus suggests that if the individual has confidence in his coping abilities then the threat is likely to be minimal. however if the person is unsure of these abilities he is likely to feel helpless and may become overwhelmed by the threatening situation. Many researchers today are in agreement that perception is a significant factor in an individual's interaction and reaction to their environment (Polworth, 1985).

In a complex society work occupies a central role in a person's life. It plays a major role in one's past, it determines one's present, shapes one's future. Not only does it dictate the quality of the life-style, but it also provides a major means of personal identity and self realization (Hingley & Cooper, 1986). It is not surprising to find that life in the work setting can prove to be a great source of stress. In any occupation there will be a large number of potential stressors. Stress in the work place is a very complex issue in which individual

differences in perception and response will determine the outcome. The cost in terms of physical and mental ill health is a cost borne not only by the individual, but by the organization in which he/she operates, and by society in general. But it is not limited to the work area alone, as work-induced stress will eventually feed into his/her domestic life, which in turn has the potential for affecting the whole quality of family life (Hingley, & Cooper, 1986).

During the past decade there has been increasing interest in the study of stress in nursing; however most of this research has emphasized the stress experienced by staff nurses in special care areas such as intensive care units, coronary care units and operating rooms (Reres 1972, Reichle 1972). Those nurses occupying leadership positions, such as head nurses not only have the clinical stress to deal with, but at the same time they are exposed to the stress that is usually associated with managerial positions (Katz & Kahn 1966).

The role of the head nurse is decidedly different today, than it was a decade ago. The head nurse today is the pivotal person in nursing care, nursing administration, and nursing education. She is responsible for the smooth functioning of her unit. She accomplishes this through fiscal responsibilities, involvement in policy development on a departmental level (also has input on an administrative level), implements the philosophy of the institution on the operational level and is clearly responsible for quality

patient care which is cost effective (Ehart, 1990). The head nurse role has been described by various authors as stressful or potentially stressful (Darling & McGrath, 1983; Alderman, 1985; Gleeson, Nestor, & Ridell, 1983). Jennings (1986) reported that there have been very few research studies to support this contention and more research was needed.

STATEMENT OF THE PROBLEM

While research has attempted to identify the specific stressors in nursing (Numerof, 1984; Nicholson, 1990). There is a limited amount of information concerning specific stressors related to the head nurse position. Since the department of nursing in an acute care hospital is usually one of the largest, the need for competent nursing managers has become critical (Stevens, 1981). Hospitals find themselves in the midst of a nursing shortage, and a shortage of nursing managers was evident by a recent survey conducted by the Association of Nurse Executives (1990). In which they reported that the national vacancy rate was 6.8%. Regional differences were reported as low 2.9% and as high 13.5%. They also reported that 10.2% of the nurse managers participating in the survey (500 nurse managers) were planning on leaving their positions within the next six months, and 40% of them were not willing to return to another management position. Hospitals must not only

attempt to recruit competent nurse managers, but more importantly, they must retain the ones they currently employ.

PURPOSE

The purpose of this study was to identify the work site stressors of head nurses, and to determine the relative amount of stress exerted on these professionals by these stressors.

ASSUMPTIONS

The following assumptions are present in this study:

1. The work of site of the head nurse is stressful.
2. Head Nurses are capable of identifying stressors in the work environment truthfully.
3. The instrument used to identify work site stressors specific to the head nurse in the workplace is valid and reliable.
4. Individuals responded to their identification honestly.
5. Individuals responded to the ranking questionnaire honestly.

LIMITATIONS

The limitations of the study are as follows:

1. The number of head nurses responding to the study was limited to the number employed by acute care facilities.
2. The area of nursing practice of the respondents is not known.
3. The head nurses participation in the study was dependent upon the cooperation of the Vice-President/Director of Nursing of the hospital.

DELIMITATIONS

The delimitations of the study were as follows:

1. Data concerning the identification of stressors was collected from head nurses currently employed in the Tidewater area, Richmond area, Northern Virginia area, and from the mid region of the Commonwealth of Virginia.
2. Participation in the study was voluntary.
3. Identity of the respondents was unknown.
4. Confidentiality of the responses for each participant was maintained.

5. Data was collected over a three week period.

DEFINITION OF TERMS

Head Nurse The nurse appointed by the hospital organization to oversee the day-to-day operations of one patient care unit, generally, and who has responsibility and accountability for the quality of nursing care delivered to the patients housed on the patient care unit as well as for the personnel and material resources utilized by the unit. The head nurse carries out periodic performance evaluations of the staff assigned to the unit and has input into hiring, firing, counselling, and promotion of employees on the unit Other labels or names commonly associated with the position are nurse manager, clinical coordinator, and patient care coordinator. (Alderman, 1985)

Stress - is a specific state which comprises a variety of induced changes in the human biological system.(Seyle,1956)

Stressor - a stress producing agent, a stimulus. (Seyle,1956).

Role Expectations - are the collections of cognitions, beliefs, subjective probabilities, and elements of knowledge which specify in relation to complementary roles the rights, duties, and appropriate conduct for persons occupying a particular position (Hardy, 1978).

Role Ambiguity - is a condition which an individual experiences when role expectations are not clear, or are vague, ill-defined and inconsistent (Hardy, 1978)

Role Conflict - is a condition that is experienced by an individual when expectations for his role performance are incompatible, mutually exclusive or contradictory (Hardy, 1978).

Role Overload - is a condition that exist when an individual is confronted with excessive role demands, all of which individually he can complete competently, but which together he is unable to carry out in the time available (Hardy,1978).

Role Set - refers to different groups of individuals that a subject must interact with while performing a specific role. This includes all role relationships directly involved with a particular social position. The groups may include one or more individuals of like or similar role functions and for head nurses may include such groups as staff nurses, physicians, ancillary staff etc. (Alderman, 1985).

CHAPTER TWO

REVIEW OF THE LITERATURE

This chapter provides a review of the literature relevant to the current study. The chapter will review four important concepts: Role of the Head Nurse, Occupational Stress in Health Care, Nurses & Stress, Head Nurses & Stress.

Role of the Head Nurse

The role of the head nurse today is far different from what it once was. Traditionally, the head nurse was responsible for directing and supervising clinical decision making on a patient care unit. The head nurse also supervised and managed nursing personnel who were assigned to that particular unit. Basically, he/she received direction from nursing service and did pretty much what he/she was told.

The head nurse of today is responsible for managing a multi-million dollar department. The individual head nurse has the authority, the responsibility and the accountability for the administrative, clinical, and human resource management and development of a specific patient care area. The head nurse is a pivotal position that links management with

nursing care. He/she is instrumental in bringing the mission, the philosophy, the goals, and the objectives of the institution to the operational level. The head nurse is the primary gate keeper for effective, efficient care of the patient in an acute care institution (Report from AONE Survey, 1991). The emerging role for head nurses is one of a middle manager (Ganong & Ganong, 1975; McPhail, 1978; Stevens,1974). O'Donnovan (1976) recognizes middle managers as integrators, the funnel through which intentions of top management flow down, and information about the organization flows up. However, numerous problems intrinsic to the role of middle managers have been documented (Bradford & Cohen, 1984; Katz & Kahn,1978). The effective job performance of middle managers is often dependent upon activities of other people (Bradford & Cohen, 1984: Uyterhoven, 1983). Dependence on other people and things not directly under the managers control is one of the biggest frustrations reported by middle managers (Kotter, 1983). Since middle managers must accomplish their goals largely by managing relationships, there are few things a manager can do alone. The task of the middle manager is threefold: to act as a subordinate, a peer and a superior (Uyterhoven, 1983). Baker and Ganti (1980) describes the head nurse as one "who is expected to be all things to all people". To his/her staff the head nurse is teacher, mentor, leader, decision maker, advocate, spokesperson, representative. To the patient, the head nurse may be "the nurse" who can solve any

immediate problem. From the supervisor's perspective the head nurse is the implementor of hospital policy and procedure, the manager of patients and personnel, and the coordinator of goals and objectives. The medical staff sees the head nurse at different times as: one of the staff nurses; one to communicate displeasure or give instructions and/or as a person to collaborate with.

Occupational Stress in Health

A potential stressor associated with the organizational role and of particular concern to the 'caring' professions is the responsibility for people rather than things. An early study by Wardell (1964) found that those in his sample who were responsible for people were significantly more likely to develop cardiovasular heart disease than those responsible for things. In a more recent study Leppanen and Olkinoura (1987) identified five major sources of stress for health care workers:

1. Work content - Individuals who enter the health care field usually have a tendency to have a strong desire to help people. Health care professionals find themselves working with a segment of society who are seen to have problems. These may be social, psychological, or physical. Working with diseased, disabled and sick people is a very stressful undertaking. Also, when the work content is or is perceived to be beyond the individual's ability, qualitative

overload can occur causing stress (Leppanen and Olkinoura, 1987).

2. Work Organization - Is concerned with the efficiency and effectiveness of the planning and organization of the work area. Work overload is caused by anyone of a number of situations, too much work to perform, not enough time to complete one's work, insufficient staff (this can be in terms of numbers; or qualified staff), insufficient and/or inadequate equipment (Leppanen and Olkinoura, 1987). Shift work, irregular hours, 24 hour call and emergencies are all part of everyday life of a health care environment, nevertheless they produce stress for the individuals who work with in that environment.

3. Responsibility - This area is receiving more and more attention in health care, when responsibility is "unclear and undefined" it can produce varying amounts of stress (Leppanen and Olkinoura, 1987). The very nature of their work health professionals are clearly responsible for the health, comfort, safety and in many instances the lives of their patients, this has been identified as a key stressor. Patients can be difficult, aggressive, dependent, fearful, and confused. More and more individuals in the health professions are held legally accountable for their own actions.

4. Role Conflict/Ambiguity - Are the duties and expectations of the job clearly defined ? When the job and/ or role are ill - defined or vague individuals will

experience stress. Role conflicts usually arise when one own expectations are incompatible with others in the organization, or as one attempts to satisfy a number of incompatible demands arising from other people's expectations of the specific role. With increasing technology, controversial social issues, and protocols, experimental procedures and life - sustaining measures, individuals in health care find themselves dealing with increasingly difficult, and complex issues and situations at work, where their personal values may be in direct conflict with their work responsibility.

5. Career Development - The rapidity of technological change and its effects on the health care field requires health care workers to keep their skills and credentials up-to-date through some type of continuing education program. These programs can be voluntary or they can be mandated and controlled by the governing body of the specific health care field, or they may be required or encouraged by the employing organization.

Nurses and Stress

Ivancevich and Matteson (1980) conducted a survey to identify job factors that create stress for nurses. A Stress Diagnostic Survey was devised to assess which job factors create stress for nurses. The survey contained two types or categories of stressors: (1) an organizational set

of stressors which looks at those factors that are part of the hospitals policies, and procedures. Areas included in this category are politics, communications, and rewards. (2) the other category a job set of stressors specified those factors that are inherent to the job itself. Areas included role conflict, role overload, and responsibility for people. The survey indicated that the five most stressful stressors from the organizational categories were:

1. Human Resource Development
2. Politics
3. Working Conditions
4. Rewards
5. Communications

The human resource development category was described as the support the hospital administration demonstrated in regards to the professional development and growth of its nurses. The political stressor items focused on the political power plays occurring between supervisors, nurses, physicians and administrators. These were the two categories with the highest mean values for hospital stressors.

The five most stressful areas from the job level categories were:

1. Responsibility for people
2. Time pressures
3. Role conflict
4. Relationships with other nurses

5. Relationships with superiors

Time pressure was also identified as a significant stressor. The lack of well developed policies concerning scheduling, staffing, and/or minimal staffing, the impact of call-ins, lack of in-house staffing pools to cover staffing shortages, conflicting demands from physicians, patients, and supervisors all have an impact on the individual nurse finishing her work assignment in a timely manner.

In 1983 Numerof and Abrams conducted an empirical investigation of stressors in nursing, 154 nurses participated and the most frequently noted stressors were as follows: (Numerof and Abrams, 1983)

1. Dealing with patient's families
2. Inadequate staffing
3. Work load
4. Responsibility for patients
5. Insecurity or lack of confidence to perform job
6. Interpersonal conflicts with administrators, physicians, and other nurses

Nursing Stress Inventory (NSI) scores were computed and measured for frequency and sources of stress. This study suggested that experienced stress is not just a function of frequency or degree of stress, but a combination or interaction of these two factors. Nurses described the existence of chronic stressors, by associating them as ongoing and identifying them with mild to moderate amounts

of stress. Numerof (1983) suggested that such ongoing stressors seem to have a cumulative effect which may be as serious or even more serious than the effect of more dramatic stress events.

A Nursing Stress Scale was developed in 1981 to measure the frequency and sources of stress among nurses by Gray - Toft and Anderson. Seven major factors of stress were identified within three major environments:

1. The Physical Environment
2. The Psychological Environment
3. The Social Environment

There was a single factor identified in the physical environment, work load. The work load stressor included lack of qualified staff, scheduling problems, having too large of patient assignment, and lack of sufficient time to complete one's work assignment.

Within the psychological environment the stressors involved the responsibilities of working with patients. Six factors were identified: dealing with death and dying, performing painful procedures on patients, insufficient training to deal with the patients emotional needs, lack of peer support in regards to venting frustrations and sharing experiences, uncertainties about treatment plans due to poor communications with physicians, and dealing with emergency situations prior to physician arrival.

In the social environment, the major factor identified was interpersonal conflicts and criticisms. These included

nurse - physician conflicts, nurse - nurse conflicts, and nurse - administration conflicts.

The Health Professions Stress Inventory conducted in 1988 in which 1,242 health professionals participated found that the mean stress score for nurses was higher than that of other health professions, which supported earlier findings by Wardell (1964) and Caplan (1970).

Head Nurses and Stress

A Canadian study of 153 head nurses from nine different specialities across nursing, provided findings which suggested five types of stress; relating to their administrative role, type of patients, task ambiguity, staffing, and physician contact. (Leatt & Schneck, 1980)

Role - related stressors, or administrative role indicators included insufficient resources, conflicting demands, unclear responsibilities, personality conflicts, insufficient knowledge, staffing, workload, and crises.

Task - related stressors were viewed in relation to patients and physicians. Indicators of patient - related stressors were if the patient's behavior was a problem, prognosis poor, the age of the patient, (It was reported that the older the patient was, the more sressful it was) the patient was dying, the nursing care painful, and the patients family being upset and/or not informed of patients' condition. Indicators for physician - related conditions

were if the physician was available or not communicating and if the physician was critical.

The nine speciality areas in which the head nurses practiced were: medical, surgical, intensive care, pediatric, rehabilitation, psychiatric, obstetrical, and medical/surgical units.

The results showed that there was no significant differences in 20 of the 21 items measuring stress among the head nurses across the different nursing specialities. The one variation was concerned with patients families being upset, pediatric head nurses rated this area more stressful. The authors also look to see if there was a difference in the perception of stress by the head nurses based on speciality area, age, experience, and education. The results showed that those factors had little or no effect on the perceived stressfulness of the events. The highest agreement among the head nurses was relating to crises. The highest source of stress was related to physicians not being available. Another interesting finding in this study was that the perceived frequency of occurrence of stress situations varied considerably from the perceived level of stress associated with each event. The high sources of stress did not necessarily occur frequently.

In a more recent study, Alderman (1985) looked at Role Conflict and Role Ambiguity among head nurses in acute care hospitals. Seventy - two head nurses took part in the study, two research questions were posed: what factors are

associated with role conflict and role ambiguity as experienced by head nurses in acute care hospitals?, and what problems do head nurses describe in relationship with their head nurse role?

Findings revealed that the head nurses in the sample reported significantly higher levels of role conflict than ambiguity. The source of conflict most frequently described in the study was incompatible demands between administrative role responsibilities and clinical role responsibilities.

The finding of greater levels of role conflict, than role ambiguity for head nurses in this sample supported earlier studies by Hamner and Tosi (1974) which suggested that organizational level is a factor in the experience of role conflict and role ambiguity.

Role conflict was identified at lower and middle levels of the organization as a more important phenomenon relative to job satisfaction than ambiguity.

Head nurses who were interview reported working conditions, interpersonal relationships, and interpersonally factors as contributing elements in their experience of role conflict and ambiguity.

Role conflict is a greater role stressor to the head nurses in this sample, than role ambiguity, and is associated with span of control, education (a degree) in a discipline other than nursing, working conditions, interpersonal relationships with physicians and staff nurses, and intrapersonal issues of self esteem. Tenure in

the head nurse role appears to reduce but not completely resolve the experience of role conflict.

Some role ambiguity did exist although it was not reported as significant as conflict. It sources were: lack of communication, job security, changes in the role, and little or no feedback on their performance. These experiences were related to their supervisors, and attributed to inadequacies in that relationship.

A study of a 193 head nurses in Alabama (Pilon, 1988) provided an overview of the relationship of organizational, interpersonal, and personal factors in relation to role ambiguity, role conflict, and role strain. The results are as follows:

The type of hospital in which the head nurses practiced was associated with role conflict. Head nurses working in for - profit hospitals experienced high levels of role conflict. Education level was associated with the amount of role stress. Diploma prepared nurses experienced lower stress than professionally prepared nurses.

Age of the head nurses was only related to ambiguity. As head nurses aged, role ambiguity decreased. Conflict and stress showed no relationship to stress.

The number of employees reporting to the head nurse was related positively to ambiguity and conflict for the less experienced head nurses (2 yrs. or less), but not to role stress. Also with the less experience head nurses,

interaction with their staff as well as with their diverse role set was related to role conflict.

Personality was associated with role ambiguity, but not with role conflict in the overall study; with the less experienced head nurses introverts experienced higher levels of both ambiguity and conflict

SUMMARY

The major stressors common throughout nursing have been described as; interrelationships, organizational issues, resources, work content, operational/situational, role conflict/ambiguity, responsibility, work environment, and career development. Certainly, the nature of the role changes that have taken place in the last several years, and the anticipation of the changes that head nurses will be facing in the future, hospital administrators must focus on the specific stressors that have such far reaching consequences on this specific group of nurse managers.

CHAPTER THREE

METHODS

This chapter provides a discussion of the methodology used to conduct this study. The topics include the following: research questions, selection of sample, instrumentation and procedures used to administer the instrument to the sample population. And lastly analysis of data is discussed.

RESEARCH QUESTIONS

The purpose of this study is to identify the work site stressors of head nurses and to determine the relative amount of stress exerted on these professionals by these stressors.

Two research questions were generated from this statement of purpose:

1. What are the most significant stressors specific to the head nurse role in the workplace as perceived by head nurses who are currently practicing?
2. What is the relative stressfulness of each of these worksite stressors?

SELECTION OF SAMPLE

One hundred and fifty questionnaires were sent to fifteen hospitals across the state of Virginia. The Vice President/Director of Nursing from each of the selected hospitals was invited to have his/her head nurses participate in the study. Head nurses were asked to identify five of the most significant stressors they encountered in the workplace during their normal work day. Eighty five or 56.6% of the questionnaires were returned completed. The responses were listed and then consolidated, yielding a total of 63 items.

For the second part of this study, two hundred questionnaires were sent to seventeen hospitals from the state of Virginia. The hospitals were selected at random from the Virginia Hospital Association listing in the Southeastern Hospital Conference Directory 1990. This directory reflects all the hospitals in the state of Virginia. The head nurses were asked to rank the 63 stressors previously identified. The head nurses were selected by the Vice President/Director of Nursing from the participating hospitals. Sixty three or 31.5% responded to the second part of the study.

INSTRUMENTATION

Two questionnaires were developed via a Modified Delphi technique. The first questionnaire asked each head nurse to identify the most significant stressors encountered in the workplace specific to the head nurse role. This questionnaire is presented in Appendix A.

The second questionnaire asked each head nurse to compare each of the 63 stressors listed to the stress of having inadequate time/staff to provide continuing staff development/education for staff. The head nurses were to assign a numerical value between 0 and 1000 to each of the stressors. If the stressor listed was less stressful than having inadequate time/staff to provide continuing staff development/education for staff, the head nurse was instructed to rate it between 1-499. If the stressor listed was equally as stressful as having inadequate /education for staff, it was to be rated as a 500. Items which were perceived as more stressful than having inadequate time/staff to provide continuing staff development/education were to be rated between 501 and 1000. If the activity was not considered stressful, the head nurse was instructed to record a 0. The second questionnaire, cover letter, and demographic form are presented in Appendix B. This questionnaire methodology was used to identify stressors

specific to the head nurse role, and then to rate the stressfulness of each of these stressors.

PROCEDURES

The initial questionnaire was mailed to fifteen hospitals throughout the State of Virginia on November 26, 1990. All items reported on the initial 85 questionnaires were listed and similar items were grouped. The questionnaire eventually provided a list of 63 specific stressors.

The second questionnaire was developed and contained a list of 63 stressors in no specific order. Head nurses were instructed to complete the form by rating each stressor item from 0-1000. The respondents were also asked to indicate the number of times each particular item had been a stress to them during the last six months, to indicate whether or not they had control of the stressor by placing a check mark in the appropriate place. And lastly, each head nurse was asked to complete a demographic data sheet and return all forms using an enclosed self-addressed envelope. This questionnaire was mailed out February 3, 1991 and was to be returned by February 25, 1991.

CRONBACH'S ALPHA

Cronbach's alpha is a measure of internal consistency which provides a reliability estimate requiring only a single instrument administration. The value for alpha can vary between .00 and 1.00. Cronbach's alpha describes the relationship between interitem correlation and overall sample variance (Carmines & Zeller, 1979).

FACTOR ANALYSIS

Factor analysis is used to discover patterns among variations in values of several variables. This is done through the generation of artificial dimensions (factors) that correlate highly with several of the real variables and that are independent of one another. These factors can be divided into two areas: those that are common to two or more variables and those that may be unique to each variable (Kim & Mueller, 1978). Common factors are the unmeasured or hypothetical, which are underlying variables and the source of variation in at least two observed variables. Communality is the variance of an unobserved variable accounted for by the common factors (Kim & Mueller, 1978). Communality measures the variability within responses to an item explained by its association with the remaining variables observed. An eigenvalue or characteristic root is

a mathematical property of a matrix. It is used in relation to the decomposition of a covariance matrix, both as a criterion of determining the number of factors to extract and as a measure of the variance accounted for by a given dimension (Kim & Mueller, 1978).

t-TEST

The t-test is used to determine whether the difference between two sample means is significant. This is especially useful with small samples if the assumptions of randomness, a normal distribution, and interval level of measurement are met (Champion, 1981).

SUMMARY

This chapter discussed sample selection, instrumentation, procedures, and data analysis that were used in this study. The group of head nurses that generated the initial list of stressors, and the group utilized to rank the 63 stressors, were selected randomly from the Virginia Hospital Association listing in the Southeastern Hospital Conference Directory 1990. Analysis of the data was performed on the IBM 3090 computer using the SSPS-X Information Analysis System.

CHAPTER FOUR

ANALYSIS OF RESULT

This chapter includes an analysis of the data collected from the survey and is divided into four sections:

1. Sample characteristics
2. Demographics
3. Instrument reliability
4. Research questions

SAMPLE CHARACTERISTICS

Permission to collect data from head nurses was sought from 20 hospitals chosen randomly from the Virginia Hospital Association listing in the Southeastern Hospital Conference Directory 1990. The Vice-President/Director of Nursing was contacted by mail or in person from each facility. It was the Nursing Administrators' decision to invite their head nurses to participate in the survey. Two hundred questionnaires were sent or delivered to the 20 hospitals. A response rate of 31.5% was achieved with 63 head nurses responding to the survey. Of the 63 responses, some items on the survey form were not filled out. In discussing the results those missing responses will be identified.

DEMOGRAPHICS

The respondents were 94.4% female (n=51) and 5.6% male (n=3). Nine respondents did not fill in a response. The findings revealed that the average number of years in the nursing profession was 16.9 (3.2%), with a range of 4 to 38 years of experience. There were 62 valid responses and 1 missing response. The average number of years' experience as a head nurse among the participants was 6.8 (6.7%), with a range of 1-23 years. Eighteen respondents reported having 2 years or less experience in the head nurse role (1 yr.-15.9% & 2 yrs.-12.7%). The majority of respondents reported that there were 10 head nurses at their facility (20.6%) and 10 (15.4%) reported that their hospital employed 12. Hospital size was determined by having the participants report the number of beds that the facility was licensed for. Of the 61 respondents who indicated that the number of beds at their facility, 1 (1.6%) reported a size of less than 100 beds, 15 (23.8%) with 100-199 beds, 15 (23.8%0 with 200-299 beds, 18 (28.6%) with 300-399 beds, and 12 (19%) with 400-499 beds.

The average number of staff personnel reporting to the participants in the survey was 29.5. The hours per pay period (80 hours) that the participants <u>routinely</u> spent on the job: 4 (6.3%) spent 120 hours at the workplace, 13 (20.6% spent 110 hours at the workplace, 11 (17.5%) spent

100 hours, 18 (27%) spent between 90 and 98 hours at the workplace. The remainder spent less than 89 hours per pay period at the workplace.

Most of the head nurses were married, (n=43, 68.3%), 11 (17.5) were divorced, and 8 (12.7%) were single. The average age range for the respondents was 39-42 years old (22.2%) with 6 (9.5%) reported an age of 29 or less, 10 (15.9%) were from 30-35 years of age, 6 (9.5%) were from 30-38, 16 (25.4%) were between 43-48 years of age, and 9 (14.8%) were over the age of 49.

The basic nursing preparation was reported as follows: 29 (46%) were diploma graduates, 10 (15.9%) of the respondents reported an associates degree preparation, and 20 (31.7%) had a bachelor's degree as their entry level into nursing. With regard to the highest educational level attained, the respondents reported that 15 (23.8%) had diplomas, 7 (11.1%) had associates degrees, 18 (28.6%) had bachelor's degrees, 9 (14.3%) had master's (nursing) degrees, and 5 had degrees in other fields.

All of the respondents except two reported having 24-hour responsibility for their units/work areas. The majority of the respondents earned between $30,000 and $34,999, with 16 (25.4%) reporting this salary range. Twelve (19%) earned between $35,000 and $39,999 per year. Thirteen (20.6%) reported a salary of between $40,000 and $44,999 a year. Fourteen (22.2%) reported yearly earnings of between $45,000 and $44,999. The remaining 7 respondents

(11.1%) earned over $50,000 a year with 2 of these individuals earning $55,000 plus.

INSTRUMENT RELIABILITY

The internal consistency for the 63 stressors, as measured by Cronbach's alpha was .98. Babbie (1988) noted that the coefficient alpha is the average value of the alpha coefficients created by all the possible combinations of questionnaire items divided into hypothetical half-tests. Alpha coefficient values range from 0.00 to 1.00. An alpha value of 1.00 indicates the most reliable instrument. Carmines and Zeller (1979) concludes that alpha values must be greater than .70 for a scale to be considered to be reliable. Internal consistency estimates were also generated for the seven significant factors and ranged from .94 to .82. The reliability estimates are presented in Table 1.

RESEARCH QUESTIONS

In this section the research questions are restated and a discussion of their respective results are included.

1. What are the most significant stressors specific to the head nurse role in the workplace as perceived by head nurses who are currently practicing?

One hundred fifty questionnaires were sent to 15 hospitals throughout the State of Virginia. Head nurses from these hospitals were asked to identify up to five of the most significant stressors they encountered in the workplace. Eighty-five (56.6%) responded to the initial survey and generated a list of 167 stressors. This list was then compared, categorized, and classified into groups of similar stressors. From this list of 167 stressors, 63 separate stressors were identified. These 63 stressors were used to produce the rating questionnaire which was then sent to the sample group of head nurses. The list of these 63 stressors, the results of their mean ratings and relative value can be found in Table 2.

2. What is the relative stressfulness of each of these worksite stressors?

The ten most significant stressors specific to the head nurse role were identified as follows: Demands of paperwork/meetings/task forces/projects ($\underline{M}$ = 805.524; R.V. = 100) followed by nurses performing too many non-nursing

functions ($\underline{M}$ = 750.397; R.V. = 93), unrealistic expectations of nursing (by administration) ($\underline{M}$ = 683.730; R.V. = 85), workload of staff nurses unrealistic ($\underline{M}$ = 665.063; R.V. = 83), inadequate budgeted FTEs ($\underline{M}$ = 658.905; R.V. = 82), impact of head nurse position on home life ($\underline{M}$ = 651.952; R.V. = 81), physical and mental impact of head nurse position ($\underline{M}$ = 635.063; R.V. = 79), being held accountable to an unrealistic budget ($\underline{M}$ = 617.032; R.V. = 77), insufficient pay scale for head nurses ($\underline{M}$ = 613.516; R.V. = 76), inadequate communication ($\underline{M}$ = 611.349; R.V. = 76). The least stressful stressors were lack of head nurse skills related to maintenance of staff morale ($\underline{M}$ = 267.603; R.V. = 34), followed by lack of head nurse skills related to delegation of tasks and responsibilities ($\underline{M}$ = 269.032; R.V. = 34), followed by lack of head nurse skills related to job counselling/evaluation process ($\underline{M}$ = 270.381; R.V. = 34), conflicts with immediate supervisor ($\underline{M}$ = 278.492; R.V. = 35), lack of head nurse skills related to house supervision ($\underline{M}$ = 300.410; R.V. = 37), inadequate orientation of new nursing graduates ($\underline{M}$ = 310.556; R.V. = 38), role of head nurse misperceived by the ancillary personnel ($\underline{M}$ = 316.651; R.V. = 39), inappropriate orientation of staff nurses ($\underline{M}$ = 323.603; R.V. = 40), rotating to house supervision ($\underline{M}$ = 330.833; R.V. = 41), and lack of an adequate recruitment/retention program ($\underline{M}$ = 335.016; R.V. = 42). The mean rating on all 63 items was 488.1. The 63 stressors are well dispersed with 35 ranking higher than the mean and 38

TABLE 2

Mean Ratings and Relative Values of Head Nurse Stressors

Stressor	Mean Rating	Standard Deviation	Range	Relative Value
Demands of paperwork/ tasks forces/projects	805.524	282.865	0-1,000	100
Nurses performing too many non-nursing functions	750.397	272.374	0-1,000	93
Unrealistic expectations of Nursing	683.730	269.339	0-1,000	85
Work load of staff nurses unrealistic	665.063	324.286	0-1,000	83
Inadequate budgeted FTEs	658.905	377.672	0-1,000	82
Impact of head nurse position on home life	651.952	324.286	0-1,000	81
Physical and Mental impact on home life	635.063	314.876	0-1,000	79
Being held accountable to an unrealistic budget	617.032	334.272	0-1,000	77
Insufficient pay scale for head nurses	613.516	371.283	0-1,000	76
Inadequate communication	611.349	220.323	100-1,000	76
Unrealistic expectations by nursing administration	611.111	373.459	0-1,000	76
Budget constraints that negatively impact patient care	604.571	357.442	0-1,000	75
Head nurse not considered in decision making process	595.206	305.374	0-1,000	74
Impact of call-ins	584.143	297.949	0-1,000	73
Pressure of maintaining appropriate unit standards	581.730	315.600	0-1,000	72
Chronically unfilled FTEs	579.381	412.561	0-1,000	72
Indecisive, crisis-oriented priorities	571.159	279.476	0-1,000	71

TABLE 2 (cont.)

Stressor	Mean Rating	Standard Deviation	Range	Relative Value
Lengthy delay in approval processes	561.286	268.219	0-1,000	70
Lack of skills required to prepare a budget	561.095	360.943	0-1,000	70
Increasing responsibility with no increase in authority	554.048	362.631	0-1,000	69
Lack of professionalism of staff nurses	544.540	334.846	0-1,000	68
Consistently demanding physicians	541-565	374.112	0-1,000	67
Inadequate nursing management orientation and training	540-857	378.313	0-1,000	67
Pressure of being caught between staff and hospital administration	538.873	330.012	0-1,000	67
Juggling management and clinical responsibility	536.921	308.933	0-1,000	67
Lack of administrative support for education	532.492	343.341	0-1,000	66
Personal conflict when expected to implement changes that you do not agree with	520.270	304.793	0-1,000	65
Inappropriate work ethic of staff nurses	514.381	370.560	0-1,000	64
Disciplinary action related to specific job behaviors	512.889	327.337	0-1,000	64
Dealing with patient family complaints or unrealistic expectations	507-905	326.487	0-1,000	63
Role of head nurse misperceived by the hospital administration	503.968	371.901	0-1,000	63
Doubling as charge nurse/staff nurse	498.413	399.190	0-1,000	62

TABLE 2 (cont.)

Stressor	Mean Rating	Standard Deviation	Range	Relative Value
Role of head nurse misperceived by nursing administration	498.381	399.921	0-1,000	62
Multiple unjustified complaints by physicians	493.476	376.479	0-1,000	61
Professional conflicts when expected to implement changes	489.444	256.534	0-1,000	61
Unsupportive hospital administration	485.349	274.392	0-1,000	60
Verbally abusive physicians	484.571	393.796	0-1,000	60
Inadequate nursing management development	484.508	362.629	0-1,000	60
Inconsistent communication/ mixed messages from immediate supervisor	473.175	338.492	0-1,000	59
Lack of positive reinforcement	462.619	306.772	0-1,000	57
Lack of Professional autonomy	462.619	306.772	0-1,000	55
Lack of head nurse skills related to organization/ time management	422.048	354.566	0-1,000	52
Role of head nurse misperceived by physicians	421.016	329.347	0-1,000	52
No in-house staffing pool	393.651	354.996	0-1,000	49
Immediate supervisor unavailable to assist with problem solving	393.587	337.596	0-1,000	49
High turnover of staff	384.952	342.698	0-1,000	48
Immediate supervisor unable to provide adequate guidance & direction	365.619	339.334	0-1,000	45

TABLE 2 (cont.)

Stressor	Mean Rating	Standard Deviation	Range	Relative Value
Lack of peer support and cooperation	364.254	317.319	0- 950	45
Lack of meaningful feedback from immediate supervisor	364.063	331.579	0-1,000	45
Problems/conflicts with off-shift supervisors	358.714	302.707	0-1,000	44
Role of head nurse misperceived by staff	339.032	350.351	0-1,000	42
Misuse of patient classification system	337.065	340.275	0-1,000	42
Lack of an adequate recruitment/ retention program	335.016	324.187	0-1,000	42
Rotating to house supervision	330.410	335.363	0-1,000	35
Inappropriate orientation of staff nurses	323.603	326.814	0-1,000	40
Role of head nurse misperceived by ancillary personnel	316.651	295.112	0-1,000	39
Inadequate orientation of new nursing graduates	310.556	358.856	0-1,000	38
Lack of head nurse skills related to house supervision	300.410	335.363	0-1,000	37
Conflicts with immediate supervisor	278.492	375.894	0-1,000	35
Lack of head nurse skills related to job counselling/ evaluation process	270.381	274.569	0-1,000	34
Lack of head nurse skills related to delegation of tasks and responsibilities	269.032	295.986	0- 900	34
Lack of head nurse skills related to maintenance of staff morale	267.603	272.417	0- 900	34

ranking lower. The relative values of each stressor is compared to demands of paperwork/meetings/task forces/projects. In looking at Table 2, it can be seen that the amount of stress attributed to the demands of paperwork/meetings/task/ forces/projects rating = 100 (relative value scale 0-100) is essentially twice as stressful as lack of head nurse skills related to organizational/time management skills, or immediate supervisor unavailable to assist with problem solving.

The cumulative stress values for head nurses supports earlier studies, which have suggested that experienced stress is a combination or interaction between frequency and degree of stress (Numerof, 1983). Table 3 illustrates that the rating of each item can be significantly affected by the frequency of a given event. From the adjusted rating, taking frequency of occurrence into account, it can be seen that the item, "unsupportive hospital administration", ranked 36th. When viewing it in relation to its frequency, it is ranked 12th; "inconsistent communication/mixed messages from immediate supervisor" ranked 40th; subsequently moved up to 20th, "unrealistic expectations by nursing administration" ranked 11th; moved to number 4; "lack of professionalism of staff nurses" ranked 21st; moved up to 15th, "juggling management/clinical responsibility ranked 25th; moved up to 5th, and doubling as charge nurse/staff nurse ranked 32nd; move up to 16th.

TABLE 3

Cumulative Stress Values for Head Nurse Stressors

Stressor	Mean Value	Frequency of Occurrence Over 6 Mos.	Cumu-lative Value	Rela-tive Value
Nurses performing too many non-nursing functions	750.397	24.444	18,342.70	100
Indecisive,crisis-oriented priorities	571.159	28.190	16,100.97	88
Demands of paperwork/meetings/ task forces/projects	805.524	19.469	15,682.75	85
Unrealistic expectations by nursing administration	611.111	24.293	14,845.72	81
Juggling management and clinical responsibility	536.921	24.070	12,923.69	70
Increasing responsibility with no increase in authority	554.048	20.610	11,418.93	62
Work load of staff nurses unrealistic	665.063	16.638	11,065.32	60
Impact of head nurse position on home life	651.952	15.407	10,044.62	55
Unrealistic expectations of nursing	683.730	13.250	9,059.42	49
Impact of call-ins	584.143	14.870	8,686.21	47
Inadequate communication	611.349	12.684	7,754.35	42
Unsupportive hospital administration	485.349	15.864	7,699.58	42
Physical and mental impact of head nurse position	635.063	10.054	6,384.92	35
Consistently demanding physicians	541.565	6.617	3,583.53	20
Lack of Professionalism of staff nurses	544.540	6.569	3,577.08	20

TABLE 3 (cont.)

Cumulative Stress Values for Head Nurse Stressors

Stressor	Mean Value	Frequence of Occurrence Over 6 Mos.	Cumulative Value	Relative Value
Doubling as charge nurse/staff nurse	498.413	6.691	3,334.88	18
Pressure of being caught between staff and hospital administration	538.873	5.721	3,082.89	17
Pressure of maintaining appropriate unit standards	581.730	5.262	3,061.06	17
Personal conflict when expected to implement changes that you do not agree with	520.270	5.767	3,000.40	16
Inconsistent communication/ mixed messages from immediate supervisor	473.175	6.295	2,978.64	16
Inappropriate work ethic of staff nurses	514.381	5.742	2,953.58	16
Role of head nurse misperceived by physicians	421.016	5.968	2,512.62	14
Lack of positive reinforcement	462.619	5.121	2,369.08	13
Insufficient pay scale for head nurses	613.516	3.845	2,358.97	13
Dealing with patient/family complaints or unrealistic expectations	507.905	4.508	2,289.64	12
Multiple unjustified complaints by physicians	493.476	4.403	2,172.77	12
Professional conflicts when expected to implement changes	489.444	4.377	2,142.30	12

TABLE 3 (cont.)

Stressor	Mean Value	Frequency of Occurrence Over 6 Mos.	Cumulative Value	Relative Value
Inadequate budgeted FTEs	658.905	3.229	2,127.60	12
Head Nurse not considered in decision-making process	595.206	3.466	2,062.98	11
Immediate supervisor unavailable to assist with problem solving	393.587	5.210	2,050.59	11
No in-house staffing pool	393.651	4.764	1,875.35	10
Disciplinary action related to specific job behaviors	512.889	3.492	1,791.01	10
Budget constraints that negatively impact patient care	604.571	2.758	1,667.41	9
Lack of meaningful feedback from immediate supervisor	364.063	4.567	1,662.68	9
Lack of administrative support for education	532.492	3.098	1,649.66	9
Role of head nurse misperceived by hospital administration	503.968	3.214	1,619.75	9
Inadequate skill levels of staff nurses	483.317	3,250	1,570.78	9
Being held accountable to an unrealistic budget	617.032	2.540	1,567.26	9
Immediate supervisor unable to provide adequate guidance & direction	365.619	4.274	1,562.66	9
Lengthy delay in approval process	561.286	2.705	1,518.28	9
Lack of head nurse skills related to organization/ time management	422.048	3.517	1,484.34	8

TABLE 3 (cont.)

Stressor	Mean Value	Frequence of Occurrence Over 6 Mos.	Cumulative Value	Relative Value
Lack of head nurse skills related to delegation of tasks/ responsibilities	269.032	5.000	1,345.16	7
Problems/Conflicts with off-shift supervisors	358.714	3.710	1,330.82	7
Role of head nurse misperceived by staff	339.032	3.790	1,184.93	7
Chronically unfilled FTEs	579.381	2.040	1,181.94	6
Verbally abusive physicians	484.571	2.355	1,141.16	6
Role of head nurse misperceived by nursing administration	498.381	2.097	1,045.11	6
Misuse of patient classification system	337.065	2.946	992.99	5
Lack of professional autonomy	441.254	2.193	967.67	5
Conflicts with immediate supervisor	278.492	3.410	949.66	5
Inadequate nursing management orientation & training	540.857	1.371	741.51	4
Inappropriate orientation of staff nurses	323.603	2.065	668.24	4
Inadequate nursing management development	484.508	1.365	666.35	4
High turnover of staff	384.952	1.689	350.18	4
Role of head nurse misperceived by ancillary personnel	316.651	1.742	551.61	3
Lack of peer support and cooperation	364.254	1.484	540.55	3

TABLE 3 (cont.)

Stressor	Mean Value	Frequency of Occurrence Over 6 Mos.	Cumu-lative Value	Rela-tive Value
Lack of head nurse skills related to job counselling/ evaluation process	270.381	1.629	440.45	2
Lack of head nurse skills related to maintenance of staff morale	267.603	1.645	440.21	2
Lack of skills required to prepare a budget	561.095	0.758	425.31	2
Lack of an adequate recruitment/ retention program	335.016	1.000	335.02	2
Rotating to house supervision	330.833	0.918	303.70	2
Lack of head nurse skills related to house supervision	300.410	0.726	218.10	1
Inadequate orientation of new nursing graduates	310.556	0.419	130.12	0

Table 4 identifies the stressors specific to the head nurse role taking into account the relative mean values and the relative cumulative values. The top ten stressors in order are: Nurses performing too many non-nursing functions, demands of paperwork/meetings/task forces/projects, workload of staff nurses unrealistic, unrealistic expectations of nursing (hospital administration), unrealistic expectations of nursing by nursing administration, impact of head nurse position on home life, indecisive crisis-oriented priorities, physical and mental impact of head nurse position, inadequate communication, and the impact of call-ins.

Factor analysis of the stress scores yielded seven different factors accounting for 66.5% of the variance. The seven multi-item scales were developed as follows (also see Table 5):

1. Relationships with superiors - consists of 10 items reflecting various dimensions of conflict with supervisors, management inconsistencies, meeting demands, and lack of feedback from superiors, all of which can lead to role conflict/ambiguity (40.9% of variance).
2. Psychological environment includes 8 items describing the emotional demands of the job dealing with high staff turnover, unrealistic workload of staff nurses, demanding

physicians, misperception of head nurse responsibilities by others (5.9% of variance).

3. Organizational environment is a 9-item scale which addresses lack of support by administration, unrealistic expectations, lack of peer support, juggling management/clinical responsibilities (5.0% of variance).
4. Performance/personnel issues consist of 9 items which look at staff performance, patient/family issues, professional autonomy (4.2% of variance).
5. Resources is a 6-item scale which looks at the availability of people (staff), money, and time (3.9% of variance).
6. Situational issues includes 8 items that have to do with a variety of situations which the head nurse deals with as part of that role responsibility including staffing issues, performance, professionalism, work ethics (3.6% of variance).
7. Tasks (head nurse skills/abilities) is a 5-item scale which underlying theme is very specific to the skills needed for the head nurse position (3.0% of variance). The factor matrix is presented in Table 5. Pooled variance t-tests were used to identify statistically significant differences between

TABLE 4

Relative Rankings of Stressors Based Upon Cumulative Stress Values and Mean Ratings

Stressor	Relative Mean Value	Rank	Relative Cumulative Value	Rank	Total Ranks
Nurses performing too many non-nursing functions	93	2	100	1	3
Demands of paperwork/ meetings/task forces/ projects	100	1	85	3	4
Work load of staff nurses unrealistic	83	4	60	7	11
Unrealistic expectations of nursing by hospital administration	85	3	49	9	12
Unrealistic expectations of nursing by nursing administration	76	9	81	4	13
Impact of head nurse position on home life	81	6	55	8	14
Indecisive, crisis-oriented priorities	71	17	88	2	19
Physical and mental impact of head nurse position	29	7	35	13	20
Inadequate communication	76	9	42	11	20
Impact of call-ins	73	14	47	10	24
Increasing responsibility with no increase in authority	69	20	62	6	26
Juggling management and clinical responsibility	67	22	70	5	27
Inadequate budgeted FTEs	82	5	12	25	30

TABLE 4 (cont.)

Stressor	Relative Mean Value	Rank	Relative Cumulative Value	Rank	Total Ranks
Insufficient pay scale for head nurses	76	9	13	23	32
Pressure of maintaining appropriate unit standards	72	15	17	17	32
Lack of Professionalism of staff nurses	68	21	20	14	35
Lack of administrative support for education	66	26	33	9	35
Being held accountable to an unrealistic budget	77	8	9	28	36
Consistently demanding physicians	67	22	20	14	36
Pressures of being caught between staff and hospital administration	67	22	17	17	39
Head nurse not considered in decision-making process	74	13	11	29	42
Budget constraints that negatively impact patient care	75	12	9	33	45
Personal conflict when expected to implement changes that you do not agree with	65	27	16	19	46
Inappropriate work ethic of staff nurses	64	28	16	19	47
Unsupportive hospital administration	60	36	42	11	47
Doubling as charge nurse/ staff nurse	62	32	18	16	48

TABLE 4 (cont.)

Stressor	Relative Mean Value	Rank	Relative Cumulative Value	Rank	Total Ranks
Lengthy delay in approval process	70	18	9	33	51
Dealing with patient/family complaints or unrealistic expectations	63	30	12	25	55
Disciplinary action related to specific job behaviors	64	28	10	31	59
Multiple unjustified complaints by physicians	61	34	12	25	59
Professional conflicts when expected to implement changes	61	34	12	25	59
Inconsistent communication/ mixed messages from immediate supervisor	59	40	16	19	59
Chronically unfilled FTEs	72	15	6	45	60
Role of head nurse misperceived by hospital administration	63	30	9	33	63
Lack of positive reinforcement	57	41	13	23	64
Role of head nurse misperceived by physicians	52	43	14	22	65
Inadequate skill levels of staff nurses	60	36	9	33	69
Inadequate nursing management orientation and training	67	22	4	51	73

TABLE 4 (cont.)

Stressor	Relative Mean Value	Rank	Relative Cumulative Value	Rank	Total Ranks
Immediate supervisor unavailable to assist with problem solving	49	45	11	29	74
Lack of skills required to prepare a budget	75	18	2	57	75
No in-house staffing pool	49	45	10	31	76
Role of head nurse misperceived by nursing administration	62	32	6	47	79
Immediate supervisor unable to provide adequate guidance & direction	45	48	9	33	81
Lack of meaningful feedback from immediate supervisor	45	48	9	33	81
Verbally abusive physicians	60	36	6	46	82
Lack of head nurse skills related to organization/time management	52	43	8	41	84
Inadequate nursing management development	60	36	4	51	87
Lack of professional autonomy	55	42	5	49	91
Problems/conflicts with off-shift supervisors	44	51	7	43	94
Role of head nurse misperceived by staff	42	52	7	43	95
High turnover of staff	48	47	4	51	98

TABLE 4 (cont.)

Stressor	Relative Mean Value	Rank	Relative Cumulative Value	Rank	Total Ranks
Lack of adequate recruitment/retention program	42	52	2	57	99
Misuse of patient classification system	42	52	5	48	100
Lack of peer support & cooperation	45	48	3	55	103
Lack of head nurse skills related to delegation of task & responsibilities	34	61	7	42	103
Inappropriate orientation of staff nurses	40	56	4	51	107
Conflicts with immediate supervisor	35	60	5	50	110
Rotating to house supervision	41	55	2	57	112
Role of head nurse misperceived by ancillary personnel	39	57	3	55	112
Lack of head nurse skills related to job counselling/ evaluation process	34	61	2	57	118
Lack of head nurse skills related to maintenance of staff morale	34	61	2	57	118
Inadequate orientation of new nursing graduates	38	58	0	63	121
Lack of head nurse skills related to house supervision	37	59	1	62	121

TABLE 5

Factor Analysis of Head Nurse Stressors
(Only Significant Factor Loadings Identified)

Stressor	Factor Loadings 1	2	3	4	5	6	7
Unrealistic expectations of Nursing					.67		
Head nurse not considered in decision-making process	.41						
Unrealistic expectations by nursing administration			.51				
Inconsistent communication/ mixed messages from immediate supervisor	.84						
Lack of positive reinforcement	.82						
Immediate supervisor unavailable to assist with problem solving	.74						
Immediate supervisor unable to provide adequate guidance & direction	.80						
Lack of meaningful feedback from immediate supervisor	.79						
Conflicts with immediate supervisor	.70					.44	
Inadequate budgeted FTEs						.44	
Chronically unfilled FTEs						.48	
High turnover of staff		.43				.67	
Lack of an adequate recruitment/ retention program						.64	
Impact of call-ins						.77	
No in-house staffing pool				.57			
Lack of administrative support for education			.45				

TABLE 5 (cont.)

Stressor	Factor Loadings 1	2	3	4	5	6	7
Insufficient pay scale for head nurses					.63		
Work load of staff nurses unrealistic		.44			.66		
Nurses performing too many non-nursing functions					.53		
Inadequate skill levels of staff nurses				.55			
Lack of professionalism of staff nurses				.53		.40	
Inappropriate work ethic of staff nurses				.60		.42	
Disciplinary action related to specific job behaviors				.79			
Dealing with patient/family complaints or unrealistic expectations				.55			
Lack of head nurse skills related to organization/ time management				.47			.47
Lack of head nurse skills related to job counselling/ evaluation process							.83
Lack of head nurse skills related to delegation of tasks and responsibilities							.80
Lack of head nurse skills related to house supervision			.80				
Lack of head nurse skills related to maintenance of staff morale							.61
Multiple unjustified complaints by physicians		.79					

TABLE 5 (cont.)

Stressor	Factor Loadings 1	2	3	4	5	6	7
Verbally abusive physicians		.75					
Consistently demanding physicians		.82					
Demands of paperwork/meetings/ task forces/projects					.43		
Rotating to house supervision			.68				
Doubling as charge nurse/ staff nurse			.59				
Juggling management and clinical responsibility			.43				
Increasing responsibility with no increase in authority	.61						
Pressure of maintaining appropriate unit standards				.45			
Lack of professional autonomy				.42			
Pressure of being caught between staff and hospital administration	.47						
Lack of peer support and cooperation			.64				
Professional conflicts when expected to implement changes							.47
Personal conflict when expected to implement changes that you do not agree with	.40						
Role of head nurse misperceived by the hospital administration		.41	.45				
Role of head nurse misperceived by the nursing administration		.41	.47				

TABLE 5 (cont.)

Stressor	Factor Loading 1	2	3	4	5	6	7
Role of head nurse misperceived by physicians		.57					
PERCENT OF VARIANCE EXPLAINED	40.9	5.9	5.0	4.2	3.9	3.6	3.0

The following 17 stressors did not load significantly on the 7 factors:
Unsupportive hospital administration; Indecisive, crisis-oriented priorities; Inadequate communication; Lengthy delay in approval process; Misuse of patient classification system; Inappropriate orientation of staff nurses; Inadequate nursing management orientation and training; Inadequate nursing management development; Inadequate orientation of new nursing graduates; Lack of skills required to prepare a budget; Being held accountable to an unrealistic budget. Budget constraints that negatively impact patient care; Physical and mental impact of head nurse position; Impact of head nurse position on home life; Role of head nurse misperceived by ancillary personnel; Role of head nurse misperceived by staff; and Problems/conflicts with off-shift supervisors

the demographic sub-groups for variance for the total stressors and the composite stressors (Table 6).

SUMMARY

This chapter presented a discussion of the analysis of the results of the study. The degree of stressfulness of 63 stressors was rated by randomly selected head nurses from throughout the State of Virginia. The reliability of the rating instrument, using Cronbach's alpha, was determined to be a .98. The mean stress rating for each item was used to rank the stressors. The cumulative stress value was determined by multiplying the mean value times the frequency of occurrence of the event. The final rankings of the stressors specific to the head nurse role was determined by adding the relative mean rank to the relative cumulative rank to generate the total rank. Factor analysis revealed that seven factors accounted for 66.5% of the total variance. Pooled variance t-tests indicated 7 significant mean differences within the composite instrument. Salary, hospital size, and marital status showed the greatest difference (Table 6).

TABLE 6

t-test Comparisons of Demographic Characteristics on Total Stressors and Total Composite Stressors

Variable	Groups	t-Value	df	sig.
Total Stressors	$35,000-39,000 vs $50,000-54,000	-3.11	13	.008
	100-199 beds vs 400-499 beds	-2.73	21	.012
	$40,000-49,000 vs $50,000-54,000	-2.84	14	.013
	$30,000-34,000 vs $50,000-54,000	-2.64	15	.019
	Single vs Married	-2.13	43	.039
	200-299 beds vs 400-499 beds	-2.00	25	.050
Total Composite Stressors	Single vs Married	2.49	19	.022

CHAPTER FIVE

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This chapter summarizes the study and is divided into four parts: Summary, Interpretation and Implications, Conclusions, and Recommendations.

SUMMARY

The purpose of this study was to identify the worksite stressors of head nurses and to determine the relative amount of stress exerted on these professionals by these stressors. Most research concerning stress in nursing has focused on staff nurses in specialty areas (intensive care, coronary care, operating room, etc.). The following research questions were developed from this purpose:

1. What are the most significant stressors specific to the head nurse role in the workplace as perceived by head nurses who are currently practicing?
2. What is the relative stressfulness of each of these worksite stressors?

The 85 head nurses who completed the stressor identification questionnaire voluntarily participated and

provided anonymous information. The 63 head nurses who provided the completed ranking questionnaires were randomly selected, participated voluntarily and remained anonymous throughout the study.

Reliability of the 63 items on the stressor survey was determined by Cronbach's alpha and was estimated to be .98.

INTERPRETATION AND IMPLICATIONS

A review of the ten most significant stressors reveals that head nurses are primarily affected by lack of resources. Workload of staff nurses, nurses performing to many non-nursing functions, inadequate budgeted FTEs, salary, being held accountable to an unrealistic budget, and demands of paperwork/meetings/task forces/projects. Most of these stressors can be related to the economic changes affecting health care as a result of reimbursement issues, and the fact that nurses have a variety of options or choices when planning their career path.

Third party payors and other regulatory agencies are requiring that providers be able to demonstrate that quality care is being rendered. This is accomplished though various utilization review procedures and chart audits. If the proof is not there, it can have significant consequences on the amount of reimbursement the facility receives. The responsibility is ultimately passed to the head nurse to ensure appropriate care, and yet fiscal restraints that

health care fascilities find themselves under in order to ensure their own financial viability limits their resources.

Health care comsumers are more educated about their health care entitlements than ever before. They are also more aware of the litigation process. If the comsumer preceives a bad outcome from from an in-patient stay, the head nurse recognizes that the potential for someone to make a charge that the unit was not staffed appropriately to meet their needs, whether the resources were there or not is very real. Does the liability lie, solely with the facility? Where does the head nurse stand? Staffing is the head nurses responsibility, and he/she has 24 hour responsibility for their unit.

Everyone looks to the head nurse to solve problems; staff, patients, physicians, nursing supervisors, and administration. The head nurse must be all things to all people. The head nurses themselves feel they must satisfy all demands. The toll that is taken on the head nurse as a person, psychologically, emotionally, and physicially affects his/her self esteem and sense of accomplishment, and eventually leads to burn-out.

All nurses have more opportunities than ever before. Many competent nurses have been lured away from the more traditional acute care setting because of the environment that they feel exists; by third party payors, staffing agencies, pharmaceutical companies, industry, and companies that sell and/or rent durable medical equipment. More

nurses are going into independent practice, consulting, and working for review organizations to name a few. Hospital administrators should recognize that people go to hospitals primarily for nursing care. It is imperative that they become competitive in the marketplace to recruit and retain qualified personnel.

It was expected that the stressors "consistently demanding physicians, multiple unjustified complaints by physicians, or verbally abusive physicians" would have ranked higher than 22, 34, and 36 respectively. Uncooperative physicians have been a major source of stress in earlier studies. Two major sources of stress in this study were: relationship with supervisors (lack of positive reinforcement, inconsistent communications/mixed messages), and performance/personnel issues (inadequate skill levels of staff nurses, lack of professionalism of staff nurses, and inappropriate work ethic of staff nurses).

Seven factors were identified as accounting for 66.5% of the variance for the composite instrument. The amount of variance attributed to items falling at the bottom two-thirds of the list of stressors are those items which the respondents found moderate to mildly stressful without much variation between the rates. Since the largest amount of the overall variance can be accounted for within the seven factors, future rating scales can be simplified and shortened.

CONCLUSIONS

In conclusion, the following findings are based on the research questions and methodologies outlined in Chapter Three and data presented in Chapter Four:

1. Instrument reliability was .98 as measured by Cronbach's alpha.
2. The five most significant stressors specific to the head nurse role were: demands of paperwork/meetings/task forces/projects; nurses performing too many non-nursing functions; unrealistic expectations of nursing (by hospital administration); Work load of staff nurse unrealistic; and inadequate budgeted FTEs.
3. The five least stressors were: lack of head nurse skills related to maintenance of staff morale; lack of head nurse skills related to tasks and responsibilities; lack of head nurse skills related to job counselling/evaluation process; conflicts with immediate supervisor; and lack of head nurse skills related to house supervision.
4. Seven factors were identified which accounted for 66.5% of the variance of the composite instrument. (See Table 5)

RECOMMENDATIONS

The following are recommendations after reviewing the completed study:

1. More research needs to be done to identify specific stressors related to the head nurse role.
2. More research needs to be done to provide insight into the head nurse role.
3. The extent of stress related to the impact of the role on home life.
4. Research into which specific personality traits, if any, affect the amount of stress specific to the head nurse role.
5. The extent of stress-related illness of head nurses.
6. The instrument should be refined to reduce the apparent confusion which some respondents experienced in the study.
7. Future studies should include a personal interview with the respondents.

Much work is still needed to identify and hopefully, to control the sources of role stress in head nurses. This study was able to isolate some factors related to the

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Date

Dear Name: Vice President/Director of Nursing

I am a graduate student at Old Dominion University, in the Community Health Professions Program. In partial fulfillment of requirements for a graduate degree, I would like to invite participation of your nurse managers in a study to identify specific stressors related to head nurses in acute care facilities.

The responses to this survey will become part of a composite list of head nurse specific stressors and your head nurses will be asked at a later date to rate the stressors in a separate survey. Your institution and your nurse manager's participation is completely voluntary and all responses will remain confidential.

Thank you very much for your cooperation.

Sincerely,

Joan A. Breen, B.S.N.

November 26, 1990

Dear Head Nurse:

Considerable research has been conducted in the field of occupational stress and its relationship to physical and mental illness. The purpose of this survey form is to identify worksite stressors in the field of nursing, specifically, those stressors of professionals who serve as head nurses. Hopefully at the end of this study the results will be published and used by nursing administrators to lessen the workplace stress and burnout associated with this most difficult and responsible position.

Your responses to this survey will become part of an aggregate data base and a composite list of head nurse-specific stressors will be generated. You and other head nurses will be asked to rate this list of stressors in a separate survey.

Your responses are confidential and voluntary, so please do not write your name or put any other identifying mark on the form.

At this point we would appreciate if you would identify the five most significant stressors (sources of stress) that you encounter in the workplace as a head nurse.

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

Thank you for your cooperation and you will be asked to rate this list of stressors at a later date.

Joan Breen, B.S.N.
Graduate Student

Date

Dear Name: Vice President/Director of Nursing

In the first phase of this study nurse managers throughout the State of Virginia were asked to identify significant stressors they encountered in the workplace. This list generated sixty-three separate stressors which are presented in the following survey. At this point, I invite the nurse managers at your facility to participate in the second phase of this study, by rating the stressors.

Participation by a facility and/or nurse managers is completely voluntary and shall remain confidential. The results of the survey will be shared with the facilities invited to participate. Thank you for your assistance.

Sincerely,

Joan A. Breen, B.S.N.

STRESSORS OF HEAD NURSES

In the first phase of this project, you were asked to identify the most significant stressors to head nurses on the job. An exhaustive list was developed and presented below and we very much appreciated your contribution.

Its now time for the second phase in which we ask you to rate each stressors on a scale of 0 to 1,000 based upon the following criteria:

If the stressor listed is **LESS** stressful than **inadequate time/staff to provide continuing staff development/education for staff,** then rate the stressor between 1 and 499.

If the stressor listed is **EQUALLY** stressful as **inadequate time/staff to provide continuing staff development/education for staff,** then rate the stressor at 500.

If the stressor listed is **MORE** stressful than **inadequate time/staff to provide continuing staff development/education for staff,** then rate the stressor between 501 and 1,000.

If the activity listed **DOES NOT** effect you as a stressor, then rate the activity with a 0. If you would like a copy of the results, please place your name and address on the lines provided at the end of the instrument. Please return to me by February 25, 1991. Thanks again for your help.

Joan Breen, B.S.N.
M.S. Candidate at Old Dominion University

COMPARED TO INADEQUATE TIME/STAFF TO PROVIDE CONTINUING EDUCATION/ DEVELOPMENT FOR STAFF	RATING (0 - 1,000)	# of TIMES YOU WERE AFFECTED IN LAST 6 MOS.	DO YOU HAVE CONTROL OF STRESSOR? (✓ = YES)
Unsupportive hospital administration	______	______	______
Indecisive, crisis-oriented priorities	______	______	______
Inadequate communication	______	______	______

COMPARED TO INADEQUATE TIME/STAFF TO PROVIDE CONTINUING EDUCATION/ DEVELOPMENT FOR STAFF	RATING (0 - 1,000)	# of TIMES YOU WERE AFFECTED IN LAST 6 MOS.	DO YOU HAVE CONTROL OF STRESSOR? (✓= yes)
Unrealistic expectations of Nursing	______	______	______
Head nurse not considered in decision-making process	______	______	______
Lengthy delay in approval processes	______	______	______
Inconsistent communication/ mixed messages from immediate supervisor	______	______	______
Lack of positive reinforcement	______	______	______
Immediate supervisor unavailable to assist with problem solving	______	______	______
Lack of meaningful feedback from immediate supervisor	______	______	______
Conflicts with immediate supervisor	______	______	______
Inadequate budgeted FTEs	______	______	______
Chronically unfilled FTEs	______	______	______
High turnover of staff	______	______	______
Lack of an adequate recruitment/retention program	______	______	______
Impact of call-ins	______	______	______
No in-house staffing pool	______	______	______
Misuse of patient classification system	______	______	______
Inappropriate orientation of staff nurses	______	______	______

COMPARED TO INADEQUATE TIME/STAFF TO PROVIDE CONTINUING EDUCATION/ DEVELOPMENT FOR STAFF	RATING (0 - 1,000)	# of TIMES YOU WERE AFFECTED IN LAST 6 MOS.	DO YOU HAVE CONTROL OF STRESSOR? (✓ = yes)
Lack of administrative support for education	______	______	______
Inadequate nursing management orientation and training	______	______	______
Inadequate nursing management development	______	______	______
Inadequate orientation of new nursing graduates	______	______	______
Insufficient pay scale for head nurses	______	______	______
Work load of staff nurses unrealistic	______	______	______
Nurses performing too many non-nursing functions	______	______	______
Inadequate skill levels of staff nurses	______	______	______
Lack of professionalism of staff nurses	______	______	______
Inappropriate work ethic of staff nurses	______	______	______
Disciplinary action related to specific job behaviors	______	______	______
Dealing with patient/ family complaints or unrealistic expectations	______	______	______
Lack of head nurse skills related to organization/ time management	______	______	______
Lack of head nurse skills related to job counselling/ evaluation process	______	______	______

COMPARED TO INADEQUATE TIME/STAFF TO PROVIDE CONTINUING EDUCATION/ DEVELOPMENT FOR STAFF	RATING (0 - 1,000)	# of TIMES YOU WERE AFFECTED IN LAST 6 MOS.	DO YOU HAVE CONTROL OF STRESSOR? (✓ = yes)
Lack of head nurse skills related to delegation of tasks and responsibilities	______	______	______
Lack of head nurse skills related to house supervision	______	______	______
Lack of head nurse skills related to maintenance of staff morale	______	______	______
Multiple unjustified complaints by physicians	______	______	______
Verbally abusive physicians	______	______	______
Consistently demanding physicians	______	______	______
Lack of skills required to prepare a budget	______	______	______
Being held accountable to an unrealistic budget	______	______	______
Budget constraints that negatively impact patient care	______	______	______
Demands of paperwork/meetings/ task forces/projects	______	______	______
Rotating to house supervision	______	______	______
Doubling as charge nurse/staff nurse	______	______	______
Juggling management and clinical responsibility	______	______	______
Increasing responsibility with no increase in authority	______	______	______

COMPARED TO INADEQUATE TIME/STAFF TO PROVIDE CONTINUING EDUCATION/ DEVELOPMENT FOR STAFF	RATING (0 - 1,000)	# of TIMES YOU WERE AFFECTED IN LAST 6 MOS.	DO YOU HAVE CONTROL OF STRESSOR? (✓= yes)
Physical and mental impact of head nurse position	______	______	______
Impact of head nurse position on home life	______	______	______
Pressure of maintaining appropriate unit standards	______	______	______
Lack of professional autonomy	______	______	______
Pressure of being caught between staff and hospital administration	______	______	______
Lack of peer support and cooperation	______	______	______
Professional conflicts when expected to implement changes	______	______	______
Personal conflict when expected to implement changes that you do not agree with	______	______	______
Role of head nurse misperceived by the hospital administration	______	______	______
Role of head nurse misperceived by physicians	______	______	______
Role of head nurse misperceived by the ancillary personnel	______	______	______
Role of head nurse misperceived by staff	______	______	______
Unrealistic expectations by nursing administration	______	______	______

COMPARED TO INADEQUATE TIME/STAFF TO PROVIDE CONTINUING EDUCATION/ DEVELOPMENT FOR STAFF	RATING (0 = 1,000)	# of TIMES YOU WERE AFFECTED IN LAST 6 MOS.	DO YOU HAVE CONTROL OF STRESSOR? (✓= yes)
Problems/conflicts with off-shift supervisors	______	______	______

TO RECEIVE A COPY OF THE RESULTS, PLEASE WRITE YOUR NAME AND ADDRESS BELOW:

____

____

____

Thanks again for your help!

DEMOGRAPHIC INFORMATION

GENDER: 1. Female 2. Male

NUMBER OF YEARS AS A NURSE: ________________

NUMBER OF YEARS AS A HEAD NURSE: __________________

NUMBER OF YEARS AS A HEAD NURSE AT CURRENT FACILITY: _______

NUMBER OF NURSES YOU SUPERVISE: _____________

NUMBER OF HEAD NURSES AT YOUR FACILITY: ____________

BASIC NURSING PREPARATION: 1. Diploma 2. AD 3. B.S.N.

HIGHEST LEVEL OF EDUCATION ATTAINED:

1. Diploma
2. AD
3. B.S.N.
4. M.S.N.
5. Other _______________

AGE:

1. 21-24
2. 24-26
3. 26-29
4. 30-32
5. 33-35
6. 36-38
7. 39-42
8. 43-45
9. 46-48
10. 49-51
11. 52-54
12. 55 & over

MARITAL STATUS:

1. Single (never married)
2. Married
3. Divorced
4. Widowed/er

HOSPITAL SIZE:

1. Less than 100 beds
2. 100-199 beds
3. 200-299 beds
4. 300-399 beds
5. 400-499 beds
6. 500-599 beds
7. 600-699 beds
8. 700 beds & greater

ANNUAL SALARY RANGE:

1. $20,000 - 24,999
2. $25,000 - 29,999
3. $30,000 - 34,999
4. $35,000 - 39,999
5. $40,000 - 44,999
6. $45,000 - 49,999
7. $50,000 - 54,999
8. $55,000 & higher

WORK SCHEDULE:

1. 24-hour responsibility for your unit? Yes___ No____
2. Average number of hours worked per week ____________
3. Average number of hours worked per pay period ______

VITAE

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Place of Birth:

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