

Critical Care Nurses' Work Environments: A Baseline Status Report

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Attracting qualified people into nursing is the first step in ensuring that adequate numbers of registered nurses (RNs) are available to meet the needs of hospital patients. Perhaps more critical is the need to create healthy work environments that encourage nurses to work in hospitals in general and in critical care areas in particular. The envi-

ronment in which RNs work is an essential issue in their job satisfaction and turnover, and it plays a role in patients' outcomes.^{1,5}

Recognizing that a healthy work environment is the base for recruiting and retaining nurses and ultimately for providing optimal care for patients, the American Association of Critical-Care Nurses (AACN)

began a major effort in 2001 to actively promote and support healthy work environments.⁶ At the 2003 AACN National Teaching Institute and Critical Care Exposition, in the Act Boldly Campaign, AACN called on critical care nurses to actively commit to addressing workplace issues in the nurses' organizations.⁷ That same year, AACN conducted a national survey, part of which solicited more details on healthy and unhealthy work environments.⁸ AACN position papers were developed on prevention of violence in the workplace and on zero tolerance for abusive behaviors.^{9,10} In 2004, AACN completed the landmark National Critical Care Survey, the first survey to provide data on critical care units and the environments in which critical care nurses work.¹¹ Before this study, little information specific to critical care environments was available.

In January 2005, AACN published national standards for establishing and sustaining healthy work environments.¹² Specifically, the standards address skilled communication, true collaboration, effective decision making, appropriate staffing, meaningful recognition, and authentic leadership in the work environment.

The standards complement and support the American Nurses Association Code of Ethics for Nurses,¹³ the Institute of Medicine recommendations,^{5,14,15} the elements of a healthy work environment as determined by the Nursing Organizations Alliance,¹⁶ the recommendations from the Joint Commission on Accreditation of Healthcare Organizations,¹⁷ and

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attributes of organizations receiving Magnet designation.¹⁸

In early 2006, a year after the standards were released, AACN, Nursing Spectrum (a communications company and division of Gannett Co), and Bernard Hodes Group (a world leader in integrated talent solutions and a division of Omnicom), conducted a national survey of critical care nurses to determine the status of critical care work environments. The nurses were also asked about their satisfaction with nursing as a career, their intent to stay in or leave their current positions, reasons for planning to stay or leave, and what might cause them to reconsider leaving. In this article, we present the major results of the survey.

Study Design and Sample

The online survey instrument contained questions based on the AACN healthy work environment standards and on previous research about RNs' work environments. The questionnaire was pilot tested with a national sample of RNs, and no major changes were made as a result of the pilot data. Convenience sampling was used. Members and other constituents of AACN were invited via e-mail to participate in the study. The e-mail invitation contained an online link to the survey instrument. Respondents were offered an incentive to participate: the chance to win a complimentary registration to the AACN National Teaching Institute and Critical Care Exposition. The survey was conducted from April 18, 2006, to May 3, 2006. Frequencies, percentages, SDs, and means were determined for each question and were cross-tabulated against demographic variables. Because a conven-

ience sample of RNs associated with AACN was used, the generalizability of the findings is limited.

A total of 4346 RNs from every state and the District of Columbia responded to the survey. Of these, 4034 reported currently working as an RN. The responses of RNs who were not currently working as RNs were not included in the data analysis. Table 1 gives the demographic information.

Results of the Survey AACN Healthy Work Environment Standards: Overview

More than 50% of the respondents indicated that they were aware of the AACN standards for healthy work environments. Slightly less than 40% said that how well they established and sustained a healthy work environment plays a major (12.7%) or substantive part (27.1%) in their performance evaluations.

Questions about the status of work environments based on the AACN standards were asked for both organizations as a whole (macrosystems) and for the units on which the respondents worked (microsystems). In all instances in this survey, the respondents rated the health of their unit work environments higher than the health of their organizations (Table 2).

Communication and Collaboration

In addition to the questions about RNs' proficiency in communication and about RNs being relentless in

Table 1 Demographics of the sample (n=4034)

Characteristic	Value
Average age, y	44.6
Female, %	89.6
Ethnicity, % white (non-Hispanic)	86.2
Years of experience as a registered nurse, mean (range)	17.5 (<1-45)
Work full time, %	83.6
Work in acute care hospitals, %	92.0
Work in direct patient care, %	62.4

pursuing and fostering true collaboration (Table 2), respondents were asked to rate the communication and collaboration in their work units among RNs and between RNs and physicians, frontline nurse managers, and administrators (Table 3). The highest levels of communication and collaboration were among RNs; the lowest levels, between RNs and administrators.

Respect

Respect is a component of communication, of collaboration, and of valuing the contributions of each RN. When asked to rate the respect for RNs shown by other RNs, physicians, frontline nurse managers, administrators, and other health-care colleagues, RNs' respect of each other was highest; administrators' respect of RNs was rated the lowest (Table 4).

Physical and Mental Safety and Abuse

Physical and mental safety in terms of sexual harassment, discrimination, verbal abuse, and physical abuse were assessed. RNs were asked if during their work as a nurse in the past year they had personally experienced any of these and from whom

Table 2 Status of work environments according to the American Association of Critical-Care Nurses healthy work environment standards

Standard/statement	Degree of agreement, % of respondents (n = 4034)*			
	Strongly agree	Agree	Disagree	Strongly disagree
Standard 1, skilled communication: Nurses must be as proficient in communication skills as they are in clinical skills.				
Registered nurses (RNs) are as proficient in communication skills as they are in clinical skills				
In the RN's organization	5.8	45.4	43.4	5.4
In the RN's work unit	16.8	47.8	30.8	4.5
All team members are provided with support for and access to education programs to develop communication and collaboration skills				
In the RN's organization	13.1	41.7	36.4	8.7
In the RN's work unit	17.3	40.3	33.9	8.5
Standard 2, true collaboration: Nurses must be relentless in pursuing and fostering true collaboration.				
RNs are relentless in pursuing and fostering true collaboration				
In the RN's organization	4.9	42.8	46.0	6.4
In the RN's work unit	16.3	46.7	32.2	4.8
Standard 3, effective decision making: Nurses must be valued and committed partners in making policy, directing and evaluating clinical care, and leading organizational operations.				
RNs are valued and committed partners in making policy, directing and evaluating clinical care, and leading organizational operations				
In the RN's organization	14.6	45.2	30.3	9.9
In the RN's work unit	23.8	45.7	22.3	8.2
RNs have opportunities to influence decisions that affect the quality of patients' care				
In the RN's organization	14.6	54.3	24.9	6.2
In the RN's work unit	24.1	52.2	18.2	5.4
Standard 4, appropriate staffing: Staffing must ensure an effective match between patients' needs and nurses' competencies.				
RN staffing ensures an effective match between patients' needs and nurses' competencies				
In the RN's organization	7.5	43.6	36.1	12.8
In the RN's work unit	19.6	45.9	24.7	9.8
Formal processes exist to evaluate the effect of staffing decisions on patients' and systems' outcomes				
In the RN's organization	7.2	36.3	41.8	14.7
In the RN's work unit	8.8	36.8	40.9	13.6
Standard 5, meaningful recognition: Nurses must be recognized and must recognize others for the value each brings to the work of the organization.				
RNs are recognized for the value each RN brings to the organization				
In the RN's organization	10.8	46.2	32.5	10.5
In the RN's work unit	17.8	46.9	25.6	9.6
RNs recognize others for the value the others bring to the work of the organization				
In the RN's organization	8.2	58.5	28.7	4.6
In the RN's work unit	15.8	57.9	22.1	4.3
Standard 6, authentic leadership: Nurse leaders must fully embrace the imperative of a healthy work environment, authentically live it, and engage others in its achievement.				
Nurse leaders (formal and informal) fully embrace the concept of a healthy work environment				
In the RN's organization	11.6	45.6	32.4	10.4
In the RN's work unit	20.2	46.6	24.6	8.6
Nurse leaders (formal and informal) engage others in achieving a healthy work environment				
In the RN's organization	9.0	44.4	36.7	9.9
In the RN's work unit	16.0	46.8	29.0	8.3

*Because of rounding, percentages do not all total 100.

the threat had come (patients, patients' families and/or significant others, other RNs, physicians, nurse managers, administrators, or other healthcare personnel). In more than 9000 instances, RNs reported at least one occurrence (Table 5). Because the questions had only yes and no response options, a yes response

Table 3 Communication and collaboration

Quality of communication between registered nurses and . . . , %*				
Rating	Registered nurses	Physicians	Frontline nurse managers	Administrators
Excellent	13.5	8.8	12.0	3.9
Good	58.2	48.9	43.3	21.4
Fair	24.9	34.9	33.8	38.4
Poor	3.4	7.3	10.9	36.3

Quality of collaboration between registered nurses and . . . , %*				
Rating	Registered nurses	Physicians	Frontline nurse managers	Administrators
Excellent	16.5	8.8	9.3	3.3
Good	58.2	47.7	43.0	22.4
Fair	22.9	35.9	35.8	39.2
Poor	2.4	7.7	11.8	35.1

*Because of rounding, percentages do not all total 100.

could represent one occurrence or many. At least one instance of sexual harassment, regardless of the source,

and the actual occurrence of such behavior. The results indicated that 46.5% of the respondents' organiza-

was reported by 18.2% of the respondents and discrimination by 26.6%. A large majority (64.6%) reported at least one instance of verbal abuse; 22.2% reported at least one instance of physical abuse.

Respondents were also asked about zero tolerance policies on abuse and disrespectful behavior

tions had zero tolerance policies on both abuse and disrespectful behavior, 19.1% on abuse only, 0.5% on disrespectful behavior only, and 15.5% on neither. A total of 18.4% of respondents did not know whether or not their organizations had such policies. When asked to what degree abuse and disrespectful behavior was tolerated in their organizations, only 24.1% answered not at all, which would indicate zero tolerance; 19.6% answered frequently; 32.4% said occasionally; and 23.8% said rarely.

Nursing Leadership

Respondents were asked to rate the skills of their frontline managers and their chief nurse executives. In every instance, the skills of the managers were rated higher than the skills of the executives (see Figure).

Table 4 Respect

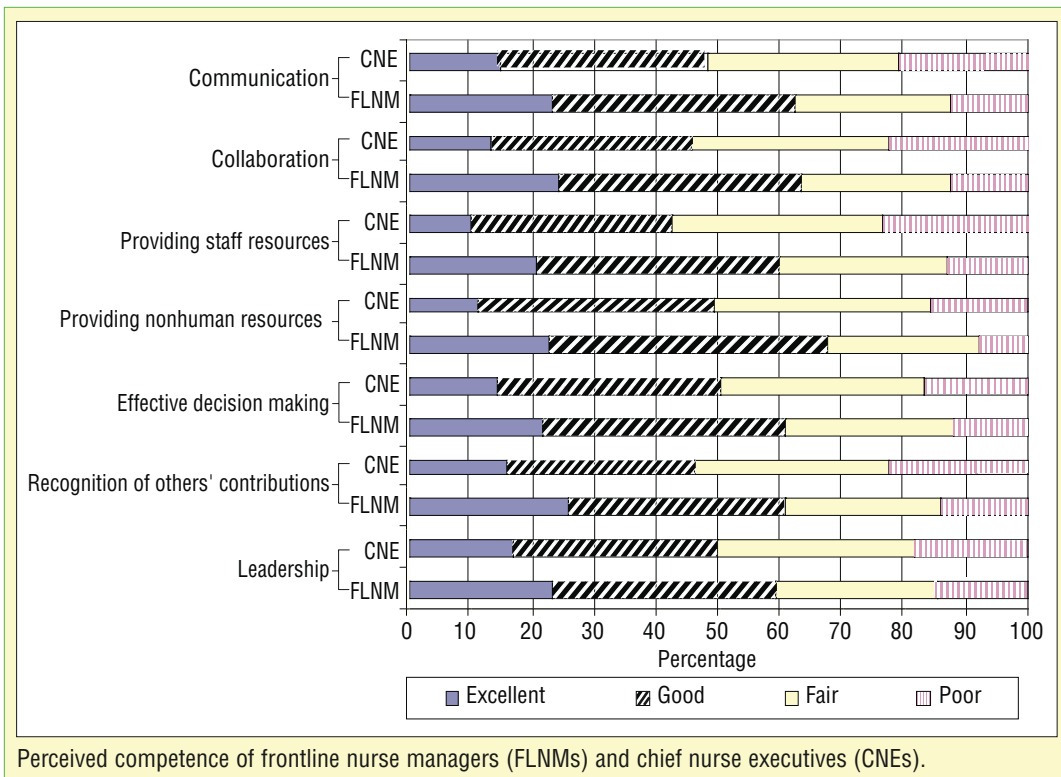
How would you rate the respect for registered nurses by . . . ?*

Rating	Registered nurses	Other healthcare colleagues	Frontline nurse managers	Physicians	Administrators
Excellent	21.1	10.4	13.4	9.9	7.1
Good	57.0	58.4	48.6	47.5	31.6
Fair	19.3	26.9	29.5	34.2	37.0
Poor	2.6	4.2	8.6	8.4	24.3

*Because of rounding, percentages do not all total 100.

Table 5 Physical and mental safety and abuse: number and percentage of registered nurses who reported experiencing at least one incident in the past year while working as a nurse

Abuse from	Sexual harassment		Discrimination		Verbal abuse		Physical abuse	
	No.	%	No.	%	No.	%	No.	%
Patients	451	11.2	321	8.0	1432	35.5	848	21.0
Patients' families or significant others	170	4.2	349	8.7	1366	33.9	81	2.0
A physician	174	4.3	307	7.6	1248	30.9	11	0.3
Another registered nurse	112	2.8	340	8.4	709	17.6	13	0.3
A nurse manager	17	0.4	249	6.2	262	6.5	1	0.0
An administrator	18	0.4	205	5.1	201	5.0	1	0.0
Other healthcare personnel	127	3.1	135	3.3	283	7.0	7	0.2
Total	1069		1906		5501		962	



selected good. In reply to a question about having the right number of RN staff with the right knowledge and skills, an indication of the AACN standard for appropriate staffing, 6.1% of the respondents indicated that standard is met all the time; 43.0%, more than 75% of the time; 29.4%, 50% to 75% of the time; 16.8%, 25% to 49% of the time;

and 4.9%, less than 25% of the time. The survey also asked about the work that gets completed on a typical shift. Direct care tasks (eg, giving medications, doing procedures) and activities of daily living (eg, skin care and oral hygiene) get done most often (Table 8). Other aspects of nursing care such as comforting, teaching, planning, and preparing for discharge are completed less often.

Satisfaction With Nursing and With Current Position

Survey participants were asked about their satisfaction with nursing as a career and with their current positions. Overwhelmingly, respondents were satisfied with nursing as a career and, to a slightly lesser degree, with their current jobs (Table 9). More than half (54.1%) would definitely advise a qualified individual to pursue a career in nursing, and another 34.0% probably would.

Support for Professional Development

Support for professional development was assessed by asking questions about organizational support for continuing education and specialty certification (Table 6). More than 75% of the respondents worked for organizations that provided in-house continuing education, and 55.4% worked for organizations that provided paid time off for continuing education. Registration fees for continuing education were paid by 47.8% of the organizations. Specialty certification was less supported, although 47.9% of the respondents reported that initial examination fees were paid for or reimbursed, and 45.0% said that nurses who achieved certification were recognized.

Recognition

Respondents were more likely to say that RNs recognize others for the

value the others bring to the work organization than to say that RNs are recognized for the value each RN brings to the organization. When asked who provided the most meaningful recognition, 45.9% of the respondents indicated patients and patients' families; 26.0% said other RNs. No other group (administrators, frontline nurse managers, physicians, or other healthcare colleagues) was selected by more than 10% of the respondents.

Quality and Outcomes of Patients' Care

The majority of respondents rated the quality of care in their work units and organizations as excellent or good (Table 7). More than half indicated that the quality of care had increased in their organizations in the past year. When asked to describe the quality of the RNs in their work unit, 32.0% selected excellent, and 52.7%

Table 6 Organizational support for continuing education and certification

Continuing education support	% of organizations
Provides in-house continuing education	75.7
Provides paid time off for continuing education	55.4
Pays continuing education registration fees	47.8
Provides time off without pay for continuing education	33.2
Pays for travel for continuing education programs	26.0
Provides no support	4.9
Certification support	
Pays/reimburses initial examination fee	47.9
Recognizes nurses who achieve certification	45.0
Provides salary differential for certification	24.2
Pays/reimburses for recertification fee	22.2
Pays registration fees for courses to prepare for examination	20.8
Gives bonus for initial certification	13.8
Gives bonus for recertification	12.0
Offers unpaid time off for courses to prepare for the examination	11.0
Offers paid time off for courses to prepare for the examination	9.8
Offers no support	15.9

When asked to indicate the 2 main factors that keep them working in their current organizations, 53.0% selected the people I work with; 34.9%, salary and benefits; 30.8%, the patients I care for; and 14.1%, opportunities for professional development. All other response categories were lower.

Retention

In order to assess future retention, participants were asked to indicate whether they planned to leave their current nursing positions within the next 12 months or within the next 3 years. One in 5 (20.0%) indicated that they plan to leave their current position in the next 12 months; 28.6% plan to leave in the next 3 years. A little more than half (51.9%) indicated

that they have no plans to leave their current position in the next 3 years.

Among those who said they plan to leave their current position, the most common reason for such planning was to take another position in clinical nursing (38.5%). Other reasons, in order, were returning to school to pursue additional nursing education (17.5%) and taking a different position in nonclinical nursing (17.0%).

Only 5.3% of those planning to leave (2.6% of the total respondents) said that they were leaving their current position to pursue a job in another profession.

Respondents who reported plans to leave their current positions were asked how likely certain changes were to cause them to reconsider. Better leadership was the most frequently cited change; 44.0% of those who planned to leave said that better leadership would be very likely to cause them to reconsider leaving. Other changes that would make them reconsider leaving were higher salary and benefits, better staffing, more opportunities for professional development, more respect from both frontline management and administration, more meaningful recognition, and more opportunities to influence decisions about patients' care.

Other Findings

In addition to the findings presented in this initial report, the data collected in the survey indicated significant differences according to the variables of age of the nurse, experience (most notably RNs with less than 5 years' experience and those with more than 20 years' experience), highest educational degree, and the Magnet status of the organizations

Table 7 Quality and outcomes of patients' care

The quality of care for patients is		
Rating	%*	
	Organization	Work unit
Excellent	20.4	40.5
Good	58.1	45.7
Fair	19.2	10.1
Poor	1.7	1.3
Not applicable	0.6	2.4
The change in the quality of patient care in the past year was		
Rating	%*	
	Organization	Work unit
Much better	14.7	20.3
Somewhat better	36.1	28.3
No change	19.3	22.1
Somewhat worse	23.7	21.7
Much worse	3.8	3.4
Not applicable	2.5	4.2

*Because of rounding, percentages do not all total 100.

Table 8 Amount of work completed on a typical shift*

Type of work	Percentage of work completed			
	0-50	51-74	75-99	100
Direct care	1.6	8.4	55.0	35.1
Skin care	9.6	26.9	44.6	19.0
Oral hygiene	13.1	25.1	43.5	18.3
Comforting/talking with patients	14.1	33.6	39.6	12.7
Teaching patients or family	13.0	35.1	39.8	12.1
Developing or updating care plan	25.5	32.4	31.5	10.6
Preparing patients and families for discharge	23.3	30.6	34.4	11.6

*Values are percentages. Because of rounding, percentages do not all total 100.

Table 9 Satisfaction with career as a registered nurse (RN) and with current position and willingness to recommend nursing as a career*

Satisfaction with nursing as a career and with current position	Being an RN	With current position
Very satisfied, %	62.9	30.9
Somewhat satisfied, %	29.5	45.1
Somewhat dissatisfied, %	5.8	18.5
Very dissatisfied, %	1.8	5.5
Likelihood to advise nursing as a career	%	
Definitely would	54.1	
Probably would	34.0	
Probably would not	10.4	
Definitely would not	1.5	

*Because of rounding, percentages do not all total 100.

in which the nurses worked. These differences are beyond the scope of this article and will be presented in detail in subsequent presentations and publications.

Discussion

This survey provides important information on the current health of work environments in critical care settings, RNs' career and job satisfaction, RNs' intent to stay in or leave current positions, and actions that would cause RNs to reconsider leaving. Organizations can use the findings as a blueprint to improve work environments and increase

healthcare as "a small group of people who work together on a regular basis to provide care to discrete subpopulations of patients,"^{19(p 474)} have been identified as the key building blocks of macrosystems. Microsystems are the "moments of truth" of the macrosystem, the places at which the delivery of patients' care either succeeds or fails.

In every instance throughout the survey, respondents rated the work environment higher in the microsystems than in the macrosystems. This finding needs to be investigated further. In contrast to the view that "the grass is always greener" elsewhere,

retention of critical care nurses.

Microsystems and Macrosystems

Healthcare systems are composed of organizations (macrosystems) and work units (microsystems). Microsystems, defined in

RNs in the survey consistently thought that things were better in the units/microsystems where the nurses worked than in the rest of the organization/macrosystem. Perhaps the respondents have the best practices in their microsystems or they are less informed about what occurs outside their own microsystems. In either case, opportunities to share information and collaborate would be advantageous.

Communication and Collaboration

Communication and collaboration have a critical influence on both RNs' satisfaction and patients' outcomes. Beginning with the classic study published by Knaus et al in 1986,²⁰ which first revealed the relationship between the degree of coordination in intensive care and the effectiveness of that care, many studies²¹⁻²⁵ have indicated the relationship between collaboration and increased positive outcomes for both patients and RNs. In addition, in reports of the Joint Commission on Accreditation of Healthcare Organizations,²⁶ inadequate communication is consistently cited as the most frequent root cause of sentinel events.

The results of the survey indicate that the highest level of communication and collaboration is among RNs and then between RNs and physicians. However, both areas have room for improvement. Communication and collaboration between RNs and frontline nurse managers and administration was rated lower. This finding supports the results of a previous AACN survey⁸ in which less than half of the AACN members ranked their relationships with managers and administrators as

positive. Our respondents also indicated room for improvement in the communication and collaboration skills of frontline nurse managers and chief nurse executives.

Respect

Mutual respect is a key component of effective, professional, collaborative relationships.²⁷ Respect is related to job satisfaction and intent to leave.^{28,29} In this survey, the majority of RNs rated the respect from administration as fair (37.0%) or poor (24.3%), a matter of concern. Respect from physicians was rated the next lowest and should also be a concern. RNs who indicated plans to leave their current positions in the next 3 years also noted that more respect from frontline nurse managers and from administration would very likely make the RNs reconsider leaving. Nurses often talk about respect (and disrespect), yet little research specifically addresses how nurses define and what behaviors are associated with respect and disrespect.²⁸ Additional inquiry into this topic is needed.

Physical and Mental Safety and Abuse

Sexual harassment, discrimination, and verbal and physical abuse should be zero tolerance issues, but the survey results (>9000 instances reported) clearly indicated that they are not. Almost 1 in 5 respondents reported experiencing sexual harassment and more than 1 in 4 reported experiencing discrimination in the preceding year while working as a nurse. In addition, the majority of the respondents reported experiencing verbal abuse, and more than 1 in 5 reported physical abuse. Much of the verbal abuse reported came

from patients, patients' families or significant others, and physicians; almost all of the physical abuse came from patients.

These data support previously reported research on physical and mental abuse in nursing work environments.^{30,31} Healthcare continues to lead other industries in the incidence of nonfatal injuries and assaults. In 2004, more than 284 600 recordable nonfatal occupational injuries and illnesses occurred in hospitals, and another 124 600 occurred in ambulatory healthcare settings.³² Of additional concern, these data most likely are conservative, because assaults and acts of violence often are not reported.^{33,34}

Creating safe work environments is the legal and moral responsibility of every organization. As indicated in the survey results, having policies in place does not equate with zero tolerance. Almost 20% of respondents did not know whether policies existed in their organizations.

Nursing Leadership

The American Organization of Nurse Executives has identified leadership development as a critical factor in creating excellent work environments.³⁵ In addition, in a study of 29 high-performing clinical microsystems, Nelson et al¹⁹ found that leadership was a key factor in success.

In this survey, the respondents' ratings of the skills of both frontline nurse managers and chief nurse executives underscore the need to make leadership development a priority. According to the American Organization of Nurse Executives, effective leadership development can only occur with a sustained organizational commitment to skills

training in management and leadership, defined management career paths, and ongoing succession planning. Processes to evaluate and improve leadership effectiveness that include meaningful staff involvement, mutual learning, and follow-up are also required.³⁵

Influence and Control Over Practice

Influence and control over their practice by RNs contributes to job satisfaction and improved patients' care.³⁶⁻³⁸ As a result, in its 2003 report,⁵ the Institute of Medicine strongly recommended that direct care nursing staff be involved, engaged, and empowered in decisions about patients' care and how that care is provided.

In this survey, almost 70% of the respondents strongly agreed or agreed that in their work units RNs are valued and committed partners in making policy, directing and evaluating clinical care, and leading organizational operations. About three fourths of the respondents also strongly agreed or agreed with the statement that RNs have opportunities to influence decisions that affect the quality of patients' care.

Shared governance is one method for involving staff. In this survey, more than 1 in 3 RNs (36.5%) reported working in organizations with a formal shared governance model in place. Another 10.96% reported that their organizations were implementing shared governance. These percentages are lower than the findings of the 2004 National Critical Care Survey,¹¹ in which 55% of 300 units reported having formal shared governance programs.

Support for Professional Development

Continuing education is essential for maintaining competency and for individual professional growth. Continuing education and opportunities for professional development also are essential contributors to retention of nurses.^{39,40} More than three fourths of the respondents indicated that their organizations provided in-house continuing education, and about half of the organizations offered paid time off for such education and/or paid the registration fees.

Although most nurses say that they become certified for personal reasons,⁴¹ evidence exists that certification also benefits patients and healthcare organizations. In the largest international study⁴² of the certified nurse workforce, the benefits of achieving certification included improved quality care, patients' satisfaction, and retention of staff. The study⁴² also indicated that certified nurses have increased confidence, competence, credibility, and control and that recently certified nurses (within 5 years of certification) may be quicker to recognize problems and intervene and less likely to commit errors than are nurses who are not certified. Programs such as the AACN Beacon Award for Critical Care Excellence and the Magnet Recognition Program require that a significant percentage of staff be certified because certification benefits patients, organizations, and nurses and should be supported more fully.⁴¹

Support for specialty certification in this survey was similar to that found in the 2004 National Critical Care Survey.¹¹ Other than paying for the initial certification examination

(47.9%) and recognizing nurses who achieve certification (45.0%), no other support was reported by more than 25% of the respondents. This lack of organizational support is unfortunate and shortsighted.

Recognition

Individuals who receive recognition and praise have increased productivity, engagement, and job satisfaction, but to be effective, recognition must be individualized, deserved, and specific.⁴³ The respondents in our survey were clear that recognition from patients and patients' families rated highest; next highest was recognition from other RNs. Recognition from frontline nurse managers, administrators/executives, and physicians was rated much lower.

The results of the survey suggest that having programs or processes that facilitate recognition of RNs by patients and patients' families and by other RNs would be advantageous. An example is the highly successful Cameos of Caring nurse recognition program created by the University of Pittsburgh in 1998 and, since then, replicated at other institutions.⁴⁴ Understanding how recognition from frontline nurse managers, administrators/executives, and physicians could be more meaningful would also be useful.

Quality and Outcomes of Patients' Care

The survey findings about work that does and does not get done are the most striking when the quality of patients' care and outcomes is considered. Similar to the results of Aiken et al,¹ in this survey, giving medications, doing procedures, monitoring, and providing skin care

and oral hygiene were most often completed. However, nursing activities that require critical thinking and synthesis, such as comforting patients, teaching patients and their families, developing and updating care plans, and preparing patients and their families for discharge were completed far less often.

It continues to appear that higher level nursing contributions are being sacrificed for lower level tasks. Patients' participation in decision making, a key tenet of the AACN Synergy Model for Patient Care,⁴⁵ is made considerably more difficult when nurses do not have sufficient time, as indicated in this survey, for talking with patients and teaching and preparing patients for discharge. Patient acuity indices used in critical care generally do not provide assessment of these higher level nursing activities.

Satisfaction With Nursing and With Current Position

National surveys of employees have repeatedly found that employees who have close relationships with the people they work with are more satisfied and more engaged in the work of their organizations than are employees without such relationships.⁴⁶ The percentage of respondents in this survey who reported that they were very satisfied with being nurses is considerably higher than that found in previous studies. Satisfaction with their current position was consistent with that expressed by nurses in other recent surveys.⁴⁷ The 4 principal factors that respondents indicated keep them working in their current organizations were the people they work with, salary and benefits, the patients

they care for, and opportunities for professional development.

A key indicator of career satisfaction is the willingness to recommend your career to others. In this survey, more than half (54.1%) of the respondents definitely would recommend a nursing career, and another 34.0% probably would. This percentage is higher than that found by Buerhaus et al,⁴⁷ perhaps because the respondents to this survey were critical care nurses.

Retention

Although nearly half (48.4%) of the respondents indicated that they planned to leave their current positions in the next 3 years, of note, only a small percentage planned to leave the nursing profession. Almost 75% of the RNs who expressed plans to leave their current positions said they would do so to take other clinical and nonclinical positions in nursing or to return to school to pursue additional nursing education. Organizational strategic initiatives that support such professional development and advancement can allow RNs to achieve these career plans while remaining in the organization.

The respondents who planned to leave their current positions also indicated actions by employers that would cause them to reconsider leaving; the highest rated action was better leadership. Organizations that ensure the competency of their nursing leaders have an advantage in retaining nurses.

Summary

AACN has taken a leading organizational role in explaining and promoting the fundamental need for healthy work environments, not only in critical care but across all of

healthcare. This initial survey report provides information on the status of work environments 1 year after the publication of the association's Standards for Establishing and Sustaining Healthy Work Environments. In the spirit of the AACN Act Boldly Campaign, the survey results indicate pressing challenges and offer a starting point for dialogs that can lead to solutions and a baseline for future measurement. The commitment of critical care nurses and nurse leaders to initiate these dialogs and to stay actively involved in the solutions until the solutions are working is essential to achieving healthy work environments.

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References

1. Aiken LH, Clark SP, Sloane DM, et al. Nurses' reports on hospital care in five countries. *Health Aff (Millwood)*. May-June 2001;20:43-53.
2. Aiken LA, Clarke SP, Sloane DM, Sochalski J, Silber JH. Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *JAMA*. 2002;288:1987-1993.
3. Institute for Safe Medication Practices. *ISMP Survey on Workplace Intimidation*. Huntingdon Valley, Pa: Institute for Safe Medication Practices; 2004.
4. Maxfield D, Grenny J, McMillan R, Patterson K, Switzler A. *Silence Kills: The Seven Crucial Conversations in Healthcare*. Provo, Utah: VitalSmarts LC; 2005. Available at: <http://www.aacn.org/AACN/pubpolcy.nsf/vwdoc/workenv>. Accessed July 6, 2006.
5. Institute of Medicine. *Keeping Patients Safe: Transforming the Work Environment of Nurses*. Washington, DC: National Academy Press; 2004.
6. American Association of Critical-Care Nurses. *AACN's Healthy Work Environment Initiative Background*. Aliso Viejo, Calif: American Association of Critical-Care Nurses; 2005.
7. American Association of Critical-Care Nurses. *Act Boldly Campaign*. Aliso Viejo, Calif: American Association of Critical-Care Nurses; 2003. Available at: http://my.aacn.org/ecomtpro/timssnet/actboldly/aacn_actboldly_frontpage.cfm. Accessed July 6, 2006.
8. American Association of Critical-Care Nurses. *Strategic Market Research Study*. Aliso Viejo, Calif: American Association of Critical-Care Nurses; 2003.

9. American Association of Critical-Care Nurses. *Workplace Violence Prevention Position Statement*. Aliso Viejo, Calif: American Association of Critical-Care Nurses; 2004. Available at: <http://www.aacn.org/AACN/pubpolcy.nsf/vwdoc/workenv>. Accessed July 6, 2006.
10. American Association of Critical-Care Nurses. *Zero Tolerance for Abuse Position Statement*. Aliso Viejo, Calif: American Association of Critical-Care Nurses; 2004. Available at: <http://www.aacn.org/AACN/pubpolcy.nsf/vwdoc/workenv>. Accessed July 6, 2006.
11. American Association of Critical-Care Nurses. *2004 National Critical Care Survey: Findings Report*. Aliso Viejo, Calif: American Association of Critical-Care Nurses; 2005.
12. American Association of Critical-Care Nurses. *AACN Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence*. Aliso Viejo, Calif: American Association of Critical-Care Nurses; 2005.
13. American Nurses Association. *Code of Ethics for Nurses With Interpretive Statements*. Washington, DC: American Nurses Association; 2001.
14. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.
15. Institute of Medicine. *Health Professions Education: A Bridge to Quality*. Washington, DC: National Academy Press; 2003.
16. Nursing Organizations Alliance. *Principles and Elements of a Healthful Practice/Work Environment*. Lexington, Ky: Nursing Organizations Alliance; 2004.
17. Joint Commission on Accreditation of Healthcare Organizations. *Healthcare at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis*. Oakbrook Terrace, Ill: Joint Commission on Accreditation of Healthcare Organizations; 2002.
18. Kramer M, Schmalenberg CE. Essentials of magnetism. In: McClure M, Hinshaw AS, eds. *Magnet Hospitals Revisited*. Kansas City, Mo: American Academy of Nursing; 2002:25-59.
19. Nelson EC, Batalden PB, Huber TP, et al. Microsystems in health care, I: learning from high-performing front-line clinical units. *Jt Comm J Qual Improv*. 2002;28:472-493.
20. Knaus WA, Draper EA, Wagner DP, Zimmerman JE. An evaluation of outcome from intensive care in major medical centers. *Ann Intern Med*. 1987;104:410-418.
21. Shortell SM, Zimmerman JE, Rousseau DM, et al. The performance of intensive care units: does good management make a difference? *Med Care*. 1994;32:508-525.
22. Baggs JG, Schmitt MH, Mushlin AI, et al. Association between nurse-physician collaboration and patient outcomes in three intensive care units. *Crit Care Med*. 1998; 27:1991-1998.
23. Misener TR, Cox DL. Development of the Misener Nurse Practitioner Job Satisfaction Scale. *J Nurs Meas*. 2001;9:91-108.
24. Rafferty AM, Ball J, Aiken LH. Are teamwork and professional autonomy compatible, and do they result in improved hospital care? *Qual Health Care*. 2001;10(suppl 2):ii32-ii37.
25. Larrabee JH. Predicting registered nurse job satisfaction and intent to leave. *J Nurs Adm*. 2003;33:271-283.

26. Joint Commission on Accreditation of Healthcare Organizations (JCAHO). *Statistics: Root Cause Statistics—Root Causes of Sentinel Events (All Categories)*. Oakbrook Terrace, Ill: JCAHO; 2005. Available at: <http://www.jointcommission.org/SentinelEvents/Statistics/>. Accessed July 19, 2006.
27. Laschinger HK, Finegan J, Shamian J, Wilk P. A longitudinal analysis of the impact of workplace empowerment on work satisfaction. *J Organ Behav*. 2004;25:527-545.
28. Laschinger HK. Hospital nurses' perceptions of respect and organizational justice. *J Nurs Adm*. 2004;34:354-364.
29. McGuire M, Houser J, Jarrer T, Moy W, Wall M. Retention: it's all about respect. *Health Care Manag (Frederick)*. January-March 2003;22:38-44.
30. Ulrich BT, Buerhaus PI, Donelan K, Norman L, Dittus R. How RNs view the work environment: results of a national survey of registered nurses. *J Nurs Adm*. 2005;35:389-396.
31. American Nurses Association. Nursing-World.org Health & Safety Survey, September 2001. Washington, DC: American Nurses Association; 2001. Available at: <http://www.nursingworld.org/surveys/hssurvey.pdf>. Accessed July 6, 2006.
32. United States Department of Labor, Bureau of Labor Statistics. Incidence Rates of Non-fatal Occupational Injuries and Illnesses by Industries and Case Types, 2004. Washington, DC: United States Department of Labor, Bureau of Labor Statistics; 2005. Available at: <http://www.bls.gov/iif/oshwc/osh/os/ostb1487.pdf>. Accessed July 6, 2006.
33. Erickson L, Williams-Evans SA. Attitudes of emergency nurses regarding patient assaults. *J Emerg Nurs*. 2000;26:210-215.
34. Duncan S, Estabrooks CA, Reimer M. Violence against nurses. *Alta RN*. March-April 2000;56:13-14.
35. McManis & Monsalve Associates and American Organization of Nurse Executives. *Healthy Work Environments: Striving for Excellence. Insights From a Key Informant Survey on Nursing Work Environment Improvement and Innovation*. Vol 2. Washington, DC: American Organization of Nurse Executives; 2003.
36. Kramer M, Schmalenberg CE. Magnet hospital nurses describe control over nursing practice. *West J Nurs Res*. 2003;25:434-452.
37. Larrabee JH. Predicting registered nurse job satisfaction and intent to leave. *J Nurs Adm*. 2003;33:271-283.
38. Laschinger HK, Finegan J, Shamian J, Wilk P. Impact of structural and psychological empowerment on job strain in nursing work settings: expanding Kanter's model. *J Nurs Adm*. 2001;31:260-272.
39. HSM Group Ltd. *Nursing Recognition and Retention Study*. Washington, DC: American Organization of Nurse Executives, Institute for Patient Care Research and Education; 2000.
40. Robinson C. Magnet nursing services recognition: transforming the critical care environment. *AACN Clin Issues*. 2001;12:411-423.
41. American Association of Critical-Care Nurses, AACN Certification Corporation. Safeguarding the patient and the profession: the value of critical care nurse certification. *Am J Crit Care*. 2003;12:154-164.
42. Cary A. Certified registered nurses: results of the Study of the Certified Workforce. *Am J Nurs*. January 2001;101:44-52.
43. Rath T, Clifton DO. *How Full Is Your Bucket? Positive Strategies for Work and Life*. Princeton, NJ: Gallup Press; 2004.
44. University of Pittsburgh, School of Nursing. *Cameos of Caring*. Pittsburgh, Pa: University of Pittsburgh; 2006. Available at: http://www.cameosofcaring.nursing.pitt.edu/event_info.html. Accessed July 6, 2006.
45. Hardin SR, Kaplow R. *Synergy for Clinical Excellence: The AACN Synergy Model for Patient Care*. Sudbury, Mass: Jones & Bartlett; 2005.
46. Crabtree S. Getting personal in the workplace: are negative relationships squelching productivity in your company? *Gallup Manage J*. June 10, 2004. Available at: <http://gmj.gallup.com/content/default.asp?ci=11956&pg=1>. Accessed July 6, 2006.
47. Buerhaus PI, Donelan K, Ulrich BT, Kirby L, Norman L, Dittus R. Registered nurses' perceptions of nursing. *Nurs Econ*. 2005;23:110-118, 143.