

Commentary

Nursing Work Force of the Future: The Administrative Perspective

The nursing work force shortage is having a major impact on an industry that is already reeling from major assaults driven by inadequate payment and reimbursement. This article evaluates the current work force shortage as it relates to the competitive marketplace, the data regarding the shortages, the work environment, and the intergenerational issues that sabotage teams. There are recommendations for action in the areas of recruitment and retention, training and education, leadership and management, and improving the work environment. Key words: *nurses, nursing shortage, work environment, work force*

Karren Kowalski, PhD, RN, FAAN
President
Kowalski & Associates
Castle Rock, Colorado

A recent article in the *Harvard Business Review* described health care as the “most entrenched, change-averse industry in the United States.”¹ The hypothesis presented by Christensen et al.¹ suggests that health care is in desperate need of “disruptive innovations,” which employ simpler, less costly, more convenient initiatives. Such innovations would address the needs of the largest segment of the population rather than using extremely high-cost technology on everyone when it is necessary in only 5% of cases. For example, many community hospitals have epidural rates of greater than 85% and continuous fetal monitoring on all laboring women rather than only on those mothers who truly need such interventions and meet specific criteria.

One example of a “disruptive innovation” is a small, portable X-ray machine, the approximate size of today’s EKG machine, that could go from unit to unit rather than transporting patients to radiology. Such machines cost a fraction of what stationary machines in radiology cost and decrease the need for “transporters.” In considering the present and the future

Submitted for publication: December 5, 2000
Accepted for publication: February 8, 2001

J Perinat Neonat Nurs 2001;15(1):8–15
© 2001 Aspen Publishers, Inc.

of the health care work force, such thinking could significantly affect how care and the corresponding work force issues are perceived and addressed. The purpose of this article is to help orient the reader to the many factors influencing the current nursing work force utilization as well as those issues that will confront nursing during this decade.

CURRENT INFLUENCES ON THE NURSING WORK FORCE

Competitive Marketplace for Nurses

Health care delivery systems have now moved to the survival mode. Reimbursement for services from both the federal government and health maintenance organizations (HMOs) has steadily declined even though costs of equipment and pharmaceuticals continue to outpace inflation two- to three-fold. Personnel costs consume more than 60% of both hospital and out-of-hospital care budgets.

The competition to attract physicians, who are still the gatekeepers and greatly influence patient volumes in both acute and ambulatory care settings, is intense, particularly in metropolitan areas where multiple systems and facilities exist. With the current nurse staffing problems in many major cities there is also intense competition and proliferation of recruiting inducements for nurses. The quality of patient care a facility can deliver is a primary factor in attracting both physicians and patients. This quality, in a major part, is dependent on the quality and quantity of the registered nurses on the staff.

Professional Nursing Personnel Shortages

Labor shortages and staff issues are ranked as the second most crucial concern

of hospital executives after reduced government reimbursement.² Vacancy rates for registered nurses (computed by dividing the number of vacant full-time equivalent (FTE) RN positions by the total number of budgeted positions) are difficult to estimate because there is no consistent tracking mechanism and many institutions do not reveal the true numbers. However, Henshaw's group,² in their interviews of state hospital associations, state nursing boards, and state nurses associations have estimated vacancy rates for 12 states. From these states, they estimate a 7% to 8% vacancy rate nationally. However, many large metropolitan areas such as Atlanta, Denver, Kansas City, Memphis, and others suggest that the rate is running in excess of 10%. Although there is debate regarding exact numbers, it is generally believed that vacancy rates greater than 10% constitute a definite shortage.

Even though total patient beds decreased by 15% between 1985 and 1994, the total number of personnel in acute care settings has steadily increased through the 1990s. There are more RNs employed today than 10 years ago. Projections are for continued increases as a result of the aging population of Baby Boomers as well as the increasing acuity of hospitalized patients. For example, the very low birth weight infants who are surviving in the neonatal intensive care units often require more than one nurse to attend to all the life-sustaining technology in addition to the nurturing needs. To keep pace with these sicker patients, the institutional staff mix of RNs to nonprofessionals increased from 43% RNs in 1977 to 63% in 1998.² Of necessity, most neonatal intensive care units (NICUs) and many high-risk labor and delivery areas have more than 90% RN staff.

At the same time, the average age of practicing nurses in the United States is

44+ years, and less than 9% of practicing nurses are age 30 or younger. The National Council of State Boards of Nursing indicates that numbers of graduates passing the RN licensure examinations has steadily fallen from 75,827 in 1995 to 61,248 in 1999.² Should such a trend continue, Peter Buerhaus's estimate that only three new RNs will be graduated to replace every 10 RNs who retire in 2010 could become a reality.³

Thirty years ago, work or professional choices for women were quite limited and were restricted primarily to nursing, teaching, and secretarial work. Today, 43% of those enrolled in medical school are women. Obviously women have many more options than they had in the past. It is not surprising that nursing school enrollment is down nationally, when there are newspaper articles and television and radio reports about the long hours and stress in the workplace. In addition, the computer and data industries are hiring new graduates for \$60,000/year or more. These industries are more flexible, have lower levels of stress, certainly fewer lawsuits, and higher salaries.⁴

Financial Situation

Because of the intense cutbacks in gross revenue for most health care systems and the competitive bidding for HMO contracts, hospital profit margins have progressively decreased and spiraled into budget deficits leading to buyouts, mergers, and ever-enlarging health care systems. Although nursing salaries have been tied to the rate of inflation, they are just now beginning to respond to the nursing shortage. They are beginning to creep up, partly because of the excessive rates paid for traveling or temporary agency nurses who are used to fill the gaps in the staffing patterns. Increasing the salaries is less ex-

pensive than extensive use of travelers. This has been a last resort due to the overall impact on budgets, particularly as staff work overtime and extra shifts at high rates that can include time-and-a-half and bonus dollars. Yet "float pool" nurses in many systems make only \$21 to \$23 per hour. Is it surprising that it is difficult to recruit nurses into these jobs? In spite of the impact on the facility budget, salaries are certain to rise as the shortage increases.

Work Environment

The workplace today is fraught with difficulty. There is continuous pressure about the budget, including ongoing efforts to have people available when they are needed for patient care and to send them home when the patient volume is down. In high census periods, some areas of the country are requiring mandatory overtime as a short-term solution. In addition to long hours, there is an ongoing effort to streamline costs of supplies and to be certain all charges are posted. One of the consequences of these conditions is high turnover, sometimes as much as 20% annually in the professional ranks and even higher in the assistant categories. This results in a state of flux in the nursing department, making it difficult to form and nurture effective teams. Because of all the change going on in health care, particularly in the financial reimbursement arena, and because of the litigious nature of the perinatal and neonatal specialties, physicians are upset and scared. Many have become demanding of institutions and are looking for scapegoats or someone to blame. Frequently this is administration and nursing. The result is conflict, which only adds to the stress of the workplace. It takes truly creative, effective leadership to resolve such issues—leadership from medicine, administration, and nursing.

Table 1. Five generations of the 20th century

<p>In spite of the aging nursing population there are a number of different age groups represented on any nursing team. Washburn¹¹ has summarized the five generations of this past century in an overarching fashion, which identifies trends and has developed general descriptions and timeframes for each.</p> <ul style="list-style-type: none"> <p>• GI Generation: born 1901–1925 Major institutions, civic, religious, fraternal, and professional have been shaped by this generation, which survived the Great Depression and fought in World War II. This generation, which was marked by its heroic journey, tends to be joiners of churches, professional organizations, and clubs. They believe in civic virtue, upward mobility, and the American Dream.</p> <p>• Silent Generation: born 1926–1945 This generation, greatly influenced by the patriotism and self-sacrifice of the WWII struggle, has been the keeper of the flame. They may not have challenged the status quo, but they have been great caretakers. They have worked to extend the environment they inherited through their allegiance to proper principles and rules, law and order, patriotism and faith.</p> <p>• Baby Boomers: born 1945–1964 The Boomers have been the largest, most important generation of this century. They came out of the postwar optimism and were the first generation to be the recipients of direct marketing of material goods. They have been focused on instant gratification regardless of debt. Boomers don't accept moral or ethical authority. They aren't joiners and are unlikely to make sacrifices for the group. They will have a significant impact on government and health care as they age.</p> <p>• Generation X: born 1965–1981 There are 25 million fewer GenXers than Boomers. They are caught between two significantly larger birth cohorts and feel overlooked. They also feel they will get less in a material sense than preceding generations. Insecurity is key in the GenXers' consciousness, and thus they are more focused on close friends and virtual family than on material success or organizational loyalty. Institutions are viewed as lacking in authenticity and "reality."</p> <p>• Generation Y or the Millennium Generation: born 1982–2003 This generation, which has grown up with computers, e-mail, and instant communication, will have an enormous impact on business and infrastructure. They will not know a time when technology did not exist. Some researchers estimate that Generation Y will spend nearly one-third of their lives on the Internet.¹² This implies that they will have less social or face-to-face interaction and consequently will have fewer social skills and will appear more shy and less confident.</p>

Intergenerational Issues

There are many differences among the members of the current nursing work force, including education, values, backgrounds, expectations, communication skills, pur-

pose, and goals (see Table 1). The two primary groups of workers in any setting are the Baby Boomers and the GenXers, along with some of the Silent Generation who will retire in the next 10 years and a very small number of Generation Y. Each group

The Silent Generation or Boomer managers, who have always worked long hours, see overtime as a solution to a staffing crisis, while GenXers and Generation Y workers are not interested in overtime or the extra money it brings.

is distinctly different in its values and beliefs, yet all must find a way to work together. Many middle managers are from the Silent Generation or the Baby Boomers, while the front-line workers are from the Boomers and GenXers. For example, the Silent Generations or Boomer managers, who have always worked long hours, see overtime as a solution to a staffing crisis, while GenXers and Generation Y workers are often not interested in overtime or the extra money it brings. Family, friends, and time off are more important. Mandatory overtime that requires these young people to work spirals into union activity and revolt.

If a communications breakdown is added to the basic differences in the values and priorities of these groups, the ensuing conflict is predictable. A "cache of curmudgeons" composed of Silent Generation and Boomers who are threatened by change and a "coven" of irreverent young upstarts who think they know it all constitute a conflict management nightmare, especially for an inexperienced manager.

To understand the conflict, it is valuable to look more closely at these groups. According to Raines,⁵ the GenXers were raised, during their formative years, with only limited parental interaction. Over 50% were latch-key kids because both parents worked, striving for the American Dream, the better life. These young people learned early to be autonomous and take

care of themselves. They survived the fall of American heroes from televangelists Jim and Tammy Bakker to the resignation of President Richard Nixon. With corporate downsizing, mergers, and reorganizations, they witnessed their parents and relatives being laid off—a testimony to the rewards of loyalty to a corporation. They experienced a 50% divorce rate, and nearly all were touched by this through their own parents, aunts and uncles, or the parents of close friends. Most GenXers can speak extensively about this pain. The message they received was "be careful out there," as opposed to the message the Boomers received, which was "you can do anything" even if it requires putting in long hours.

The GenXers see their parents and other Baby Boomers as workaholics who sacrificed their ideals for money and power at the expense of the family and the environment. As a result, they want balance in their lives and are intensely loyal to their friends. They are delaying marriage (the average age is 25 for women and 27 for men), and over 87% plan to marry only once. They are skeptical considering the world they are inheriting: pollution, crime, racial tension, AIDS, and a questionable economy. They are not impressed with titles or authority figures but with effectiveness, role modeling, and consideration. They are technologically expert and somewhat intolerant of the previous generations, many of whom have limited technical skills. Given these differences, it is not surprising that the Silent Generation see mandatory overtime, "redesign," cost-cutting, and layoffs as effective short-term solutions. At the same time, the younger generations see health care as unstable, lacking in quality control, ineffective, and devoid of role models and leaders. Is it any wonder that such differences might breed conflict and lack of understanding in the

workplace and lead to turnover and problems with quality in patient care?

RECOMMENDATIONS

Recruitment and Retention

Nurse educators can speak to recruitment into the profession, much of which is ongoing from the educational setting. There is a glimmer of hope in that many of the GenXers see themselves as the “repair” generation and are entering such professions as teaching and nursing at slightly higher rates. On the other hand, the retention strategies are the direct responsibility of the work settings that employ these young people. One recruitment strategy for agencies and hospitals is to partner with schools of nursing and create paid summer externships for student nurses. Through working on the units, these students gain valuable experience, become familiar and oriented to the facility, and are more easily recruited to that facility. This seems to be a more effective strategy than expensive sign-on bonuses and can decrease new graduate orientation time.

At the same time, the focus has been so directed to cost-cutting and survival that many hospitals, agencies, and institutions have lost sight of the interventions that can encourage professional staff to remain active and participative in the workplace. A strong education department can set up new graduate programs that include classes, mentors/preceptors, and buddy systems that increase retention. It would be valuable to review Marlene Kramer’s seminal work for additional ideas.⁶ Another approach would be to teach all the generations about the differences among them and how to honor and respect these differences without polarization or making one another wrong. Have these groups

actively participate in identifying values that can be supported by all and hold one another accountable for the behaviors that reflect these values. Have all staff participate in problem solving and move toward consensus whenever possible. Expend resources on team building within units and most essentially, focus on formal education (academic programs) and continuing professional development for the nursing leaders and potential leaders at all levels. If people believe the facility is investing in them, they are much more likely to stay.

Training and Education

When there is budgetary stress, many institutions cut education first because this delays cuts at the bedside. Rather than cutting education, the strongest, most active groups in a facility should be the nurse educators and clinical specialists. In times of consumer concern about quality, the focus, after meeting basic safety, needs to be on how to improve quality. One approach is to make certain the caregivers are the best prepared they can be. This can best be accomplished through education and competency-based practice. Education also needs to be competency-based and can reflect the subspecialty knowledge necessary.⁷

This can begin with a subspecialty immersion course for new graduates who have little experience in perinatal or neonatal nursing or experienced nurses who have never worked in the subspecialty. There is a critical need for unit-based education that can be classroom style (direct contact, face-to-face between instructor and participant) or computer-based and accomplished during any 30-minute quiet time. The computer age is fast approaching in nursing, and staff will be able to complete unit-specific coursework online. Many schools of nursing

are putting courses online, particularly courses needed in completion programs for bachelor of science in nursing degrees and basic graduate courses as well as courses such as perinatal and neonatal pharmacology updates.⁸ Institutions will not have to construct all these programs; they will be available through professional organizations as well as universities and from for-profit dot-coms.⁹ To ensure ongoing clinical staff competencies in facilities delivering more than 1,200 babies per year, there needs to be a dedicated educator for perinatal and neonatal services, at least on a part-time basis. A clinical specialist is preferred.

Leadership and Management

The need for leadership, from the unit level to the chief executive officer, is critical. The GenXers would tell us that leadership is not related to title or authority but to vision and “walking the talk.” This is particularly true in this era of crisis and upheaval in health care. What do we do to prepare leaders in the profession, particularly at the unit level? Frequently, the best clinician is promoted to management and little is done to support the person in this extremely difficult role. With the cuts in education there are few courses available, and those that are available are usually taught in the old model—through didactic lecture (and not in a very interesting way). Leaders/managers need competency-based education also. This could be accomplished through mentoring and role modeling, through the buddy system with experienced successful leaders/managers, and through the use of a team approach within a department (ie, women’s and children’s) where both successful and unsuccessful strategies are shared. Individual coaching

for these newly learned skills is critical because behaviors do not change without consistent support and follow-up.

If Warren Bennis¹⁰ is correct, then leadership is as much a reflection of one’s character and personal growth as the behaviors that are practiced. It is not a case of “I have arrived. I’m now a nurse manager.” Rather, it is a focus on growing, learning, and reflecting every day. Such character development and personal growth need to be nurtured and supported by administration with the assistance of the education department. This nurturing and growing is the primary role of any director or administrator and requires frequent interactions, trust, empowerment, vision, excitement, respect, and a deep love of the leader role and of mothers and infants for whom they are responsible.

Work Environment

Since employee satisfaction studies still rank money from seventh to tenth in order of importance at a job, clearly other things are more important. Most consistently, employees rank relationships with colleagues at or near the top of the list. They like their coworkers and often establish friendships that transcend the workplace. How they are treated in the workplace is very high on the list. The challenge is to create an environment in which staff feel they work in a special place because both colleagues and leaders “walk the talk.” This is a workplace where employees are honored, respected, and acknowledged; where the work is exciting and challenging; where they use all their skills, tools, and critical thinking. This is an environment where they make a difference for the patients and families. If all these environmental goals are accomplished, recruitment and retention will not be an issue. Such facilities develop

a reputation not only for the best quality but also for being progressive, on the “cutting edge,” or “best practice.”

There are hundreds of creative ideas that can emanate from health care providers to solve all sorts of problems from staffing

shortages and utilization to new technology to educational opportunities. These ideas can create a better system and increased quality of care to patients and families. Now is the time to discover these and experiment with them.

REFERENCES

1. Christensen CM, Bohmer R, Kenagy J. Will disruptive innovations cure health care? *Harvard Business Review*. 2000;Sept.–Oct.:102–112.
2. Henshaw L. Seeing red from a shortage in white: A look at rising nursing pressures. Available at: http://www.healthleaders.com/index.cfm?section=18&screen=news&news_id=5239. Accessed November 22, 2000.
3. Buerhaus PI, Staiger DO, Auerbach DI. Implications of an aging registered nurse work force. *JAMA*. 2000;283:2948–2954.
4. Sinclair BP. Where are the nurses? *AWHONN Lifelines*. 2000;4:4–7.
5. Raines C. *Beyond Generation X: A Practical Guide for Managers*. Menlo Park, CA: Crisp Publications, Inc. Printed by Von Hoffman Graphics, Inc.; 1997.
6. Kramer M. *Reality Shock*. St. Louis, MO: C.V. Mosby; 1974.
7. Lenburg CB. The framework, concepts and methods of the competency outcomes and performance assessment (COPA) model. *Journal of Issues in Nursing* [serial online]. 1999;Sept. 30. Available at: <http://www.nursingworld.org/ojin/topic10/tpc10.2.htm>. Accessed March 2001.
8. Norwicki CR. 21 predictions for the future of hospital staff development. *Journal of Continuing Education in Nursing*. 1996;27(6):259–266.
9. Neafsey PJ. Computer assisted instruction for home study: a new venture for continuing education programs in nursing. *Journal of Continuing Education in Nursing*. 1997;28(4):164–172.
10. Bennis W, Nanus B. *Leaders: The Strategies for Taking Charge*. New York: Harper and Row; 1985.
11. Washburn ER. The five generations. *Physician Executive*. 2000;6(1):54.
12. Hammel S. Living their lives online. *US News & World Report*. 1999;127(21):79.