The Irish Nurses Organisation
&
National Council of Nurses of Ireland

Cumann na nAltraí Gaelacha
&
Comhairle Naisiúnta Altraí na hÉireann

THE EXPERIENCE OF STRESS AMONGST IRISH NURSES

A Survey of Irish Nurses Organisation Members

SUMMARY REPORT

The experience of stress amongst Irish nurses

A survey of Irish Nurses Organisation members

Printed in Ireland

As President of the Irish Nurses Organisation, it is with a tremendous sense of pride and achievement I welcome the publication of the Stress Study Report.

Much credit is due to the delegates at Annual Delegate Conference, in 1991, for the adoption of the motion to fund the Study and to the Executive Council, in 1992, for commissioning it.

The INO acknowledges with grateful thanks the partial funding received from the EC.

I wish to publicly acknowledge and record my sincere appreciation to Dr Richard Wynne and his staff at the Work Research Centre for their professional approach, patience and guidance throughout the Study.

A steering committee was set up to assist in devising the questionnaire and to monitor the progress of the Study on your behalf. The members of that committee were - Anne Cody, Liz Guinan, Siobhan McSweeney, Anna Monaghan, Peg Nealon, Dympna Walsh and Kathy Foy, staff member, INO. This involved a commitment of their time which they gave willingly and unquestionably with a firm sense of purpose and commitment to the task. I thank each of them most sincerely and commend them for their diligence to the project.

All of you, who responded to the questionnaire, provided the results necessary for the authenticity leading to this publication. I am truly grateful.

In welcoming this Study, it is as well to remind you that the Study must be of benefit to our members in determining better conditions of employment, education, occupational health counselling and, not least, the need to be consulted in the development of future health policies in general and nursing policies in particular. This Study is also useful as a reference and should be a mandatory purchase for every Nursing Library in the country.

Stress is a concept which evolved from engineering - it describes how material, when unequal to the pressures placed upon it, eventually weakens and breaks, causing total failure of function. Not all stress is negative. Stress can act as a stimulus - working under a certain amount of pressure generates positive action in some individuals. Stress can be functional, leading to learning and increasing the ability to cope. It can also be dysfunctional, leading to poor performance and attainment. A sense of personal control is important. If the demands made exceed the ability to cope then stress is felt - if the demand is met then one has a sense of achievement. So, stress is pertinent to individuals and their level of ability to cope.

We will never have a stress-free working environment because of the nature of nursing. A strategy of coping needs to be developed and there are two ways of doing this:

Direct
- By change of work practices;
- Prioritising work at ward level
- Peer support.

Indirect
- By education in nursing and training development;
- By a properly-focused leisure and relaxation plan.

At present a palliative method of coping is most frequently used but it is the least acceptable.

Employing Agencies have a duty of care to employees and that must be invoked. The high level of morbidity amongst nurses is a serious problem in financial terms, not to mention the interference in the smooth running of the Health Service.

Absenteeism, owing to stress-related illness, must be addressed - not least by an active and realistic Occupational Health Service for nurses, which would include a comprehensive and confidential counselling service.

We must not be ashamed to say when we are stressed, to shout STOP so we do not reach the point of no return - "Burnout". If, as professionals, nurses are unable or unwilling to care for themselves, how can they be expected or even trusted to care for others?

The publication of the Report will ensure a healthy debate on coping strategies and the development of coping mechanisms for the nurse of the nineties and a fitting legacy of professional awareness for the twenty-first century.

Katherine J. Craughwell

KATHERINE J. CRAUGHWELL
PRESIDENT

FOREWORD

This Study represents a major break-through by which nurses, speaking for themselves, and having their comments scientifically and analytically interpreted, identify the level and extent of stress in nursing.

The Study is the first comprehensive, objective and scientific study of this major and growing area of concern to the profession.

The Irish Nurses Organisation invited the Work Research Centre to undertake the Study in order to validate its claim of several years that nurses and midwives are subject to stress while providing positive health care to all other members of society.

The fact that the Study confirms the arguments presented on many previous occasions by the Organisation should not be interpreted negatively. Rather, the Study is presented to provide an opportunity to academics, analysts, professionals and employers to evaluate, on the one hand, the contribution made by nurses (the single largest element in any health service work force) to the health services and, on the other, to enable employers to identify the cost to the Health Services of not providing nurses with a stress-free work environment.

All of this must be seen against the background of the growing demands being made on employers arising from EC Directives which, in turn, are themselves applying elements of the Safety, Health and Welfare at Work Act (1989). In evidence of this we are pleased to record our appreciation to the European Commission for part funding this Study.

In order to guarantee the integrity of the analysis presented in these pages, and the conclusions drawn from them, no commercial sponsorship was sought by the Organisation for the Study. It has been funded, aside from the generous contribution of the EC, by the members of the Irish Nurses Organisation.

The result is, therefore, the property of the Irish Nurses Organisation and one in which every nurse and midwife should take pride and to which each should also claim ownership.

In a particular way the Executive Council of the Organisation wish to place on record their appreciation to each nurse and midwife who took the trouble to respond to the very-detailed questionnaire whose results form the basis of the analysis.

Through the involvement of the Work Research Centre, whose staff were responsible for all elements of structuring the questions and analysing the data - the Executive Council remaining at arms length from the exercise in order to guarantee its validity - we are satisfied that the Study will prove valuable to academicians, researchers, employers and, not least, to all nurses and midwives, including student nurses.

Finally, it is the hope of the Executive Council that this Study, in raising issues which require further analysis, will, in turn, be an agent for additional, more-specialised studies which can only benefit this historic, important, ever-relevant profession, to a broadening of its research base.

P.J. MADDEN, M.A.
GENERAL SECRETARY

Acknowledgements

The authors would like to thank the following people for their help in conducting this survey:

- The INO Stress Committee - Anne Cody, Liz Guinan, Siobhan McSweeney, Anna Monaghan, Peg Nealon, Dympna Walsh and Kathy Foy, staff member, INO - for their invaluable efforts in helping to design the questionnaire, helping in the administration of the study and commenting on the results of the survey as they emerged.
- Ms Katherine Craughwell, President of the INO, for her continuing interest in the survey.
- Mr P.J. Madden, General Secretary of the INO, for his interest, support and advice during the conduct of the study.
- Mr Kevin Downey, INO, for his help in drawing up the sample.
- Ms. Audrey Sherlock, WRC, for her help in administration and data entry.
- The European Year of Safety, Hygiene, and Health Protection at Work (through the Health and Safety Authority) for their financial support.
- All of the nurses who helped ensure the return of the questionnaires.
- All of the nurses who returned completed questionnaires, without whom there would have been no survey.

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Conclusions

The key issues which have emerged from the survey strongly suggest that nursing is in a (perhaps unrecognised) state of crisis. Some of these issues may have been suspected as being important to the development of nursing and the reduction of stress before the survey was undertaken - the survey results now provide hard data on these issues. The conclusions outlined below provide a new perspective on what are the critical issues facing nursing today and form the basis on which the recommendations for stress management in nursing are framed.

Students

Students experience the highest levels of stress, the most stress related negative outcomes and in general, use more negative coping strategies and fewer positive coping strategies.

Survivor population

The findings that there were no relationships between age and outcomes; that shift-workers did not report higher outcomes than non-shiftworkers; that part-time nurses report poorer health; and that many nurses leave the profession for health reasons strongly suggest that the population surveyed are a "survivor population". This means that the health costs of being a nurse are hidden, and are being exported from the profession through people leaving.

Shift work and nursing

The types of shifts worked by nurses are far from optimal. Particularly, the predominance of seven nights on seven nights off systems and of 12 hour shifts, which were reported by large numbers of the sample is of concern. These shifts are far from the ideal shift system which should seek to maximise the operational needs of staffing, and the social and health needs of workers.

Non-nursing duties

The findings from this survey indicate that nurses estimate that not much more that 50% of the working day is spent on nursing duties. Over 40% of time was spent on clerical, domestic, portering and other non-nursing duties.

Assault

More than 46% of nurses reported having been assaulted at some stage during their careers and that of those who were assaulted in the past year, they were assaulted an average of three times. Levels of verbal abuse are equally disturbing. Little or no support is provided by official sources to those who have been assaulted.

Post graduate training

Nurses report receiving little or no support in the area of professional development after initial training. Findings show that access to training, financial support for training, recognition given for post-graduate training and the nature of training itself are all rated as being far from adequate.

Support at work

Lack of management support and lack of adequate support were both strongly related to a range of work-related and more general stress related outcomes. Also, in relation to assault, it was widely perceived that support, particularly from management was lacking after such incidents.

Professional development

Nurses reported that their professional needs are not being satisfied by the current structuring of the job. They report that the opportunity to practice management, counselling and communication skills, teamwork, nursing care and teaching are well below what they would regard as being the optimum for professional nurses.

Structures for Occupational Health

Under the 1989 Health, Safety and Welfare at Work Act, workers are entitled to elect their own health and safety representatives, to take part in health and safety committees, to have access to information regarding workplace hazards and to receive appropriate training to function effectively in these roles. Many nurses are unaware of the existence of health and safety committees (partly because they don't actually exist in many workplaces) and of the existence of health and safety representatives.

The induction process in nursing

During the induction process into nursing (student years and the immediately following years), a number of negative processes appear to take place. Students reported higher sources of stress, higher levels of outcomes and higher rates of negative coping styles. Staff nurses also reported high levels of stress. In essence, the structures and institutions of nursing appear to be operating upon new entrants to the profession in such a way as to discourage many of them from remaining in the profession. The findings regarding nursing turnover back up this view, where more than half of those who leave, leave either the profession or the country.

Communications

Though nursing is considered to be a profession in which communications skills are at a premium, these skills do not appear to be applied to working relationships in nursing. The findings of high levels of stress coming from conflict with nurses, the prevalence of the coping style of keeping problems to yourself, the fact that the third most common measure suggested for reducing stress related to improved communications and the findings concerning lack of management support all lend credence to this view.

Working Conditions

There is considerable room for improvement in the working conditions of nurses. Reports of low pay being a considerable source of stress, lack of career development opportunities and access to further training and the effects which job tenure have on generating negative stress related outcomes indicate the need for improvement.

The Survey Background

The INO survey

Many factors have contributed to the high levels of stress experienced by nurses. At a global level, the 1980's saw financial constraints placed on health services world-wide. In particular, these have had the effect of increasing the ratio of patients to nurses, increasing patient turnover due to shorter hospital stays, cutting resources, and introducing part-time and student staff. All of these factors have added to the burdens placed on nurses.

Against this background the INO commissioned this survey to examine the 'The Experience of Stress among Irish Nurses'. It has four aims:

- To describe the main sources of stress;
- To outline the major coping strategies used by nurses;
- To describe the main outcomes of stress;
- To propose courses of action to manage stress.

Strengths and weaknesses of surveys

When interpreting the results from surveys such as these, one should be aware of the strengths and weaknesses of the survey approach. They are good at documenting the experience of stress, through taking a snapshot of a representative sample of nurses at a given point in time. This allows statements to be made with confidence regarding the prevalence of stress at that point in time.

They are also good at identifying factors which are associated with the experience of stress - statements can be made regarding stress levels in different groups of nurses. Statements can also be made about the factors which are most associated with stress, all other factors being controlled for.

However, it is difficult to make statements regarding the process of stress, and the mechanisms whereby stress related outcomes are produced solely on the basis of the data collected from the survey. In an ideal world, longitudinal surveying (and other methods) would be used to make completely confident statements on causation. However, one can use knowledge gained elsewhere to make informed statements about likely causation, and this is what has been done in reporting the results from the present survey.

The context of Nursing

One should also be aware of the context in which nursing takes place when interpreting the results. There are many differences between nursing workplaces and nurses themselves, and they operate within different institutional structures. Obviously, it is not possible to measure every aspect relevant to the stress process in a survey such as this. Concrete statements can only be made about features of the nursing stress process which have been measured in the survey, but informed statements can be made more generally. When reading this report, it should therefore be borne in mind that the precise configuration of the stress process may differ in your workplace.

Focus on problems

The findings reported below of necessity focus on the various problematic aspects of nursing which have been identified in the survey. This is because the brief was to identify issues which, if acted upon, would reduce the levels of stress found among the nursing population. It is recognised that there are also positive aspects to nursing - if they have not been highlighted enough, this is due to the need to identify factors which are open to improvement.

Stress in Nursing

From the large number of international studies on the experience of stress in nursing, the level of agreement on the main sources of nursing stress world-wide is remarkable. These include stress from workload, patients' death and dying, lack of support and poor working conditions. The outcomes of stress are also generally recognised to include burnout, psychological distress, low job satisfaction and intentions to quit.

Nursing is thought by its very nature to be a stressful profession, with many stress factors experienced on an almost daily basis. A quote from Hingley, while perhaps overstating the point, illustrates some of the stressful situations facing nurses in their daily jobs.

"Everyday the nurse confronts stark suffering, grief and death as few other people do. Many nursing tasks are mundane and unrewarding, many are, by normal standards distasteful and disgusting, others are often degrading , some are simply frightening"

Other factors associated with nursing stress include working in an enclosed atmosphere, working against the clock , excessive noise or undue quiet, sudden swings from intense to mundane tasks, no second chance, unpleasant sights and sounds and standing for long hours. Even though nurses are continually confronted by such events they are expected to be caring, professional, supportive, and able to cope at all times, putting the needs of patients first. Against this background it is perhaps hardly surprising that nurses report high levels of stress.

In addition to these features of the nursing role, there is evidence that the way nursing work is organised can also produce stress. Poorly designed shift systems, failures in communications, high patient-nurse ratios, higher levels of non-nursing duties, management style, poor working conditions and contractual conditions have all been shown to increase the stress load on the nurse.

Why is nursing stress a cause for concern ?

Stress is an important factor in determining job performance, sickness absence, job satisfaction and staff turnover. Occupational stress research shows that stress related illnesses carry a considerable human and economic cost. Human costs have typically been measured in terms of both mental and physical ill-health, either of which may ultimately lead to impaired job performance. Economic costs have been measured in terms of turnover and absenteeism.

Within nursing specifically, the economic costs related to stress include absenteeism, rapid staff turnover and reduced quality of patient care. The human costs of stress are repeatedly shown to contribute to feelings of inadequacy, self-doubt, lowered self esteem, irritability, depression, somatic disturbance, sleep disorders and burnout. From these outcomes, it is apparent that nursing stress not only affects the nurse, but also the organisation, the patient and the patients family.

Survey methods

The questionnaire was devised in conjunction with the 'stress committee', which was made up of INO members. They provided valuable advice on issues which are specific to nurses as an occupational group. An initial questionnaire was drawn up with the help of this committee and was piloted on a group of 59 nurses. On the basis of feedback from the pilot survey, the questionnaire was modified and improved and a final questionnaire was drawn up.

Questionnaires were distributed by post to the sample, who were requested to return completed questionnaires directly to the Work Research Centre. In this way confidentiality was ensured.

The survey took place between late July and early November 1992. Questionnaires were issued directly to respondents and reminder letters were sent out to non respondents approximately three weeks after the date of issue.

The sample

A 10% random, stratified sample was drawn from the INO membership database (12178 members), which aimed to ensure that nurses from each Section (the area of the INO membership database in which the nurse was working, e.g. general, midwifery, occupational health), and grade were selected.

A total of 1662 questionnaires were distributed and in all 771 completed questionnaires were returned - giving a response rate of 46.4%. This is a high response for a postal questionnaire survey.

Who took part in the survey ?

Age, sex

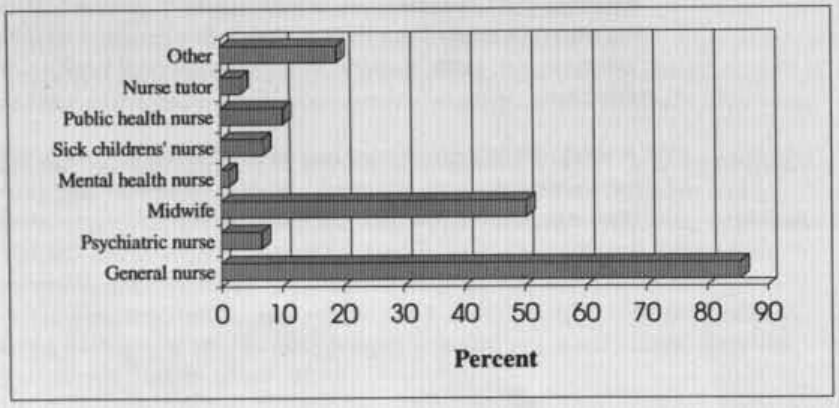
The biggest single age groups were those aged 30-39 (36.5%), with only 23.8% of the sample aged under 30 years and 39.7% over 40. This age profile is older than might have been expected. 97.3% of the sample were female and 2.7% male.

Experience

The mean number of years nursing experience in the sample was 14.4 years. 20% of the sample had less than 6 years nursing experience while 65% had more than 10 years experience

Registrations held

The Figure below illustrates the registrations held by the sample. This is a highly qualified sample, many of whom hold two registrations, of which the most common pairing is maternity and general nurse.



Registrations held by the sample

Grade

The grade distribution of the sample reveals a wide range of work areas and job roles captured by the survey, the largest group being staff nurses at 52.2%. Students, at 13.1%, were the next largest grade, followed by PHNs who made up 9.4% of the sample. Tutor grades were represented by 3% of the sample.

Area of work

The table below shows the wide range of workplaces investigated by the survey. Though these figures indicate high levels of working in hospitals, large percentages worked in non-general hospitals and outside of hospitals.

Area	Percent	Area	Percent
Medical	10	Surgical	8.3
Maternity	6.6	Mental Health	1.7
Paediatric	3.6	Special Care Unit	4.5
Public Health Nurse	9	Geriatric	16.0
Psychiatric Nurse	1.2	Accident and Emergency	6.6
Theatre	5.9	Other	26.6

Areas worked in by the sample

The working week

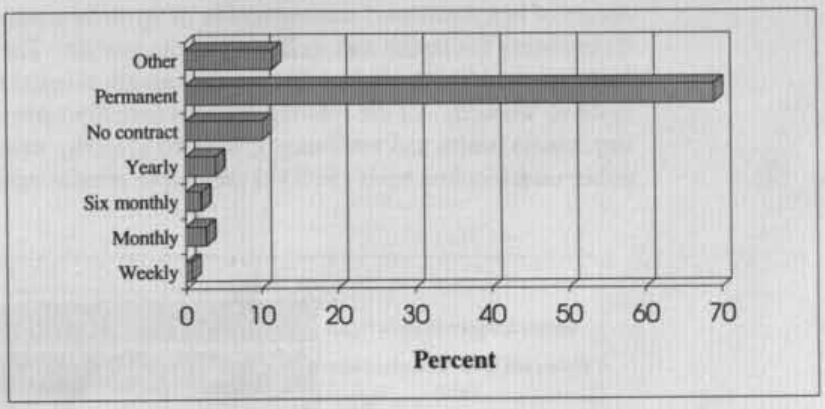
Although the mean working week was 38.5 hours, a sizeable portion, 12.5%, work more than an average of 40 hours per work. 39% officially work a 39 hour week and 33% a 40 hour week. Of those working an official 39 hour week, but who actually work 40 hours, 42% got their 1 hour back as accumulated time, (e.g. 4 or 8 hours at a time). However 17% of respondents do not seem to get their extra hour back at all.

Job tenure

66% of the sample held full-time permanent contracts, with 3.5% holding part-time permanent contracts. 12.5% had full-time temporary contracts and 4.2% had part-time temporary contracts. Of the remainder, 8% were job-sharing, 0.4% were agency nurses, and 5.4% had 'other' types of job tenure.

Contracts

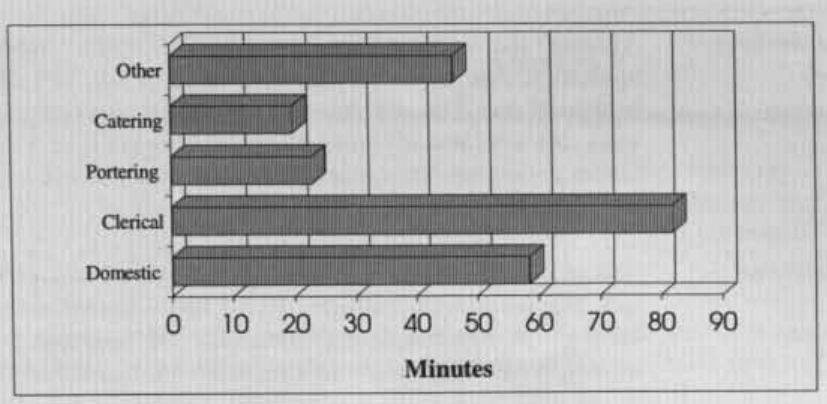
The Figure below shows the length of contracts held by the sample. While almost 70% of the sample have permanent contracts it should be noted that a large percentage reported having no contract at all (10.1%).



Types of job contract held by the sample

Non-nursing tasks

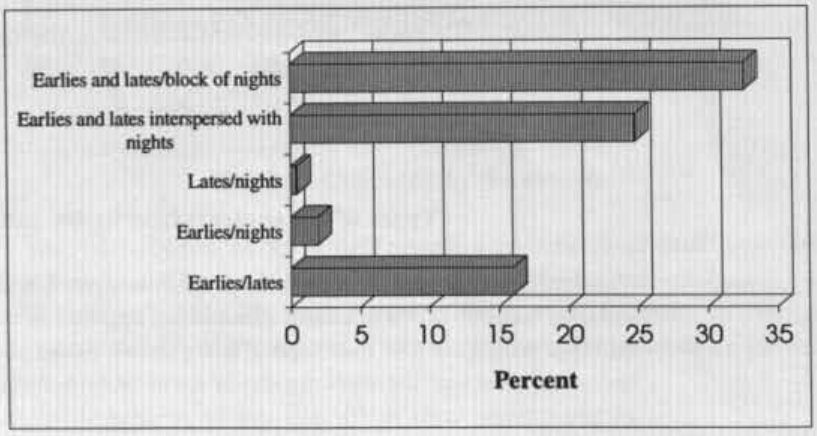
The findings indicated that a mean of 4.7 hours per 8 hour shift was spent on nursing tasks by hospital based, clinical (as opposed to administrative) nurses, and that only 22.4% of these spend more than 6 hours per day on nursing tasks. Almost half the working day is spent on non-nursing tasks. The type of non-nursing tasks performed and the average amount of time spent on them per shift is shown in the Figure below.



Average amount of time per shift spent on non-nursing tasks

Type of shift

The high percentage of the sample working shifts (66.9) reflects the 24 hour nature of hospital-based nursing and is likely to be a major factor in determining the health and wellbeing of the sample. The five most common shifts worked by the shiftworkers in the sample account for 75.7% of the shift systems worked. All are rotating systems (usually associated with negative impacts on health and wellbeing), with the majority involving night work, either on a blocked basis (34%) or on a more regular basis (26%).



Most common shift systems worked by the sample

Day shifts

Data on the longest shifts indicates the high and continuing prevalence of 12 hour (or often longer) shifts. As many as 18.4% of nurses report working more than five shifts on average which indicates the presence of split shifts and of either systematic overtime or double-jobbing or both.

Night shifts

The duration and number of consecutive night shifts worked by the sample revealed cause for concern from the point of view of health and wellbeing, as the predominant night shift schedules run contrary to recommendations on the design of shiftwork. 46.6% of the shiftworking sample worked between 1 and 30 nights in the past six months. This indicates an average of 5 nights per month, and if these were spread evenly there would be little cause for concern. However, the typical pattern for working nights involves seven consecutive nights (worked by 81.3% of night workers) of 12 hours duration (worked by 79.3% of night workers). In some cases the length of night shift was even longer than 12 hours per night).

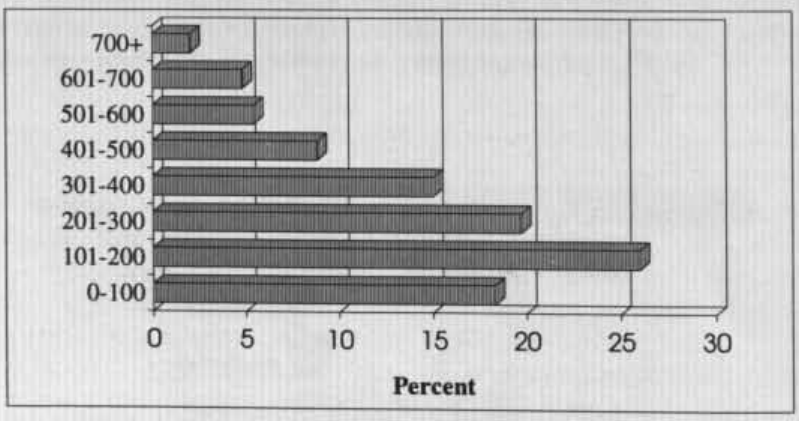
Where did the sample work ?

In this and the following sections, details of the kinds of workplaces in which the sample worked are provided. Information was sought on the workplaces in which the majority of the sample work - the hospital, community care and education. It was not possible to seek detailed information regarding some of the more disparate workplaces. Throughout these sections, the percentages quoted refer only to those nurses working within a specific workplace.

Hospital-based nurses

Hospital size

584 (75.7% of the sample) nurses reported working in hospitals. The Figure below shows the percentage of the hospital based nurses working in hospitals of different sizes. The average number of beds for the sample was 276.1. 85.8% of the sample worked in either Health Board or voluntary hospitals, while 61.5% worked in a hospital with an affiliated training school.



Hospital size

Nurse-patient ratios

The sample reported an average of 4.4 student nurses and 10.3 registered nurses working on their ward, or 14.7 staff in total. An average of 26.5 permanent beds per ward was reported. This is an average ratio of almost 1:2 for a twenty-four hour period. Assuming three shifts per day that gives us an estimate of 1 nurse per shift for every six patients.

Extra beds

On a typical day, an average of 0.6 extra beds per ward were reported , with 23.7% of the sample reporting having extra beds on the ward at an average of 2.5 days during the last month.

Nursing turnover in hospitals

The data in relation to nursing turnover should be interpreted with caution since it was collected by asking nurses in the sample for information in relation to those who had left and is subject to error. The estimate of annual turnover rate was 9.8%. This is a very high turnover rate (in industry,

turnover rates are generally of the order of 1-3%), and may reflect both the ease with which nurses can move jobs, and the effects of nursing stress.

Why nurses left

The three most frequently reported reasons relate to movement from one workplace to another. The most common reason was "to take up a position in another country" (56% of those who had left), followed by "in another hospital" (55%) and "another unit" (41%). 21.1% cited retirement as a reason and an alarming figure of 18.5% left "for health reasons".

Occupational Health Structures

Findings in relation to occupational health structures in the workplace showed a considerable lack of development. Health and Safety legislation in place since 1989 states that each workplace must at minimum have a health and safety statement and a health and safety committee. More than a third of the sample reported not having or not knowing of a health and safety committee in their workplace, whilst 51.2% of the sample reported that their workplace had no safety statement, or that they did not know of one. Only 16.2% reported that their workplace had an explicit or written health policy and only 10% reported that their workplace had a policy on sexual harassment. A disturbing 42.7% of the sample did not know who their health and safety representative was. These findings reflect a lack of priority placed on occupational health issues in nursing workplaces and a lack of effective communication systems within workplaces. They also pose a barrier to implementing the recommendations from this report.

Nurse Tutors

The sample of tutors and working conditions

26 tutors from a sample of 40 (this represents 3.4% of the sample) replied to this section of the questionnaire. Of these, 45% were clinical tutors, 35% were tutors based in both classroom and clinical areas, and 20% were solely based in the classroom. 23.1% of the sample reported having no formal teaching qualifications. This percentage (although based on a small sample) is a disturbing figure, with implications for quality of training. In addition, it is relevant to the debate on professionalisation in nursing.

Number of students and duties

The sample reported that they were responsible for a mean of 156.7 students. The average number of tutors in the hospital was 7.4. The average number of hours taught per day was 3.4 hours.

Tutor turnover in hospitals

The same qualifications apply to the data described below in relation to tutors, as applies to the discussion on reasons for leaving among hospital based clinical staff. It was estimated that the turnover rate among tutors was 9.3%, though particular caution should be used when interpreting this figure due to the small sample size.

Why tutors left

The reasons for leaving describe quite a different pattern than was the case for hospital based clinical nurses. First, the numbers retiring (27.3%) seem higher and are identical to the figures reported for giving up the profession permanently, which implies that early retirement is not a significant feature among tutors. Second, a far smaller proportion of tutors leave the country

(22.7%). And finally, fewer tutors leave the profession for health reasons (8.7%).

Tutor support

When asked about the adequacy of the clerical support available to them 50% of tutors reported it to be 'bad' or 'very bad'. Only 24% reported that they had adequate time for preparation within duty hours. 30% reported spending 6 hours or more per week preparing classes outside duty hours. Similarly, only 26.9% reported adequate time during duty hours for correcting written work. 47.4% spent 4 hours or more per week outside duty hours on correction of written work. These results suggest a population under severe time pressure and considerable workload.

Public Health Nurses

Working conditions of PHNs

There were 70 (9.1%) PHNs in the sample. 41.2% of PHNs reported having responsibility for more than 1000 patients, which is an astonishing figure with implications for effectively meeting this level of demand and also for quality of service. 33.8% of the sample reported having less than 16 colleagues in their community care area and 92.1% reported that client turnover had increased somewhat or greatly over the last three years.

Patient groups

The Table below presents the type of patient groups and the percentage of PHNs reporting having patients in these categories. It illustrates the wide variety of demands and expertise required by PHNs and the fact that such high percentages are found for each suggests that almost all those surveyed had patients in the majority of groups, the exception being AIDS and HIV Positive patients.

Type of patient	Percentage
Elderly	90.0
Mothers and Infants under 3 years	93.3
School Clinics	72.4
Domiciliary Nursing Duties	85.0
At risk or vulnerable families	91.7
Mothers and Children over 3 years	90.0
Health Clinics	90.0
Physically Disabled	88.3
Mentally Disabled	88.3
Terminal Care	91.0
Child Welfare Clinics	84.7
HIV + AIDS Positive	30.4

Distribution of types of patient among PHNs

PHN turnover

The same qualifications apply to the data for PHNs, as apply to the discussion on reasons for leaving among hospital based clinical staff. It was estimated that annual turnover rates for PHNs was 3.5%, which is considerably lower than the figures relating to hospitals. This may reflect a relatively settled labour market pool, with relatively few people having the qualifications to become PHNs, a relative lack of job opportunities compared to hospital based

nurses (particularly in relation to travelling abroad), or higher satisfaction with the nature of the job. 59.7% left to retire and 25.4% for health reasons which suggests that PHNs are an older group of nurses than hospital based nurses.

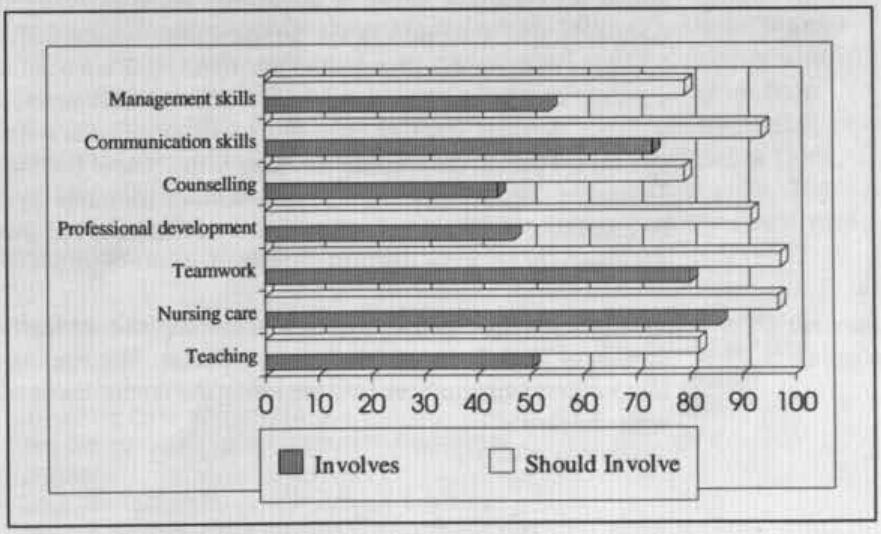
PHNs and support

Findings indicate that there is relatively little support provided to PHNs by fellow members of their Community Care team. The overall impression is that there is relatively little teamwork within Community Care teams, despite the high levels of demand which PHNs (and other team members) face.

Professional development

The ideal and the actual

The Figure below reveals serious disparities between what nurses perceive their role should involve and what it actually involves. For example, 40.8% reported that the nursing role at present involves nursing care completely, whereas 69% said it should. Large disparities were seen in relation to each of the other aspects, with particularly large discrepancies between the ideal and the actual in relation to management skills, communication skills, counselling skills and teaching. These findings indicate a high level of dissatisfaction with the current practice of the nursing role.



The ideal and actual nursing roles

Training for nurses

The issue of training has important implications for nurses and the amount of stress they suffer. If nurses feel inadequately prepared for the demands placed on them they are exposed to what is termed qualitative work overload. This is a significant predictor of stress and the negative effects associated with it. Also, related to this is the issue of personal and professional development where feelings of stagnation can reduce job satisfaction and performance.

In-service training

30.5% of the sample reported no in-service training in the last year and a further 32.6% reported only 1 or 2 days training. When asked what was covered in these training courses the most commonly reported topic was updating knowledge in a specialised area (72.1%). Training to use new equipment was next at 32.4% and management training followed at 24.9%.

Access to training and support

47.9% and 37.6% report receiving financial assistance for training either none of the time or only some of the time. Moreover, 73.5% report not being allowed any time off to study, 51.5% report not being allowed time off for exams, 65.1% report 'never' or 'sometimes' being encouraged to enhance their education, 83.7% report 'always' or 'sometimes' having difficulty gaining access to training, 62.4% reported that relief staff were not arranged during training, 91.1% report no financial rewards and 82% report no recognition for training. In short, it seems clear that post-qualification training plays no significant part in most nurses working lives. These findings describe an extremely negative environment and facilities for training, which will have to be addressed if the wishes of nurses for professional and personal development are to be realised.

Barriers to training

The most common barrier was lack of funding and the least common was the outside of work factor of family commitments. This finding runs contrary to many common prejudices held regarding the commitment of married nurses with children.

Sources of stress

This section outlines the principal sources of stress, coping strategies and the outcomes of stress reported by the sample. In addition, results relating to the issue of assault of nurses are also presented. A later section describes the relationships between the experience of sources of stress and outcomes.

Generic sources of work stress

The table below presents the five most common sources of stress, i.e. factors which caused them stress 'frequently' or 'always'. In general, the way work is organised causes most stress, rather than the nature of the work itself.

Source of stress	Percentage scoring 'frequently' or 'always'
Overwork	56.3
Lack of consultation/communication	46.6
Being undervalued	44.1
Insufficient resources	31.9
Factors not under your direct control	30.7

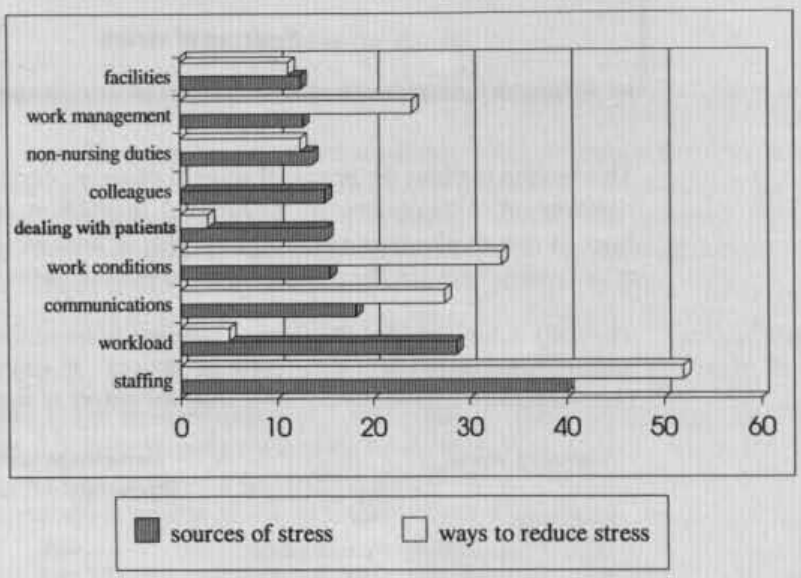
Nursing specific sources of stress

The nursing stress questionnaire examined a wide range of potential sources of stress. Much of the content of this questionnaire deals specifically with patient-nurse interactions, and is of questionable relevance to nurses from administrative backgrounds. The findings below are therefore particularly related to nurses with direct interaction with patients. The following Table highlights the five highest scoring items from the nursing stress scale. The percentages refer to the percentages of nurses reporting these sources of stress either 'frequently' or 'very frequently'.

Source of stress	Percentage scoring 'frequently' or 'very frequently'
Too many non-nursing tasks	60.9
Not enough time to provide emotional support to patients	57.0
Lack of involvement in policy/decision making	48.4
Nursing patients whose conditions stem from social conditions	44.1
Dealing with difficult, demanding or uncooperative patients	39.7

Self-defined sources of stress

Apart from the general and nursing stress questionnaires the respondents were asked to spontaneously report the three most important sources of stress for them and the three most important measures that could be taken to reduce stress amongst nurses. The Figure below details the findings.



Spontaneously reported sources of stress and ways to reduce stress

Inadequate staffing levels is the single most important source of stress amongst the sample, closely followed by the related issue of work overload. The single most important strategy for reducing stress relates to improving staffing levels. The next most important stressor is workload, while the next most important way to reduce stress was to improve working conditions and communications. Most of the important sources of stress refer to the way in which work is organised (with the sole exception of dealing with patients), and that all of the strategies proposed to reduce stress concern the organisation of work. (Note: there was little demand for coping skills training).

Intentions to quit

Research has shown that for those under severe workplace stress the only option may be to leave the profession. In order to examine this issue, respondents were asked about the likelihood of their leaving nursing assuming the availability of another job. A disturbing 40.2% of the sample reported that they would be either "quite likely" or "very likely" to give up nursing if another job was available. This is indicative of a population under severe stress and is considerably higher than most comparable data from other professions.

Stress from the physical work environment

By far the most frequent sources of stress in the physical work environment are lack of space, lifting patients and excessive heat, with in excess of 40% of the sample reporting large amounts of stress from each of these sources. An interesting finding concerns the relatively high levels of stress caused by having to deal with bodily fluids (25% reported stress 'frequently' or 'always' from this source). This may indicate a lack of awareness of, a lack of belief in, or even a lack of workplace policy and procedures to deal with the problems posed by HIV and Hepatitis viruses.

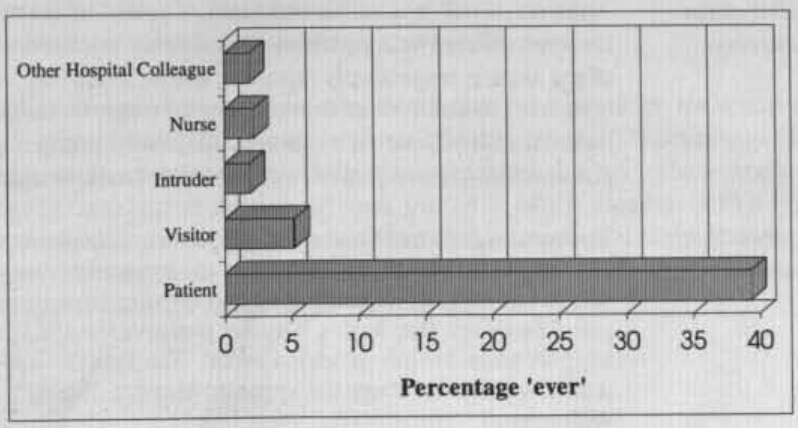
Assault

Assault in Nursing

The issue of assault in the workplace is one of increasing concern in the health care area particularly in Britain and the United States. The prevalence of assault amongst a nursing population in Ireland has not been systematically documented to date. This study investigated a range of aspects of this issue. Data on frequency, source, severity of injuries received, outcomes and support received for both physical and verbal assault were obtained.

Frequency of assault

A startling figure 39.3% of the sample reported experiencing assault from patients at some time in their career, with 5% of nurses reporting assault from visitors (see Figure 5.4). Small percentages also reported assault from intruders, fellow nurses or other hospital colleagues. These figures mean that in excess of 46.6% of the sample had been assaulted at some time during their course of their work (almost making it a normative feature of nursing), and that physical assault is a considerable source of threat to health and wellbeing.



Frequency of assault by source

Frequency of Assault

30.9% of the sample reported assault from patients in the past year while the figures for fellow nurses, hospital colleagues, intruders and visitors were 1.3%, 1.4%, 1.4% and 4.3% respectively. These findings are perhaps even more striking, as they indicate that assault is not an isolated nor a chance phenomenon. With regard to assaults from patients, those who had been assaulted (n=238) reported an average of almost 4 assaults in the past year, while assaults from fellow nurses (n=10) and other hospital colleagues (n=11) averaged more than two in the past year. Assaults from intruders (n=11) occurred on average twice during the past year, while assaults from visitors (n=33) occurred 1.8 times on average. This evidence of consistent physical assault asks important questions regarding the steps which are taken to reduce the phenomenon.

Injuries from physical assaults

The most common and severe injuries as a result of assault were emotional. Of those who have experienced assault only 22.3% experienced no emotional distress while 65.9% reported minor or moderate distress and 11.8% severe distress. Another disturbing finding is the reporting of severe injuries in the "other" category on the part of 16.0% of the sample, while 15% of the sample reported bruising as a result of assault.

Time off to recover

Surprisingly, in spite of the prevalence of assault and its severity, the amount of time taken off by those who have been assaulted is negligible. 96.4% (346) of the sample reported having taken no time off as a result of assault, 2.2 % between 1 and 3 days, 0.3% between 4 and 6 days and 1.1 % more than 10 days. These findings are indicative of a nursing culture where showing signs of distress is discouraged (and it is hard to imagine a situation which is more likely to induce distress than physical assault) and calls into question the structures and policies in place to deal with assault.

Verbal abuse in nursing

Analysis of the data on the incidence of verbal abuse reveals the most frequent sources being patients and patients' relatives with 27.9% and 20.0% of the sample respectively reporting abuse "often" or "regularly". However, between 8% and 10% of nurses reported frequent verbal abuse from fellow hospital staff. These findings are sufficiently strong to suggest that verbal abuse is an intimate part of hospital culture and management style.

Support after assault

The most significant sources of support after incidents of physical or verbal assault come from other nurses and the spouse/partner. The least prevalent sources of support were the INO and nursing administration. It should be noted however, that nurses may not perceive the INO as a possible source of support when assault incidents occur. The lack of support from administration indicates the apparent absence of policy and procedures to deal with assault.

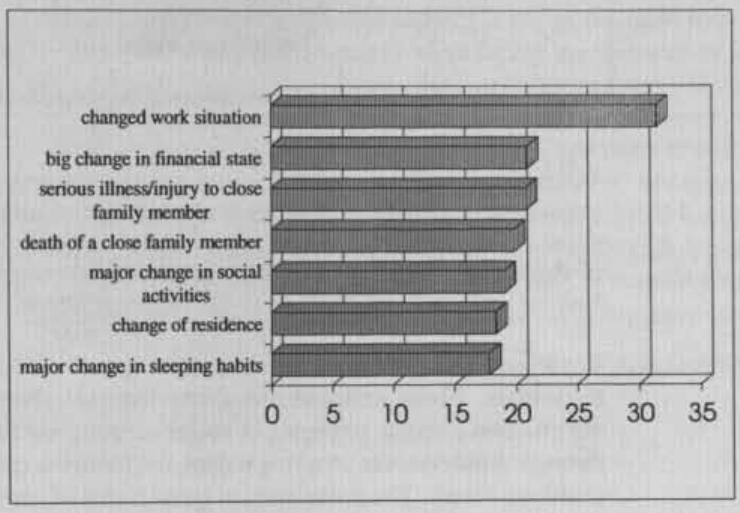
Non-work stress

Life Events

In order to determine if the outcomes observed in the sample could be due to factors outside the workplace, respondents were asked to provide information on possible sources of stress from this source. A common approach to investigating non-workplace stressors deals with the amount of change a person has experienced in the recent past. Life changes or major life events are associated with a potential stress load for the person and subsequent physical and psychological outcomes. The Figure below presents the seven most frequently reported life events.

Change in work situation

It is significant that one of the few work related events in this part of the questionnaire should be the most frequently reported (changed work situation). This is further evidence that a significant amount of the stress experienced by the sample is due to workplace factors especially when compared with the frequency of reported stress from other non-workplace stressors.



Most common sources of life events

How much stress comes from work?

A useful, if somewhat crude, measure to examine perceptions of the relative contribution of workplace versus non-workplace stress is to obtain ratings of the percentage of stress in their lives which comes from work. The average rating of percentage of stress from work was 54.6, which suggests quite a high stress load arising in the workplace. Other Irish occupational stress studies using this measure have produced ratings in the range of 40%-55%. In the present sample 59.3% gave ratings between 50% and 80%.

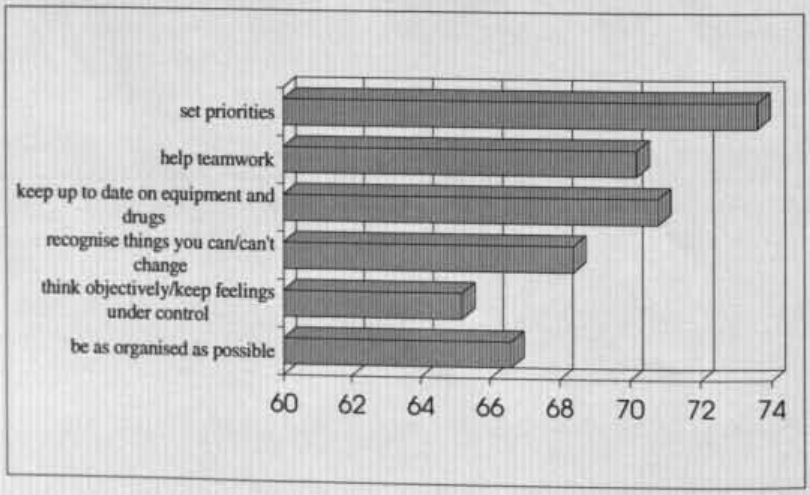
Coping and social support

When individuals are unable to cope with the demands placed on them they experience stress. Coping refers to the behaviours and actions people take to either manage demands, alter perceptions of stress or to manage the outcomes of stress. The manner in which people cope determines how stressed they become and what outcomes of stress they experience.

Coping strategies

The Figure below outlines the six most frequently used coping strategies by the sample. These strategies are all constructive - they relate to addressing the problem directly, engaging in social support, and thinking your way through problems, i.e. adopting cognitive strategies appropriate to the problems faced. The prevalence of these forms of coping strongly indicates that the sample had a series of positive coping strategies at their disposal which they practised. Therefore, the effects of stress reported below were unlikely to be due to failures in personal coping strategies.

This interpretation is supported by the results from the coping factors (i.e. where the individual coping items are grouped together into broad coping strategies). The most common coping strategies were problem-oriented coping and acceptance, while the least common strategies were feeling expression and passive coping. This profile strongly suggests that nurses, on the whole, cope well with stresses they face. However, the question as to whether this is effective or not in preventing the outcomes of stress will be addressed later.



Most commonly used coping strategies

Social support

The availability and adequacy of social support is one of the most important coping resources an individual possesses when facing the demands of stress. Social support in the workplace is among the most effective ways of coping with stress at work as people in the workplace are uniquely positioned to provide effective support. Nurse colleagues, relatives and other friends, and spouse or partner provided most support (i.e. provided "a lot" of support). Workplace management were seen as providing no support by 33% of the sample and only some support by 50.7%. These findings, though typical of many workforces under stress, indicate that the amounts of support from the workplace could be improved. On average, the amount of support received by the sample was reported to be no more than adequate.

The outcomes of stress

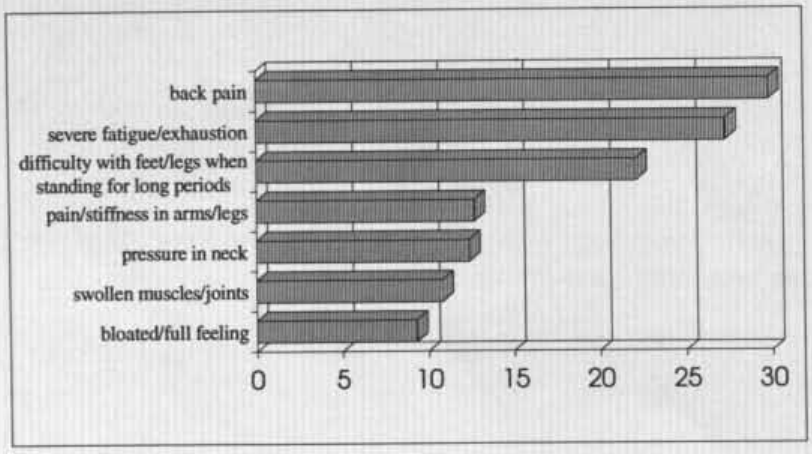
This section describes the outcomes of stress measured in the study, i.e. dimensions which can be negatively affected by stress. It is recognised that factors other than stress can influence these measures, but their relationship to the sources of stress is reported in a later section. Physical health, psychological wellbeing, job satisfaction were used as outcome measures in the study.

Absenteeism

743 nurses reported 5,700 days absent which is an average of only 7.7 days per annum. 64.7% reported 0-3 days absent in the last 12 months. This represents a rate of absenteeism which is far below the industrial norm in Ireland.

Physical symptoms

The Figure below shows the most prevalent physical symptoms among the sample. These occurred either 'frequently' or 'constantly' during the previous month. The findings indicate that six of the top seven most prevalent physical symptoms were musculoskeletal in nature is striking. It indicates the heavy physical nature of much of the work undertaken by nurses. It also constitutes evidence of occupation-related ill health.



Most prevalent physical symptoms

Job satisfaction

A seventeen item questionnaire was used to assess levels of job satisfaction among the sample. The measure provides three factor scores - intrinsic job satisfaction, which relates to the satisfiers found in the nature of the job itself; extrinsic job satisfaction, which relates to satisfiers obtained from working conditions; and overall job satisfaction, which is a combination of these latter two factors.

Sources of dissatisfaction

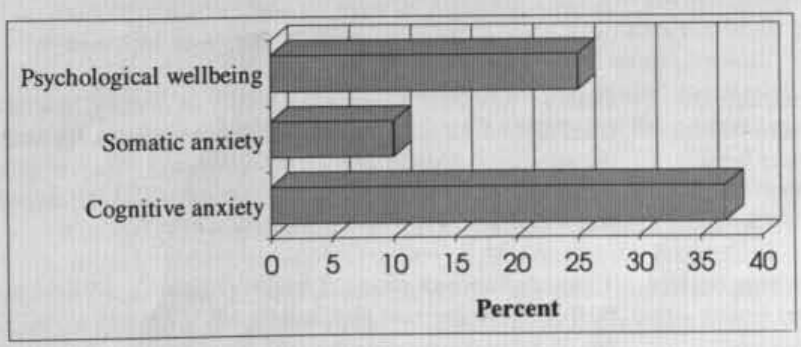
Rates of pay are by far the highest single sources of dissatisfaction amongst the sample, with 65% reporting themselves to be very or extremely dissatisfied. Of the remaining sources of dissatisfaction, three relate broadly to management style and organisational culture (the way the organisation is managed, industrial relations and recognition) while the other two refer to structural features of nursing (hours of work and promotion prospects).

Sources of job satisfaction

The biggest sources of satisfaction concerned job security (which is not surprising given the tenure of permanent nurses) and fellow workers, with almost half of the sample professing themselves very or extremely satisfied with these two aspects of work. The other sources of satisfaction largely concerned the intrinsic items of challenge, responsibility and variety in the job.

Psychological symptoms

The Figure below details the findings in relation to anxiety and psychological wellbeing. 37% of the sample reported high levels of cognitive anxiety (anxiety expressed at the level of thinking), 25% reported impaired levels of psychological wellbeing and 10% reported high levels of somatic anxiety (anxiety expressed in physical terms). These findings give rise for concern, particularly in relation to cognitive anxiety, where levels of distress are high in relation to almost all other groups sampled by the WRC and to a lesser extent in relation to psychological wellbeing, where levels of distress are considerably higher than the average for Irish employees.



Psychological Wellbeing

What groups reported most stress ?

This section describes relationships between personal and hospital demography and the experience of stress, job satisfaction and coping strategies. Two sets of inferential analyses were used to examine these issues. The first of these involved comparing variables taking a pair at a time, while the second (which is reported on later in the report) examines the relationship between demography and outcomes in a multivariate way. In interpreting these results it should be made clear that we are referring to average differences between groups - within any given group there is also considerable variation between individuals.

Grade and stress

Students report most stress

Students experienced significantly more stress than all other grades, especially in relation to stress from conflicts with nurses, lack of support and inadequate preparation. This finding strongly contradicts the literature, where in general, lower grade nurses experience the least stress.

Ward sisters most stress from workload

Although occupational health nurses and public health nurses would have similar levels of responsibility as ward sisters, they experience significantly less stress from workload than ward sisters. This suggests that it is probably structural aspects of hospital work which differentiates between those working outside of hospital settings and ward sisters.

Occupational Health Nurses report least stress

OHNs report least stress, particularly in relation to stress from nature of job, roles and relationships at work. These findings are best explained in terms of the structural aspects of their work settings - they usually work in occupational health departments, in industrial settings and as a result have more clearly defined roles and relationships.

Students report most health outcomes

The experience of physical health symptoms differed across grades. Overall, OHNs report the best physical health. Students reported significantly more health related outcomes than the other grades. It might be expected that those reporting the most stress should show the most health outcomes, however the finding that students generally report higher levels of physical symptomatology is disturbing. It is also evidence for nurses being a 'survivor' population.

Students and staff nurses report least job satisfaction

Students and staff nurses experienced significantly less intrinsic, extrinsic and total job satisfaction than ward sisters, PHNs and OHNs and other non-hospital nurses. It is also interesting that OHNs experienced most job satisfaction on all three measures and the least stress. This again suggests that the structural aspects of the occupational health nurses' work are more favourable than those of hospital nurses.

Students use passive strategies

Students use passive coping strategies significantly more often than other groups of nurses. They also use problem oriented strategies significantly less than all other nurses, whereas ward sisters use problem oriented strategies most frequently. These finding are consistent with the literature, where several studies have found that the type of coping strategy employed by nurses is related to the level of experience held. They also give rise for concern, as students also report highest levels of stress.

Nurses - a Survivor Population

The overall findings in relation to grade and the stress, process, where student nurses experience most stress, most health related outcomes while OHNs experience the opposite, suggests that those who are the most stressed have already left the profession and that those who remain are there because they are better able to cope with stress. This interpretation is supported by the finding that large numbers of nurses are leaving the profession for health reasons.

Age and stress

Under 29's most stressed

In general, the two younger age groups, under 20's and 20-29, reported greater stress than the two older age groups on all sources of stress variables. These findings are supported by those in relation to stress and grade. It is mainly students and staff nurses who make up these categories and they are the ones who experienced the most stress.

No age differences in health

There were no significant differences between nurses of different age groups and the experience of health related outcomes. This is an interesting finding, as it would be expected that older age groups would report more physical symptoms. This is further evidence for the 'survivor population' that nurses who are the most stressed and least healthy have already left the profession.

Older nurses report more job satisfaction

Nurses in their 20s experienced less intrinsic job satisfaction than those over 40, nurses in their 50s experienced more extrinsic job satisfaction than all other age groups, and nurses over 60 experienced more total job satisfaction than all other age groups. This is what might be expected since older nurses also experienced less stress than younger nurses. This finding also supports the 'survivor population' or 'healthy worker effect' hypothesis.

Age and coping

The under 29's used problem oriented strategies significantly less than all other age groups and passive strategies significantly more than older nurses. These findings are supported by the literature which suggests that it is through experience that older nurses use more positive coping strategies.

Area and stress

OHNs report least stress

Overall, OHNs report significantly less stress than other groups in relation to all sources of stress variables. This is consistent with the findings in relation to grade, where OHNs reported least stress. This is most likely due to structural aspects of their jobs being significantly better than those of hospital based nurses

A&E, Medical and Surgical nurses report most stress

Nurses working in Accident and Emergency, medical and surgical departments reported experiencing stress more frequently in relation to almost all sources of stress. This contradicts the literature, where in general it was found that all nurses irrespective of unit experienced the same two stressors most frequently (workload and death and dying) and that nurses from different units did not differ significantly in their experience of these sources of stress. The fact that associations were found in this study points to structural aspects accounting for the differences between the work of these units and other units in the hospital.

Specialist and geriatric nurses report most symptoms

Overall, there were very few differences between hospital units in relation to physical symptoms, and where these differences did exist they were small. It was found that specialist, geriatric and theatre nurses experienced more musculoskeletal and psychosomatic symptoms than paediatric nurses. Specialist nurses also reported more psychosomatic symptoms than A&E nurses and more general symptoms than OHNs. The reasons that geriatric and specialist nurses experience more symptoms may be related to the nature of their jobs - they either deal with patients who are getting worse all the time or have jobs characterised by intense work, technology and patients in critical conditions.

Geriatric nurses report lowest job satisfaction

Geriatric nurses have less intrinsic and total job satisfaction than OHNs, A&E, maternity, PHNs, special care, specialist and other nurses outside hospital settings. This finding is consistent with the literature which suggests that they experience less job satisfaction due to, for example, they lack status and are dealing with patients who get progressively worse.

More job satisfaction outside hospitals

In general the groups working outside hospital settings were more job satisfied than those within hospital settings. OHNs report more total job satisfaction, and OHNs, PHNs and nurses working in other non-hospital setting report more extrinsic job satisfaction than hospital-based nurses. This finding supports the findings in relation to sources of stress, where nurses outside of hospital settings, particularly OHNs reported least stress. It also indicates that structural aspects of the job are most likely to account for the differences between nurses from within the hospital environment and those outside.

Job Tenure and stress

Temporary nurses report more stress

There were very few significant differences between permanent and temporary nurses. However, temporary nurses reported significantly more stress from conflicts with nurses than permanent nurses. This is possibly because of factors associated with their status, for example, because they are temporary they are less involved than permanent nurses, also they may have less control over their jobs.

Part-time nurses report more symptoms

There were no significant differences between permanent and temporary nurses on any of the four dimensions of physical symptoms. However, part-time nurses reported more musculoskeletal, general and psychosomatic symptoms than full-time nurses. Part-time nurses also experienced more cognitive anxiety that full-time nurses. This is probably because of the status of their jobs, where they are uncertain of their roles, are often given the worst jobs and may have more stress from outside of work factors. It may also be evidence for nurses being a survivor population, as nurses may drift into part-time work (and eventually out of the profession) as a result of poorer health.

Permanent nurses more satisfied

While there were no differences between full-time and part-time nurses in relation to job satisfaction, permanent nurses were more satisfied than temporary nurses on all three dimensions of job satisfaction. This finding is best interpreted in relation to the significance of nurses status - temporary nurses probably have less control over their jobs and less certainty about tenure which may contribute to lowered job satisfaction.

Full-time and permanent nurses use better coping strategies

Permanent nurses and full-time nurses use problem oriented coping strategies significantly more than temporary nurses or part-time nurses. Temporary nurses also use more passive coping strategies. This indicates that nurses who are full-time and permanent have more control over their jobs and perhaps because of security of tenure they use more positive coping strategies.

Patient turnover and stress

More turnover - More stress

Nurses who felt turnover had increased greatly experienced more stress than those who felt turnover had not increased at all in relation to all nursing specific sources of stress. These findings are what might be expected due to an increase workloads which is not supported by a similar increase in resources.

What is most important in explaining the outcomes of stress ?

The second set of analyses consisted of a series of multivariate regression analyses, the aim of which was to answer questions concerning the relative importance of demographic variables, stressors, coping styles and levels of support (called predictor variables) in predicting outcomes. This analysis enables the unique contribution of personal and hospital demographic factors to explaining the outcome variables to be established.

The Table below summarises the findings from these analyses.

Sources of stress	**Physical health**	**Psychological wellbeing**	**Job satisfaction**
Conflict with nurses	Digestive, musculoskeletal symptoms		
Home-work interface	Musculoskeletal, psychomatic and total symptoms	Psychological wellbeing	
Nature of the job			Intrinsic
Career development			Intrinsic, extrinsic
Nursing workload			Extrinsic
Coping			
Keeping problems to yourself	Digestive, psychosomatic and total symptoms	Psychological wellbeing	
Keeping things in perspective		Psychological wellbeing	
Passive coping			Extrinsic
Lack of management support	Digestive, psychosomatic and total symptoms		Intrinsic, extrinsic
Adequacy of support		Psychological wellbeing	Intrinsic, extrinsic
Demography			
Experience	Digestive, psychosomatic and total symptoms		
Grade	Musculoskeletal symptoms		
Part/full-time	Musculoskeletal symptoms		Extrinsic
Maternity	Psychosomatic and total symptoms	Psychological wellbeing	
Shiftwork	Psychosomatic and total symptoms		
Other areas		Psychological wellbeing	
Special care			Intrinsic
Geriatric			Intrinsic
Surgical			Extrinsic
Job tenure			Extrinsic

The most important factors associated with stress related outcomes

The role of sources of stress

Conflict with nurses

Stress coming from conflict with nurses was strongly associated with two measures of physical symptomatology - digestive and musculoskeletal symptoms. It takes a long time for stress to produce physical symptomatology, and therefore the findings in relation to conflict with nurses indicates that stress from this source is chronic.

Nursing workload

Nursing workload was associated with extrinsic job satisfaction. This indicates that stress from levels of workload are strongly related to the dissatisfaction with the more contractual aspects of the job.

Home-work interface

Stress from the home-work interface was associated with four of the outcome variables - musculoskeletal, psychosomatic and total physical symptoms, and psychological wellbeing. This indicates that the stress nurses experience from this source is intimately involved with how well they feel. It is noteworthy in the light of increasing labour force participation by women, and of the women's movements efforts to ensure equal treatment for women in the workplace, that stress from this source plays such a powerful role. It should be noted however, that stress from this source refers to factors both in the workplace and in the home. For employers, the significance of this finding resides in their capacity to enable employees to meet both home and work demands.

Nature of the job

Stress arising from the nature of the job was associated with low levels of intrinsic job satisfaction. This finding can be interpreted in two ways - nurses who are unsuited to the job itself are dissatisfied, or that unreasonable levels of stress from this source produce dissatisfaction.

Career Development

Stress coming from career development was associated with levels of intrinsic and extrinsic job satisfaction. It should be noted that stress from this source refers both to opportunities to gain promotion and to opportunities for development within a given grade. In this context, it is not surprising to see this finding. Unhappiness with these aspects of the job receives support from the findings regarding training and professional development reported on above.

The role of coping and social support

Keeping problems to yourself

The coping style of keeping problems to yourself was associated with three measures of physical symptoms and with psychological wellbeing. In some ways there is no great surprise in these findings, as coping style is known to be related to levels of stress related outcomes. However, the fact that this is a negative coping style (only one positive coping style was associated with the stress related outcomes), and the findings reported above which indicate that this coping style is most used by students gives cause for concern. It would seem that training to reduce levels of this type of coping are indicated at the start of the nursing career.

Keeping things in perspective

The coping style of keeping things in perspective was associated with psychological wellbeing. This was the only case where a positive coping style conferred better wellbeing. This relative failure to see more benefits from the use of good coping strategies may indicate that the levels of stress

inherent in nursing overwhelm the coping resources of the individual. There is support in the literature for this finding, where its has been shown that individual coping attempts are relatively ineffectual in dealing with workplace stress.

Passive coping

The finding that passive coping styles were linked to low extrinsic job satisfaction may indicate that nurses who adopt this style are less likely to be able to influence their contractual working conditions. It may also indicate that nurses who have poor contractual working conditions are forced to adopt this coping style. In either case, it provides further evidence of the relative failure of coping in the face of nursing stress

Lack of management support

Lack of management support proved to be one of the most significant variables in the entire set of analyses. It was strongly associated with no less than five of the seven outcome variables examined, and also generally had the strongest relationships of all. It was associated with three of the four physical symptom variables and with both indices of job satisfaction. While all of these relationships make good sense, the strength of the relationships and their number is of more interest. This range of findings indicates that there is considerable room for improvement in the levels of management support provided to nurses, and that improvements in this area are likely to be the single most effective intervention that can be made to reduce stress.

The role of demography

Experience

Job experience was related to three of the indices of physical symptoms. This indicates that the cumulative demands of nursing eventually produce effects on physical symptomatology.

Maternity

Working in the maternity area was negatively associated with three of the outcome variables - psychosomatic and total symptoms and psychological wellbeing. Perhaps the most plausible reason for this finding is that maternity nursing is less demanding. The fact that most patients are not ill and that fewer patients die may contribute to lower levels of physical symptoms among maternity nurses.

Part/Full time

Working part-time was associated with two of the outcome variables - musculoskeletal symptoms and extrinsic job satisfaction. The first of these findings may indicate that part-time nurses are designated to do heavier physical work, or may also indicate that nurses with musculoskeletal symptoms are forced to undertake part-time work (this would be further evidence for the survivor population hypothesis). The findings regarding extrinsic job satisfaction are explainable in terms of reductions in income.

Shiftwork

Working shiftwork was associated with two of the outcome variables - psychosomatic and total physical symptoms. However, the fact that shiftworkers reported fewer of these symptoms was unexpected, and may be evidence for a 'healthy worker' effect, i.e. where those who have developed health problems have moved off shiftwork.

Grade

The higher grades reported more musculoskeletal symptoms than lower grades. This is an unusual finding, and may indicate that the effects of the

physical demands of nursing persist for a long time, at least in terms of these symptoms.

Surgical area Nurses working in the surgical area were associated with lower levels of extrinsic job satisfaction. This finding is not easy to explain, and may be spurious.

Other areas Nurses working in 'other' areas, i.e. outside of the main nursing specialities or outside of hospitals reported poorer psychological wellbeing than other nurses. This may be a result of the kinds of areas in which at least some of them work - they include private nursing homes and agency nursing. The lack of security and often poor working conditions probably contribute to this finding.

Job tenure Nurses who were on temporary contracts reported lower extrinsic job satisfaction than permanent nurses. This is not surprising, as the different levels of job security and pay associated with temporary nursing would be sufficient to explain this finding.

Special care Working in the special care area was associated with higher intrinsic job satisfaction. This finding would be expected, since working in special care provides nurses with one of the few opportunities for meaningful career development - in this area they can receive appropriate training and have the opportunity to put the skills learned in training into practice.

Geriatric area Working in the geriatric area was associated with lower intrinsic job satisfaction. This finding is to be expected, since the nature of the stresses to be dealt with (e.g. more patients dying, increased level of assault) together with a lack of investment in geriatric services would combine to make this less satisfying work than other areas of nursing.

Summary These findings indicate the central role which support has to play in promoting and maintaining a healthy work force. Not only was lack of management support linked to the experience of three out of four of the physical health symptoms it was also linked to lower job satisfaction. The adequacy of support is also an important predictor variable. More adequate levels of support predicted higher job satisfaction, while inadequate levels of support predicted lower psychological wellbeing.

In relation to stressors, the fact that conflicts with nurses was related to all four physical health outcomes indicates that this issue needs to be better managed, perhaps through improving communication channels and promoting the concept of team work. Stress arising from the home-work interface was related to three out of four physical health symptoms and also to poorer psychological wellbeing. This illustrates the difficulties nurses have in managing the stresses of work and home at the same time. Career development is also a major issue in the experience of both lower intrinsic and extrinsic job satisfaction, indicating that issues relating to promotion and professional development are in need of serious review.

Finally in relation to coping styles, the finding that the negative strategy of keeping problems to yourself affects both physical and mental wellbeing suggests that nurses need training in the use of more positive coping strategies.

Recommendations

Policy recommendations

The following recommendations are directed at those who are responsible for making or influencing policy with regard to nursing. They would include the INO primarily and initially, as they have commissioned this survey, but would ultimately fall within the purview of the Department of Health, the hospitals (as employers) and An Bord Altranais. All of the policy recommendations outlined below are framed with the understanding that the responsible policy making bodies generate new policies and practices to implement the recommendations.

Awareness — Awareness of occupational stress amongst nurses needs to raised, both within policy making and policy influencing bodies and within the areas of nursing for which they are responsible.

Entry into nursing — A thorough review of the conditions under which entrants to the profession are trained is needs to be undertaken, with a view to their improvement.

Training — The role and function of post-qualification training needs to be reviewed. It should focus on both professional development and the provision of operational skills.

H&S committees — Health and safety committees should be explicitly encouraged. This involves meeting the obligations of legislation and the provision of adequate resources to enable their function.

Shiftwork — Shiftwork patterns need to be redesigned in accordance with principles for ensuring least possible damage to health and wellbeing.

Assault — A comprehensive policy on assault needs to be devised and implemented.

Non-nursing duties — The issue of non-nursing duties needs to be addressed, with a view to a policy on the reduction of these being adopted.

Nurse turnover — A study of dropouts from the profession needs to be undertaken for a number of reasons - high turnover, possible occupational health problems, and insights into nursing stress.

Nursing culture — The appropriateness of nursing culture in meeting the professional and operational needs of nursing needs to be examined.

Stress management — A comprehensive and integrated plan for stress management in nursing needs to be developed.

Operational recommendations

The recommendations outlined below are targeted at the operational level, and are appropriate for implementation by employers and management within the range of nursing workplaces.

Students	Measures should be taken to improve the conditions for working and studying for students.
Training	Facilities for post-qualification training need to be improved.
H&S committees	Health and safety committees with trained nursing representation need to be established in all workplaces.
Shiftwork	Shiftwork schedules need to be assessed and redesigned where appropriate, with a view to maximising the benefits to the individual and minimising the hazards of shiftworking.
Assault	Policies and procedures to provide meaningful support to nurses who have been physically or verbally assaulted must be immediately implemented. Training in methods of avoiding assault should be provided as part of basic nursing training.
Workplace support	Management and ward-level (or unit level) support structures need to be implemented and strengthened.
Non-nursing duties	An assessment of the range and extent of non-nursing duties should be undertaken within each hospital. On the basis of these assessments, non-nursing duties should be assigned to appropriate ancillary staff.
Nursing Culture	A more open style of management should be adopted, characterised by support for the professional role, participation in decision making and improved communications.
Plan for stress management	Each nursing workplace should develop and implement a plan for stress management within the workplace. This plan should incorporate structural interventions (e.g. shiftwork design, improving communications) as well as individual interventions (e.g. training). The plan should be drawn up with the help of and be made available to all nurses within the workplace. It should work through the medium of health and safety committees and its implementation should be monitored and evaluated.
Specific sources of stress	Specific stress management interventions should take place in relation to the following sources of stress: conflict with nurses; stress from the home-work interface; career development; stress from the nature of the job and nursing workload.