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Job Stress and General Well-Being: A Comparative Study of Medical-Surgical and Home Care Nurses

The purposes of this study were to examine job stress among medical-surgical and home care nurses, and determine if high job stress predicted general well-being. A comparative, descriptive design was used. Findings support the need to examine workplace stressors and implement strategies to reduce overall job stress among medical-surgical nurses.

Stress is pandemic in today's society. Results of an occupational stress survey in the early 1990s (Northwestern National Life, 1991) showed that the proportion of workers who reported feeling "highly stressed" more than doubled between 1985 and 1990 (Speilberger & Vagg, 1999). Since that time, the work environment has become more stressful due to mergers, downsizing, and intense competition. Health care and nursing have not been spared. Increasing patient acuity and decreased length of stay in both acute and home care settings, a composite of new technology, managed care, increased supervisory responsibilities, risk and fear of litigation, and the current nursing shortage all place increased stress on today's nurses. Other key factors contributing to workplace stress include team conflict, unclear role expectations, heavy workload, and lack of autonomy (Calnan & Wainwright, 2001; Huber, 1995; Peterman, Springer, & Farnsworth, 1995; Taylor, White, & Muncer, 1999).

The Occupational Health and Safety Survey (National Institute for Occupational Safety and Health [NIOSH], 1995) confirmed the deleterious effects of stress in certain occupations. An examination of more than 22,000 health records of employees from 130 occupations showed 40 occupations had higher than expected incidences of stress-related disorders. Along with six other health professions, nursing was among the occupations experiencing the negative impact of stress.

Failure to acknowledge and take action to reduce nursing occupational stress has potential physiological, psychological, spiritual, occupational, and economic effects. In an early study, Harris (1989) compared stress-related symptoms in surgical nurses to the general population and found that nurses presented with higher mortality rates, stress-related disease, high blood pressure, anxiety, and depression. Even more alarming, Metules and Bolanger (2000) reported that suicide is among the top five causes of death among nurses — a much higher rate than the general population.

High stress leads to negative work environments that rob nurses of their spirit and passion about their job. Low job satisfaction in nurses is linked empirically to chronic absenteeism, decreased morale, reduced job performance, burnout, increased tardiness, high turnover, and substance abuse (Lancero & Gerber, 1995; Laschinger, Wong, McMahon, & Kaufmann, 1999; Lobb & Reid, 1987). Moreover, high stress affects over-

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all quality of care. Loss of compassion for patients, and increased incidences of mistakes and on-the-job injuries are consequences of high stress levels (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Laschinger et al., 1999; Laschinger, Finegan, Shamian, & Wilk, 2001; Lusk, 1997).

Some authors have attempted to estimate the impact of stress in terms of economic consequences. Stress has been estimated to cause half of workplace absenteeism and 40% of turnover, which is projected to cost the U.S. economy \$200 – \$500 billion annually (Department of Health and Human Services [DHHS], 1999; Matteson & Ivancevich, 1987; Maxon, 1999). Discussing the negative impact of psychological stress resulting from downsizing, Wright and Smye (1996) quoted an earlier estimate by Spielberger and Vagg (1991) projection the overall costs to business and industry of burned out or dispirited employees at \$150 – \$180 billion a year.

Job stress combined with the stress from everyday life can lead to detrimental physical and emotional outcomes for nurses and their families. This awareness has been responsible for growing attention to employee well-being. There are two common components to well-being: the actual physical health of workers and the mental, psychological, or emotional aspects of workers (Budge, Carryer, & Wood, 2003; Geiger-Brown et al., 2004; Pomaki, Maes, & Ter Doest, 2004). *Well-being* comprises the various work/job-related satisfactions (for example, satisfaction and/or dissatisfaction with pay, the job itself, co-workers, and supervision), as well as life/non-work satisfaction enjoyed by individuals. There are personal and organizational consequences of well-being. Nurses' and other health care providers' experience of constant stress may affect their well-being and lead to disengagement, poor judgment, distress, and burnout. Stress and concomitant decreased well-being are contributing factors to organiza-

tion inefficiency, high staff turnover, absenteeism because of sickness, decreased quality and quantity of care, increased costs of health care, and decreased job satisfaction (Abu Al Rub, 2004).

Recognizing the clearly established relationship between high levels of stress and adverse employee and organizational effects, nurse leaders must begin to examine levels of workplace stress and factors contributing to stress. Proactive interventions then can be used to decrease the target stress and/or help nurses adopt strategies to cope with stressors. Hence, the purpose of this study was to identify stressors and the intensity of stressors for nurses employed in medical-surgical and home care units, and to determine the relationship between stress and mental well-being. It was hypothesized that nurses employed on medical-surgical units would report higher stress levels and that nurses reporting high job stress would have negative affect scores.

Methodology

A comparative, descriptive study was designed to explore the causes and the severity of stress in hospital-based medical-surgical and home care nurses, and to examine the relationship of occupational stress to nurses' affective mood. The target population was drawn from RNs and LPNs in two hospitals from a Northeast health care system (one urban and one suburban location) and three area home care agencies, representing both freestanding and hospital-based agencies. Convenience sampling was used.

Instrumentation

The majority of quantitative measures of stress, such as the Work Environment Scale (Moos, 1994), Occupational Stress Indicator (Cooper, Sloan, & Williams, 1988), and NIOSH Generic Job Stress Questionnaire (Hurrell & McLaney, 1988), focus on identifying job stressors and determining the *intensity* of each stress. Measurement of stress is generally not discipline-specific. Rather,

these measures focus on commonly known aspects of work situations that result in job strain. Thus they address items such as "making critical, on-the-spot decisions" or "conflict with other departments" instead of specifically identifying "decision making in a code situation" or "conflict with a physician."

Focusing on job stressors themselves in the absence of frequency assessment may not provide a full picture of the work environment (Spielberger & Vagg, 1991). The impact of stress is influenced not only by the severity of the stressor but also by the frequency of its occurrence. For example, a "code situation" in either home care or in the acute care environment may be considered highly stressful; however, if one nurse experiences that stress weekly and another experiences the stress annually, the stress phenomenon is different. Consequently, measures of occupational stress that evaluate both the perceived severity of specific sources of stress and the frequency of occurrence of that stressful event within a preset time period may provide a more accurate measure. The method of measurements prevents overestimating the effects of highly stressful events that rarely occur in a particular work setting, as well as underestimating the impact of moderately stressful events that occur quite frequently (Spielberger & Vagg, 1991).

Job stress survey. In this investigation, occupational stress was measured by using the Job Stress Survey (JSS) (Spielberger & Vagg, 1991). The JSS measures the perceived severity (intensity) and frequency of occurrence of 30 general sources of work-related stress that are experienced commonly by both men and women employed in a wide variety of business, industrial, and educational settings. The JSS has been used to provide information about specific work-related stressors that adversely impact employees, as well as to evaluate and compare the stress levels of employees in different work departments and settings. The

instrument contains 30 items. Each item is rated twice by the participant on a 9-point scale, first for perceived severity and then for frequency of occurrence within the last 6 months. The JSS yields scores for three scales and six subscales. The three scales are total scores for job stress severity (JS-S), job stress frequency (JS-F), and job stress index (JS-X). The JS-X combines the severity and the frequency ratings of the 30 items and is an overall indicator of perceived stress level.

Factor analysis of the JSS has demonstrated consistently two major components of job stress: job pressure (JP) and lack of organizational support (LS). Ten-item subscales for each of these components provided additional information on pressures associated with the job itself (JP) and lack of support (LS) from supervisory personnel, fellow workers, or an organization's administrative policies and procedures. Three scores are reported for JP and LS, yielding the six subscale scores. These scores are similar to the overall job stress scale scoring and provide information on the severity of the stress within the category, the frequency of occurrence, and the overall index score.

The JSS has been used extensively in professional health care settings. Data have been normed on 1,873 individuals drawn from managerial, professional, health care, and clerical employees. Cronbach's alpha for the overall job stress scale, the severity subscale, and the frequency subscale all were reported above the 0.80 level. Cronbach's alpha for this study was high, with a severity index alpha of 0.96 and a frequency index alpha of 0.92. The overall total reliability score for the stress index in this investigation was 0.95.

Affect balance scale. The Affect Balance Scale (ABS) (Bradburn, 2001) was employed to measure mental well-being or overall affect. This 11-item questionnaire contains two subscales, a five-item positive affect scale (PAS) and a five-item negative affect scale (NAS). The 11th ques-

tion asks participants to rate their general happiness. Each question is scored on a 3-point scale assessing the frequency of occurrence of the positive or negative feeling. The ABS score is computed by subtracting NAS scores from PAS scores and adding a constant of 5 to avoid negative scores. The model specifies that an individual will be high in psychological well-being to the degree to which he or she has an excess of positive-over-negative affect and will be low in well-being in the degree to which negative predominates over positive (Bradburn, 2001).

The original instrument was normed on a probability sample of 2,006 adults ages 29 to 49 living in four small Illinois communities. The test-retest reliability was reported by Bradburn to be 0.76. Positive affect was correlated with social participation, companionship, and sociability. Negative affect was correlated with tensions, worry, and difficulty adjusting to work or marriage (Boyd & McGuire, 1996).

Interview guides. An interview guide designed of five open-ended questions was used to elicit in-depth responses to overall job stress, workplace stressors, support, and perceived well-being. The interview guide was prepared by the researchers and reviewed by two nursing administrators who had an active program of stress research. After completion of the quantitative survey, nurses who indicated a willingness to be questioned for a broader look at workplace stress were contacted by the researchers in either phone or face-to-face interviews, or through focus group interviews.

Data Collection

Institutional review board approval was obtained through both the hospital system and the academic facility where the researcher was employed. Permission from the vice president of nursing also was obtained at each of the home care sites. The participating acute care organization was selected conveniently and the home care agencies were

selected to represent the main referrals from the agency. The participating acute care units were designated by the agency to be medical-surgical units. A site resource manager assisted with on-site survey distribution and collection, and kept the completed research packets in a locked cabinet until returned to the investigator. Research packets consisted of a cover letter advising the nurses of the purpose of the research, an informed consent, the Job Stress Survey, the Affect Balance Scale, a demographic sheet, and an envelope for returns. All packets were numerically and color-coded to differentiate by unit. No personal identifiers were used. A total of 142 research packets were distributed to all eligible RNs on the five participating units/sites. Data collection proceeded over a 1-month period. Qualitative interviews were conducted after completion of the quantitative portion of the study with a purposive subsample of nurses who agreed to be interviewed.

Data Analysis

Independent sample *t*-tests were used to determine differences in stress cores between medical-surgical and home care nurses. One-sample *t*-tests were used to compare the group results with known normative scores for professional women. A significance of 0.01 was set because the analysis would require multiple *t*-tests and this would reduce the likelihood of a type 1 error.

Results

Sample and setting. Of the research packets distributed, 95 packets were returned (67%); however, only 89 were used for analysis because of missing data. Table 1 provides the demographic characteristics of the sample by age, work status, position, education, and years in nursing. The majority of respondents were middle-aged, female, and employed as staff nurses with many years of nursing experience.

Job stress. Table 2 shows that the total stress score and sub-

Table 1.
Demographics of Survey Respondents

	Medical-Surgical N = 31		Home Care N = 58		Total N = 89	
	n	%	n	%	n	%
Gender						
Female	29	93.5	57	98.3	86	96.6
Male	2	6.5	1	1.7	3	3.4
Age						
21-30	7	22.6	1	1.7	8	9
31-40	8	25.8	12	20.7	20	22
41-50	10	32.3	30	51.7	40	45
>50	6	19.4	15	25.9	21	24
Education						
LPN	1	3.2	1	1.7	2	2.2
RN Diploma	2	6.5	7	12.1	9	10.1
RN Associates	11	35.5	18	31.0	29	32.6
RN Bachelors	15	48.4	26	44.8	41	46.1
RN Masters	2	6.5	6	10.3	8	9.0
Years in Nursing						
1-10	13	42.0	11	19.0	24	27
11-20	10	32.3	21	36.2	31	35
21-30	6	19.4	18	31.0	24	27
>30	2	6.5	8	13.8	10	11
Years in Position						
<5 years	14	45.2	36	62.1	50	56.2
5-10 years	8	25.8	12	20.7	20	22.4
11-15 years	6	19.4	5	8.6	11	12.4
16-20 years	2	6.5	1	1.7	3	3.4
21-25 years	0	0	3	5.2	3	3.4
>25 years	1	3.2	1	1.7	2	2.2
Work Status						
Full-time	27	87.2	40	69.0	67	75.3
Part-time	2	6.4	10	17.2	12	13.5
Per diem	2	6.4	8	13.8	10	11.2
Position						
Staff nurse	26	83.8	44	75.9	70	78.7
Assistant manager	2	6.5	3	5.2	5	5.6
Manager	3	9.7	5	8.6	8	8.9
Supervisor	0	0	4	6.9	4	4.5
Director	0	0	2	3.4	2	2.3

scale scores for nurses employed on medical-surgical units were higher than for those employed in home care. To test the hypothesis that medical-surgical nurses would have higher stress scores than home care nurses, authors performed independent sample t-tests. These findings showed there was no difference in mean scores for job stress severity (JS-S), but there was for job stress frequency (JS-F) ($t [78] = 4.04, p < 0.001$) and the overall job stress index (JS-X) or total job stress ($t [74] = 3.18, p = 0.002$). Findings thus supported the

hypothesis. A comparison of the scores from both groups of nurses to normative scores from a sample of 340 female professional employees showed that nurses employed on medical-surgical units had higher stress scores than the normative group. Stress levels for home care nurses were similar to the normative data.

Figure 1 converts the mean scores into percentile rankings to illustrate the scores obtained in this sample compared to normative scores provided by the Job Stress Survey. The overall job stress index score of 28.49 for

medical-surgical nurses placed this group in the 79th percentile of stress rankings as compared to home care nurses whose job stress index was in the average range (50th percentile).

Examination of the 10 most stressful items (the item index scores) showed that there were five common top stressors for both medical-surgical and home care nurses, and five unique stressors per environment. Table 3 presents these top stressors. Excessive paperwork was the top stressor for both groups of nurses. The other stressors, although

ranked differently by each group, included meeting deadlines, frequent interruptions, insufficient personnel to handle an assignment, and insufficient personal time. For medical-surgical nurses, all other top-10 stressors fell in the "lack of support" category and included events involving other people. For home care nurses, the additional stressors related to job factors such as travel, the weather, and work environment.

Job pressure. Table 2 summarizes job pressure scores. Medical-surgical nurses reported higher job pressure severity and frequency (and thus a higher pressure index) than home care nurses; however, independent sample t-tests did not meet the significance criteria of $p < 0.01$. In comparison to the normative data on professional women, medical-surgical nurses had significantly higher job pressure scores for all three pressure measures. Home care nurses had similar job pressure severity when compared with the normative scores, but had greater job pressure frequency. After conversion of the mean scores to percentiles, Figure 1 shows that medical-surgical nurses were well above the average 50th percentile with an overall pressure index score placing them at the 84th percentile. The job pressure index for home care nurses was also above average at the 65th percentile.

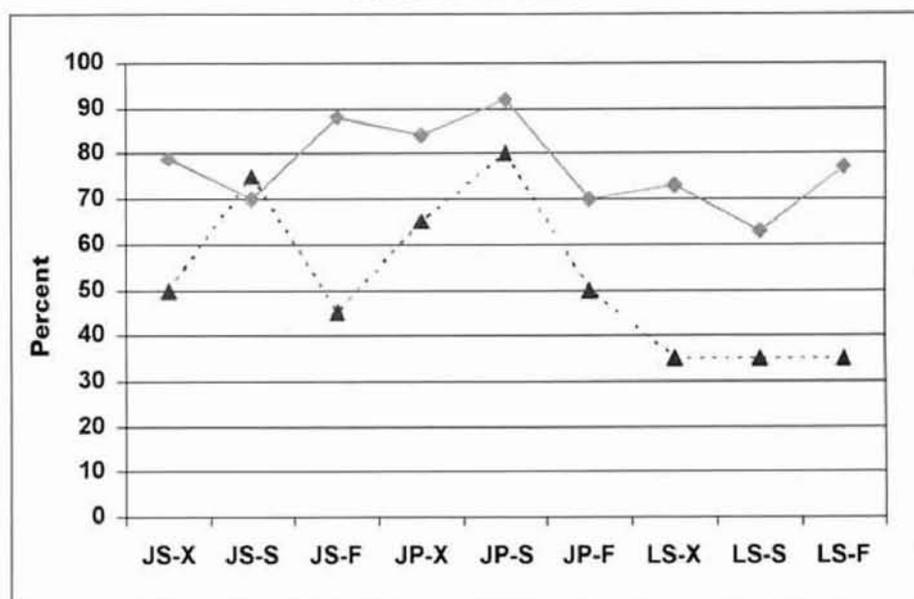
Lack of organizational support scale. Table 2 presents the mean scores for organizational support among medical-surgical and home care nurses. Independent t-test results showed that lack of support severity scores did not differ between the two groups, but medical-surgical nurses had significantly higher lack of support frequency ($t [82] = 5.03, p < 0.0001$) and lack of support index scores ($t [81] = 5.09, p < 0.0001$). A comparison of medical-surgical and home care nurse scores to the normative data revealed similar severity scores but different frequency scores. Medical-surgical nurses had higher lack-of-support frequency scores when compared to the

Table 2.
Job Stress Scores

	Medical-Surgical		Home Care		t-test
	X	SD	X	SD	
Job Stress Severity (JS-S)	5.56	1.16	4.88	1.59	ns
Job Stress Frequency (JS-F)	4.65	1.31	3.22	1.65	<0.001
Job Stress Index (JS-X) (Total)	28.49	10.74	19.13	12.06	<0.01
Job Pressure Severity (JP-S)	6.25	1.22	5.60	1.88	ns
Job Pressure Frequency (JP-F)	5.80	1.53	4.86	2.21	ns
Job Pressure Index (JP-X) (Total)	33.34	11.40	27.04	16.50	ns
Lack of Support Severity (LS-S)	6.04	1.46	5.16	1.84	ns
Lack of Support Frequency (LS-F)	4.58	2.11	2.39	1.81	<0.0001
Lack of Support Index (LS-X) (Total)	27.40	16.32	12.10	10.97	<0.0001

p value for significance: $p < 0.01$

Figure 1.
Percentile Profile



JS-X: Job stress index
 JS-S: Job stress severity
 JS-F: Job stress frequency
 JP-X: Job pressure index
 JP-S: Job pressure severity

JP-F: Job pressure frequency
 LS-X: Lack of support index
 LS-S: Lack of support severity
 LS-F: Lack of support frequency
 ▲: Home Care
 ◆: Medical-Surgical

norm ($t [30] = 3.56, p < 0.001$), and home care nurses had significantly lower lack of support frequency scores when compared to the norm ($t [52] = -3.39, p < 0.001$). Figure 1 translates the mean scores into percentiles, demonstrating that the lack-of-support scores were above the average 50th percentile for medical-surgical nurses and below average for

home care nurses.

Relationships between demographics and job stress scales and subscales. Pearson Product Moment Correlation was calculated to determine relationships between job stress index scales and demographic variables. Years employed in nursing was related negatively to the lack of support index ($r = -0.27, p < 0.05$), indicating

Table 3.
Top-10 Stressors

Medical-Surgical Nurses		Home Care Nurses	
Rank			Rank
1	Excessive paperwork	Excessive paperwork	1
2	Fellow workers not doing their job	Meeting deadlines	2
3	Insufficient personal time	Frequent interruptions	3
4	Frequent interruptions	Insufficient personnel to handle an assignment	4
5	Poorly motivated co-workers	Insufficient personal time	5
6	Insufficient personnel to handle an assignment	Noisy work area	6
7	Covering work for another employee	Working overtime	7
8	Conflicts with other departments	Inadequate salary	8
9	Inadequate support by supervisor	Assignment of increased responsibility	9
10	Meeting deadlines	Making critical on-the-spot decisions	10

that older nurses perceived a lower frequency of lack of support. Similarly, age was negatively related to lack of support index ($r = -0.26, p < 0.05$) and to the job stress severity index ($r = -0.23, p < 0.05$). Older nurses experienced less job stress and perceived less lack of support. Full-time employees had higher job pressure index scores ($r = -0.25, p < 0.05$). Average caseload was correlated positively with the job stress index ($r = 0.327, p < 0.01$), job pressure index ($r = 0.336, p < 0.01$), and lack of support index ($r = 0.250, p < 0.05$), showing the higher the case load (patient care load), the higher the stress.

Affect balance scores. Descriptive statistics were used to determine frequencies of nurses with negative and positive moods. Scores were grouped as negative, moderate (neither negative or positive), and positive. A negative affective mood was found in 21.3% ($n=19$) of the sampled group of nurses, 44.9% ($n=40$) had moderate scores, and 33.7% ($n=30$) had positive mood scores. Comparison of general affect according to site worked showed no difference between mood scores for medical-surgical and home care nurses on an independent sample t-test. Data were then analyzed as total sample data.

To test the hypothesis that those with higher job stress would have negative affective moods, researchers used a one-

way ANOVA. ANOVA results across the three mood groupings showed that job pressure index varied by mood grouping ($f = 4.464, p < 0.01$), as did the job stress index ($f = 5.723, p < 0.005$). Post hoc analysis using Scheffe contrast showed that there was a significant difference between those with a negative mood and those with a positive mood in both the stress and pressure index scores. Those with higher stress and pressure scores were more likely to have negative mood scores, and those with lower stress and pressure scores were more likely to have moderate or positive mood scores. Thus the hypothesis that nurses who indicate high job stress will report a negative affective mood was supported.

Qualitative findings. Qualitative interviews were used to gather in-depth information of the areas of stress identified by nurses employed on medical-surgical units and in home care departments. A small subset of five home care nurses and five medical-surgical nurses was interviewed. It was found that "paperwork" was the biggest source of stress for both home care and medical-surgical nurses, corroborating quantitative findings. Nurses found the paperwork to be redundant and time-consuming, and completing paperwork took away from what they perceived to be time with the

patients. "Lack of cooperation" among co-workers was also a common theme to both groups of nurses in the qualitative findings; however, the medical-surgical nurses discussed this in greater breadth and depth. The final common theme was "time stress associated with workloads" that were perceived at times to be unrealistic. Both groups of nurses remarked that time management is an essential skill but that even with strong time management skills, the work demand often superceded the designated shift time. One medical-surgical nurse commented, "I spend a few minutes at the beginning of the shift organizing myself, setting priorities, and reviewing what I need to get accomplished. Then I can work more efficiently. But all the planning and all the efficiency doesn't matter. At times the workload is so overwhelming, it just can't be accomplished in the allotted time. The sad thing is that quality suffers."

Home care nurses identified work-related stressors, such as maintaining their schedule, driving/traffic, bad weather, noise in the office in the morning, and decreased decision making secondary to third-party payer guidelines. Despite these stressors, home care nurses felt they were less stressed than in their previous medical-surgical work environments. Further, the home care nurses expressed a feeling of

greater control over their practice and over the environment than they did when they were working in acute care. One home care nurse remarked, "As a case manager in home care, you can control your stress by shifting your environment to keep things from getting way out of control." This shift was not seen as possible in the acute care environment. Although the home care nurses believed that they had good job control, they did identify that third-party reimbursement and changed Medicare regulations had decreased their autonomous decision making or decision latitude. Lack of patient/family support was identified as a stressor for the home care nurse. This was well articulated by one nurse, "If there is no family support in the home, then your role extends, and this is stressful."

Medical-surgical nurses identified competing demands of equal priority and frequent interruptions to be significant stressors. Interruptions included phone calls, other personnel needing assistance, emerging priorities, and need for collaboration when physicians made rounds. Stressors related to personnel were of prime concern. Lack of teamwork, lack of independent initiative among staff, problems with delegation, and problems with laziness were discussed by most of the medical-surgical nurses. Verbal abuse by physicians, colleagues, and on occasion family members were cited as stressors in the medical-surgical environment, as was the lack of respect for the medical-surgical nurse by other specialty nurses and by many physicians. Additional discussion involved identified changes in job expectations of the staff nurse that required more involvement in leadership and independent decision making on the unit; they were less able to rely on a nurse manager for problem solving and assistance because the role of the nurse manager had assumed more hospital-wide responsibility. Excessive paperwork, fellow workers not doing their job, fre-

quent interruptions, poorly motivated co-workers, and inadequate support by the supervisor were quantitative stressors substantiated in the qualitative findings.

Discussion

In the last several years, abundant research has addressed the work environment and the need to create organizational cultures more supportive of nurses (Adams & Bond, 2000; Aiken et al., 2002; Aiken, Havens & Sloane, 2000; Aiken & Patrician, 2000; Aiken & Sloane, 1997; Laschinger et al., 1999). Findings of the current study showed that workplace stress was significantly above the norm for medical-surgical nurses as compared with home care nurses and a normative group of professional women. What was especially noteworthy in these findings was that the job stress severity was similarly high for both work settings. It was the fact that this severity was significantly more frequent for medical-surgical nurses as compared to home care nurses that resulted in an overall higher job stress index or total job stress score. Job pressure severity scores also were similar for medical-surgical nurses and home care nurses, but the frequency of that pressure was significantly higher among medical-surgical nurses. The sharpest contrast in findings was in the difference in "lack of support" scores. Medical-surgical nurses had much higher ratings on severity, frequency, and the overall index score, indicating that medical-surgical nurses perceived significantly less organizational support than their home care counterparts or the normative group of professional women. Eisenberg, Bowman, and Foster (2001) cited lack of available support systems as a cause of stress among health care workers. In their study, lack of support from colleagues appeared to be a major factor contributing to the lack of support. Review of the top-10 stressors among medical-surgical nurses revealed that five were items involving lack of support specific to interaction with other personnel. These items,

"fellow workers not doing their jobs," "poorly motivated co-workers," "covering work for another employee," "conflicts with other departments," and "inadequate support from the supervisor," all reflected the interdependency of the role of the medical-surgical nurse.

Results in this study were compared to the normative data of the Job Stress Data. This normative group consisted of women in professional careers. Medical-surgical nurses' job stress, job pressure, and lack of organizational support were significantly higher than the normative data of professional women. For home care nurses, job stress scores and job pressure severity scores were similar, but job pressure frequency was higher and lack of support was in fact lower than the normative data. The results showed that overall the medical-surgical work environment was more stressful. The home care environment had similar stress severity and more frequent job pressure; however, some of this was offset by the low lack of support scores, indicating that home care had more supervisory and peer support.

Qualitative findings were consistent with the top-10 stressors identified in the survey. Difficulties managing the expanded workload discussed in the qualitative findings were consistent with the priority items of "paperwork," "insufficient personal time," and "insufficient personnel to handle an assignment." Managing the workload was intensified by "frequent interruptions," and "meeting deadlines" was a major stressor in light of the work to be accomplished within a designated shift. Medical-surgical nurses spoke of the significant stress associated with teamwork and collaboration with other disciplines and departments. This was consistent with the five "lack of support" stressors among the top-10 stressors for medical-surgical nurses and dramatically different than the home care nurses who did not rate "lack of support" items in their top 10 stressors.

For the medical-surgical nurse,

accomplishing his or her work required others to be doing their jobs. It also required effective working relationships and communication with others. The emphasis on this category of stressors pointed to the need for ongoing team-building efforts, as well as examination of the interdependency of systems and the need for efficiency and cooperation across systems/departments.

Medical-surgical nurses identified inadequate support from supervisors as a priority stressor, whereas home care nurses did not. This lack of support may have been due to increased demands placed on managers and supervisors in hospitals. Role changes for managerial personnel moved them away from the bedside and even away from the unit, which may have contributed to a sense of lack of support. In contrast, home care organizations were small health care "ecosystems" in which supervisors had greater availability and visibility to nurses and could afford help to staff if needed on a one-on-one basis, thus contributing to the lower stress score for this specialty of nurses. Nursing staff in home care were more autonomous and appreciably less dependent on each other to get the work done. This contributed to the overall reduction in stress in the home care environment.

The most common job stress factor in both groups of nurses was paperwork, with mean scores of 6.7 and 6.9 respectively for home care and medical-surgical nurses. This egregious amount of paperwork may be due to increased governmental demands, accrediting regulations, and the constant threat of litigation for nurses and institutions leading to the need for more forms and more documentation. Computer-based documentation using "intelligent" systems is predicted to result in a major decrease in paperwork demands; however, because the cost of these systems is high, many nurses have no promise of a reprieve.

Nurses who were older and more experienced had lower stress levels. This finding was

consistent with the findings of Aiken and Sloane (1997). Their study of stress and emotional exhaustion in over 800 nurses in magnet and nonmagnet hospitals on medical-surgical units and on AIDS-dedicated units also found older, more experienced nurses had less stress. This may have been due to a larger repertoire of coping reactions, drawn from an expanded nursing experience and leading to greater confidence in nursing practice than the younger nurses.

The hypothesis that nurses who indicate high job stress will report a negative affective mood (decreased well-being) was supported in this study. This finding was similar to those of Bourbonnais, Comeau, Vezina, and Dion (1998) and Bourbonnais, Comeau, and Vezina (1999). Both groups of researchers found significant relationships between nurses' job strain, and symptoms of psychological distress and emotional exhaustion. Cheng, Kawachi, Coakley, Schwartz, and Colditz (2000) used data from the Nurses Health Study to link job strain similarly to decline in functional health status over a 4-year period. Findings of this study suggest that assessment of working conditions that produce job strain is needed to identify priorities for workplace intervention in order to reduce job strain and negative-well-being.

Recommendations

A limitation of the study was the use of a small convenience sample. The study needs to be replicated using a larger number of nurses, a wider geographic distribution, and random sampling methods. This replication should attempt to survey nurses from institutions and units of varying size and specialty areas in order to see whether stress varies based on specific characteristics (teaching versus non-teaching hospital, specialty versus non-specialty unit, large versus small hospital, etc.).

Clinical Implications

This study suggests that job stress in the clinical environment is related to general affect or well-

being. What can be done to sustain well-being? Attention to the work environment and key areas of stress within the job likely will improve job satisfaction, well-being, and organizational effectiveness. The higher job stress scores and job pressure scores among medical-surgical nurses creates a compelling impetus for more attention to the workplace environment. Moving toward computerized medical records may alleviate stress due to paperwork. The lack of staffing is a more difficult problem to tackle and may require long-term strategies, such as sponsoring individuals in RN education.

In the interim, this study directs attention to providing support for nurses. Medical-surgical nurses had higher "lack of support" scores and qualitatively, this was a major theme. Support needs to be provided in ongoing team development so there is attention both to competency and interpersonal relations. Older, more experienced nurses in this study experienced less stress. These nurses should be used as mentors to the younger, less-experienced nurses, but caution must be taken not to overload them and put them into higher stress categories. Team building is needed to enhance cooperation and minimize conflict. This cannot be a one-time intervention but an ongoing strategy. Use of unit-based clinical nurse specialists or clinical experts to serve as mentors and team builders may provide the necessary support to practicing nurses even in the face of short staffing. Perhaps the best approach to providing support would be to begin with focus groups of the staff, listening to the areas where support is needed, but listening by itself will be insufficient. The information from the focus group can provide data for unit-based priorities so support can be provided where it is needed most.

Conclusion

The experience of stress at work has undesirable effects on the health and safety of the workers and on the health and effectiveness of their organizations. Nursing is, by its very nature, a

stressful profession; however, the stress is exacerbated by a range of organizational issues. This study identified job stress for medical-surgical nurses as significantly above the norm and significantly greater than nurses working in home care. Workload issues and lack of support (team building and collaboration issues) were major stressors. Attention to these priority stressors is critical

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in order to maximize the quality of nurses' working lives, and contribute to the general health and well-being of the nursing workforce. Job stress can be evaluated periodically using a combined qualitative/quantitative approach similar to this study. This would allow identification of high-risk areas along with a qualitative explanation of specific stress factors. As a generic approach, a focus on providing support and conditions that support professional nursing practice may yield high returns. Job stress and job pressure are high in nursing, especially medical-surgical nursing. It may not be possible to eliminate or even minimize this stress, but changes definitely can be made in level of support. ■

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