From Nursing Economics

What Nurses Want: The Nurse Incentives Project

K. Lynn Wieck, PhD, RN, FAAN; Jean Dols, PhD, RN; Sally Northam, PhD, RN
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Introduction

Although nurse job satisfaction has been linked to retention, a gap remains in identifying specific factors which can be managed or changed to improve satisfaction and reduce turnover. Knowing that nurse satisfaction is related to physician interactions, policies, or autonomy provides very broad areas of interest with few specific actions that can lead to immediate improvement. Policies are by definition generally applicable to all without making any distinction for generational preferences or needs. Benefits are one of the few variables which can be adjusted for each generation or even each person. A generational analysis of staff nurses in relation to their happiness with their financial and non-financial benefits is presented. Benefits as incentives or disincentives are related to job satisfaction, perceived stress, and intent to stay on their current jobs. The purpose of the Nurse Incentives Project was to determine satisfaction with current employment incentives and potential managerial actions which might decrease or delay turnover by registered nurses.

Review of Existing Evidence

Generations. Today's workforce consists of four distinct generations: Veterans, Boomers, Generation X, and Millennials. Each generation has distinct attitudes, behaviors, and expectations in the workplace which provide unique challenges to today's manager. A brief description of generational attributes which are important to job satisfaction and retention efforts is found in Table 1.

Creating an environment where all four generations can coexist and thrive is proving to be a challenge to corporate America. Raines and Tulgan (2006) say the chief role of today's manager is to capitalize on the strengths of each generation. "It's all about the work!" (p.16). Veterans claim that satisfying work motivates them; Boomers get their identity from their work; Gen Xers want to gain marketable skills from their work; and Millennials want to make a difference by the work they do. Making the work and the workplace user friendly is a priority in today's work environment.

Work environment factors. The shortage of RNs in hospitals is expected to increase to 340,000 by 2020 (Auerbach, Buerhaus, & Staiger, 2007). Nurses believe that in the future, the shortage will cause increased stress (98%), lower patient quality (93%), and continued exodus of nurses from the profession (93%) (Buerhaus et al., 2005). In spite of small successes in getting more nurses, analysts project that all 50 states will experience a shortage of nurses to varying degrees by the year 2015 (Health Resources and Services Administration, 2006). Furthermore, recent studies put a dollar amount on the face of nurse turnover. Jones (2005) estimates costs between $10,000 and $60,000 to replace a departing nurse. Others estimate as much as $42,000 to replace a medical-surgical nurse and $64,000 to replace a specialty nurse (Strachota & Normandin, 2003). Indirect costs of turnover such as orientation costs, decreased productivity of the new hire, and eroding staff productivity and morale probably increase the cost of nurse turnover 4 to 5 times more than is typically reported by hospitals (Johnson & Buelow, 2003).
Employment in U.S. hospitals rose in 2007 by over 4.5 million persons, an increase of 115,500 over the past year (American Hospital Association, 2008). However, the U.S. turnover rates in hospitals have gradually climbed over the past decade from 12% in 1996, 15% in 1999, and 26.2% in 2000 (Larrabee et al., 2003). Currently, U.S. hospitals need 118,000 RNs to fill vacant positions nationwide. This translates into a national vacancy rate of 8.5. Even more alarming is the finding that average turnover for first-year nurses has been reported from 27.1% (Pricewaterhouse- Coopers, 2007) to as high as 30%, resulting in a high personal toll to the nurses and a huge financial loss to the institutions (Bowles & Candela, 2005). Hafer and Graf (2006) found that if the new graduates remained on the job for 18 months, their satisfaction scores were positive. Nurse satisfaction grew with mastering two stressful areas for novice nurses: work organization and clinical tasks.

Job stress is not unique to nurses. The pace of work, changing dynamics of work processes, introduction of new technology, and the challenges of working with a multigenerational workforce have all contributed to workplace stress. Ample studies of professional nurses are available to suggest that stress is related to job satisfaction, and job satisfaction affects turnover and patient outcomes (Aiken, Clarke, Sloane, Lake, & Cheney, 2008, Flanagan, 2006). In an international study, nurses with high burnout scores were three times more likely to leave their current position (Estryn-Behar et al., 2007). Nurse satisfaction is more easily predicted than turnover which is subject to many intervening factors, such as market conditions, employability, family needs, and career stage (Stone et al., 2005). A common factor when discussing nurse satisfaction is concern about staffing. Nurse dissatisfaction and feelings of emotional exhaustion (burnout) increase when nurses have increased patient loads (Aiken, Clarke, Sloan, Sochalski, & Siler, 2002). Stressful situations, such as short staffing and high emotional intensity, may also be responsible for driving nurses away from the profession and decreasing the likelihood that young people will make nursing a priority career choice. Generational differences in job satisfiers have resulted in innovative work models to increase nurse satisfaction and retention in health care. Roberts, Jones, and Lynn (2004) found that satisfied new graduates were significantly more likely to remain than those who were dissatisfied. Nevertheless, high levels of job stress along with low levels of job satisfaction among new graduates are being reported in international nursing communities (Lavoie-Tremblay et al., 2008). And at the other end of the age spectrum, retirement in nurses is primarily influenced by financial independence, personal health issues, work intensity, and spouse health care needs (Cyr, 2005).

Incentives/Disincentives. Attention to incentives is becoming a major priority for nursing. International attention to incentives in nursing is demonstrated by a World Health Organization publication which notes “Incentives are important levers that organizations can use to attract, retain, motivate, satisfy and improve the performance of staff” (Global Health Workforce Alliance, 2008, p. 11). The top two issues that nurses generally identify as affecting their intention to leave or stay at a job are better working conditions and wages. Incentives, such as innovative work schedules, have been effective for encouraging nurses to return to the workforce and to remain (Young, Albert, Paschke, & Meyer, 2007). The incentive system must be seen as desirable by the staff in order to impact retention. An incentive scheme that nurses regard as irrelevant, contrary to personal or professional values, or destructive to their own well-being or that of their clients will fail in its purpose (Global Workforce Alliance, 2008).

Unruh (2003) identifies the need for policies and strategies to stabilize the demand for nurses, improve working conditions (particularly staffing), and raise wages and benefits to a level competitive with comparable occupations as the most important paths to solving current and future nursing shortages. Today’s nurse executives are struggling with leadership challenges of managing the multigenerational workforce, financial imperatives to deliver better care for lower costs, and competition to provide the optimal work environment to retain nurses. This study spawned recommendations regarding the role of incentives in designing an environment where benefits and perks will be seen as incentives to stay and thrive in the current nursing workplace.
Study Design

A non-experimental correlational design was used to determine relationships between study variables. The Nurse Incentives Project explored the influence of perceived stress, work-related factors, incentives/disincentives, floating, and intent to stay on job satisfaction. The conceptual model driving this study sought to identify potential intervention areas while examining the generational nurse characteristics. General Systems Theory was proposed by Ludwig von Bertalanffy (1968) as a way to think about interactions within a system. Kuhn (1974) later focused on the aspect of knowing about one part of a system to enable knowledge of the other parts. Communication and transaction among the components of an open system allow decisions to be made when all of the information that can be known is not available. General Systems Theory provides a framework to recommend actions to achieve the desired outcomes. In this study, the "throughput" stage was the prime potential intervention area for incentives realignment (see Figure 1). The throughput stage is seen as the best opportunity for manager intervention to improve outcomes; however, the study did not measure outcomes beyond satisfaction.

Figure 1. Conceptual Model: Systems Theory

Adapted from von Bertalanffy (1968)

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Research Questions

This study was driven by the following research questions: (a) What are the relationships among perceived stress, satisfaction with incentives, floating, intent to stay in the current position, and satisfaction? These variables were then examined to determine if the data support the theoretical model. (b) What are the most important work benefits to nurses? (c) Are there generational differences in how nurses value benefits as incentives?

Limitations of this study should be considered before generalizing findings. First, none of the hospitals were involved with collective bargaining contracts. It is unclear what effect union presence would have on satisfaction with incentives. Second, the low response rate is discussed later and may limit generalizability. Third, the list of benefits is not exhaustive and may not include every benefit available to every nurse. Hospitals wishing to duplicate this study would be advised to adjust the incentives.
Scale to include all benefits available to nurses in their area. Finally, the rich ethnic mix of this sample is interesting but probably not indicative of many areas of the United States and should be noted when findings are being generalized. None of these limitations were considered to highly impact the findings of this study and did not undermine our confidence in the findings.

Data Collection and Methods

Approval was received from the university institutional review board prior to data collection. The setting for data collection was a 22-hospital system located in four states in the southern and western United States. Hospital sizes ranged from as small as 12 beds to several with over 500 beds, and none of the hospitals were unionized. Two of the hospitals were rehabilitation centers, the remainder were general hospitals offering a full range of services. Nurses from all of the hospitals were invited to participate in the study and were promised anonymity. Anonymous surveys eliminate the possibility to target non-responders for followup in an effort to increase response rates. From a total of 5,176 RNs in the potential study population (see Table 2 ), a total of 1,581 surveys were returned with 1,559 used for analysis (30% response rate). While response rates of 70% are desirable, some authors state that 30% to 40% are common and may be adequate (Badger & Werrett, 2005; Krosnick, 1999).

Nevertheless, a response rate of 30% is considered low and could serve as a potential source of bias if some groups are under-represented. Readers are cautioned to consider group demographics before generalizing these findings.

The study was designed to allow predictive modeling of a set of independent variables, including incentives and disincentives, in relation to what causes nurses to be dissatisfied and leave their jobs. The design is non-experimental since no variables were manipulated in this non-random, convenience sample. Further, correlations were included to provide a basis for determining if this group of nurses was similar to previous groups where higher job satisfaction was related to increased retention. A hierarchical regression analysis was used as the predictive model to allow readers to determine the relative importance of each of the independent variables entered into the equation in predicting a change in the nurse job satisfaction scores. Hierarchical multiple regression was used to examine the impact of multiple independent variables on a single outcome variable (satisfaction) using a preset alpha of 0.05.

The online survey was conducted over a 3-month period using the hospital intranet. Participation was invited by flyers posted on nursing units and through intranet advertisements with assurances that identifying information could not be linked to the survey participant. The online survey contained four parts: demographic data, an incentives index measuring presence and importance of benefits, the perceived stress scale (Cohen, Karmarck, & Mermelstein, 1983), and job-related items including satisfaction levels and intent to stay. At their convenience, nurses could access the survey from computer terminals on the nursing units and complete the survey. They were not required to input an employee number or any identifier, so it is possible that they could respond more than once; however, the length of the survey makes it unlikely that multiple entries from one nurse would occur. Some duplicate surveys were discovered in auditing and were omitted from analyses.

Nurse Incentives Index. The Nurse Incentives Index included 33 specific benefits which were defined to ensure that all nurses viewed the benefit the same way. Factor analysis of the items using principal components analysis with varimax rotation, showed six components explained 32% of the total variance. The index allowed nurses to identify their current benefits and rate their importance. An incentive was defined as an available benefit the nurse wants and considers important. All incentives were summed to create an Incentive Score. A disincentive was defined as a benefit the nurse considers important but is not available. Disincentives were also summed to create the Disincentive Score. Benefits considered unimportant (scored 5 or less on a 10-point Likert scale) were theorized as
not affecting job satisfaction and were excluded from the summed scores. Cronbach's alpha for the Incentives Scale was 0.85 and for the Disincentives Scale was 0.78.

Perceived Stress Scale (PSS). The Perceived Stress Scale (Cohen et al., 1983) is a simple 10-item scale which allowed respondents to indicate the amount of stress in their lives. It is not specifically for nurses, so the questions are not clinically oriented. The responses are on a five-point scale and range from "never" to "very often." The four positively worded questions, items 4, 5, 7, and 8, were recoded to make higher scores indicate greater stress. The scale showed internal consistency with a Cronbach's alpha of 0.91. Factor analysis using principal components analysis (PCA) with varimax rotation supported that the 10 items measured a single component and explained 56% of the variance. The summed PSS score ranged from 10 to 50 (M=25.44, SD=6.80).

Intent to stay. A single item was used to indicate expected turnover among the RNs. Respondents were asked: "How many more years do you plan on staying with your present employer?" A space for input of a numerical quantity was provided. Support for using a single-item measure of intent to turnover is found in recent studies. Kovner et al. (2007) reported on length of time new graduates planned to stay in their first RN job using a single item with the following five responses: "Don't know," "1 year but less than 2 years," "2 years but less than 3 years," "3 years or more," "Indefinitely." Ulrich, Buerhaus, Donelan, Norman, and Dittus (2007) used a single-item indicator of intent to leave current position in comparing Magnet® and non-Magnet nurses. When asked if they had plans to leave their current positions in the next 12 months or the next 3 years, 43% of RNs in non-Magnet organizations reported such plans, compared with 38% in Magnet organizations and 32% in the Magnet-in-process organizations (p<0.05). Intent to stay for the current study is indicated as nurses' self-report of the number of years they intend to continue working for their current employer. The responses ranged from 0 to 40 years (M=9.98, SD=8.0).

Floating. Floating was measured by a single item asking how many times the nurses had been floated off of their assigned unit in the last year. The responses ranged from 0 to 150 (M=3.44, SD=8.1).

Satisfaction levels. Job satisfaction was measured by the summed score of four key questions: (a) How likely are you to recommend your current employment setting to a colleague as a desirable place to work? (b) Knowing what you know now, how likely are you to take this same job again? (c) To what extent are you fairly rewarded considering the responsibilities you have? (d) Overall, how satisfied are you with your current position? Each response was a four-point scale. Higher scores meant higher job satisfaction. The sum score ranged from 4 to 17 (M=11.97, SD=2.8). Alpha reliability was 0.854. Factor analysis showed that one factor explained 63% of the variance using a PCA with a varimax rotation. Incentives satisfaction was measured with a single item using a 10-point visual analogue scale. The respondent indicated level of satisfaction with current incentives by selecting a number on the scale from 1 to 10 with 1 indicating "Not Happy at All" to 5 signifying "Moderately Happy" to 10 indicating "Extremely Happy." Higher numbers indicated more satisfaction with the current incentives/bonus program at the facility. The scores ranged from 1 to 10 (M=3.67, SD=2.45).

Study Findings

Data were analyzed with and without imputations of missing data. Management of missing data, necessary for AMOS modeling, were done by imputing the series mean on model variables not demographics. The mean age of nurses in this incentives study was 42.24 years, and 88.5% respondents were female. The ethnic breakdown was 5.3% African American, 6.7% Asian, 70.3% Caucasian, 16.4% Hispanic, and 1.3% listed other or no response. Sixty-two percent of the total group had assistance with the support of themselves and their families while over a third of the sample acknowledged themselves as sole support. The average number of years as an RN ranged from less than 1 year to 48 years with a mean of 14 years. The average number of years as a nurse at the
current hospital was 8.48 with a range of 0 to 37. Educational achievement was 42% BSN, 55% ADN/diploma, and 4% graduate degrees.

Respondents were asked about work environment. The most frequently represented clinical specialty areas were critical care (18%), medical-surgical (15%), pediatrics/neonatal (11%), and operative services (11%). Survey participants worked an average of 11.6 hours per day. When asked how many days they were floated off their home unit in the previous year, the average was 3.4 days (SD=8.1) with half reporting they had never floated, but 59 nurses reported floating more than 20 times.

The Nurse Incentives index showed that the most important benefit to the overall sample of nurses (M=9.28, SD=1.5) was the work environment described as "Cohesive work environment: working with people who help you, share the work and pull together as a team." The least important preferences were fairly consistent across generations: luxury items, day care, and subsidized transportation.

While nurses expressed high job satisfaction, they tended to be less satisfied with their current benefits. Over three-quarters (78.5%) indicated they were moderately unhappy to extremely unhappy with incentives (scores of 5 or less on a 10-point scale). However, when asked about satisfaction with their current position, 85.5% were generally or highly satisfied.

Comparative analyses. Some of the analyses are appropriate for the entire sample, while some are more instructive when reported by generation. For example, because of the differences in the generational sample sizes (Millennials, n=94; Gen X, n=601; Boomers+, n=864), comparisons using the entire sample’s benefits preferences as a whole would be skewed toward those benefits preferred by the older nurses. Therefore, comparative analyses for the entire sample are reported on a more limited basis than for the individual generational cohorts.

Nurses with higher stress scores were significantly less satisfied with their jobs (r = -261, p=0.000). There was also a direct relationship between intent to stay and job satisfaction (r=3.72; p=0.000) and an inverse relationship between intent to stay and stress (r=-0.091; p=0.001). That indicates that nurses who plan on staying longer in their current jobs are more satisfied and less stressed. Three-quarters of the respondents had stress scores below the midpoint of the stress scale, indicating lower levels of stress.

Since nurse satisfaction is a good indicator of whether or not a nurse will leave, regression analysis was used to determine which factors were most highly related to their satisfaction levels. Exploratory data analyses were done to evaluate if the assumptions of multiple regression were met. Hierarchical linear regression was done to test the hypothesis that overall job satisfaction could be explained by satisfaction level with current benefits, disincentive scores, age, years planning to stay with present employer, perceived stress, and number of times the nurse was floated off the unit in the last year.

Path analysis using multiple regression analysis to test the causal theory was used to analyze the model. All missing data were recoded with means so the path analysis testing data matched the AMOS data which will not run with missing data. Initially, simultaneous regression was done to assess the relationships with satisfaction as the dependent variable and average daily work hours, stress, incentives, disincentives, absences, own illness absences, family illness absences, involuntary days off, vacation days, intent to stay, and floating as independent variables entered into simultaneous regression. The 11 variables explained 68% of the variation in satisfaction (R²=0.68, F=274.83, p=0.000, df=11, 1548). The hypothesized model was then evaluated using AMOS 16 with chi-square analysis, the comparative fit index (CFI), the normed fit index (NFI), and the root mean square error of approximation (RMSEA).

Figure 2 shows the tested model with four endogenous variables (incentives, floating, stress, and intent to stay), one exogenous variable (satisfaction), and one error term. Error is a standard consideration in modeling because latent concepts are never measured perfectly. The model explained 68% of the variation in satisfaction. The chi-square test was non-significant, indicating a good match between the data and the model, X² (1, N=1,561) = 1.075, p=0.30. The fit indexes also
demonstrated that the hypothesized model was a good fit with the data (CFI=1, NFI=0.997, RMSEA=0.007). CFI and NFI values of 0.95 or greater are deemed acceptable and RMSEA values greater than 0.1 indicate a poor fit (Meyers, Gamst, & Guarino, 2006, p. 633). The path coefficients are shown on the lines from the four exogenous variables to satisfaction. Co-variance estimates are noted on the curved lines of the four independent variables in the model. Total variance estimates are the numbers noted above each exogenous variable. The impressive regression findings and model fit supported the importance of the independent variables in explaining satisfaction.

Figure 2.
Nurse Incentives Model

Generational comparisons. Demographic findings for the generations are found in Table 3. In comparing the generations, it must be noted that the Millennial generation was disproportionately smaller than the other two, covering only about a 6-year span. This fact needs to be considered when interpreting the findings of the group comparisons.

Among generations, the mean "incentive scores" were remarkably similar: Millennials 44.6 (SD=5.6), Gen X 44.6 (SD=5.7), Boomers+ 44.3 (SD=5.7). However, the "disincentive scores" were very different. These scores reflected items that nurses thought were very important but they did not possess. Disincentive scores were higher for the younger nurses: Millennials 14.2 (SD=5.0), Gen X 13.7 (SD=4.9), and Boomers+ 12.7 (SD=5.0). There was a significant difference between the youngest and oldest generation (F=5.6, df=2, p=0.004). Ranked incentives by generation (see Table 4) showed differences in which variables were ranked highest by generation. The Millennials and Gen Xers both ranked overtime and premium pay among their most important incentives while the Boomers and older nurses stressed pension and retirement benefits. All of the generations appear to value premium pay described as "time and a half or double-time pay for working weekends or holidays - not overtime." Generational differences were also found in stress scores and years the nurses intended to stay. The Gen X nurses (M=26.3, SD=6.9) were more stressed than the Boomer+ nurses (M=24.8, SD=6.6) and the Millennial nurses (M=25.4, SD=7.4). The difference between the older nurses and the Gen Xers
was significant (F=9.04, df=2, \(p=0.000\)). Stress has been related to turnover. Even though many of them are anticipating retirement in the next 10 to 15 years, the senior nurse group planned to stay longer than their younger counterparts (F=5.64, df=2, \(p=0.004\)). The Millennials planned to stay another 7 years (SD=8.6), the Gen Xers another 10 years (SD=0.5), and the senior nurses 10.3 years (SD=6.5). These results show that the youngest nurses were the most stressed and the most likely to leave.

**Recommendations for Applying Findings**

Strategies to improve retention based on the findings of this study include provision of nurse-specific stress intervention programs for both younger and senior nurses. Nurse managers must actively listen to nurses who express job stress or are unhappy with their job. This study shows that they are more likely to leave if the problems are not addressed. Furthermore, nurses want opportunities to have input into the organizational decisions which may affect job satisfaction. Investing in these issues is much less costly than turnover, recruitment, hiring, orienting, and training. Hospitals may improve the work environment by preparing nurse leaders to build cohesive environments that are conducive to friendships, not hostility; promoting respectful relationships between staff and physicians, peers, administrators, and other departments; and facilitating good communication. Strategies include promoting nurse involvement through task forces and speaker series, which nurses can attend on work time, addressing issues identified as undermining work cohesiveness.

Nurses want greater control over their schedules. Job satisfaction is undermined and nurses more likely to leave when they are forced to float to another unit. Hospitals should consider a float team comprising nurses who are comfortable with multi-unit assignments, offer suitable reward for "inconvenience duty," and discontinue the practice of floating as the first line of coverage in the staffing model.

Benefits programs are a source of dissatisfaction for nurses. Hospitals should consider the following strategies to retain nurses: (a) Allow nurses to select from a menu of benefits and structure a benefits package that maximizes their incentives and reduces disincentives. (b) Make benefits packages transparent and individualized. Recognize that only when a benefit is seen as important and available to the nurse is it considered to be a true incentive. (c) Focus on ways to offer the benefits that nurses want. Of particular importance is committing resources to recognize those nurses who truly contribute to solutions by innovation or longevity and promoting efforts toward mentoring the new crop of nurses. (d) Finally, pay attention to generational differences regarding work environment and benefits.

Generational differences were found in perceived stress, job satisfaction, and likelihood of leaving. Provide mechanisms to get intergenerational input into proposed solutions.

In conclusion, this study indicates that nurses know what they want. Attention to generational priorities and flexible benefits programs may help to create the cohesive work environment that nurses seek. Investment into creating delivery arenas where satisfied nurses are caring for satisfied patients is a goal worth the effort.

**Sidebar: Executive**

- Today's nurse executives are struggling with leadership challenges of managing the multigenerational workforce, financial imperatives to deliver better care for lower costs, and competition to provide the optimal work environment to retain nurses.
- The purpose of the Nurse Incentives Project was to determine satisfaction with current employment incentives and potential managerial actions which might decrease or delay turnover by registered nurses.
This study spawned recommendations regarding the role of incentives in designing an environment where benefits and perks will be seen as incentives to stay and thrive in the current nursing workplace.

The results show that nurses know what they want.

Attention to generational priorities and flexible benefits programs may help to create the cohesive work environment that nurses seek.

Investment into creating delivery arenas where satisfied nurses are caring for satisfied patients is a worthwhile goal.

References


**Authors and Disclosures**

K. Lynn Wieck, PhD, RN, FAAN, is Jacqueline M. Braithwaite Professor, The University of Texas at Tyler, and CEO, Management Solutions for Healthcare, Houston, TX.

Jean Dols, PhD, RN, is System Director of Quality and Nursing Excellence, CHRISTUS Health System, Houston, TX.

Sally Northam, PhD, RN, is a Professor, The University of Texas at Tyler, Tyler, TX.

The Fairness of Patient Assignments

Further to our CREW Update #3 message from yesterday, we would like to clarify something. The fact that our unit manager will be doing the patient assignments for a month has no reflection on our Clinical Nurse Leaders, to whom this difficult task falls fairly often. This crossed my mind in reading the mail-out post dispatch. Our CNLs do the best that they can to please everyone re: patient assignments. Not an easy task. However, we all must take responsibility here. Change IS needed, and this initiative is a first step in exacting something positive-something 'better'.

In reviewing our CREW mail-out, I felt it necessary to expand upon this. Dorothy wants to look at trends in patient assignments while monitoring any decrease or (hopefully) an increase in both staff (and patient) satisfaction. This is not about making a few people feel more respected, but it entails making ALL of us feel better about coming to work. This is what we are trying to accomplish with CREW. It is all about us!

CREW is not a management tool, but we certainly need the input of everyone, management included, to achieve our objective here. It is about a FAIR allocation of work. Dorothy is giving CREW 100% support, and wants to make her relationship with us a dialogue,...not a monologue. There may be
no choice in assigning someone an unwanted task. This is a SHARED mission; the goal remains an increase in civility and respect in our work place, and not simply "more of the same". Thank you.

Duncan MacDonald for CREW
CIVILITY IN THE WORKPLACE

What is the impact of one factor, the culture of disrespect, on the nursing shortage, patient safety, teamwork and the economic bottom line? Lately, CREW facilitators have (unfortunately) had their attention directed to the flaws that exist between (some) nurses and (certain) physicians. Disrespect toward nurses DOES exist. What can we do about it?

PATIENT SAFETY
- Nurses who feel intimidated
  - Will avoid communicating with the MD
  - Will not question inappropriate orders
  - Will not speak up as a patient advocate
  - Will not report their observations

ECONOMIC IMPACT
- Sick calls
- Loss of productivity
- Decreased commitment to the organization
- Medication errors
- Malpractice consequences
- Cost of orientation

Civility is behavior that shows respect toward another, causes another to feel valued, and contributes toward mutual respect, effective communication and team collaboration. A lack of civility points to verbal abuse, physical abuse and/or negative behavior.

Verbal Abuse
- Profanity, demeaning comments, intimidating language, yelling, devaluing, discouraging, condescending language or voice intonation, impatience with questions or phone calls
- Being reprimanded in front of others, MD insulting the RN’s knowledge in front of patient/family, threat, criticizing others in public, argumentative behavior.
Physical Abuse
- Throwing objects (instruments or charts)
- Outbursts of rage or violence

Negative Behavior
- Scapegoating, backstabbing, complaining, perpetuating rumors, and behavior whose purpose is to control, humiliate, denigrate or injure the dignity of oppressed colleagues.

- Being expected to do another's work (clean up after them), behaviors which undermine team cohesion, staff morale, self worth and safety, unethical or dishonest behavior, ineffective, nonproductive forms of conflict resolution, repeated failure to respond to a call, lack of respect, cultural bias.

Where does this occur? It is said directly to the person, to others, on the phone, and via e-mail. Who is guilty? Nurses, physicians, patients, families, support staff and supervisors. It is true that we have a Code of Conduct for dealing with disruptive behaviors, but this cannot stand alone to create a culture of civility...more is needed!

LACK OF CIVILITY: CONSEQUENCES

Patient Safety
- Increase in collaboration equals a decrease in the odds of a negative outcome.

- Have your past experiences with intimidation altered the way you handle order clarification or questions about medication orders?

- Have you ever asked colleagues to help interpret or validate an order, so that you did not have to interact with an intimidating prescriber?

- Have you ever encountered a reluctance or refusal to answer questions or phone calls?

- Have you encountered impatience with questions?
• Have you ever been involved in a medication error during the past year in which intimidation clearly played a role?

**Patient Safety: RN-MD Interactions**

- There are significant correlations between physician-nurse collaboration and nurse satisfaction and self-esteem.
- If physicians and nurses are in conflict, an unhealthy work environment ensues.
- Patient needs are neglected when there is a lack of collaboration with physicians.
- Collaborative interaction between nurses and physicians on critical care units significantly related to mortality rates and length of stay in the units.
- Physicians who insult nurses' in front of patients, families, and staff cause them to question the nurses' competence and advice.

**Economics**

- The most common circumstance stimulating disruptive behavior is placing calls to physicians to clarify orders.

- Nursing is Not About the Money.

- Would you say that the workplace environment was an even stronger factor than compensation when it came to nurse satisfaction? High salaries and bonuses may be offered but it doesn’t matter, nurses won’t stay at a place that has an abusive environment.

**Teamwork**

It is almost impossible to have effective teamwork and communication if team members feel intimidated by others.

• RN/MD relationships must be:
- Collaborative: willing cooperation based on mutual power
- Collegial: physicians treat nurses as equals
- Student/teacher: doctors teach nurses and RN's teach and influence doctors.

Collaboration is an interaction...” between a doctor and a nurse that enables the knowledge and skills of both professionals to synergistically influence the patient care being provided.”

Weiss, SJ. Nursing Resources 1985;34(299-305)

Trust
The willingness to rely on others under conditions of risk and the expectation that other's behavior is predictable & beneficial.

Constructive Controversy
Open-minded discussion occurring within a strong cooperative context, of various perspectives that allows disagreement & exploration

STRESSORS FOR RNs
- Staffing
- Assignments
- Caseloads
- Patient acuity

STRESSORS FOR MDs
- Nurses placing calls to them
- Nurses questioning or seeking clarification of their orders
- Feeling their orders were not carried out correctly or in a timely manner
- Perceived delays in the delivery of care

- RNs fear confrontation, escalation, retribution, lack of confidentiality and administrative support

With CREW, we hope to hold open forums to discuss the topic and define workplace intimidation and the process for handling such situations. We hope to illuminate the reality of the problem and invite discussion. We need to analyze stressors and systems’ issues contributing to lack of civility and begin to lay the groundwork for significant changes. We invite physicians to
attend our meetings, as RN attendance is low. Perhaps all is well in ICU/CCU?

Parting Thoughts

• This didn’t happen overnight… and it won’t be fixed overnight.

• Every major change takes place with one initial first step

• Obstacles are what you see when you take your eye off the goal.

• You are either part of the solution, or part of the problem.

Take That First Step Today!

NEXT CREW MEETING:

Aug 10, 2009 at 2pm
CREW UPDATE # 1

Good day:

Please accept this invitation to join your CREW facilitators for ICU/CCU (Jen Bettens, Alana Coady and Duncan MacDonald) at our 2nd meeting tomorrow - June 22nd - at 1330 in CCU. It is YOUR commitment to CREW that will make it successful! Hope to see you there!

Our first meeting, held on Monday, June 8th, scratched the surface and opened the door to some great beginnings. The main focus was on respect for each other, and the lack of it. Staff really opened up as to the lack of respect in keeping our nursing desk, break room, med room and kitchen areas clean. This lack of effort shows disrespect to all who use/enjoy these spaces. Signs bearing the CREW logo now adorn these areas, and will remind us of the importance of teamwork, respect and common courtesy. Respect for visiting hours was touched upon, and we are going to work as a more cohesive unit re: this. For now, staff is interested in biweekly CREW meetings, but we stressed that they could have them weekly if they so desired. Staff want to know how we will “calm” some of the stormy personalities/work situations that exist if we cannot identify the individuals. We will try to focus on situations and trends without pointing
fingers. EVERYONE must feel safe to express his or her concerns without fear or apprehension!

All were pleased with our big "Kick-Off" on Wednesday, June 3rd. We had approximately 60 people attend. The CEO, three physicians, the Chief Nursing Officer, both Directors of Nursing, and a host of managers and (most importantly) staff from ICU/CCU and 4C were there. It was great!!! For now, staff expressed interest in bi-weekly CREW meetings, but we stressed that they could have them weekly if they so desired.

So...several staff have suggested that CREW should focus on other ways that staff might be more collegial and respectful to each other. A few of them are offended by the amount of gossip that exists in our unit(s). This is a tough one, and may be beyond repair, but we have to try. What can we all do?

Stop gossip in the workplace by beginning with yourself and upper-level management. Set the example and refuse to listen to gossip on any level. Present a professional image by being cheerful, courteous and pleasant. But when employees come to you with gossip about colleagues, tell them you prefer to leave personal issues alone.
Our next CREW meeting might be a good place to talk about how you want to stop gossip in your workplace. Define gossip. Some people may not realize they are gossips. Some simply see it as chatting and exchanging information. Let them know that gossip includes rumours that are personal and intimate in nature and seem sensational or emotionally exciting. It's never appropriate to talk about another person's private life. Could we establish a company policy that forbids tolerance of gossip?

Let’s curb gossip and walk away when someone else wants to gossip. Fires that are not fuelled soon burn out.

Nip conflict in the bud before rumours start spreading. We must ALL want to stop gossip in the workplace not only on a personal level, but also gossip that arise about company/legal issues.

We all have things we want to make better about our work lives. If we don’t bring them to a boil, how will we enjoy the meal? We hope you can all come to the meeting...1330...CCU.... MONDAY the 22nd.

Duncan MacDonald, Jenn Bettens and Alana Coady...your CREW facilitators.
Hello, Friends:

Welcome to CREW - Civility, Respect and Engagement at Work.

CREW is a program aimed at improving the social aspect of work environments. It is designed to enhance the quality of work life by improving environments so that employees experience greater satisfaction, enjoy healthier relationships and achieve a sense of accomplishment at work. CREW operates through a series of meetings called civility sessions in which employees strive to enhance the quality of interactions among team members. Working groups identify issues, set goals for improving teamwork and evaluate progress toward these goals. With this in mind, please accept this invitation to join your CREW facilitators for ICU/CCU (Jen Bettens, Alana Coady and myself) at our third meeting Wednesday -July 8th- at 1330 in CCU. It is YOUR commitment to CREW that will make it successful! Hope to see you there!

Issues discussed at our second meeting on Monday, July 22nd: After lunch was served, there was a review of our first meeting. Promises
made re: CREW initiatives were acted upon. Signage was posted in the ICU and CCU kitchens, med rooms and break rooms, which enticed staff to work together (respectfully) to keep these areas neat and stocked. Many hands make light work, and we are proud to report that things ARE improving in these areas! As well, we have designated the area between ICU and CCU as our “CREW TERRITORY”. This will be the place to take a deep breath, and take in all things ‘CREW’.

Signage was strategically placed throughout the units with the hope of drawing our attention to incivility and gossip within ICU/CCU. Examples are: "When a rumour reaches your ear, let it go out the other", and "Resist the urge to jump to conclusions about people and their motives. Go to the source, get the facts, and then decide", and “Let’s make our unit a ’rumour-mill free zone”. The majority applauded the messages. We CAN also boost our morale while recognizing CREWish behaviour from “Floor” staff, lab staff, housekeepers, blood collections staff, security, ...and yes, even doctors, now and then.

At this second meeting, we (eventually) got down closer to the core of the disrespect and gossip that exists in our two units. A new guest (a
social worker) suggested that we should take ownership for our anger ("I am angry" as opposed to "You make me angry"). Talking things out and resolving bad situations was hashed out. The unit managers from ICU (Dorothy) and CCU (Barb) attended the meeting, as staff invited them. This was a good thing, as it turned out. The reduction of gossip took center stage. A mass e-mail (entitled CREW UPDATE #1) gave suggestions to aid in the reduction of gossip. Many staff commented on this. This was, in fact, the beginning of our CREW Communications E-Binder. A paper version will be implemented in both units for those without access to e-mail, or who just like to read the old fashioned way. We included this version in our ICU/CCU Communication binders (which are read by ALL staff).

We used examples of ways that we could recognize 'CREW-ish' behaviour (e.g. 'Star of the Week'). WE will add so much more to respect and civility than a simple thank-you! We will use Tim Horton’s coffee cards and delicious chocolate bars (with CREW logos affixed) as incentives/rewards for "CREWish" behaviour. We will be introducing CREW ‘comment cards’ as well. These cards (completed in recognition of every CREWish action recognized) will be given out BY
THE STAFF to those recognized for CREWishness, and will then be deposited into a secure box. Weekly prizes will be awarded to our “CREW star of the week” (e.g. a meal at subway, movie passes, etc.).

Our next meeting will take place on Wednesday, July 8th, at 1330. All attendees agreed upon this time. We have changed the day from a Monday to allow those to attend that cannot come (on Mondays): staffs have requested this! We will continue to watch our CREW staff dictate the course of our journey, and ask for their input re: ways to move forward successfully. So far, it’s working.
CREW UPDATE # 3

Greetings:

Welcome to CREW- Civility, Respect and Engagement at Work.

CREW is a program aimed at improving the social aspect of work environments. It is designed to enhance the quality of work life by improving environments so that employees experience greater satisfaction, enjoy healthier relationships and achieve a sense of accomplishment at work. CREW operates through a series of meetings called civility sessions in which employees strive to enhance the quality of interactions among team members. Working groups identify issues, set goals for improving teamwork and evaluate progress toward these goals. With this in mind, please accept this invitation to join your CREW facilitators for ICU/CCU (Jen Bettens, Alana Coady and Duncan MacDonald) at our next (fourth) meeting Tuesday - July 21st - at 1400 in CCU. It is YOUR commitment to CREW that will make it successful! Hope to see you there! Our (third) CREW meeting on a sunny Wednesday, July 8th was not as well attended as the previous two, but was very productive!
Look for a laundry bag in our ICU break room. Those ‘courteous’ staff on third (night shift) break can fill it with (our) blankets from the days breaks and wheel it back to the Unit. First break in the A.M. can wheel over an empty one to the break room for that days/night breaks. Let’s make it a habit. Our breaks are awesome, so let’s show some respect for our co-workers and keep our break room tidy.

We are, beginning on Monday, July 13th, introducing CREW Compliment Cards and Recognition Chocolate Bars. If someone (anyone) behaves in a way that goes beyond the norm and you want to recognize them, then you might give them a compliment card OR a CREW bar to express your admiration or appreciation for their action. Both the giver and receiver can sign the card (or bar wrapper) and deposit it in our new CREW Compliment Box. This locked box will be located on the wall in the neutral zone between ICU/CCU. Once a week, a wrapper (or card) will be drawn, and the giver/receiver will win a prize: such as movie passes, Subway coupons or Tim Horton's coupons valued at 10.00 per winner! This is open to ALL staff, from any floor! Anyone who behaves in a positive way can win, so let’s have fun with it!
CREW is being embraced by more staff every day and is causing us to reflect on our work environment. Please continue to give us your input. If you cannot attend the meetings, your voice WILL still be heard. We are here for you.

As everyone can’t seem to get on the same page regarding visiting hours, we have brought the staff’s concerns regarding this to our unit managers in attendance at the meeting. Visiting hours will be from 1000-1300 and 1500-2000. As in the past, families of patients who are at end-of-life and close to same will forego these hours (at the RN's discretion). However, All other visitors WILL NOT be admitted prior to 1000. Our unit manager will support us 100% on this, and strives to have it passed immediately! A professionally done sign at our entrance will make the visiting hours quite clear.

Ward clerks will be integrated into “circle” reports, and will be updated by the Clinical Nurse Leads and RNs. We want to make ALL staff more aware of the direction of the shifts!
Several staff members felt that the patient assignments are being done unfairly and with not enough forethought and (possibly) favoritism and sometimes based on skill mix. Your CREW facilitators brought forward your concerns to management. As somewhat of a pilot project, Dorothy has agreed to do the daily assignments (12D and 12N) for one month. This will begin on Monday, July 13th. It will be done in a factual manner, with fairness and respectful of staff and patients alike. Please keep the lines of communication open and help to make our work place better.

On Monday, August 3rd, CREW asks you to join in welcoming our friends from the Glace Bay ICU. There will be a CREW party with all our friends from 4C on Wednesday, July 22nd beginning around 1930-2000 or so. Let's get out and have some fun!

Remember, our next (fourth) meeting is **Tuesday, July 21st, at 1400 in CCU**. We need YOUR INPUT to get to the REAL issues! We CAN promote change! If it is beyond the scope or ability of your CREW facilitators, then we will take it to the appropriate level for you, if you so desire. The momentum is growing. Let's make CREW an even bigger part of our workplace culture...TOGETHER!
Why CREW Works

CREW works by targeting behavior within the control of a workgroup (way its members interact with each other). Good working relationships have such an impact on feelings, plans, and identity that they affect the rest of the experience. When individuals are treated respectfully, they feel better overall and they are healthier and happier at work. Improved relationships boost employees' attendance and help them to become more committed to their organization and more engaged in their profession.

*CREW leads to a more productive organization that makes the most of its most vital resources - its employees' talent, knowledge and energy.*

CREW UPDATE # 4

RE: CREW MEETING

July 21, 2009

Topic #1

Further to the previous email regarding Assignments, it was brought to the attention of the CREW team that perhaps a staff meeting should be held to discuss assignment allocation. It had been previously suggested that the unit manager delegate assignments for both days and nights. However, feedback received by the CREW team about such a change was both positive
and negative. Is this change for better or worse? It has only been two
weeks for such a change so perhaps another two weeks would be appropriate
for this pilot. Please give feedback to one of the CREW members: Jen
Bettens, Duncan MacDonald or Alana Coady. Remember that your feedback is
100% confidential and any feedback is welcome.

Topic #2

Break Room/Med Room Cleanup/Respect

“Working very well” according to many staff members. Thanks to everyone
for their effort in keeping these areas clean/tidy. Kelly is on vacation, so
our diligence re: this is vital. Helen has been very “CREWISH” in ensuring a
laundry basket is placed into the ICU break area to encourage blankets, etc
to be placed inside. Big thanks to Helen for that role.

Topic #3

Visiting Hours/Quiet Time

Signs have been put up to let families know that Visiting/Quiet Time hours
are now 1000-1300/1300-1500 (QT)/1500-2000. Staff has been doing
fairly well to keep visiting hours respected, making it easier on the entire
team on the units to work together to ensure these hours are respected.

Please do remember that in extenuating circumstances (i.e.: an actively dying
patient), ward clerks, support staff and front line RNs should all be aware so
that exceptions to this rule can be made. IN addition, could we please
respect the “2 visitors at a time” rule so we are all on the same page and
there are no discrepancies that may cause tension between visitors and
front line staff (i.e.: if one family can only take in 2 and notice another room
has 3 or more). TO RNs: please take time out of your busy schedule to
review blood work cards with the Ward Clerks, remember that they too may
be Day 1 of their shifts and need to know the scoop!!!!

Topic #4

Comment cards are now available in the ICU and CCU. The box has been
installed on the wall in between the units so the cards can be placed in it for
a weekly prize draw. Remember, that both the writer and the receiver win
if the card is picked out.

Please accept this invitation to join your CREW facilitators for ICU/CCU
(Jen Bettens, Alana Coady and Duncan MacDonald) at our next (fifth)
meeting Monday -August 10th- at 1400 in CCU. It is YOUR commitment
to CREW that will make it successful! Hope to see you there! We need
YOUR INPUT to get to the REAL issues! We CAN promote change! If it is
beyond the scope or ability of your CREW facilitators, then we will take it to
the appropriate level for you, if you so desire. The momentum is growing.

Let’s make CREW an even bigger part of our workplace!

NEXT MEETING

Aug 10, 2009 at 2pm…. Food will be provided.

What does everyone think of a Ball Game as an outing on a Saturday in future?

WE NEED YOUR IDEAS!
CREW UPDATE # 5

CREW is being embraced by more staff every day and is causing us to reflect on our work environment. Please continue to give us your input via face-to-face or by e-mail. If you cannot attend the meetings, your voice WILL still be heard. We are here for you.

RE: CREW MEETING

August 10th, 2009

Topic #1

Winners of CREW Draw # 2, and (each) recipients of a 10.00 Subway gift card are SARAH JESSOME and MARIANNE SHARPE. Congratulations ladies, and keep up the civil and respectful work environment!

Topic #2

We received an e-mail from an RN that read as follows: “Something that I would like to have addressed is the improper setup of the cubicles. It doesn’t happen that often, however I have noticed of late that dirty suction liners are not being removed post discharge of patients and when the new admission is received, the suctions are not ready and the same liners are there from the previous patient. Also, open bottles of saline and sterile water are being left behind from the previous patient. This poses a safety
issue from an infection control standpoint. I realize that it has been extremely busy and we are pressured at times to take an admission very quickly, however we have to ensure our cubicles are ready and setup properly, hence displaying respect for our co-workers, along with our patients”. This is disrespectful, and we must ensure that we take a few minutes to be certain that the room is ready for our next ‘guest’. It is, in fact, the RNs responsibility.

Topic #3

Visiting Hours/Quiet Time

We talked about the relationship(s) that exist between physicians and nurses (including RTs, PTs, and so on). CREW sent out an e-mail, which touched on this subject; thanks to those who took the time to read it, as it can be a major forum for incivility and disrespect. Our unit manager felt it appropriate to see that this message will find its way into the inboxes of all physicians with whom we interact. This might be interesting.

Topic #4

We will be looking at the option of placing the (Locked Unit) intercom/phone and door-release button within reach of a (seated) Ward Clerk. This will make their (at times harrowing) task more palatable.
Topic #5

No visitors before 1000? We as nurses must tell the ward clerks IF there are any exceptions. Otherwise, they will refuse entry to all visitors before 10 AM.

In closing, it is evident that a couple of CREW signs were defaced both in ICU and CCU. It seems that Dorothy hired some adolescents; not very professional folks—certainly not very 'CREWish'.

We are looking at organizing a softball tournament for September 26th where ICU/CCU could take on 3A, 4C, Physicians, and anyone else who wants to taste defeat! This could be a real blast...what do you think?

It is YOUR commitment to CREW that will make it successful! Hope to see you there! We need YOUR INPUT to get to the REAL issues! We CAN promote change! If it is beyond the scope or ability of your CREW facilitators, then we will take it to the appropriate level for you, if you so desire. Let's make CREW an even bigger part of our workplace! **Tuesday - September 8th- at 1400 in CCU.** WE NEED YOUR IDEAS!
We had arguably the best CREW meeting yet this afternoon. Incivility, disrespect and negativity were on the table, and a great discussion regarding the subject ensued. It is becoming more evident through our discussion today that incivility, disrespect, meanness, bullying, and demeaning behavior are still present in our workplace. What is it that accounts for this negativity among us, and what can be done to perhaps soothe and diminish the high degree of rancor, meanness, incivility and disrespect?

When we are unconscious of how we are and who we are, when we are unable or unwilling to engage in self-reflection, our tendency is to associate and behave with a “herd” mentality – witness the high-pitch ever-escalating level of disrespect, sarcasm, (in the guise of humor), mocking and bullying that is taking place in our workplace. So, how does one become more conscious of ones behaviors? By consciously considering what is underneath one’s need to be uncivil, mean, disrespectful, and demeaning.

The ED is pushing very hard to get patients to the critical care units. Yes, we accept patients 24/7, but patience and respect in the transfer of our clients must trump all else. Rudeness from an ED nurse (in a leadership role) toward a critical care nurse over the phone recently came to light. Despite the nurses best efforts to facilitate the transfer post-haste (the room awaiting cleaning), the ED nurse was extremely rude and it should be noted that ED management was well aware of this uncivil and disrespectful behavior as it was occurring. The same thing happened during an extremely busy shift in ICU (on days) Friday. The supervisor was pushing hard to get an ED patient into our last empty bed at end of shift. The acuity was high at the time (a code in progress, another patient in an SVT rhythm with a HR > 200). The supervisor was made aware of this. The ED actually attempted to try and get in touch with the RT and facilitate the transfer DESPITE the aforementioned! One of our senior nurses quelled this disrespectful action very professionally. This chaos continued into the night shift.
Let us not single out the (more than occasional) uncivil and disrespectful attitude and actions of our colleagues in the ED and Recovery Room who could certainly benefit from CREW. It is also happening among us! The disrespect of (some) co-workers toward others was noted (and brought up today) during the "higher intensity" shift(s) over this past weekend. Participants in today's CREW meeting also sought clarification as to management's role regarding “mandating”? Basically, it was stated that it is almost “insulting” to staff that management must be contacted at home at times regarding those times when we are working short. Why can't we, as mature professionals, work these situations out for ourselves, since WE are in the unit and know what is doable? We could take it on a situation-by-situation basis, and settle it among ourselves. Why do we even allow the word "mandate" to be spoken?

If a staff member feels that they can do an extra six hours (OR twelve) and wish to step up and "volunteer" to do so, should they be berated for this by other staff? Can we get past the "us versus them" mentality? Can supervisors and management put the ball in the hands of the nurses RE: this? Also, as discussed by staff today, if a nurse comes in to do an OT shift, we should not give them the 'easy' assignment because they are 'doing us a favor. Nor should we dole out the 'worst' assignment because they are the "expensive" nurse. Let's just be fair to everyone and get the work done...together!

Incivility and negativity are all about 'resistance' to someone or something "out there" with which one feels uncomfortable. Incivility and negativity are all about being 'unconscious' of how one is in relationships. Incivility and negativity are all about the ego's need for control, recognition and security and being unwilling to go 'inside' and explore why one needs to hurt, be verbally abusive, and disrespect another. Incivility and negativity are largely about the mantras "I'd rather be right than happy." Or "I have to be somebody at the expense of being seen as nobody".

Life, after all, is choices. Do I choose to be reactive, negative, hurtful and uncivil? Why? Really, really, really...WHY? As a wise man once said “Out beyond right and wrong doing there is a field...I'll meet you there”.

Our next meeting is slated for Monday, September 21st at 1400 in CCU.
CREW UPDATE # 7

RE: CREW MEETING September 21st, 2009

In order for any group, organization, or institution to be able to build and maintain itself as a functioning entity capable of achieving its potential, it must be able to manage its interpersonal relationships in a positive - civil and respectful - manner. One of our nurses stated, via e-mail, that “a lot of individuals we work with put their shoes on chairs, both the seat and the arm rest, and also on the table many eat off of in the break room. Being health care workers we all know about cross contamination and the likely hood that our shoes are contaminated with many bacteria and viruses; not to mention stool, urine, and other bodily fluids. Being a germ conscious person this bothers me greatly. I have mentioned it to a few people but most disregard my concerns”. We can change this, and show some respect to each other to boot!

Most in attendance felt that nurse-to-nurse/staff 'issues' are getting better, but problems with management (communication) remain. There are those who wonder why ICU nurses must work in CCU? There are some who question why some (ICU) nurses are going to put in a half-dozen shifts in CCU, and some have not been scheduled to help out next door? These queries were put to me privately, and AFTER the CREW meeting. Barb and Dorothy could address this. One RN reminded me “before January 26th (when CCU reopened) we used to work together”. Aside from this, she felt that there seems to be less animosity between the units lately. Fact is, our friends in CCU are in a rough patch, and we can help out until they fill their lines. Another person informed me of an incident where rudeness and voice raising occurred the day of (but not at) the CREW meeting! Can we get past this? Some people are accustomed to tolerating behaviors that are outside the realm of considerate conduct and are unaware that they are doing so. These behaviors affect the organizational climate, and their negative effects multiply if left unchecked. Interventions for incivility and bullying behaviors are needed at both individual and administrative levels. CREW aims to give workers a starting point to eradicate such behavior. One (female) physician was recently heard to say, “Nurses are a catty bunch, anyway”. Don’t let her (stereotypical) view of us be correct!
Some housekeeping next: (1) If enough people are interested, there will be a baseball game at Our Lady of Fatima diamond from 1500-1700. Our ICU/CCU team would play 3A and 4C, with a party to follow. The sign-up sheet is in the washroom. If raining, then we just PARTY!!! (2) We are considering CREW t-shirts for those staff who would like to show their support for making our workplace better. A sign up sheet will follow. (3) We want you to come up with a name for our group here in ICU/CCU to grace these t-shirts (e.g. CREW-saders). The winning entry will get a nice prize!

Duties Civility Imposes

✓ Our duty to be civil toward others does not depend on whether we like them or not.
✓ Civility creates not merely a negative duty not to do harm, but an affirmative duty to do good.
✓ We must come to the presence of our fellow human beings with a sense of awe and gratitude.
✓ Civility assumes that we will disagree; it requires us not to mask our differences but to resolve them respectfully.
✓ Civility requires that we listen to others with the knowledge of the possibility that they are right and we are wrong.
✓ Civility requires that we express ourselves in ways that demonstrate our respect for others.
✓ Civility allows criticism of others, and sometimes even requires it, but the criticism should always be civil.
✓ Civility discourages the use of legislation rather than conversation to settle disputes, except as a last, carefully considered resort.

Taken from Civility: Manners, Morals, and the Etiquette of Democracy by Stephen L. Carter

Our next meeting is slated for Wednesday, September 30th at 1400 in CCU. THERE WILL BE FOOD!!!

Peace.

Duncan, Alana & Jenn.
CREW UPDATE # 8

RE: CREW MEETING September 30th, 2009

A Dialogue with Management (a.k.a. Dorothy and Barb)

What do nurses want?

Do they want better pay? Better hours? Less mandatory overtime? More autonomy? Better benefits? Absolutely. But as the literature tells us, most nurses really want to go to work each day at a place where they will be valued, where they feel like they are part of a team that really works together. Working conditions seem to matter even more than financial rewards, and hospitals and other facilities that provide a positive work environment are more likely to have a satisfied nurse workforce. The number one, most important incentive for staying in a hospital (job), according to our lit review, was a cohesive work environment; working with people who help you share the work and pull together as a team. This kind of environment is something that unit managers can directly affect. They can start by recognizing nurses for their accomplishments and by saying, “Thank you, you did a very good job.” Unit managers can help to build cohesive environments by recognizing the contributions that nurses make, and by getting rid of factors in the environment that are not conducive to cohesion. CREW is about giving ALL staff a better work life. Without a sense of COMMUNICATION and TRUST between our unit managers, and us then all the rest is pointless. As your CREW facilitators, we felt that this should be the focus of this newsletter.

On that note, both Barb and Dorothy stepped up and, with CREW Update #7 in mind, addressed some “hot” topics: these being the (1) LPN taking shifts in CCU and (2) ICU staff being floated to CCU. These were, in retrospect, more of a “communication” problem than a “management” problem (as was stated in CREW Update #7). Both managers sent out e-mails to (all) staff, and I feel no need to expand on these. However, these e-mails are appended at the end of this newsletter. Both Dorothy and Barb were invited (by me) to speak to those in attendance at our CREW meeting. Barb had a previous commitment, and (regrettably) could not break free. In her defense, I did
not give her much notice. Dorothy spoke with those of us in attendance for 45 minutes, and the mood seemed positive at the meetings end. The meeting accomplished what we (CREW) hoped it would...it got people talking about moving FORWARD.

Yes, trust and communication must be reinforced. Before we blow things out of proportion, we could try and get the answers we seek from Barb and/or Dorothy. Their (appended) e-mails offer openness and availability, and a desire for communication and (mutual) respect. As a nurse who was not here (ICU/CCU) for things that happened “in the past” in (and between) these units, I am unaware of a lot of the baggage that came with them. Dorothy asked that ALL staff “let go of the past” and “move forward”. This feels like we are moving in the right direction. An important intent of disseminating the information from these meetings is to stimulate conversations between nurses, other staff, and management.

We must say (collectively) “ENOUGH” to disrespect and incivility! We CAN change our work lives for the better! Of course, a disrespectful workplace can’t be fixed overnight, but managers can’t afford to sit on the fence on this issue. They have to take that first step. It seems today that they have. Like American President Barack Obama stated in his Inaugural Speech: “...we will extend a hand if you are willing to unclench your fist”.

The CREW ( Civility, Respect and Engagement at Work) program is designed to identify issues of incivility at work and address them head on. Please join your CREW facilitators Alana Coady, Jenn Bettens and myself, Duncan MacDonald, for our next meeting on Wednesday, October 7th in CCU. Thank you.

From Barb:

Glad to hear that those in attendance felt that nurse –to-nurse/staff “issues” are improving. Our CREW team’s efforts and commitment are surely making a difference, KUDOS to you! © Disappointed to hear, this way, that there is “management problems”. I like to think that I have an open door policy, and if it doesn’t feel that way to everyone, then I need to know that, so that I can make adjustments. I am available by email and phone as well. I am also disappointed that the CCU staffing issues continue to be food for discussion. We did have a staff meeting to address that as well as other issues, and I felt that it was clear. However, there was very poor attendance, so again, maybe the messages did not get out in a timely and/or accurate fashion. I am very grateful to Dorothy and
all the ICU staff for their assistance and support. Everyone that I have approached to do a shift or two in CCU has said yes and without hesitation, some telling me they don't mind coming “anytime”. I can't help but be concerned about the reasons why this is such an issue. The work is different and I understand that if you “signed up” for ICU that is where you prefer to work, and vice versa. However we have worked together for about 15 months and I hoped that we could still be a “team” and help each other out. If there are other reasons I would be open to sit down with anyone or a group to find out what the problems are that have people not wanting to do a few shifts here. **I can’t fix it if I don’t know!** 3 (and now 4) vacant lines in a 12.6 FTE schedule is a huge burden to staff and still ensure everyone receives some well deserved time off, that is the whole reason behind the reassignments. Our patients need to be cared for and you all have the skills and abilities to do so. At times (more lately) we do have ICU patients, as we accept ICU patients from the floor when there is no bed available in ICU, and rather than opening an additional un-staffed bed. This has worked well, with no issues (that I am aware of) from the CCU staff. When there is a bed in ICU the patient is transferred across because that is where they belong. These decisions are difficult and at times we are required to make decisions that you are not in favor of, that are in the best interest of our patients. Let’s keep a healthy dialogue open on this subject, so we can get to the root of the problem and become the more cohesive team that I know we can be.

Thanks Barb

**From Dorothy:**

As discussed in the Crew meeting today this is the email that I didn't get to send on Friday but reviewed in the meeting today.

I will respond to the nurses who came forward to you about the CCU shifts.

There were a lot of concerns over the empty lines in CCU. The amount of empty line shifts was not workable then Barb found out 3 empty lines turned into 4. Barb made an effort to provide help with the addition of a LPN who would have been orientated to the unit(CCU) in addition to loads of OT. There was some miscommunication around this and it created MUCH concern amongst some individuals in CCU as well as some ICU staff. I am going to point something out here - both units got together on this...Lots of discussions took place and I hope it eased the concerns for staff in both units. We, actually I, went to plan "B" in Barb's absence, and that was to go to upper management (Martha) and make a suggestion to keep the 10th bed in ICU "unused" for now and the 7th nurse would fill in the CCU empty line shifts. (a management decision) This helped Barb & CCU greatly & the truth be known it would have been a directive from senior management to re-assign staff sooner than later, so we offered first..

When I picked staff to fill in CCU I used the sheet that was signed stating
that you didn't mind working in either area. If for any reason that changed
I have not been approached by a single person about this topic. I think there
might be 1 person who has not picked up OT or a regular shift in CCU in the
recent past re-assigned for a shift. I tried to make it seamless as in
re-assigning a "full set" or "your 2 days" or "2 nights", some shifts were
not so easy but I mentioned it to the person or it was someone who regularly
says "I don't mind"

If you have reservations or don't want to do these shifts my door, email &
phone are always open or on. I will understand...and please note I haven't
perfected the art of reading minds.

For the staff who some how feel this was disrespectful it was in no way
meant to be...I was following a direction "you" gave me when I posted the
note" please sign if you will work CCU as well as ICU. I have to ask the
question to the person who approached Duncan...is it the fact that "you"
dont want to work in CCU or is that" someone else" isn't?? My guess is the
latter of the two and it has nothing to do with CCU and that is my concern
reading this; is the old back & forth stuff raising it's head (probably not)
so I caution all of you before making any assumptions. It seems like the
weekends bring out the burning embers that ignite into inferno's by Monday
mornings and that is why this is so important for me to actually type on
this Friday night when I should be packing ..... :) 
I hope for CCU sake that this is a temporary situation and before we know it
the lines will be filled.

In regards to the update I dont think this is a "management problem as
such" so Duncan I respectfully must disagree :) however I feel the need to
explain. There are times Barb & I have to make decisions about our units,
it's called "operational requirements" we cant take the time to call all of
individually, so we try our best. I thought I sent out an email to ICU
staff explaining the need to do shifts in CCU but maybe I didn't....H1N1 has
me a bit foggy!!

I think there is a difference between not liking a management decision and
calling it disrespectful ....I am not getting paid the hourly rate I wanted
but I certainly didn't say Martha was disrespectful ( this is only an
example, light humor...lol) but you get my point. The workplace requires
leadership and that's what I am trying to do....each of you are leaders
working at the bedside and I envy you, I miss the bedside at times but at
this point in my career I felt I could contribute more and make a difference
in this role of leadership and with this role comes management decisions.

I have heard alot of "....but in the past" , if you cant let go of the past
the present & future will never improve for you. I am asking each of you to
please let go of the past and look to the future, your a great bunch of
people with loads of skills, experience and fun to share. We as a team need to move forward......there is a whole world of critical care nursing out there that is exciting and new, but quite frankly we are not going to move anywhere if you are stuck in the past....please think about where you want OUR units to go, in what direction and what "you" are willing to do to get there and how can Barb & I help...it's a team effort!!!!

My message....
Work as a team...you are all friends in one way or the other!!
Have fun.....maybe the ball game is just what is needed...ICU/CCU should be out there winning the "cup" ...is there a "cup" Duncan???

The CREW initiative has made a difference for sure & I want to thank Duncan, Jen & Alana for your leadership . ICU & CCU staff need to know though that Barb & I are still here and open to conversations but it seems like we only get approached when the issue has been tabled for discussion elsewhere leaving us to back track and trying to explain assumptions...the whole communication piece is not perfect but we can work at it...emails seem to help , so if you have a question or concern about a decision we made send a note, call but get ahold of one of us first before going to the entire staff with assumptions...one of us is always here, except Saturday or Sunday but I always check my email and so does Barb.

I hope this settles any rapid heart beats or rumors that may erupt from this up date...I have personally not had one concern or complaint about CCU shifts :) and when I spoke to staff on several shifts everyone seemed to agree that this was a good decision.

Have a great weekend peeps...Jen & I are off to get "smrt" apparently!!!! We will be bringing back lots of ideas ......

Dorothy

Our next meeting is slated for Wednesday, October 7th at 1400 in CCU.

Peace.

Duncan, Alana & Jenn.
CREW UPDATE # 9

The role of leadership in overcoming staff turnover in critical care

Why are our co-workers leaving the ICU and CCU venues? What can management do retain these nurses? Can they do anything? Why did/do YOU want to work in critical care? As your CREW facilitators, we felt that this should be the focus of this newsletter. Let's talk about it.

What are the causes of and solutions for staff turnover in the critical care setting? This issue is of profound significance to management and staff because the workforce is shrinking as a result of impending retirements and, as the population ages, the demand for intensive care services are growing considerably. These factors are further compounded by the fact that the complexity of care provided in the ICU/CCU demands professionals who are highly trained and skilled. In this environment, turnover can be costly to the organization because of the significant expenses associated with recruiting and training workers.

There are many well-documented reasons for staff turnover in the intensive care setting. These include job dissatisfaction due to inflexible scheduling practices, insufficient opportunity for professional development, as well as a lack of collaborative decision making around clinical and practice issues.

There are other important reasons for turnover that should be considered by ICU/CCU leaders, and these include burnout and generational diversity. Burnout is a prevalent phenomenon in critical care, and the nursing literature suggests that issues such as moral distress when engaging in futile care contributes to burnout. The consequence of burnout is that there is a negative impact on quality of care and staff morale, which can ultimately cause turnover. Look around at your fellow nurses. The generational diversity found in the ICU environment can also be a source of turnover of staff. It is well documented that Generation X (born in 1965-1980) and the Millennial Generation (born in 1980-2000) have a strong desire for more
balanced work life than Veterans (born in 1925-1945) and Baby Boomers (born in 1946-1964). Clearly, it is important for leaders to be attuned to these generational differences when developing recruitment and retention plans and redesigning the workplace environment.

CREW wants to highlight the importance of ICU leadership working with frontline staff to create a vision and strategy that addresses the core reasons for turnover. It is essential that this vision be aligned with the vision, mission and values, and strategic plan of the health care organization. Furthermore, the "team" should assess whether their hospital is highly reputable, has high patient satisfaction, and sufficient resources and equipment to provide care. All of these components are signs of a positive work environment, and leadership can build on these attributes to recruit and retain staff. The other key factor in this process is the use of a teamwork approach. Team work training in the areas of conflict resolution, learning styles and giving feedback, as with the CREW initiative, will help the staff to work together to create and achieve an inspiring vision. Although the financial and human resource investments required to engage in this process are considerable, there is substantial evidence in the literature that highly functioning, satisfied staff lead to more efficient patient care and better outcomes.

Staff turnover is a critical issue that ICU leaders need to understand and address in their unit settings. Attention to this issue with a systematic, evidence-based approach that focuses on team work and collaboration will not only improve retention but will also make the ICU a highly competitive and desirable place to work. Are we moving forward? Why are our co-workers leaving the ICU and CCU venues? What can we retain these nurses? Can we do anything? Why did/do YOU want to work in critical care? Dorothy requests that we stop and reflect on why WE came to the ICU in her e-mail that reads:

"Hi Gals & Guys: I am wondering if any or hopefully all of you can put into words from your hearts “why you chose critical care” for your careers. I have a couple of reasons for this, one is for our web site and the other I will share at a later date. Please! Please! Please! Share your thoughts... I will not identify where the quotes come from unless you give me permission to share your name...so if you don’t mind please let me know that as well. Please mention this email to your co workers so they can check their emails..."
We should work together in this endeavour, as it could attract staff to work in our units, thus helping to avoid being short-staffed and possibly mandated.
Answer the following questions truthfully, and ask, “what can be done to improve the situation in our units”?

(Respect): People treat each other with respect in my work group.

(Cooperation): A spirit of cooperation and teamwork exists in my work group.

(Conflict Resolution): Disputes or conflicts are resolved fairly in my work group.

(Coworker Personal Interest): The people I work with take a personal interest in me.

(Coworker Reliability): The people I work with can be relied on when I need help.

(Antidiscrimination): This organization does not tolerate discrimination.

(Value Differences): Differences among individuals are respected and valued in my work group.

(Supervisor Diversity Acceptance): Managers/Supervisors/Team leaders work well with employees of different backgrounds in my work group.

E-mail me with your thoughts. Everything is confidential, and I can relay your input to management IF you want it to be brought to the surface. It’s YOUR work life. Speak out...make a difference!

On another note, from our last meeting; CREW has it from reliable sources (RNs) in the Emergency department that the ER CNLs are pushing HARD to move patients to the “controlled environments” (ICU/CCU) with orders not filed, meds not given, etc. ER staff (some) feels pressured to move these souls out, but when the aforementioned are overlooked, then it becomes a PATIENT SAFETY issue. Also, there have been two (very recent) instances
where PHARMACISTS have contacted the physician and obtained NEW orders that have been transcribed to a physician order sheet and THE RN HAS NOT BEEN NOTIFIED OF THE SITUATION! This is disrespectful and dangerous, and should be addressed!

Is CREW going to end after November 17th (the date of our official CREW Wrap-Up in Halifax)? The ICU/CCU staff will determine this. As to CREW t-shirts, approximately 50 of you signed up for this initiative...thank you for supporting a positive work community! A special thank you to Pam McGillivary, who thought of a GREAT slogan for the t-shirts. Pam, see Jen Bettens for your Tim Hortons coffee card...YOU ROCK!

Pam’s logo is:

Crew = Civility
I will respect and
Value other’s opinions.
I will express my concerns and
Listen to others.
I will encourage positive attitudes.
Together, we may reach our potential.
You CAN make a difference!

We are looking at a night out (Midnight Bowling) sometime in November. Also, we are considering an even split (50-50) with the profits going to an ICU/CCU Education Fund. Perhaps a pub-crawl in November with the profits directed toward an ICU/CCU Education Fund? Give us your input. Without YOU, CREW is meaningless.

The CREW (Civility, Respect and Engagement at Work) program is designed to identify issues of disrespect and incivility at work and address them head on. Please join your CREW facilitators Alana Coady, Jenn Bettens and myself, Duncan MacDonald, for our next meeting on Wednesday, October 21st in CCU. Thank you.

Happy Thanksgiving
Building a Respectful Workplace

What is a respectful workplace?

A respectful workplace supports the physical, psychological and social well being of all employees. In a respectful workplace

- Employees are valued
- Communication is polite and courteous
- People are treated as they wish to be treated
- Conflict is addressed in a positive and respectful manner
- Disrespectful behavior and harassment are addressed

Why do we need a respectful workplace?

We all deserve a respectful workplace. When people at work offend, embarrass or humiliate us, it hurts our dignity and well-being. It also hurts our working relationships and can lower our productivity. Over time, disrespect in the workplace can lead to an unhealthy work environment and a high rate of employee turnover.

Who is responsible to prevent disrespect?

Everyone has a responsibility to prevent disrespect.

Source

The person whose action offends others. If you think your behavior offends someone else, stop the behavior.

Target

Tell someone if his or her behavior offends you. Ask them to stop. Give a respectful response and avoid blaming. If the behavior continues or is serious, report the incident to the appropriate person in the workplace.

Observer

The person who sees disrespectful behavior occurs. You are not innocent. You have a responsibility to call attention to the disrespectful behavior. Offer suggestions for more respectful behavior.
Supervisors and managers should address disrespect immediately. Ultimately, it is the employer’s responsibility to provide a respectful and harassment-free workplace.

**What can your employer do?**

Your employer is responsible to provide a healthy work environment. Some ways employers can build a respectful workplace are:

**Training**

- Provide training on respectful workplaces to all workers and management
- Hold orientations with all new employees and review their rights, responsibilities and obligations toward other employees
- Provide diversity training
- Provide conflict resolution training and make sure all management and supervisors are skilled in handling conflict

**Policies & practices**

- Review policies & practices to make sure they encourage respect
- Develop a respectful workplace policy with the involvement of workers
- Support and encourage people who practice respectful behavior

**Build accountability**

- Hold management and workers responsible for their behavior
- Investigate all complaints of disrespect and harassment
- Assess respectful behavior in performance evaluations

**What can YOU do?**

You can model respect by practicing the following behaviors:

- Try to understand the other person’s point of view
- Accept values and opinions that are different from your own
- Identify your own feelings before you share your concerns with another person
- Do not blame, threaten or name call even if you are angry or hurt
- Report abuse, discrimination or harassment

**CREW UPDATE # 10**

Disrespect for one’s co-workers seems all too common here at the CBRH. And it often causes people to leave their jobs. For employers this means losing good people, and then having to hire and train new ones. For co-workers it means having to get used to working with new people, and “picking up the slack” until new employees can be found. The saddest part of the lack of respect in the workplace is that many people don’t realize they are being disrespectful. They aren’t trying to hurt someone’s feelings. They just aren’t trying to not do that. We do not consider the negative effect that our disrespect might have on someone.

**The Actions to Avoid**

How can we avoid offending the people we work with? It seems as if it should be blatantly obvious. But if it were we wouldn’t even be writing this article, and CREW would be unnecessary in our work community. Let’s take a look now at actions that may offend your co-workers (in no particular order).

- Not cleaning up after yourself in the staff kitchen
- Showing up late for report
- Neglecting to say please and thank you
- Wearing too much perfume
- Taking the last of something without replacing it (e.g. thermometer probes)
- Talking behind someone’s back
- Using cell phones for non-work-related reasons (e.g. texting your BFFs) while on the job
• Blaming someone else when you are at fault

• Taking credit for someone else’s work

• Asking a subordinate to do something unrelated to work, i.e. run errands

• Sending unwanted email (hopefully NOT these CREW Updates)

• Telling offensive jokes (this is a tough one)

• Not pulling your own weight

• Having a condescending attitude toward others

• Complaining about staff assignments

• Complaining about the company, boss, and co-workers

The workplace is full of stories about co-workers "behaving badly". What we don't hear enough about are co-workers doing nice things for one another. These stories do exist ... don't they? Has a co-worker covered for you when you were too sick to work? Did a co-worker get you a cup of tea/coffee just because you looked like you needed it? Did a co-worker do your patient's bath while you were on break? Did a CCU nurse come over to ICU and offer to help because she knew ICU was busy? These things DO happen, because I witnessed them on my last set!

Things are improving, but they could get a lot better. Dorothy (ICU) sees big changes since the inception of CREW. She is happy to come to work each
day, and could not think of one negative thing to pass on via CREW. Barb is willing to meet with any of her staff and wants to reaffirm her open-door policy. As the manager of CCU, she spoke to me of a genuine desire to make her unit better. Staff should take advantage of such an opportunity, and take a seat in her office and let her know what she can do to make things better! All personnel who govern, manage, or work at the frontlines of the health care system should strive to foster a positive workplace environment and to prevent behavior that may poison that environment.

Do you respect our Clinical Nurse Leaders in their roles? Why or why not? These ladies want to be the best that they can be, and if the staff does not respect them in their role, there must be a reason. Let’s percolate this stuff to the top and have a discussion as to how we can make our work place the best one in the CBDHA!

Is there still a wall of animosity that exists between ICU and CCU? OF COURSE THERE IS! WHY??? Can we ALL do our job and not worry so much about the (not job-related) things that are going on “on the other side of that door”? The quality of health care workplaces is enhanced when all health care personnel cooperate with one another and treat one another with respect and courtesy. Conversely, the quality of health care workplaces is eroded when any health care personnel exhibit disruptive behavior and/or are disrespectful or discourteous in their interactions with one another. Disruptive, discourteous, or disrespectful workplace behavior by any health care personnel should not be tolerated.
IN CLOSING:

CREW will continue as long as the staff wants it to continue. Dr. Sabe De has the distinction of being the first physician to join CREW, and promises to attend our next meeting. Not to take anything away from Dr. Paul MacDonald, but is has been noted that it takes more than wearing a CREW pin on your lanyard to be in the CREW...you have to BE respectful of those who surround you!

CREW will continue as long as the staff wants it to continue. CREW meetings will be held on a monthly basis from here on in. The ETA for our CREW t-shirts is about one week (thanks Alana). Vicky’s party is November 14th. Rose’s party is December 11th. Spread the good cheer, my friends!

Our next meeting is slated for Thursday, December 10th at 1400 in CCU.

Duncan, Alana & Jenn.