PERCEIVED STRESSORS OF FLOOR NURSES

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CHAPTER 1

INTRODUCTION

Stress is an everyday occurrence in a hospital. During the past decade there has been increasingly more research on stress in hospitals, but most studies emphasized patient stress rather than the stress experienced by nurses. Nurses acknowledge that their work is often stressful, and they can quickly list numerous causes of stress in the work environment. Nurses working in a hospital setting have continuous exposure to stressors during the course of their working day such as ministering to dying patients, situational crises, patients' families, physician moods, administrative difficulties, and hospital policies. However, little research has been directed towards validating stressors and stress levels in nurses, particularly those who work on general medical/surgical units.

One of the major problems facing hospitals today is the high turnover of nursing personnel.

> The national average turnover rate for registered nurses is approximately 32%, according to the National Association of Nurse Recruiters, and 40%, according to the American Nurses' Association. This means that three to four nurses out of every ten nurses quit their jobs each year. (Wolf, 1981, p. 233)

The high turnover rate of nursing personnel and the increased expenses related to recruitment and retention seem to have left no hospital unaffected. It has been suggested that the high turnover rate is related to stress. Therefore, how to effectively approach the problem of stress in nursing is an urgent challenge for the 80s. Finding out what nurses perceive as stressful in their work seems indicated as a necessary step toward meeting that challenge.

Problem of Study

Research indicates that intensive care unit nurses experience significant levels of stress, but the amount of stress experienced by general floor nurses has been in the most part ignored. Therefore the problem addressed in this study was to identify and determine the level of perceived stressors of general medical/surgical floor nurses.

Justification of the Problem

In the United States there are more than half a million nurses. The majority of these nurses work in a hospital setting and most of the hospital nurses work on general medical-surgical floors.

> American Hospital Association reported there were 859,792 full time licensed nurses of whom 602,660 were registered nurses located in all U.S. hospitals.

> Almost two-thirds (65%) of all employed were employed in hospitals. (Brimmer, 1981, p. 3)

When asked regarding the primary clinical practice area, more nurses marked medical-surgical nursing (39.2%) than any other area (Brimmer, 1981). A study conducted in Tennessee by the National Institute for Occupational Safety and Health found that health care professionals such as nurses are involved in stress producing jobs. Since nurses do experience stress in the work environment it is important to identify some of the stressors that floor nurses experience (Matteson & Ivancevich, 1980).

Determination of the level of stress of general medical/surgical floor nurses could serve several purposes. The research of stress as perceived by nurses would assist hospital administrators and nurses to find solutions to reducing stressors in the work environment. By decreasing stressors perceived by the nurse, turnover rates may also decrease. Stress research would not only benefit individual nurses, but nursing as a whole. Once nurses can identify stressors at work, they may also find ways to reduce the stress. By decreasing or handling stress at work, nurses may be happier in their jobs and exhibit a greater measure of job satisfaction. With an increase in job satisfaction also comes a possible decrease in staff turnover.

Conceptual Framework

The concept of stress according to McGrath (1976) is broad and incorporates a wide range of problems and situations. He stated that stress occurs as a result of physical threat to self, an actual or anticipated injury or pain to the psychological self, an actual or anticipated difficulty in social relationships, or the environment. The focus of this study is on the stressors resulting from the environment.

Stress was first defined by Selye (1956) as a nonspecific physiologic response. Since that time there have been a multitude of definitions and theories to describe stress. Stress is defined by McGrath (1976)

> as the anticipation of the inability to respond adequately or at a reasonable cost, to perceived demand, accompanied by anticipation of negative consequences for inadequate response. (p. 2)

McGrath's definition indicates there is a potential for stress when the environmental situation is perceived as presenting a demand which threatens to exceed the person's capabilities and resources for meeting the demand under conditions where he expects a substantial differential in the rewards and costs for meeting it. Lazarus (1976) also wrote a similar definition of stress. Lazarus believed

> an environmental demand can produce psychological or perceived stress only if the focal organism anticipates that he will not be able to cope with it without endangering other goals. (p. 17)

These perceptual views of stress suggest that subjectively experienced stress will be highly contingent upon a person's assessment of the situation. Past exposure to the stressor condition and practice dealing with the situation could operate to affect the level of subjectively experienced stress from a given situation.

What kinds of situations and stimuli cause stress? For a stimulus to be considered stressful, it first must be perceived by the person experiencing the stress.

> The sequence of events which is of interest begins in the environment, with a demand of some sort which the environment is placing upon some system. (Kahn, 1976, p. 98)

Stress is not just an individual emotional state, but a particular kind of reaction of an organism to environmental events. Thus it is the perception that something in the environment is a threat that causes stress.

Secondly, a stimulus must be interpreted by individuals in relation to their ability to meet the demand. "Stress is the anticipation of inability to respond adequately to perceived demands accompanied by anticipation of negative consequences for inadequate responses" (McGrath, 1976, p. 16). An environmental demand can produce perceived stress if the individual anticipates that he will not be able to cope with it, or cope with it adequately, or cope with it without endangering other goals (McGrath, 1976). Stress

then involves some relationship between an individual and the environment. An individual is an active, adaptive, coping organism rather than passive and reactive. Stress occurs when there is substantial imbalance between the environmental demands and the response capability of the organism (McGrath, 1976).

Thirdly, the individual must perceive the potential consequences of successfully coping with the stress as more desirable than the expected consequences of leaving the situation unaltered. The effects of stress conditions are mediated through subjective psychological processes (for example, cognitive appraisals of threat or secondary appraisals of coping resources) which are affected by many perspectives of the individual (McGrath, 1976).

Adaptation and learning affect intraindividual differences in perception of threat over time, under the "same" conditions. Also, many individual physiological, psychological, and behavioral processes vary through time as a function of factors which are more or less equal to environmental stressful events, thereby introducing further inter and intraindividual variability in the perception of threat and response to the threat. Individuals use their physical environments to cope with stressful situations, as well as being affected or stressed by the environment (Altman, 1976).

Therefore, nurses on general medical-surgical units will perceive a stimulus as stressful. It is the nurses' perception that something in the environment is a threat that causes stress. The nurses will interpret the stimulus according to their ability to meet the demand and examine the consequences of coping with the stressor.

Assumptions

For the purpose of this study the following assumptions were considered:

1. Nurses are subjected to stressors at work.
2. Nurses will assign priorities to stressful events.

Research Questions

The following research questions were formulated for this study:

1. What factors in the work environment do general medical/surgical floor nurses perceive as most stressful?
2. What is the level of work stress experienced by general medical/surgical floor nurses?

Definition of Terms

The following terms were defined for the purpose of this study:

General Medical/Surgical Floor--a nursing unit in a hospital with primarily medical and/or surgical patients.

Nurse--an individual currently licensed to practice professional nursing in the state of Texas and currently employed in the study institution.

Stress--the anticipation of inability to respond adequately to perceived demands, accompanied by anticipation of negative consequences for inadequate response (McGrath, 1976), as measured by the Medical/Surgical Nurse Stress Survey (Hage, 1981).

Limitations

This study was limited to the hospital from which the random sample of general medical/surgical floor nurses was drawn. Therefore the results cannot be generalized beyond this target population.

Summary

Chapter 1 briefly explained the problem of the study of perceived stressors of floor nurses. Since the majority of hospital nurses work general medical/surgical floors, it is important to identify the stressors which these nurses perceive they are experiencing in their jobs. Therefore, now is the time for floor nurses to also become involved in identifying stressors in their area of nursing. Stress is a problem of the profession. Stress is not present just in one area of nursing, such as the Intensive

Care Unit; stress is also present in all areas of the nursing profession.

Chapter 2, the review of literature, discusses the problem of stress and what stressors nurses experience. Chapter 3 explains the method of data collection and the treatment of the data to meet the purposes of this study. Chapter 4 describes the statistical analyses of the data obtained. Chapter 5 contains the summary, a discussion of the results of this study, conclusions and implications, as well as recommendations.

CHAPTER 2

REVIEW OF LITERATURE

Nurses are exposed to many situations that have a potential for producing stress. Stress, and its effect on health care providers, has become a problem of national concern. The nurses' perceptions of the event or demand and the intensity of the demand are key elements in job related stress in nursing. This chapter explores the concept of stress, discusses situations in nursing that have the potential for producing stress in a nurse, describes turnover rates in nursing and how they are related to job stress, and examines methods of improving stressful situations.

The Concept of Stress

There are many definitions of "stress" found in the literature. The term is used in reference to both physical and psychological stress as well as reactions to stress. Stress means many different things to different people.

In terms of the body's response to stress, Selye (1979) defined stress as "the nonspecific response of the body to any demand made upon it" (p. 562). Whenever an organism adjusts to maintain normalcy, it is under stress.

Selye (1965) also stated that "stress is the rate at which we live at any moment" (p. 97). All living beings are constantly under stress; thus, stress is the wear and tear exerted upon the body.

Today, Selye's (1965) concept of the "stress syndrome" or the general adaptation syndrome (GAS) is widely used. Selye's general adaptation syndrome is explained as the body's reaction to stress of any kind and is similar to a defense mechanism. There are three stages of GAS. These stages include the following:

1. Alarm reaction--this is when defense forces are mobilized in the fight or flight response. For example, on her first day in the coronary care unit a new nurse hears a patient's alarm. The nurse's heart and respiratory rates increase, her muscles tense, and her pupils dilate. Her body is either ready to fight the stressor or flee from the stress producing event. If the nurse survives the first few weeks in the unit, she will become accustomed to hearing monitor alarms. She will move into the stage of resistance, for she cannot exist in a constant state of alarm.
2. Stage of resistance--in this stage the body overcomes the stressor and repairs any physical damage. The body's resistance to that particular stressor increases

and the body may even adapt to that stressor. For example, after several weeks, the new unit nurse will respond to the sound of a monitor alarm differently than she did initially. Her actions will be deliberate, quick and purposeful.

3. Stage of exhaustion--an organism exposed to a stressor for a prolonged period loses its adaptaion ability and dies. A person responds to continual stressors by exhausting his ability to adapt. The results may be ulcers, headaches, and hypertension (McConnell, 1979; Selye, 1965).

Selye's concept has also been divided into four levels of stress. Level I stress includes routine day to day stressors which elicit the alarm-resistance response. Adaptive resources are used automatically, the situation is not perceived as threatening and the response is practically imperceptible to the individual. Level II stress includes mildly stressful, new or less routine events which are perceived as threatening to the individual. The alarm-resistance cycle is more obvious but not prolonged. Level III or moderate stress occurs when the individual encounters persistently stressful events which adaptation has not resolved. The individual is potentially unable to function during this state. Level IV, severe stress, is the burnout

or exhaustion stage where events and situations are perceived as dangerous. Exhaustion can also occur when multiple stressors affect the body simultaneously (Valiga, 1979).

As Selye (1965) pointed out, a moderate degree of stress is good for an individual, but too much stress will have an adverse effect on the ability to cope. One area of stress to which people are constantly exposed is that of the environment.

Lazarus (1966) and Glass and Singer (1972) identified the environment as being related to stress. According to Lazarus (1966):

> Stress is the common denominator of all adaptive reactions in the body. Stress is elicited by an actual or perceived disparity between the environmental demands and the organism's capacity to cope with these demands and is manifested through a variety of physiological, emotional, and behavioral responses. A person's reaction to stress is a cognitive process in that demands are made on the person that may pose a threat or that exceed the person's ability to cope with events. (p. 2)

Psychological stress resides neither in the environment nor in the person alone, but depends on the transaction between them. Thus, how a situation is appraised by the individual can be as important as the event itself. Whether the individual will be stressed by interaction with the environment depends on the intensity of its demands, as well as his or her adaptive resources. If environmental

demands exceed the ability of the person to cope with them, there will be a stress response. The nature of that response and whether it is perceived as one of harm, threat, or challenge, depends on the appraisal of the individual (Lazarus, 1966).

According to Glass and Singer (1972), actual induction of stress in human beings depends upon cognitive factors. A great many environmental events have the potential for causing a stress response; the human being depends upon his or her own psychological structure to determine whether or not a stress response will occur. Glass and Singer (1972) noted several features unique to man which are incorporated to determine whether or not he or she responds to a stressor. These include:

> 1) his intellectual resources; 2) his knowledge and motive strength; 3) the cognitive features of the stimulus situation, this being the degree of control that he feels he has over the threatening event, and its predictability of occurrence. (p. 6)

Wolf (1950) pointed out that man reacts not only to actual existence of danger but to threats and symbols of danger as well. A threat of danger, according to Wolf (1950), can evoke a reaction of longer duration and greater magnitude than the original assault. The nature of the response is dependent upon the nature of the individual and his past experience and future goals more than merely the "noxious agent" causing the reaction.

Definitions for stress have been compiled by many authors. McGrath (1976) defined stress as "the anticipation of inability to respond adequately or at a reasonable cost to perceived demand accompanied by anticipation of negative consequences for inadequate response" (p. 23). Psychological stress refers to all processes originating in the external environment or within the person which imposes a demand on the organism (Engel, 1971). King (1981) defined stress as follows:

> A dynamic state whereby a human interacts with the environment to maintain balance for growth, development, and performance, which involves an exchange of energy and information between the person and the environment for regulation and control of stressors. (p. 98)

Stress has also been described by Stellman (1977) as "that physical and emotional experience which results from a requirement to change from the condition of the moment to any other condition" (p. 54).

Whether a stressor causes a response depends on the meaning that the stressor has for the individual. Man has always tried to identify and neutralize those stressors which could be considered negative. Stress that is not noticed or dealt with at the time of its initial occurrence can create a particularly fertile place for similar stress-producing situations to grow--often magnified by the original unresolved stress (Stellman, 1977).

It has been shown that stress is a part of life, there are many definitions of stress, factors in the environment can lead to a stress response, and all people have their own manner in responding to stressors (Glass and Singer, 1972; Lazarus, 1977; McGrath, 1976; Selye, 1965, 1979). With these basic concepts in mind, a review of the literature is presented concerning job stress in nurses and the identified stressors of hospital nurses. Characteristics of stressors in hospital floor and intensive care unit nurses including interpersonal relationships and communication, administration/institution policies, patient care, and environment/unit management are presented. Effects of stressors, such as turnover, and studies dealing with ways of decreasing stress on nurses are discussed.

Job Stress in Nurses

Job stress has been defined as "the condition in which some factor or combination of factors at work interact with the worker to disrupt his psychological or physiological homeostasis" (Claus & Bailey, 1980, p. 16). The nurses' perception of the event or demand and the intensity of the demand are key elements in job-related stress in nursing.

Staff nurses in a general hospital fit a Type A_2 behavior pattern. In Type A_2 the individual requires an environment of haste, hurry, and acceleration. The Type A_2

individual is simply a conscientious person who is presented with a situation in which there is constant pressure on one's time (Tierney & Strom, 1980).

Staff nurses are responsible persons who have been educated to give thorough, comprehensive nursing care. Yet, they are placed in a milieu in which they are expected to perform numerous tasks and psychosocial interventions in a short period of time. They must pass out medications, complete treatments, be available to assist physicians with procedures, assist nonprofessional personnel in patient care, and answer questions from families who visit the floor. Staff nurses must accept new patients, record orders as they are written, and be prepared to act in emergency situations--completing their routine chores after the emergency is all over (Tierney & Strom, 1980).

Nurses often experience danger or stress as a continuing condition in their lives by virtue of their choice of profession. There is danger from sickness or injury among patients for whom they are responsible as well as the threat from inaccurate information about a patient's condition. There is stress for nurses at other levels of experience--insufficient resources to meet the needs and wants of patients; not enough time to provide needed patient care and other pressures from a hospital position (Haber, Leach, & Schudy, 1978; Hunt, 1976).

Nursing-related occupations in one study by Ivancevich and Matteson (1980) were ranked 3rd, 10th, and 27th in production of excessive stress. Thus, out of 130 occupations, nursing-related occupations ranked extremely high.

Nurses experience a great deal of stress in their daily workplace: nurses confront suffering and death as few other people do; they work with ill people under stress; they face heavy demands for pity, compassion, and sympathy; and they are often expected to do the impossible in the way of providing comfort or cure. Many nursing tasks are, by ordinary standards, disgusting, distasteful, and frightening. Indeed, there is no scarcity of situations which exposes nurses to stress (Mauksch, 1966; Menzies, 1960; Scully, 1980).

Categories Identified as Stressors for Nurses

Not all sources of frustration identified by nurses are present in all hospital-care units all of the time. Some may be present to a greater degree in one type of unit than in another. Others may be more prominent in a particular institution with its physical setup or administrative structure than in another institution. Nevertheless, these sources can be grouped into five broad categories: (1) the patient and his care, (2) personnel, (3) environment, (4) families, and (5) other (Bilodeau, 1973).

Huckabay and Jagla (1979) studied 46 nurses in an intensive care setting in the Los Angeles and Orange County area of California. They identified four categories of stressful factors in the ICU. These include: patient care, interpersonal communication, environmental, and knowledge base (Huckabay & Jagla, 1979).

Cassem and Hackett (1972) identified seven areas of conflict in the CCU nurse. These areas of stress include: nursing administration, scheduling and staffing, families, research procedures, other nurses, patients, and physicians.

In a sample of 1,238 ICU Nurses from 74 hospitals in the San Francisco area, Grout, Steffen, and Bailey (1981) reported the following categories were identified as sources of stress: (1) patient care, (2) interpersonal relationships, and (3) knowledge and skill. Management of the unit was identified as the fourth category.

Anderson and Basteyns (1981) studied 182 full-time ICU nurses. Key stressors identified by these nurses included the patient and his care, peronnnel, environment, and families.

Another system of categorization, including internal as well as external stressors, was proposed by Hay and Oken (1972). Nurses' ratings regarding frequency, severity, and forced-choice comparison of stressors yielded 12

groups of items: heavy lifting; cardiac research; unpredictable scheduling; heavy responsibility; patient anxiety; hectic pace; annoyance by patients' families; severity of patient illness; lack of time off; insecurity; patient personalities; and nurse-nurse conflicts.

Jacobson (1978) reported a classification scheme of nurses' stress in the neonatal intensive care unit. Eighty-seven nurses from seven NICUs identified the five categories of most stressful situations included: nurse-physician problems; understaffing; heavy work load; sudden death; personal insecurity; and shock of sights and smells.

The four areas of stress that were mentioned by most authors and for which there seems to be agreement as to their importance are discussed in depth below. These four areas are interpersonal relationships, administrative/ institution policies, patient care, and environmental/unit management.

Interpersonal Relationships and Communication

Steffen (1981) reported that in a national survey "interpersonal conflict was identified . . . as the major source of stress of ICU nurses and the second most significant source of stress among nurses in the regional survey" (p. 42). Many researchers have identified communication

difficulties as a source of major stress among nurses. Stress occurs from communication problems with physicians, families of the patients, and hospital administrators. There also tend to be communication problems among personnel (West, 1975).

Hay and Oken (1972) found work in the ICU as providing formidable stresses for nursing personnel. The special nature of the work promotes communication breakdowns with physicians, relatives, and nursing and hospital administration, leading to lack of support from these crucial groups and, indeed, added stress. The necessity for intimate cooperation leads to intragroup tensions. Several researchers found intrapersonal situations as major causes of stress in nursing today (Cassem & Hackett, 1972; Koumans, 1965; Stehle, 1981). The most frequently occurring professional stressor reported was found in interpersonal relationships with co-workers, supervisors, subordinates, physicians, patients, other departments and administrators (Johnson, 1982; Stehle, 1981).

Jacobson (1978) reported that, of the nurses working in NICUs, "a striking feature of the nurses' reports was their emphasis on psychosocial conflicts" (p. 147). Other researchers found that interpersonal relationships were the second most common source of perceived stress for nurses (Claus & Bailey, 1979).

As noted by Huckabay and Jagla (1979), ICU nurses have told researchers that interpersonal conflicts are the greatest source of stress in their work environment. People, whether families of patients, physicians, or other staff nurses, were consistently perceived as the most common aspect of stress.

Patients' families were often recognized as a source of stress for nurses. Many researchers identified interpersonal relationships with families as high stressors (Grout et al., 1981; Huckabay & Jagla, 1979).

Meeting the psychological needs of the patient's family was rated a moderately high stressor, according to Reichle (1975). The patient's family seeks constant reassurance and support from the nurses. Placed under the strains of time pressure, patient and family needs, and their own feelings, ICU staff nurses experience feelings of stress.

Cassem and Hackett (1975) identified in their survey families being overwrought and anxious as the fourth highest stressor and families annoying the staff as the sixth highest stressor for nurses in ICU and CCU. A family may overwhelm the staff with its need for emotional support. A family often copes with the illness of its loved-one by becoming angry with the nurses and by inferring that they

are not providing enough care. On the other hand, some nurses may view the activities of certain family members as interfering with the care of the patient (Calhoun, 1980; Cassem & Hackett, 1972; Hay & Oken, 1972; McConnell, 1979; Oskins, 1979). Family members turn to nursing personnel to meet their needs for reassurance, information, and guidance. Nurses may feel the lack of time or ability to meet these needs. The family may be coping with their feelings in ways that are threatening or overwhelming to the nurses, or the family may be interfering in some way with patient care (Bilodeau, 1972).

Researchers have found communication with family ranks extremely stressful for nurses (Altman, 1976; Cassem & Hackett, 1972; Ivancevich & Matteson, 1980; Leatt & Schneck, 1980; Longest, 1974). As sources of stress, poor communication can lead to job dissatisfaction in nurses.

Researchers have also found that interpersonal relationships with doctors often cause unnecessary stress on the nurse (Anderson & Basteyns, 1981; Cassem & Hackett, 1975; Garbin, 1979; Hay & Oken, 1972; Huckabay & Jagla, 1979; Ivancevich & Matteson, 1980; Leatt & Schneck, 1980; McConnell, 1979). Lack of availability and poor communication headed lists of nurses' complaints. Few things were as anxiety-provoking or as frustrating as being unable to reach a

doctor when he was needed. The physician's immediate availability is essential to the nurse. The physician is needed not merely for emergencies but for frequently updating changes in orders, for advice--and for reassurance. A survey of headnurses found, according to Leatt and Schneck (1980), "the highest source of stress was relating to physicians not being available" (p. 40). The authors reported that "ninety-four per cent of the headnurses indicated that this situation produced stress" (p. 40).

Poor physician-nurse relationships are a primary concern to nurses (Schultz & Johnson, 1971; Sheard, 1980). Nurses resent physicians' lack of professional respect for them. Nurses and physicians are in a position to police one another's performance, and this policing has caused problems on both sides of the patient care (Schultz & Johnson, 1971; Sheard, 1980).

Conflict has long plagued staff nurses and physicians in their hospital relations (Sheard, 1980). While they carefully present an image of harmony and cooperation to the public, these practitioners often conceal a deep level of misunderstanding, resentment, and anger. According to Sheard (1980), the occupations clash for two reasons:

> Nurses and physicians structure work in radically different ways and, though they work side by side, they tend to misunderstand the methods and inner logic of one another's work. A combination of

> differing approaches and mutual ignorance weakens the complementary nature of their respective roles and produces continual frustration and conflict.
>
> Also since nurses operate on a very strict schedule, they resent interruptions in their work routines. (pp. 14-15)

Another source of interpersonal relations stress is between staff nurses. Researchers have found conflicts within nursing between staff members is a source of stress, but to a lesser degree than other interpersonal relations (Cassem & Hackett, 1974; Grout et al., 1981; Huckabay & Jagla, 1979; Leatt & Schneck, 1980).

Ivancevich and Matteson (1980) found relations with other nurses as the third most stressful area. Other researchers also found relationships between peers (nurse-nurse) stress producing because of a perceived lack of support from other nurses (Maloney, 1982; Reichle, 1975; Shubin, 1979). Edwards (1980) found poor communications between staff in a hospital setting as one of the nurses' greatest problems. Selverston (1980) noted that in a survey of 579 critical care unit nurses, 58% "felt half or more of their workday was spent dealing with distress" (p. 28).

Nurse-nurse problems also represented conflicts among staff nurses of equal rank. The continuously competitive atmosphere, along with the lack of camaraderie among the

rank, were viewed as major sources of stress in the area of interpersonal conflicts (Steffen, 1981). Shubin (1979) found that nurses are often afraid to express their feelings and emotions to other co-workers.

> Nurses like most people, are afraid of showing intense feelings. They think the "model nurse" is a very controlled personality. Consequently, normal nurses--are afraid of breaking down, afraid of losing their tempers, afraid of weeping. They have to exercise control, which inevitably leads to inhibition and to avoidance of any involvement which might cause them to lost control. (p. 54)

Researchers also identified behaviors of nurses relating to stress:

> Group indicators of stress from interpersonal relations include such behaviors as snapping at and arguing with others; scapegoating among staff members, blaming others, defensiveness, and intolerance of others' ideas or behavior. (Scully, 1980, p. 912)

Administration/Institution Policy

Nurses have identified the administration as another external source of stress. If administrators do not listen to nurses, do not respond to questions and concerns, the staff may believe they are uncaring. In surveys of nurses, personality conflicts with management and administrators ranked high as stressors for the nurses (Grout et al., 1981; Ivancevich & Matteson, 1980; Huckabay & Jagla, 1979; Longest, 1974).

Nurses' interpersonal relations with supervisory personnel are important factors in job satisfaction. A

survey by Wolf (1981) of 17,000 nurses indicated the following:

> The nurse's main complaints about supervisors centered on the individual's lack of leadership and management skills, lack of support, failure to follow through on problems and complaints, not being available when needed, and abuse of authority. (p. 235)

Godfrey (1978b) sent questionnaires to 17,000 nurses in the United States. She found the following causes of poor leadership to be major dissatisfactions in nurses:

- Inflexible supervisors determined to preserve the status quo.
- Nursing directors who haven't laid a hand on a patient in 20 years.
- Authoritarian administrators concerned only with cutting costs--at any price. (p. 90)

Often nursing administration is seen as causing a lack of unity among nurses due to poor leadership. Several surveys of nurses found hospitals breed poor communication between nurses and administrators (Edwards, 1980; Godfrey, 1978b; Hallas, 1980).

Uncertainty about one's supervisor's opinions and impressions represented an important source of stress for nurses, according to Levenstein (1982a). The evidence also showed that supervisory feedback, even when it is negative, reduces stress among nurses. If nurses are unable to ascertain how personal performance is being perceived and

received by superiors, there is a sharp rise in stress (Levenstein, 1982a).

The ICU nurse may feel that administration is out of touch with the reality of ICUs. According to Cassem and Hackett (1972), nurses had two basic complaints:

> First, administrators were unfamiliar with the complexities of CCU care and tended to be seen as incompetent judges of nursing care needs. Secondly, competent supervision was lacking during the evening and night shift. Insecurity, often mounted to great anxiety. (p. 1428)

Nurses also identified making decisions with little administrative support as stressful, as noted by Menzies (1960). Making decisions is always stressful because it implies making a choice and committing oneself to the outcome. The resultant stress is likely to be particularly acute when decisions directly or indirectly affect the well-being, health or even the life of patients, such as many nursing decisions do. The nursing service seemed to offer little protection against stress by reducing the number of possible decisions (Menzies, 1960). Decision-making change arouses stress, since it implies giving up a familiar present for a relatively unknown future. Hence, the nursing service seems to deal with this by avoiding change wherever possible and clinging to familiar ways of doing things, even when they are becoming demonstrably inappropriate (Menzies, 1960).

Because administrative policy affects all members in a staff, difficulties affecting one member usually affect the entire group. An administration which appears to make rules and regulations without the input of the staff creates anger from nurses who resent being told what to do rather than guided in problem-solving themselves (Johnson, 1982).

One of the policies upon which hospital administrators and nursing disagree is the budget. Although hospital administration and nursing service share a common problem--providing good health care on a tight budget--the administrators' prime concern has to be the bills and the nurses' prime concern has to be the patients (Godfrey, 1978a).

Another stress on nurses from administration is the lack of administrative support. Some of the very people who might be expected to provide support, the supervisors or head nurses, were found to add to the stress. The most frequently voiced complaints were the bureaucratic value systems, low recognition given by supervisors for work, and the inability of the supervisors to provide positive feedback (Hay & Oken, 1972; Huckabay & Jagla, 1979; Willis, 1979).

In a study by Wandelt, Pierce, and Widdowsen (1981), nurses were asked to rank the 10 job conditions creating the

most dissatisfaction. The third and sixth were "support given by administration of the facility and support given by nursing administration," respectively (p. 75). Nurses identified support by nursing service administration and clinically competent supervisors as keys to quality conditions of work and the care provided patients.

Patient Care

The third broad area mentioned by nurses as causing stress in their job was that of patient care. Responsibility for the care of people causes more stress than responsibility for the care of things. Nurses are responsible for the care of patients and their families (Calhoun, 1980).

As Selye (1976) emphasized, stress has both positive and negative connotations. In a study by Huckabay and Jagla (1979), direct patient care was identified as the most satisfying aspect of work, yet it also was identified as a major source of stress. As Huckabay and Jagla pointed out, the nurses' perceptions of a situation as a stressor or satisfier are crucial to any understanding of nursing stress. Several researchers have found through surveying nurses that providing patient care is a stressor on the nurse (Anderson & Basteyns, 1981; Cassem & Hackett, 1972;

Ivancevich & Matteson, 1980; Leatt & Schneck, 1980; Maloney, 1982; Oskins, 1979).

Cassem and Hackett (1972) identified four areas of patient care which caused stress for a nurse. They included the following:

> a. work load and amount of physical work required.
> b. meeting the psychological needs of the patient.
> c. meeting the needs of the family.
> d. death of the patient. (p. 1427)

Vreeland and Ellis (1969), in dealing with stresses impinging on ICU nurses, found physical and psychological conditions of patients were deemed to be the most stressful aspects of work by the nurses.

Nurses are available to patients on a 24 hour basis which forces them to be prepared to assist patients as they cope with the unpleasant experiences of illness and hospitalization. In addition, nursing practice often involves crisis situations and decisions of life and death which can expose nurses to a range of personal emotions which could in themselves be stress provoking (Volicer & Burns, 1977).

Godfrey (1978b), in her survey of 17,000 nurses, listed the following direct physical tasks of patient care as stressful:

> Caring for incontinent patients
> Changing infected dressings
> Aspirating a tracheostomy
> Giving stoma care
> Collecting urine, feces, or sputum specimens
> Giving decubitus care (p. 93)

Nurses are faced not only with the physical needs of their patients, but also with heavy demands for pity, sympathy, and compassion. Nurses are often expected to provide comfort and care to the sick and daily are forced to carry out tasks which, according to Menzies (1960), are "by ordinary standards, disgusting, distasteful, and frightening" (p. 9). Nurses' work brings them into intimate, constant contact with private functions of the human body (Menzies, 1960).

Several authors found that the core of nurses' anxiety lies in patient care and in the relationship with the patient. Nurses care deeply about the welfare of their patients. Nurses often become upset by what happens to patients which causes emotional stress (Eisendrath & Dunkel, 1979; Menzies, 1960; Patrick, 1981).

Vreeland and Ellis (1969) sought nurses' descriptions of stressors in the intensive care unit. The most frequently identified stressor was the effect upon nurses of the patients' altered physiology, or the psychological impact of the patients' illnesses and their treatments.

In a survey by Huckabay and Jagla (1979), meeting the psychological needs of the patient was identified as a stressor by the nurses. Patient care activities represented the third greatest source of stress for ICU nurses.

Emergencies and the constant potential for crisis to occur accounted for the greatest perceived source of stress. Unnecessary prolongation of life was also a stressor frequently addressed by nurses.

Aside from dealing with the patients' responses to being ill, there is another associated stress for the staff. This is the stress of dealing with frequent deaths. The stronger the attachment between staff and patient, the more painful that patient's death becomes (Eisendrath & Dunkel, 1979; Huckabay & Jagla, 1979; Reichle, 1975).

According to West (1975), the personnel who care for hospitalized patients experience primary stress in three areas: "the repetitive exposure to suffering, death, and dying; the constant threat of object loss; and feelings of personal failure" (p. 62). To be surrounded by catastrophe and suffering is not the environment most people prefer (Steffen, 1981).

Nurses frequently experience stress when patients are unable to communicate verbally for any number of reasons, including intubation, aphasia, medications, or foreign language. Patients have few means by which they can communicate or express their fears. When patients are frustrated and frightened, they may express their frustration behaviorally by taking it out on nurses (Steffen, 1981).

According to Steffen (1981), other stressors for staff people arise as a consequence of their being human. Staff members need to overcome their own feelings of inadequacy in dealing with patient problems.

Environment and Unit Management

Working conditions such as the environment and unit management are also stressors for nurses. Ivancevich and Matteson (1980), in a survey of 82 nurses, found working conditions ranked third as a stressor for nurses. Huckabay and Jagla (1979), in their survey of 46 nurses in the ICU setting, found management of the unit in a regional sample to be the major source of stress and the second most significant source in a national survey. Other surveys of nurses recognized working conditions, especially a lack of staff, as an area of high stress (Grout et al., 1981; Longest, 1974).

Nurses often voice concern that they are not able to care for their patients as well as they want to because of staffing problems. According to Godfrey (1978b), the nurses most concerned with direct patient care are the ones who complained most of understaffing. She found the following:

> 25% of the team leaders, and 21% of the staff nurses felt badly understaffed. But, only 8% of the administrators felt their institution was badly understaffed. The specialty areas most likely to feel badly understaffed were med/surg (24%) and psych (27%). (p. 95)

Others studies indicated that the prime source of stress in the ICU is work overload, in most cases resulting from inadequate staffing. Inadequate staffing over a long period of time seems to increase the nurses' sensitivity to all other stressors (Gentry & Parkes, 1982; West, 1975; Willis, 1979). According to Hallas (1980), "nurses point to hospitals and generally agree (41%) that inadequate staffing is their main offense" (p. 17).

Staffing problems were described primarily as an inadequate number of staff or incompetent, poorly trained staff. Inadequate time and staffing are high on the list of nurses' complaints. Chronic understaffing in health-care facilities is a fact of life. The frustration which results from not having enough time to give the care nurses are prepared to give can be very frustrating and stressful (Edwards, 1980; Godfrey, 1978a; Scully, 1980).

Staffing problems relate to overload and overwork. Nurses worry about whether they have completed necessary tasks; they feel guilty about not having been able to give adequate and complete care. This belief that nurses blame themselves if they are unable to finish their work is supported by Stehle (1981):

> Staffing is not sufficient for meeting the demands of health care delivery. Time is not available for giving holistic care to all clients and their families.

> Nurses blame themselves for not meeting these expectations, adding to already high stress levels and poor self-esteems. (p. 182)

Staffing may be inadequate to meet the sometimes extraordinary demands placed upon nurses. The lack of enough ancillary personnel forces nurses to do secretarial work, run errands, and carry out other non-nursing tasks (Bilodeau, 1973; McConnell, 1979).

Complaints, when they came, were about all the nonnursing chores lumped in with the job, according to Godfrey (1978a). In her study of 17,000 nurses, she found a third of all nurses responded that many or more of their duties could be carried out by persons with less education. Housekeeping was another flagrant misuse of nursing time.

Additional staffing problems result when nurses must accept shift rotation and are required to work excessive overtime in order to maintain coverage. Work in a hospital is characterized by stressful intensity and the demand for a high level of performance. Nurses must cope with long hours worked, shift rotation, and sporadic needs to work overtime (Patrick, 1981; Wolf, 1981).

Staff nurses continually complain about rotating shifts and give this as one of the reason they leave nursing. Generally nurses did not believe their jobs negatively affected family and personal lives to any great degree, as reported

by Godfrey (1978a); however, hours and schedules still caused problems for many hospital nurses. Godfrey (1978a) commented:

> If they'd realized what it would be like--working so many weekends, eating reheated, leftover turkey on Thanksgiving, missing out on the family fun at Christmas, the biological turmoil imposed on the body by rotating shifts, and most of all, having so little to say about their own scheduling--they would never have become nurses in the first place. (p. 110)

In another study, Weaver (1982) found nurses complained about rotating shifts because:

> Their body could never get adjusted to one shift before they'd have to switch to another; not eating or sleeping right, and they never saw their friends. (p. 30)

Cassem and Hackett (1975) and Levenstein (1982b) found in their studies that nurses felt they did not get enough time off and the scheduling provided poor distribution of time.

Many factors in the health care environment can be very frustrating. Complaints about lack of equipment or, even worse, equipment which does not work, are frequent (Johnson, 1982). Cassem and Hackett (1972) also identified four aspects which caused stress for the nurse in the work environment:

> Numerous pieces of equipment and their failure
> Physical injury to the nurse
> Physical set up
> Noise level (p. 1428)

Huckabay and Jagla (1979) found equipment was not anxiety producing when working correctly but was

overwhelmingly stressful when it was not working. Equipment is space consuming, may be noisy, and can interfere with getting physically close to the patient. Concern that equipment might not work necessitates frequent checking. Removing equipment from one patient for the benefit of another is also anxiety provoking (Huckabay & Jagla, 1979).

Inadequate equipment and supplies is also stressful for the nurses. The situation is increased when patient care suffers for lack of supplies or because of poorly functioning equipment (Garbin, 1979; Johnson, 1982; McConnell, 1979).

Support services in the health care setting may be less than supportive, and stress may result. Lack of supplies or delays in receiving requested equipment may necessitate compromises in patient care and thus create frustration (Scully, 1980).

The physical aspects of the unit may themselves be stressful. The patient unit may be small, and becomes even smaller when equipment is brought into the room. The noise from respirators, monitoring and suctioning equipment, paging systems and alarms can be a source of tension for nursing staff. The unit may be structured so the nurses are in a central location. However, nurses may feel trapped

because patients and family members can see them (Johnson, 1982; McConnell, 1979).

Stressful physical aspects of the unit include windows lacking, cubicles or rooms may be too small and afford little privacy or quiet, storage facilities may be inadequate, and the unit may be too small for the number of people moving about. There may be no lounge or lavatory facilities for nurses, necessitating their asking permission to leave the unit and arranging for patient coverage while they are gone. The unit may be constructed in such a way that the nurse is always in sight and within hearing distance of the patient, giving her a feeling of being "trapped" (Bilodeau, 1973, p. 360).

Not only do nurses feel trapped in their surroundings with much to do in such little time, but they also must function in an environment that offers little opportunity to concentrate. In most hospitals the nurses chart and write care plans at the nursing station, the hub of activity. Visitors are approaching; the phone is ringing; staff members are talking; physicians are communicating information about their patient (Tierney & Strom, 1980).

Thus, physical environment and unit management are contributing factors to stressors for nurses. ICU versus floor nurse stress studies are examined for signs of stress in nurses and ways to decrease stress in nurses.

ICU Versus Floor Nurse Stress Studies

There have been very few studies that viewed the stressors of floor nurses. Gentry, Foster, and Froehling (1972) reported results of a study designed to determine response to stress among ICU and non-ICU nurses. The survey consisted of 34 volunteer nurses from three ICUs and three non-ICUs. The nurses from the acute care units showed more depression, irritability, and resentment than did non-ICU nurses.

Maloney (1982) studied 30 intensive care nurses and 30 nonintensive care nurses to study stress. She found non-ICU nurses experienced more state anxiety than ICU nurses. The non-ICU nurses also had significantly higher levels of trait anxiety than did the ICU nurses. Maloney concluded that the "intensive care nurses may perceive fewer anxiety-producing events in their present work environment than nonintensive care nurses" (p. 32).

Data to compare anxiety/stress among nurses employed in various units were gathered by Johnson (1979) and revealed that "state and trait anxiety was lower in critical care nurses than in medical and surgical nurses" (p. 5). This finding was supported by Stehle (1981) who pointed out that "widely generalizable data have not yet been published confirming the belief that critical care is more stressful

than other types of nursing care" (p. 182). This is reemphasized by Leatt and Schneck (1980) who stated that while ICU Nurses appear to be differentially stressed by work overload and issues of death and dying, there is no clear basis for believing that they are collectively more stressed than non-ICU Nurses.

Gentry, Foster, and Froehling (1972) summarized the studies of stress in ICU and non-ICU Nurses as follows:

> Perhaps the literature has been overly dramatic in its description of intensive care nursing, leading to the belief that intensive care nursing is formidably stressful. The interest of the intensive care unit may have led researchers to overlook the nonintensive care nurse, who according to this study is under more stress and demonstrates more of the consequences of stress. Significant increases in somatic complaints, personal and family problems, and workload dissatisfaction are more common among nonintensive care nurses. (p. 796)

Signs of Stress

There is stress present among nurses who work in hospitals. Stress is individualized and all persons respond to stress differently. A great deal of research has been conducted linking the working conditions of a particular job and its relationship to physical/mental health. Kornhauser (1965) found that poor mental health was directly related to unpleasant work conditions, the necessity to work fast and to expend a lost of physical effort, and to

excessive and inconvenient hours. Welches and De Joseph (1981), in a survey of 1,090 nurses, found the following:

> an important dissatisfier was how the staff members felt mentally and physically at the end of the shift, with 36 percent rating this as unfavorable. These findings point to considerable work stress perceived by nursing personnel. (p. 43)

Stress is a physical and emotional phenomenon. Some symptoms of prolonged stress include hypertension, cardiovascular disease, and general ill health, as well as emotional outbursts and unexplained lapses in performance and memory (Tierney & Strom, 1980). The problem of psychological stress is seen in terms of nursing dropouts, high incidence of absenteeism due to minor illnesses and vague somatic complaints, restlessness, requests for transfers, intra-staff conflict, and depersonalization in the nurse-patient relationship. Staff turnover rates can also be signs of staff stress (Gentry et al., 1972).

In a survey of 579 nurses, Selverston (1980) found that in 1979 absenteeism related to illness, almost half (41%) of the nurses believed their sick days were stress related. Selverston also reported that signs of staff stress can be reflected in turnover rates.

The implications for the hospital and health care industry are clear when cost associated with failure to reduce the impact of job stress is investigated. Studies

indicated a higher accident rate both on and off the job for those in high-stress jobs (Handbook of Labor Statistics, 1976; Margolis, n.d.). The quality of patient care also suffers. In a study of a community hospital, Georgopoulous and Mann (1962) found that the quality of patient care was adversely affected by conflict.

Schnechter (1980a) found that in metropolitan areas, turnover for staff nurses had reached as high as 200%. Nurses have fled the profession because they refuse to work under the constraits they encounter in hospitals.

Several studies have found dissatisfaction with the work environment to be a major factor in nursing turnover. A high staff turnover rate may reflect nurses' attempts to escape a stressful environment. Recent trends of tardiness, absenteeism, errors, inefficiency, and rapid staff turnover may also indicate the presence of stress in the group (Garbin, 1979; Schnechter, 1980b; Scully, 1980; Kahn, 1966).

Wolf (1981) identified four reasons for the nursing turnover:

1) the employee
2) the work division and responsibility
3) supervision and coordination, and
4) the administrative system. (p. 234)

Hospitals' failure to respond effectively to the needs of nurses has been a major factor contributing to the attrition of practicing nurses (Schnechter, 1980b).

In summary, studies support the fact that the impact of dysfunctional stress is manifested in lower productivity, higher absenteeism, loss of work time due to illness, higher job turnover, increased work errors, and narrowing of attention resulting in poor judgment. Nurses are concerned about the quality of care they are able to render patients; when quality is compromised because of the work environment, nurses become dissatisfied with the job of nursing (Calhoun, 1980; Kahn, 1966; Wandelt et al., 1981).

Ways to Decrease Stress in Nurses

For the return of more nurses to the workplace to become reality, changes in the workplace must take place; education must be modified so nurses are better prepared for the actualities of hospital work (White, 1980). Identifying signs of stress is the first step for successful coping. Next, sources of stress must be identified. There is a need for nursing service to clarify the sources of stress that exist in the clinical working environment (Gentry & Parkes, 1982; Scully, 1980).

The workplace has been called an ideal setting for stress-prevention programs since it provides access to large groups of people who encounter stressful situations every day. Certainly a hospital work setting provides numerous

individual-environment interactions that potentially lead to stress. Nurses, therefore, might benefit from stress reduction practices (Garbin, 1979).

Nursing administrators need to be aware of the importance of inservice education for stress. The lack of stress education indicates a definite need for continuing education in stress management and its relevance for nurses (Oskins, 1979).

Interpersonal relationships can be both stressors and coping resources. Training in systems-involvement communication and conflict, resolution skills might improve nurses' adaptation to stress. Effective communication skills might help the nurses develop better relationships with patients, patients' families, other nurses, and physicians (Stillman & Strasser, 1980; Stubbins & Friedrich, 1981).

There are other administrative maneuvers that may also decrease staff stress. Discrete periods of the day when staff can temporarily withdraw from the unit are important. A coffee area away from patient care areas may be helpful. Insuring sufficient staffing to allow meal times away from the unit is also useful (Eisendrath & Dunkel, 1979; Huckabay & Jagla, 1979). Nursing administration could also provide an area where the staff can concentrate on charting and writing comprehensive nursing care plans. The nurse

cannot sit in the center of activity and be expected to concentrate (Tierney & Strom, 1980).

The management can also reduce nursing stress by providing adequate ancillary personnel. This should include secretarial help, messenger service, volunteers, and male attendants for turning and lifting patients (Bilodeau, 1973).

Orienting the family to the unit and personnel should help diminish apprehension and thus stress on the nurse. The use of available hospital resources to work with families such as the social service department and volunteers could be an additional stress reducer (Bilodeau, 1973).

Gentry and Parkes (1982) proposed that nursing service could help keep environmental stress to a minimum by adequately staffing the non-ICUs with competent nurses and supervisors. The nurse-patient ratio should remain small to prevent work overload. Thus non-ICU nurses would be able to practice the type of nursing they were taught.

Another means to decrease stress for nurses is to provide consultation on stress. One way is to use a clinical nurse specialist as a liaison and consultant to facilitate communication, foresee problem areas, and propose interventions. The consultations should involve problem solving and support for difficult patients and families. The consultant can form groups, workshops, or other

interventions to deal with the work or environmental stresses of nurses (Gentry & Parkes, 1982; Welches & De Joseph, 1981).

The preceding administrative measures may reduce stress for the nurse, and patients will benefit as well. The quality of patient care depends on the people who provide the care. Caregivers' effectiveness is a function of their psychological states as well as their technical expertise.

Summary

This chapter was centered on the relationship of stress to nurses. The concept of stress and its effect on human functioning were discussed. Job stress for nurses was presented. Several categories of work stress for nurses were identified and discussed. These included interpersonal relationships and communications, administrative and institution policies, patient care, and environmental/unit management. Intensive care unit versus floor nurse stress surveys were also explored. In relating stress to nursing, signs of stress in nurses and institutions were discussed. This chapter then concluded with an exploration of suggested methods of decreasing stress in nurses.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

The design used in this study was the descriptive survey method. A descriptive survey seeks to describe a set of conditions. In this survey stressors as well as the level of stress of the medical/surgical floor nurse were identified.

Setting

The setting for this study was a private general hospital with approximately 200 beds in a small medical center in southeast Texas. There were approximately 100 licensed nurses in this facility, of which approximately 55 were medical/surgical floor nurses. This hospital also has a separate nursing staff for each unit.

Population and Sample

The target population for this survey consisted of approximately 55 medical/surgical floor nurses at the study institution. The sample was composed of 37 of these nurses randomly selected using a table of random numbers. To accomplish selection of the sample, a list of names was provided by the nursing administration office of the hospital.

Protection of Human Subjects

Approvals were obtained from Texas Woman's University and the study agency (see Appendix A). A letter of introduction was given to each nurse selected for the study. The letter explained the topic under investigation and assured the exclusion of names from the research report as well as from the questionnaire. Subjects were informed that completion and return of the survey represented consent to participate in the study (see Appendix B).

Instrument

No instrument was available that adequately measured stressors of general medical/surgical floor nurses. Therefore, the investigator developed an appropriate instrument.

The procedure for developing the instrument was the following: (a) review of current literature and identification of stressors in nursing; (b) development of items and format for a measurement scale; (c) validation of the questionnaire by panel review; (d) pretest of questionnaire; and (e) revision of questionnaire. Therefore, five steps were identified to develop the questionnaire. The questionnaire was examined for content validity and reliability in steps three and four, respectively.

The first step involved a search of literature which identified four categories as stressors for nurses. The

categories identified include: (1) management of the unit and environment--staffing, scheduling, floating, work space, equipment, supplies, and so forth; (2) interpersonal relationships and family communication--personality conflicts (physicians and other nurses) and communication problems and conflicts with family members; (3) patient care--unstable patients, time consuming patients, chronic patients, uncooperative patients, and routine procedures; and (4) administration and institution policy--supervisors' reactions, administration and hospital rules (Cassem & Hackett, 1972; Grout, Steffen, & Bailey, 1981; Huckabay & Jagla, 1979; Stephaney, 1974).

In the second step statements were developed from the established categories, which identified stressors affecting floor nurses. A Likert-type scale with statements ranked from always to never is the response format of the questionnaire. A category "Doesn't Apply" is also included.

The third step consisted of submitting the items to a panel of experts in medical/surgical nursing to be examined for content validity. In addition the panel members were asked if they agreed with the category placement of each item. From the pool of items on which consensus by the panel was reached, a minimum of 28 items were selected that

represent the scope of identified stressors for nurses. Items selected were distributed evenly across the four categories (see Appendix C).

In the fourth step the instrument was pretested by 10 medical/surgical floor nurses chosen by convenience by the investigator from the study institution. The pretest was administered to this selected sample to be evaluated for reliability and clarity as well as to acquire an estimate of the time needed to complete the survey. In addition the following was accomplished with the pretest:

1. The statements which the majority of nurses indicate as not applying were identified.
2. Reliability of the questionnaire was determined using Cronbach's coefficient alpha which, on the pretest of 28 questions, was $\underline{r} = .52$ (Appendix D).

After the pretest the fifth step involved revising the questionnaire into final form. Statements for which a majority of nurses indicated "does not apply" were eliminated. Thus, to ensure reliability four questions, one from each category, were eliminated from the final survey. Questions eliminated were #14, 21, 22, and 27. The questionnaire consisted of 24 statements to which the subjects responded by using a Likert-type scale. The statements were selected from the following four categories: interpersonal

relationships, patient care and families; administration/ institution policies; patient care and environment management of unit. The six highest ranked items from each category remained in the survey. The scale ranged from "always" to "never." There are equal numbers of statements in each category. The Cronbach's coefficient alpha on the 10 pretests of 24 items was $\underline{r}$ = .7004 (Appendix E).

The questionnaire was scored in the following manner:

1. In positive statements: never = 5, rarely = 4, sometimes = 3, frequently = 2, and always = 1.
2. In negative statements: never = 1, rarely = 2, sometimes = 3, frequently = 4, and always = 5.

The lowest level of stress in the nurse was represented by one times the total number of items on the scale, while the highest level of stress was represented by five times the total number of items on the scale.

The final questionnaire is called the Medical/Surgical Floor Nurse Stress Survey. A Cronbach's coefficient alpha correlation calculated using the study data to determine reliability for the final survey was r = .743.

Data Collection

Upon approval of Texas Woman's University and the study agency, the investigator began data collection. The investigator discussed the purpose of the study with the

medical and surgical floor supervisors in the study institution. The medical and surgical supervisors then provided a list of the eligible nurses' names of which 40 nurses were selected randomly to participate. The supervisors then spoke to the head nurses of each medical or surgical unit and gave them the surveys to pass out to the nurses on their units. Participants received a letter of introduction, the survey, and an envelope from the head nurse on their unit. Nurses in the sample were instructed to complete the personal data sheet and to respond to the items on the Medical/Surgical Floor Nurse Stress Survey following the instructions given.

The nurses participating in the study were asked to complete the questionnaire on their own time and return it in the envelope to an identified box one week from the day they received the questionnaire. The investigator collected the completed questionnaires from the designated boxes one week from the starting day of the study. The minimum number of respondents to the questionnaire was 35 out of the 40 nurses given the questionnaire. If 35 questionnaires had not been collected, the investigator would have had to refer to the coded questionnaires and provided follow-up surveys for those participants failing to return the first questionnaire. However, 37 nurses returned the questionnaire.

Treatment of Data

The sample was described using the appropriate measures of central tendency, frequency, and range. To address research question one: what factors in the environment do general medical/surgical floor nurses perceive as most stressful, scores were computed for each category. The median, frequency distributions, and percentages were used to describe the types of stressors floor nurses experienced in the work environment and the ranking of these stressors. In research question two: what is the level of stress experienced by general medical/surgical floor nurses, the scores were computed to find the level of stress medical/surgical nurses experienced. The questionnaires were totaled and a mean score level of stress was computed. A mean level of stress score was also computed for each category along with a 95% confidence interval for the mean.

Summary

This chapter was concerned with the procedure used in collecting and treating data to meet the purposes of this study. The Medical/Surgical Floor Nurse Stress Survey was developed to allow nurses on medical and surgical units to identify the stressors they are currently experiencing and at what level they are experiencing the stressor. The stress survey was proven to be a valid measuring device of

stress in medical/surgical floor nurses by a panel of judges and through a pretest. The data were collected by the survey approach and the analyses of the data were made by measures of central tendency, frequency, and percentage. The level of stress experienced by general medical/surgical nurses was also computed.

CHAPTER 4

ANALYSIS OF DATA

A descriptive study was conducted for the purpose of determining what factors in the environment general medical/surgical floor nurses perceive as most stressful. The study also examined the level of stress experienced by general medical/surgical floor nurses in the study institution. The Medical/Surgical Floor Nurse Stress Survey, approved as a measuring device of work stress for floor nurses by a panel of three judges, was given to floor nurses currently employed in the study institution. This chapter is concerned with analyzing and interpreting the data that were collected.

Description of Sample

The sample was comprised of 37 registered nurses who were currently involved in medical or surgical floor nursing. The age distribution of the sample is summarized in Table 1. The majority of the nurses in the sample were in the younger age groups of 20-30 years of age. This age group was comprised of 25 (68%) of the total sample. Educational preparation of the sample of 37 registered nurses is also summarized in Table 1. Eighteen (49%) of of the sample were associate degree graduates and 11 (30%)

Table 1

Age Distribution and Educational Preparation of 37 Registered Nurses in Study of Stressors

Variable	Frequency	Percentage
Age		
20-25 years	10	27
26-30	15	41
31-35	6	16
36-40	2	5
41-45	3	8
46-50	1	3
Total	37	100
Educational Preparation		
Associate Degree	18	49
Diploma	7	19
Baccalaureate	11	30
Master's	1	2
Total	37	100

were baccalaureate graduates. Only one nurse (2%) was prepared at the master's level.

The sample of registered nurses reported the type of unit in which they were employed. The majority of the nurses, 15 (41%), worked on a surgical unit (Table 2). However, the sample was evenly distributed between medical, surgical, and a combination of both units. The type of nursing care currently being used on the units by the sample of nurses is described in Table 2. Twenty-six (70%)

Table 2

Type of Unit and Type of Nursing Care Administered by 37 Registered Nurses in Study of Stressors

Variable	Frequency	Percentage
Type of Unit		
Medical	12	32
Surgical	15	41
Both	10	27
Total	37	100
Type of Nursing Care		
Primary	11	30
Team	26	70
Total	37	100

of the nurses in the sample were involved in team nursing, while 11 (30%) indicated primary nursing as the type of nursing care.

The sample of registered nurses also reported their nursing experience: the number of years they had been registered to practice professional nursing, the length of time spent in the unit in which they were currently involved, and the length of time the nurses had been at the current institution. Table 3 summarizes these data. The majority, 22 (59%) of floor nurses in the sample had been employed in the current institution for less than three years. Since their length of time at the current

Table 3

Nursing Experience of 37 Registered Nurses in Study of Stressors

Variable	Frequency	Percentage
Number of Years in Nursing		
0-2	8	21
3-5	9	24
6-8	11	30
9-11	4	11
12+	5	14
Total	37	100
Length of Time in Unit		
0-2 years	23	62
3-5	9	24
6-8	3	8
9-11	2	6
12+	0	0
Total	37	100
Length of Time at Current Institution		
0-2 years	22	59
3-5	8	21
6-8	5	14
9-11	2	6
12+	0	0
Total	37	100

institution had been less than three years, so were the nurses' length of time in the unit. Thus, the number of experienced nurses decreased as the years at the institution and in the unit increased in this study.

Findings

The Medical/Surgical Floor Nurse Stress Survey, composed of 24 items grouped into four categories, was completed by 37 registered nurses involved in general medical/surgical floor nursing in a small medical center hospital in southeast Texas. The Cronbach's alpha correlation coefficient calculated to determine reliability on the survey was $r = .743$.

The floor nurses' responses to the items on the questionnaire were analyzed to determine what factors in the environment the majority of nurses perceived as stressful. For the analysis of each item, stress was present in the floor nurses if the item's score totaled ≥129, or had a mean ≥3.5. The total responses of the nurses were analyzed to determine their responses to each of the four categories. The six questions in each category were totaled and the mean score derived. In each category a mean score ≥21.0 was considered a stressful category to the floor nurse. The surveys were also totaled to find the level of stress experienced by general medical/surgical floor

nurses. A survey mean score ≥3.5 is considered stressful for floor nurses.

Category I--Interpersonal Relationships and Communications

Items in this category were related to interpersonal relationship and communication conflicts between family members, physicians, and other nurses. Table 4 presents six items which formed the category of interpersonal relations. The frequency distribution, percentage, range, mean, and median of the 37 nurses surveyed are shown.

Items 1 and 16 deal with family communications with nurses. Floor nurses in this study did not find communications with the family disruptive of patient care or stressful. The mean score of both was less than 3.5. The criteria for an item to be considered as stressful is that the item must have a mean of 3.5 or greater.

Items 17, 18, and 21 identify physicians' communications with nurses and patients. Physicians' criticism, availability, and support for patients from their doctors all were low stress items for the nurses. These items were ranked as sometimes stressful by the floor nurses with means of 3.0 to 3.1. Criteria established for an item to be considered stressful is a mean equal to or greater than 3.5.

Table 4

Item Analysis of Category I--Interpersonal Relationships and Communication of 37 Registered Nurses in Study of Stressors

Item	Scores 1 #	1 %	2 #	2 %	3 #	3 %	4 #	4 %	5 #	5 %	Total Score
1. Family members make excessive demands on the nurse.	1	2.7	7	18.9	15	40.5	9	24.3	5	13.5	121
Mean 3.3 Median 3.2 Range 4.0											
16. Telephone calls from the family disrupt the care of my patients.	1	2.7	13	35.1	11	29.7	11	29.7	1	2.7	109
Mean 2.9 Median 2.9 Range 4.0											
17. Physicians often criticize nurses in front of other staff members, families, and patients.	1	2.7	7	18.9	19	51.4	7	18.0	3		115
Mean 3.1 Median 3.1 Range 4.0											

Table 4 (Continued)

Item	Scores 1 #	1 %	2 #	2 %	3 #	3 %	4 #	4 %	5 #	5 %	Total Score
18. Doctors are available when they are needed.	2	5.4	10	27.0	13	35.1	10	27.0	2	5.4	111
Mean 3.0 Median 3.0 Range 4.0											
21. Patients receive little emotional support from their doctors.	1	2.7	7	18.9	16	43.2	12	32.4	1	2.7	116
Mean 3.1 Median 3.2 Range 4.0											
22. Doctors illegible orders are time consuming to transcribe which keeps me away from my patients.	0	0.0	2	5.4	19	51.4	13	35.1	3	8.1	129
Mean 3.5 Median 3.5 Range 3.0											
Category Total	6	2.7	46	20.7	93	41.9	62	28.0	15	6.7	701
Mean = 19.0; Median = 19.2; Range = 13.0											

Item 22, doctors illegible orders are time consuming, was ranked as a stressor by the floor nurses with a mean of 3.5. The established criteria for an item to be considered stress is a mean equal to or greater than 3.5.

Category I involved families' and physicians' relationships and communications. To be considered stressful the category must have a mean score of 21.0 or greater. The category of interpersonal relationships and communications, with a mean of 19.0, cannot be considered stressful for the floor nurses. The 95% confidence interval for the mean of this category was 17.987 to 19.813. This interval may be interpreted as the probability that 95 times out of 100 times the true mean will lie between these upper and lower limits. Therefore, it seems unlikely that this category should be considered a stressor to floor nurses.

Category II--Environment and Unit Management

Items in Category II were related to environment and unit management. Items include situations concerning physical aspects and equipment, availability of nursing and non-nursing personnel, coffee breaks, and lounge facilities of the floor units. Table 5 presents the items in category II of the environment and unit management of the floors.

Items 2, 10, and 11 concern the personnel available to the floor nurse. Item 2 discussed the availability of

Table 5

Item Analysis of Category II--Environment and Unit Management of 37 Registered Nurses in Study of Stressors

Item	Scores 1 #	1 %	2 #	2 %	3 #	3 %	4 #	4 %	5 #	5 %	Total Score
2. There is not enough personnel on the unit to care for the patients adequately.	0	0.0	6	16.2	14	37.8	12	32.4	5	13.5	127
Mean 3.4 Median 3.4 Range 3.0											
3. There is adequate work space.	3	8.1	12	32.4	9	24.3	9	24.3	4	10.8	110
Mean 3.0 Median 2.9 Range 4.0											
5. I get my coffee breaks and meal breaks.	1	2.7	10	27.0	14	37.8	9	24.3	3	8.1	114
Mean 3.1 Median 3.0 Range 4.0											

Table 5 (Continued)

Item	Scores 1 #	1 %	2 #	2 %	3 #	3 %	4 #	4 %	5 #	5 %	Total Score
8. Lounge facilities are inadequate or nonexistant on this unit.	1	2.7	2	5.4	9	24.3	11	29.7	14	37.8	146
Mean 3.9 Median 4.1 Range 4.0											
10. There is adequate ancillary personnel to do non-nursing tasks.	2	5.4	4	10.8	12	32.4	12	32.4	7	18.9	129
Mean 3.5 Median 3.5 Range 4.0											
11. Non-nursing personnel (i.e., lab, housekeeping, and pharmacy) are unavailable when needed.	2	5.4	8	21.6	15	40.5	10	27.0	2	5.4	113
Mean 3.1 Median 3.1 Range 4.0											
Category Total	9	4.0	42	18.9	73	32.8	63	28.3	35	16.0	739
Mean = 20.0; Median = 21.0; Range = 15.0											

nursing personnel to adequately care for the patients. The mean of 3.4 indicated that this is sometimes stressful for the nurses. For an item to be considered stressful, it must have a mean of 3.5 or greater.

Item 10, there is adequate ancillary personnel to do non-nursing tasks, had a mean of 3.5. The nurses felt not enough ancillary personnel are available to do non-nursing tasks. This item is considered stressful for the floor nurses because it meets the predetermined criteria for stress of 3.5 or greater.

In answering item 11, nurses felt non-nursing personnel was available. The mean score of item 11, non-nursing personnel's availability, was 3.1. Thus, this item did not meet the criteria for stress of a mean of 3.5 or greater.

Items 3, 5, and 8 dealt with work space, break time, and lounge facilities, respectively. Item 3, the work space is adequate, was not considered stressful for the floor nurses with a mean score of 3.0. Item 5, coffee breaks and meal breaks were adequate, had a mean of 3.1, thus it was not considered stressful. The criteria established for an item to be considered stressful is a mean of 3.5 or greater.

Item 8, lounge facilities are inadequate, was ranked as a stressor by the floor nurses with a mean of 3.9. The

predetermined criteria for an item to be considered a stressor in this survey was a mean of 3.5 or greater.

Category II--Environment and Unit Management included the availability of all types of personnel, breaks, lounge facilities, and the unit environment. This category with a mean of 20.0 indicates this is not considered an area of stress for floor nurses. To be considered stressful the category must have a mean score of 21.0 or greater. The 95% confidence interval for the mean of this category was 18.892 to 21.048. This interval may be interpreted as the probability that 95 times out of 100 times the true mean will be between these upper and lower limits. Therefore, it seems unlikely that this category should be considered a stressor to floor nurses.

Category III--Patient Care

Category III contains items that are pertinent to patient care on the floor units of hospitals. These items are shown in Table 6.

Items 7 and 9 deal with having time to talk with and teach patients, or patient education. These items were ranked as sometimes stressful by the floor nurses with means of 3.2 to 3.3. In order to be considered stressful by the criteria identified the mean must be 3.5 or greater.

Table 6

Item Analysis of Category III--Patient Care of 37 Registered Nurses in Study of Stressors

Item	Scores 1 #	1 %	2 #	2 %	3 #	3 %	4 #	4 %	5 #	5 %	Total Score
4. Patients in the unit require heavy lifting.	0	0.0	3	8.1	24	65.0	10	27.0	0	0.0	118
Mean 3.2 Median 3.1 Range 2.0											
7. I have time to talk with patients for an uninterrupted period of time.	1	2.7	8	21.6	14	37.8	11	29.7	3	8.1	118
Mean 3.2 Median 3.2 Range 4.0											
9. I have time to teach my patients about their care.	0	0.0	6	16.2	17	45.9	11	29.7	3	8.1	122
Mean 3.3 Median 3.2 Range 3.0											

Table 6 (Continued)

Item	Scores 1 #	1 %	2 #	2 %	3 #	3 %	4 #	4 %	5 #	5 %	Total Score
14. The physical aspects of a patient's care take priority over the emotional needs.	0	0.0	6	16.2	8	21.6	21	56.8	2	5.4	130
Mean 3.5 Median 3.7 Range 3.0											
20. Moaning, crying, and screaming occur on this unit.	0	0.0	10	27.0	14	37.8	12	32.4	1	2.7	115
Mean 3.1 Median 3.1 Range 3.0											
23. Some patients need time consuming physical care, such as dressing changes, so that I am unavailable for other duties.	0	0.0	4	10.8	16	43.2	15	40.5	2	5.4	126
Mean 3.4 Median 3.4 Range 3.0											
Category Total	1	1.2	37	16.0	93	41.8	80	36.0	11	5.0	729
Mean = 20.0; Median = 20.0; Range = 11.0											

Items 4, 14, 20, and 23 concern physical aspects of patient care. Item 4 deals with patients requiring heavy lifting. The mean score of this item was 3.2. The criteria for an item to be considered as stressful is a mean of 3.5 or greater. Thus, floor nurses in this study did not find patient lifting as stressful.

Item 20, moaning and crying occurs on the unit, was not considered a stressor for the nurses in this study with a mean of 3.1. Item 23 identified patients as needing time consuming physical care. The mean of this item was 3.4. Thus, floor nurses in this study did not identify these two items as stressors.

Item 14, the physical aspects of a patient's care takes priority over the emotional needs, was a source of stress for the floor nurses in this study with a mean of 3.5. The established criteria is that in order to be considered stressful, an item must have a mean of 3.5 or greater.

Category III--Patient Care involved patient care provided by the nurse, both physical and emotional, and the time to talk to and teach patients about their care. This category of patient care had a mean of 20.0 which indicates this area can not be considered a stressor for the floor nurses. To be considered stressful the category must have a mean score of 21.0 or greater. The 95% confidence

interval for this category was 18.916 to 20.484. This interval may be interpreted as the probability that 95 times out of 100 times the true mean will lie between these upper and lower limits. Thus, this category did not meet the criteria to be considered as stressful to floor nurses.

Category IV--Administration and Institutional Policies

Items in Category IV were related to hospital administration and institutional policies involving hospital administrators, nursing supervisors, and the hospital policies affecting the nurse. Table 7 presents the six items which form this category of administration and institutional policies, the frequency distribution, percentage, mean, median , range, and total score of the floor nurses surveyed.

Items 6 and 24 deal with nursing supervisors' respect for nurses and their availability; both items had a mean score of 3.0. The criteria established for an item to be considered as stressful indicates the item must have a mean of 3.5 or greater. Floor nurses did not find nursing supervisors' respect and availability as stressful.

Items 13 and 15 identify hospital administrators as understanding nursing needs and in contact with what is happening. These items were ranked as sometimes stressful

Table 7

Item Analysis of Category IV--Administration and Institutional Policies of 37 Registered Nurses in Study of Stressors

Item	Scores 1 #	1 %	2 #	2 %	3 #	3 %	4 #	4 %	5 #	5 %	Total Score
6. The nursing supervisors respect my judgments.	4	10.8	7	18.9	13	35.1	11	29.7	2	5.4	111
Mean 3.0 Median 3.1 Range 4.0											
12. I find it difficult to keep up with hospital policies and procedures.	0	0.0	8	21.6	17	45.9	11	29.7	1	2.7	116
Mean 3.1 Median 3.1 Range 3.0											
13. Hospital administrators understand nursing needs.	2	5.4	3	8.1	18	48.6	8	21.6	6	16.2	124
Mean 3.4 Median 3.3 Range 4.0											

Table 7 (Continued)

Item	Scores 1 #	1 %	2 #	2 %	3 #	3 %	4 #	4 %	5 #	5 %	Total Score
15. Nursing administrators are in contact with what is happening on the units in the hospital.	3	8.1	7	18.9	10	27.0	15	40.5	2	5.4	117
Mean 3.2 Median 3.4 Range 4.0											
19. It is OK to show my feelings or emotions at work.	1	2.7	3	8.1	16	43.2	11	29.7	6	16.2	129
Mean 3.5 Median 3.4 Range 4.0											
24. Nursing supervisors are not available when they are needed.	0	0.0	11	29.7	15	40.5	11	29.7	0	0.0	111
Mean 3.0 Median 3.0 Range 2.0											
Total Category	10	4.5	39	17.5	89	40.0	67	30.0	17	7.6	708
Mean = 19.1; Median = 12.9; Range = 14.0											

by the floor nurses in this survey with a mean of 3.2 to 3.4. Item 12, the difficulty of keeping up with hospital policies, was not stressful for floor nurses with a mean of 3.1. In order for an item to be considered stressful, it must have a mean of 3.5 or greater.

However, the floor nurses identified item 19, the hospital policy of not showing emotions at work, as a source of stress with a mean of 3.5. This meets the criteria established that an item mean score of 3.5 or greater indicates a stressor.

Category IV involves administration and institutional policies. This category has a mean score of 19.1, which cannot be considered stressful for the floor nurses in this study. To be considered stressful the category must have a mean score of 21.0 or greater.

The 95% confidence interval for the mean of Category IV was 18.307 to 19.953. This interval may be interpreted as the probability that 95 times out of 100 times the true mean will lie between these upper and lower limits. Therefore, this category did not meet the criteria to be considered stressful to floor nurses.

In response to research question 2: What is the level of stress experienced by general medical/surgical floor nurses, the scores were computed to find the level of stress.

The Medical/Surgical Floor Nurse Stress Survey indicated the floor nurses' level of perceived stress. The mean level of stress the floor nurses in this study were experiencing is 3.24 which does not meet the criteria established for the mean score of 3.5 or greater to be considered stressful (see Appendix F for item scores and means).

Summary of Findings

This chapter was concerned with the analyses and interpretation of data collected from 37 nurses involved in medical/surgical floor nursing in a small southeastern medical center hospital. The purposes of this study were to determine and identify the amount of stress perceived by general medical/surgical floor nurses.

It was determined in this study that medical/surgical floor nurses in this institution experience the majority of the stressors in this survey only sometimes. In item analysis, each category had one or two items out of six which were identified as stressors. The stressor items included: doctors illegible orders, inadequate lounge facilities, lack of ancillary personnel to do non-nursing tasks, physical aspect of patient care taking priority over emotional needs, and showing emotions at work. The other items on the survey did not meet the criteria established for an item to be considered stressful. All of the four

categories, interpersonal relationships and communications, environment and unit management, patient care, and administration and institutional policies, were areas of low stress for the floor nurses. The amount of stress for the floor nurses in this institution did not meet the study's pre-established criteria to be considered stressful.

CHAPTER 5

SUMMARY OF THE STUDY

A descriptive study was conducted for the purpose of identifying and determining the level of perceived stressors of general medical/surgical floor nurses. The study identified what factors in the work environment the sample of medical/surgical floor nurses perceived as most stressful and what level of work stress was experienced by the nurses.

Summary

To identify the perceived stressors of medical/surgical floor nurses and the level of stress experienced by the nurses, 50 items were extrapolated from the literature. These 50 items were grouped into four categories which represented stressors to nurses. The items and categories were evaluated by a panel of three judges.

The stress scale, developed from those items evaluated by the panel of judges, was then pretested by 10 floor nurses. The final Medical/Surgical Floor Nurse Stress Survey consisted of 24 items. A total of 40 surveys were distributed by the head nurses on the units to the floor nurses in a small southeastern Texas medical center

hospital. The data collection period extended from August 10, 1982 to August 17, 1982. The final sample was composed of 37 general medical/surgical floor nurses.

The scoring of the stress survey, based on 5 points for never and 1 point for always in positive statements and 5 points for always and 1 point for never in negative items, ranged from 37 to 185 for the level of stress. Item and category analyses were conducted to determine the causes of stress in the work situation. The level of stress experienced by general medical/surgical floor nurses was also computed.

It was determined that medical/surgical floor nurses in this stitution do not experience a notable level of stress; the floor nurses experience most of the stressors only sometimes. There were five stressor items identified that include: doctors illegible orders, inadequate lounge facilities, lack ofancillary personnel to do non-nursing tasks, physical aspect of patient care taking priority over emotional needs, and hospital policy against showing emotions at work.

Discussion of Findings

The sample consisted of 37 medical/surgical floor nurses. Most of the nurses were in the age group of 20-30 years of age. In this study, associate degree preparation

was indicated by the majority of the sample. Baccalaureate prepared nurses made up approximately one-third of the sample. The educational findings of this study were in keeping with those of studies by the American Nurses' Association in 1980-1981. The Association reported:

> Of the nursing school graduates in 1977-1978, almost half (47.1 percent) came from associate degree programs; about one third (31.1 percent) from baccalaureate programs, and the remaining 21.8 percent earned diplomas. According to the National League for Nursing this data reflects the growth in the number of graduates from associate degree and baccalaureate programs. (American Nurses' Association, 1981, p. 128)

The sample of nurses in this study worked on medical or surgical units. The majority of the units in this study were involved in team nursing. Team nursing is a way of organizing nursing care with a team leader who makes patient assignments and supervises the care of a number of patients. Team nursing, begun during World War II when most hospitals in the United States began using nonprofessionals to give the patient care, is a functional approach to nursing (Williams, 1981; Wobbe, 1978).

The sample of 37 medical/surgical floor nurses at the study institution were given the 24 statement Medical/Surgical Floor Nurse Stress Survey (Hage, 1981) to identify the perceived stressors at their workplace. It was determined that only 5 of the 24 items met the criteria to be considered stressful for the sample of 37 medical/surgical

floor nurses. The other 19 items were only sometimes stressful for the nurses. Although all of the items on the questionnaire were extrapolated from identified sources of stress in past research of nurses, the sample of floor nurses at the study institution did not perceive the items of the survey as sources of stress.

The survey was divided into four categories: Interpersonal Relationships and Communications, Management of the Unit and Environment, Patient Care, and Administration and Institutional Policies. Category analyses were done and none of the categories met the criteria established to be considered a source of stress. The sample of registered nurses in the study institution identified all of the categories as only sometimes stressful. Several authorities (Bilodeau, 1973; Cassem & Hackett, 1972; Grout, Steffen & Bailey, 1981; Huckabay & Jagla, 1979; Stephaney, 1974) have identified patient care, administration, interpersonal relationships and the hospital environment as stressors for nurses in their studies.

It was further shown in this study that the medical/surgical floor nurses in this institution did not meet the minimal standard established for floor nursing to be considered stressful. Several researchers have studied stress in an ICU setting versus stress in a non-ICU setting.

Several of the studies concluded non-ICU nurses do have more stress than ICU nurses (Johnson, 1979; Leatt & Schneck, 1980; Maloney, 1982; Stehle, 1981). On the other hand, Gentry, Foster, and Froehling (1972) described in their survey of 34 nurses from ICUs and non-ICUs that nurses from acute care settings were more irritable and resentful. Other researchers conclude that the ICU setting is a source of considerable stress for nurses (Anderson & Basteyns, 1981; Cassem & Hackett, 1972; Grout, Steffen, & Bailey, 1981; Huckabay & Jagla, 1979).

The sample of 37 medical/surgical floor nurses in this study was taken from a hospital which had previously held a stress-prevention program. Garbin (1979) recommended the workplace as an ideal setting for stress-prevention programs. A direct result of such a program could be reflected in the current perceptions and experiences of low stress exhibited by the floor nurses in this study.

Conclusions and Implications

Based upon the findings and within the limitations of this study, it was concluded that medical/surgical floor nurses are not experiencing or perceiving a significant level of stress in their work environment; the mean scores of the surveys did not meet the minimum criteria established to indicate stress. These conclusions must take into

account the study institution is a small medical center hospital and that inservice programs were recently held for the nurses to reduce the work stressors.

Implications for nursing practice include the following:

1. Inservice education programs to identify stressors and the nurses' responses to stress should be provided.
2. New graduates should be required to work as a floor nurse first before entering a special care setting.

Recommendations for Further Study

Based on the findings of this study, the following recommendations have been made:

1. More investigations should be made into means of measuring stress in floor nursing.
2. Research should be conducted to determine sources of stress in specific areas of floor nursing, i.e., oncology, orthopedics, and so forth.
3. A comparative study of stressors in critical care nursing and floor nursing should be undertaken.
4. A stress study of floor nurses in a large medical center hospital should also be undertaken.
5. A study of stress on floor nurses in a hospital which has not and does not plan to provide inservice

education about stress would provide a comparison to findings of this study.

6. A study to assess perceptions of the work environment and the demands made on nurses in relation to outcomes in terms of level of work satisfaction, performance, absenteeism, and turnover would be of benefit to the nursing profession.

APPENDIX A

APPROVAL FORM

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS 76204

DALLAS CENTER
1810 INWOOD ROAD
DALLAS, TEXAS 75235

HOUSTON CENTER
1130 M. D. ANDERSON BLVD.
HOUSTON, TEXAS 77030

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE _____

GRANTS TO Sharon Wade
a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem: Perceived Stressors of Floor Nurses

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report.
3. The agency (wants) (does not want) a conference with the student when the report is completed.
4. The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan.
5. Other _____

_____

Dissertation/Theses signature page is here.

To protect individuals we have covered their signatures.

APPENDIX B

QUESTIONNAIRE PACKET

9201 Clarewood, Apt. 155
Houston, Texas 11036
May 7, 1982

I am a graduate student at Texas Woman's University studying the perceived stressors of a general medical-surgical floor nurse for my thesis. I would appreciate it if you would take a few minutes to complete the attached questionnaire and return it to your head nurse in the envelope provided within one week.

1. All information and individual responses will remain anonymous; therefore please do not write your name on the questionnaire.

2. The questinnaire is coded for the purpose of facilitating follow-up of nonrespondents.

3. I UNDERSTAND THAT MY RETURN OF THIS QUESTIONNAIRE CONSTITUTES MY INFORMED CONSENT TO ACT AS A SUBJECT IN THIS RESEARCH.

Thank you in advance for your participation and cooperation. It is by your response that we can learn more about the stressors nurses experience in their work and hopefully improve the quality of health care today. If you have any questions please write to me at the above address.

Dissertation/Theses signature page is here.

To protect individuals we have covered their signatures.

PART I

Instructions: Fill in or check each of the blanks as it relates to you.

1. Age _____

2. Sex _____

3. Highest earned credential in nursing (check one)

   Associate _____

   Diploma _____

   Baccalaureate _____

   Master's _____

   Other (Please specify) _____

4. Number of years as licensed professional nurse _____

5. Length of time in present unit _____

6. Length of time at present institution _____

7. Type of nursing care

   Primary _____

   Team _____

   Other (Please specify) _____

8. Type of unit

   Medical _____

   Surgical _____

   Other (Please specify) _____

MEDICAL/SURGICAL FLOOR NURSE STRESS SURVEY (Pilot Study)

Instructions: Indicate the response which most accurately describes your opinion about the stress in the unit you are currently employed by placing a checkmark (✓) in the appropriate space. "Doesn't Apply" will be checked (✓) if such an occurrence does not occur on your unit. How stressful are the following situations/events for you?

Situation/Event	Always	Frequently	Sometimes	Rarely	Never	Doesn't Apply
1. Family members make excessive demands on the nurse.	( )	( )	( )	( )	( )	( )
2. Personality conflicts occur between medical and nursing personnel.	( )	( )	( )	( )	( )	( )
3. When patients ask questions about death or dying, it causes me to feel uncomfortable.	( )	( )	( )	( )	( )	( )
4. There is not enough personnel available on the unit to care for the patients adequately.	( )	( )	( )	( )	( )	( )
5. There is adequate work space.	( )	( )	( )	( )	( )	( )
6. I must maintain a "professional distance" between nurse and patient.	( )	( )	( )	( )	( )	( )
7. Nurses may show despair around their patients.	( )	( )	( )	( )	( )	( )
8. Equipment must be moved from one patient to another.	( )	( )	( )	( )	( )	( )
9. The pace in this unit is conducive to good patient care.	( )	( )	( )	( )	( )	( )
10. I have time to offer support to families who need it.	( )	( )	( )	( )	( )	( )
11. My expertise is respected by my patients' families.	( )	( )	( )	( )	( )	( )
12. Patients in the unit require heavy lifting.	( )	( )	( )	( )	( )	( )
13. Patients in the unit are unable to communicate their needs.	( )	( )	( )	( )	( )	( )
14. I get my coffee breaks and meal breaks.	( )	( )	( )	( )	( )	( )
15. The supervisors respect my judgments.	( )	( )	( )	( )	( )	( )
16. Since I work a rotating shift I am too tired to provide good nursing care.	( )	( )	( )	( )	( )	( )

How stressful are the following situations/events for you?

Situation/Event	Always	Frequently	Sometimes	Rarely	Never	Doesn't Apply
17. I have time to talk with patients for an uninterrupted period of time.	( )	( )	( )	( )	( )	( )
18. I feel confident in meeting my patients' physical needs.	( )	( )	( )	( )	( )	( )
19. Lounge facilities are inadequate or nonexistent on this unit.	( )	( )	( )	( )	( )	( )
20. Nurses on the unit agree on the care of the patient.	( )	( )	( )	( )	( )	( )
21. A feeling of team spirit exists on my unit which is conducive to good nursing care.	( )	( )	( )	( )	( )	( )
22. The patient frequently understands nursing care.	( )	( )	( )	( )	( )	( )
23. I have time to teach my patients about their care.	( )	( )	( )	( )	( )	( )
24. There is adequate ancillary personnel to do non-nursing tasks.	( )	( )	( )	( )	( )	( )
25. I am able to pass medication to a large number of patients without difficulties.	( )	( )	( )	( )	( )	( )
26. Non-nursing personnel (i.e., lab, housekeeping, and pharmacy) are unavailable when needed.	( )	( )	( )	( )	( )	( )
27. Staffing permits me to work a satisfying schedule.	( )	( )	( )	( )	( )	( )
28. I find it difficult to keep up with hospital policies and procedures.	( )	( )	( )	( )	( )	( )
29. Administrators understand nursing needs.	( )	( )	( )	( )	( )	( )
30. Physicians often become so involved with diagnosis and treatment that they often forget the emotional needs of the patient.	( )	( )	( )	( )	( )	( )
31. The physical aspects of a patient's care take priority over the emotional needs.	( )	( )	( )	( )	( )	( )
32. Administrators are in contact with what is happening on the units in the hospital.	( )	( )	( )	( )	( )	( )

How stressful are the following situations/events for you?

Situation/Event	Always	Frequently	Sometimes	Rarely	Never	Doesn't Apply
33. Telephone calls from the family disrupt the care of my patients.	( )	( )	( )	( )	( )	( )
34. Physicians often criticize nurses in front of other staff members, families, and patients.	( )	( )	( )	( )	( )	( )
35. Doctors are available when they are needed.	( )	( )	( )	( )	( )	( )
36. It is OK to show my feelings or emotions at work.	( )	( )	( )	( )	( )	( )
37. After collecting and charting data I have time to interpret it adequately.	( )	( )	( )	( )	( )	( )
38. Telephone orders are often difficult to understand causing me to be away from my patients longer than I want to.	( )	( )	( )	( )	( )	( )
39. Non-nursing personnel will not provide needed assistance when asked.	( )	( )	( )	( )	( )	( )
40. Family members interfere with my care for the patient.	( )	( )	( )	( )	( )	( )
41. Moaning, crying, and screaming occur on this unit.	( )	( )	( )	( )	( )	( )
42. Patients receive little emotional support from their doctors.	( )	( )	( )	( )	( )	( )
43. Doctors illegible orders are time consuming to transcribe which keeps me away from my patients.	( )	( )	( )	( )	( )	( )
44. Working several days in a row is a good schedule for me to provide continuity of care to patients.	( )	( )	( )	( )	( )	( )
45. There is continuity of care on my unit.	( )	( )	( )	( )	( )	( )
46. Some patients need time consuming physical care, such as dressing changes, so that I am unavailable for other duties.	( )	( )	( )	( )	( )	( )
47. I must not admit my fears to my nursing peers.	( )	( )	( )	( )	( )	( )

How stressful are the following situations/events for you?

Situation/Event	Always	Frequently	Sometimes	Rarely	Never	Doesn't Apply
48. Equipment works properly.	( )	( )	( )	( )	( )	( )
49. Going through the steps of administration to effect a change on my unit is not time consuming.	( )	( )	( )	( )	( )	( )
50. Supervisors are not available when they are needed.	( )	( )	( )	( )	( )	( )

APPENDIX C

CONTENT VALIDITY

9201 Clarewood #155
Houston, Texas 77036

Dear Panelist:

Thank you for participating in this research study for partial fulfillment for a Master's Degree at Texas Woman's University. A questionnaire has been developed to determine the stressors of general medical/surgical floor nurses. The items were derived from a literature review and collaboration with floor nurses. Participants in this study will be asked to respond to each item according to stressors they perceive on their units in the study institution.

A copy of the questionnaire and instructions are enclosed. Your decision about the tool is needed as soon as possible. For further clarification, please call me at 777-2521.

Dissertation/Theses signature page is here.

To protect individuals we have covered their signatures.

A questionnaire has been developed containing 50 items representative of the types of stressors perceived by general medical/surgical floor nurses. In order to insure validity of the questionnaire the following questions need your response:

A. Does the item measure a stressor?
B. Is the item written clearly and concisely?
C. Does the item fit into the category identified by the researcher?
D. Is the statement positive or negative?

Please read each item on the questionnaire and place a checkmark (✓) in the appropriate column on this form. Your suggestions are welcomed.

Item	A Does item measure a stressor?		B Is item written concisely and clearly?		C Does item fit into category identified?		D If not, which category does it fit?		E Is this a positive or negative statement?	
	Yes	No	Yes	No	Yes	No	Yes	No	Pos.	Neg.
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Item	Does item measure a stressor?		Is item written concisely and clearly?		Does item fit into category identified?		If not, which category does it fit?		Is this a positive or negative statement?	
	Yes	No	Yes	No	Yes	No	Yes	No	Pos.	Neg.
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Please write any comments below. Thank you very much for your assistance.

Administration/Institution Policy

1. The supervisors respect my judgements.
2. I find it difficult to keep up with hospital policies and procedures.
3. Administrators understand nursing needs.
4. Administrators are in contact with what is happening on the units in the hospital.
5. Going through the steps of administration to effect a change on my unit is not time consuming.
6. Supervisors are not available when they are needed.
7. It is OK to show my feelings or emotions at work.

Interpersonal Relationships and Communication/Family

8. Family members make excessive demands on the nurse.
9. Personality conflicts occur between medical and nursing personnel.
10. I have time to offer support to families who need it.
11. My expertise is respected by my patients' families.
12. A feeling of team spirit exists on my unit which is conducive to good nursing care.
13. Telephone calls from the family disrupt the care of my patients.
14. Physicians often criticize nurses in front of other staff members, families and patients.
15. Family members interfere with my care for the patients.
16. Doctors illegible orders are time consuming to transcribe which keeps me away from my patients.
17. I must not admit my fears to my nursing peers.

18. I must maintain a "professional distance" between nurse and patient.

Patient Care

19. When patients ask questions about death or dying, it causes me to feel uncomfortable.

20. Nurses may show despair around their patients.

21. Patients in the unit require heavy lifting.

22. Patients in the unit are unable to communicate their needs.

23. I have time to talk with patients for an uninterrupted period of time.

24. I feel confident in meeting my patient's physical needs.

25. Nurses on the unit agree on the care of the patient.

26. The patient frequently understands nursing care.

27. I have time to teach my patients about their care.

28. I am able to pass medication to a large number of patients without difficulties.

29. Physicians often become so involved with diagnosis and treatment that they often forget the emotional needs of the patient.

30. The physical aspects of a patient's care takes priority over the emotional needs.

31. Doctors are available when they are needed.

32. Telephone orders are often difficult to understand causing me to be away from my patients longer than I want to.

33. Moaning, crying, and screaming occur on this unit.

34. Patients receive little emotional support from their doctors.

35. There is continuity of care on my unit.

36. Some patients need time consuming physical care, such as dressing changes, so that I am unavailable for other duties.

Environment and Unit Management

37. There is not enough personnel available on the unit to care for the patients adequately.

38. There is adequate work space.

39. Equipment must be moved from one patient to another.

40. The pace in this unit is conducive to good patient care.

41. I get my coffee breaks and meal breaks.

42. Since I work a rotating shift I am too tired to provide good nursing care.

43. Lounge facilities are inadequate or nonexistent on this on this unit.

44. There is adequate ancillary personnel to to non-nursing tasks.

45. Non-nursing personnel (i.e., lab, housekeeping, and pharmacy) are unavailable when needed.

46. Staffing permits me to work a satisfying schedule.

47. After collecting and charting data I have time to interpret it adequately.

48. Non-nursing personnel will not provide needed assistance when asked.

49. Working several days in a row is a good schedule for me to provide continuity of care to patients.

50. Equipment works poorly.

APPENDIX D

MODIFIED QUESTIONNAIRE

MEDICAL/SURGICAL FLOOR NURSE STRESS SURVEY

Instructions: Indicate the response which most accurately describes your opinion about the stress in the unit you are currently employed by placing a checkmark (✓) in the appropriate space. "Doesn't Apply" should be checked (✓) if such an occurrence does not occur on your unit. How stressful are the following situations/events for you?

Situation/Event	Always	Frequently	Sometimes	Rarely	Never	Doesn't Apply
1. Family members make excessive demands on the nurse.	( )	( )	( )	( )	( )	( )
2. There is not enough personnel available on the unit to care for the patients adequately.	( )	( )	( )	( )	( )	( )
3. There is adequate work space.	( )	( )	( )	( )	( )	( )
4. Patients in the unit require heavy lifting.	( )	( )	( )	( )	( )	( )
5. I get my coffee breaks and meal breaks.	( )	( )	( )	( )	( )	( )
6. The nursing supervisors respect my judgments.	( )	( )	( )	( )	( )	( )
7. I have time to talk with patients for an uninterrupted period of time.	( )	( )	( )	( )	( )	( )
8. Lounge facilities are inadequate or nonexistent on this unit.	( )	( )	( )	( )	( )	( )
9. I have time to teach my patients about their care.	( )	( )	( )	( )	( )	( )
10. There is adequate ancillary personnel to do non-nursing tasks.	( )	( )	( )	( )	( )	( )
11. Non-nursing personnel (i.e., lab, housekeeping, and pharmacy) are unavailable when needed.	( )	( )	( )	( )	( )	( )
12. I find it difficult to keep up with hospital policies and procedures.	( )	( )	( )	( )	( )	( )
13. Hospital administrators understand nursing needs.	( )	( )	( )	( )	( )	( )
14. Physicians often become so involved with diagnosis and treatment that they often forget the emotional needs of the patient.	( )	( )	( )	( )	( )	( )
15. The physical aspects of a patient's care take priority over the emotional needs.	( )	( )	( )	( )	( )	( )

How stressful are the following situations/events for you?

Situation/Event	Always	Frequently	Sometimes	Rarely	Never	Doesn't Apply
16. Nursing administrators are in contact with what is happening on the units in the hospital.	( )	( )	( )	( )	( )	( )
17. Telephone calls from the family disrupt the care of my patients.	( )	( )	( )	( )	( )	( )
18. Physicians often criticize nurses in front of other staff members, families, and patients.	( )	( )	( )	( )	( )	( )
19. Doctors are available when they are needed.	( )	( )	( )	( )	( )	( )
20. It is OK to show my feelings or emotions at work.	( )	( )	( )	( )	( )	( )
21. After collecting and charting data I have time to interpret it adequately.	( )	( )	( )	( )	( )	( )
22. Family members interfere with my care for the patient.	( )	( )	( )	( )	( )	( )
23. Moaning, crying, and screaming occur on this unit.	( )	( )	( )	( )	( )	( )
24. Patients receive little emotional support from their doctors.	( )	( )	( )	( )	( )	( )
25. Doctors' illegible orders are time consuming to transcribe which keeps me away from my patients.	( )	( )	( )	( )	( )	( )
26. Some patients need time consuming physical care, such as dressing changes, so that I am unavailable for other duties.	( )	( )	( )	( )	( )	( )
27. Going through the steps of administration to effect a change on my unit is not time consuming.	( )	( )	( )	( )	( )	( )
28. Nursing supervisors are not available when they are needed.	( )	( )	( )	( )	( )	( )

APPENDIX E

MEDICAL/SURGICAL FLOOR NURSE STRESS SURVEY

MEDICAL/SURGICAL FLOOR NURSE STRESS SURVEY

Instructions: Indicate the response which most accurately describes your opinion about the stress in the unit you are currently employed by placing a checkmark (✓) in the appropriate space. "Doesn't Apply" should be checked (✓) if such an occurrence does not occur on your unit. How stressful are the following situations/events for you?

Situation/Event	Always	Frequently	Sometimes	Rarely	Never	Doesn't Apply
1. Family members make excessive demands on the nurse.	( )	( )	( )	( )	( )	( )
2. There is not enough personnel available on the unit to care for the patients adequately.	( )	( )	( )	( )	( )	( )
3. There is adequate work space.	( )	( )	( )	( )	( )	( )
4. Patients in the unit require heavy lifting.	( )	( )	( )	( )	( )	( )
5. I get my coffee breaks and meal breaks.	( )	( )	( )	( )	( )	( )
6. The nursing supervisors respect my judgments.	( )	( )	( )	( )	( )	( )
7. I have time to talk with patients for an uninterrupted period of time.	( )	( )	( )	( )	( )	( )
8. Lounge facilities are inadequate or nonexistent on this unit.	( )	( )	( )	( )	( )	( )
9. I have time to teach my patients about their care.	( )	( )	( )	( )	( )	( )
10. There is adequate ancillary personnel to do non-nursing tasks.	( )	( )	( )	( )	( )	( )
11. Non-nursing personnel (i.e., lab, housekeeping, and pharmacy) are unavailable when needed.	( )	( )	( )	( )	( )	( )
12. I find it difficult to keep up with hospital policies and procedures.	( )	( )	( )	( )	( )	( )
13. Hospital administrators understand nursing needs.	( )	( )	( )	( )	( )	( )
14. The physical aspects of a patient's care take priority over the emotional needs.	( )	( )	( )	( )	( )	( )
15. Nursing administrators are in contact with what is happening on the units in the hospital.	( )	( )	( )	( )	( )	( )

How stressful are the following situations/events for you?

Situation/Event	Always	Frequently	Sometimes	Rarely	Never	Doesn't Apply
16. Telephone calls from the family disrupt the care of my patients.	( )	( )	( )	( )	( )	( )
17. Physicians often criticize nurses in front of other staff members, families, and patients.	( )	( )	( )	( )	( )	( )
18. Doctors are available when they are needed.	( )	( )	( )	( )	( )	( )
19. It is OK to show my feelings or emotions at work.	( )	( )	( )	( )	( )	( )
20. Moaning, crying, and screaming occur on this unit.	( )	( )	( )	( )	( )	( )
21. Patients receive little emotional support from their doctors.	( )	( )	( )	( )	( )	( )
22. Doctors illegible orders are time consuming to transcribe which keeps me away from my patients.	( )	( )	( )	( )	( )	( )
23. Some patients need time consuming physical care, such as dressing changes, so that I am unavailable for other duties.	( )	( )	( )	( )	( )	( )
24. Nursing supervisors are not available when they are needed.	( )	( )	( )	( )	( )	( )

APPENDIX F

RAW DATA

Table A

Total Score and Mean by Item of Perceived Stress on the Medical/Surgical Floor Nurse Stress Survey by 37 Registered Nurses

Item	Total Score	Mean
1. Family members make excessive demands on the nurse.	121	3.3
2. There is not enough personnel available on the unit to care for the patients adequately.	127	3.4
3. There is adequate work space.	110	3.0
4. Patients in the unit require heavy lifting.	118	3.2
5. I get my coffee breaks and meal breaks.	114	3.1
6. The nursing supervisors respect my judgments.	111	3.0
7. I have time to talk with patients for an uninterrupted period of time.	118	3.2
8. Lounge facilities are inadequate or non-existent on this unit.	146	3.9
9. I have time to teach my patients about their care.	122	3.3
10. There is adequate ancillary personnel to do non-nursing tasks.	129	3.5
11. Non-nursing personnel (i.e., lab, housekeeping, and pharmacy) are unavailable when needed.	113	3.1
12. I find it difficult to keep up with hospital policies and procedures.	116	3.1
13. Hospital administrators understand nursing needs.	124	3.4
14. The physical aspects of a patient's care take priority over the emotional needs.	130	3.5
15. Nursing administrators are in contact with what is happening on the units in the hospital.	117	3.2

Table A (Continued)

Item	Total Score	Mean
16. Telephone calls from the family disrupt the care of my patients.	109	2.9
17. Physicians often criticize nurses in front of other staff members, families, and patients.	115	3.1
18. Doctors are available when they are needed.	111	3.0
19. It is OK to show my feelings or emotions at work.	129	3.5
20. Moaning, crying, and screaming occur on this unit.	115	3.1
21. Patients receive little emotional support from their doctors.	116	3.1
22. Doctors illegible orders are time consuming to transcribe which keeps me away from my patients.	129	3.5
23. Some patients need time consuming physical care, such as dressing changes, so that I am unavailable for other duties.	126	3.4
24. Nursing supervisors are not available when they are needed.	111	3.0
Total Survey Overall Average	119.8	3.24

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