Title:
Nursing Workforce Well-Being and Quality of Life: Predictions and Recommendations

Lin Perry, PhD
as above, University of Technology Sydney, as above, Australia
Robyn Gallagher, PhD
Charles Perkins Centre, University of Sydney, Sydney, Australia
Christine Duffield, PhD, MHP, BScN
School of Nursing and Midwifery, Edith Cowan University, Joondalup, Australia
David W. Sibbritt, PhD
Faculty of Health, University of Technology, Broadway, Australia
Xiaoyue Xu, PhD
School of Nursing & Midwifery, University of Newcastle, Callaghan, Australia

Session Title:
Promoting Well-Being in the Workforce
Slot:
N 14: Sunday, 30 July 2017: 11:15 AM-12:00 PM
Scheduled Time:
11:35 AM

Keywords:
Health, Wellbeing and Workforce

References:


Abstract Summary:
This session will identify health- and work-related elements contributing to nurses’ and midwives’ quality of life and compares them to those of the Australian general population. It will detail recommendations for workplace interventions to support nurses’ and midwives’ health and well-being, thereby supporting their delivery of quality care.

Learning Activity:

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<th>LEARNING OBJECTIVES</th>
<th>EXPANDED CONTENT OUTLINE</th>
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<tr>
<td>1. Identify those health and work-related elements that contribute to nurses’ and midwives’ quality of life</td>
<td>This session will report data related to nurses’ and midwives’ quality of life; the results of predictive modelling of health and work-related elements that contribute to nurses’ and midwives’ quality of life.</td>
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<td>2. Describe activities that may be applied to improve nurses’ and midwives’ quality of life, thereby promoting care quality</td>
<td>Recommendations derived from analyses of health-related workplace interventions to support nurses’ and midwives’ health and wellbeing.</td>
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Abstract Text:

Purpose:
A person’s quality of life (QoL) is defined by their goals, standards and concerns, especially in their cultural context. It is a subjective summary measure of wellbeing, reflecting ‘complete physical, mental, and social well-being’ (WHO 2006). All aspects of an individual’s life contribute and, for those who are members of a workforce, work life makes a sizable contribution, especially for full time workers. Links have been demonstrated between QoL and job satisfaction, and increased QoL and job satisfaction in nurses improves job performance and reduces turnover, directly influencing the quality of healthcare they deliver (Milosevic et al. 2011), and in turn reducing costs to healthcare providers (Duffield et al. 2014).

How a person feels about their job relates to individual goals and expectations and hence to QoL. Some influences on work life quality of life and/ or job satisfaction are well-recognised, such as workplace violence, bullying and harassment, workplace stress and burnout (Bartram et al. 2012; Budin et al. 2013), psychosocial work factors such as job strain, psychological job demand, decision latitude/authority and job control. The occupational pressures associated with the nursing profession are increasingly recognised and affect all ages; the problems of stress and distress, compassion fatigue, burnout, absenteeism and staff turn-over are globally significant. Irrespective of the job satisfaction reported, for nursing this has been linked to working conditions, environment and culture; to job stress, role clarity and content, organizational and professional commitment. However, these factors differ with differing work settings.

Individual health can also be influential, including on intention to leave (Perry et al. 2015); chronic, non-cancer and musculoskeletal pain have all been associated with reduced QoL, as have chronic diseases such as diabetes. Increased weight leads to poorer health but does not necessarily affect QoL. Given the diversity of potential individual and workplace influences, we sought to identify:

- To what extent health and workforce characteristics influence nurses’ and midwives’ quality of life, and how this compares to that of the Australian general population;
What recommendations can be drawn for future interventions to promote QoL and job satisfaction for nurses and midwives?

Methods:

This was an online cross-sectional survey including the Short Form-12 version 2 (Sanderson & Andrews, 2002) as a measure of QoL, calculated using the QualMetrics algorithm. This paper describes these nurses' and midwives' quality of life and compares this to that of the Australian general population (Avery et al. 2004).

Participants were nurses and midwives employed in New South Wales were recruited through the email mailing list of the NSW Nurses and Midwives Association (the NSW nursing and midwifery professional body) and by snowball distribution through professional groups and networks between May 2014 and February 2015.

The survey instrument comprised a mixture of validated instruments and items examining demographic information, workforce, health, job satisfaction and quality of life, using the Medical Outcomes Survey Short Form-12 (which produces separate physical and mental component scores: PCS and MCS). Taking a ‘mental health day’ (MHD) as sickness absence, anecdotally a common phenomenon in Australia, was determined by asking how many sick days were taken in the previous 12 months and then, “How many of these sick days would you classify as ‘mental health days’?” [6]

Sample characteristics were reported using descriptive statistics. Demographic, workplace, work and health-related potential predictive variables were analysed in relation to quality of life and job satisfaction using univariate and multivariate regression models.

Approval was granted by South Eastern Sydney Local Health District and University of Technology Sydney Human Research Ethics Committees. Study details were available on the survey webpage and informed consent was presumed with submission of a completed online questionnaire.

Results:

Nursing and midwifery participants

Of 5,446 completed questionnaires, 405 (7.4%) were excluded due to missing data or non-NSW practice. SF-12 physical and mental component scores could be calculated for 4,592 (91.1%) of survey respondents. These participants had mean age 48 (SD 11.5, range 18-78) years; 65.8% were 45 years of age and older. Most (87.7%) were female, worked full-time (53%) and shift work (53.1%) including night shifts; almost three quarters (70.6%) were employed in foundational roles (Registered Nurse/ Clinical Nurse Specialist grades); the majority were metropolitan (65.7%) and hospital-based (59.6%). These nurses were well-educated; most (64%) had at least a Bachelor degree and 39% had postgraduate qualifications. Overall their average working week was 34 hours, but 39% reported working more than 40 hours in an average week.

Health and Quality of life

General health was overall rated at median score 2 (‘very good’) but 14.6% self-rated their health as only fair – very poor. Chronic disease diagnoses and symptom frequency have been reported elsewhere (Perry et al 2016) but with an overall median of one diagnosis each, 17.7% of participants reported 3 or more diagnoses.

Overall, these nurses reported an average SF-12 physical component score of mean (SD) 51.7 (8.1) and mental component score of 48.6 (9.6). Age and sex-matched scores were not dissimilar to Australian
normative values (Avery et al. 2004) but for all ages and both sexes nurses’ and midwives’ physical component scores tracked somewhat higher and mental component scores lower than population values.

**Predictive factors**

We used multiple linear regression with forced entry of demographic, health and work-related variables for the SF-12 physical and mental component dependent variable scores, separately. Thirteen variables explained 41.5% of variability in physical component scores. Working in a foundational versus other role, any workplace injury or admission to hospital in the previous year, any diagnosed mood disorder, increasing numbers of chronic disease diagnoses and prescribed medications, greater frequency and severity of recent pain and sleep disorder, being post-menopausal, having a higher Body Mass Index and being a current smoker all predicted lower physical component scores. Those who took more sick days identified as ‘mental health’ days had higher physical component scores (F=47.481, df28, p<.001).

Twelve variables explained 41.6% of variability in mental component scores. Higher mental component scores were predicted by increasing age and job satisfaction, working office hours rather than shift work and part-time rather than full-time, taking fewer ‘mental health’ sick days, having a higher Body Mass Index and working in a non-hospital setting. Any workplace abuse or mental health diagnosis, greater numbers of ill-health symptoms, increasing frequency of pain in the last four weeks and sleep problems were all associated with lower mental component scores (F=49.865, df28, p<.001). Two scores were borderline significant: being post-menopausal and experiencing any workplace injury.

**Conclusion:**

Health is an important influence on nurses’ and midwives’ quality of life. Given the impact of QoL both for workforce wellbeing and in support of care quality, interventions to support workforce wellbeing are needed. These findings indicate new recommendations for policy and practice. Including a focus on foundational staff, interventions might entail occupational health services to complement primary healthcare for earliest detection and initiation of treatment for chronic disease including pain management and mental health disorders; addressing workplace injury rates; health education and promotion initiatives encompassing sleep hygiene, healthy eating, menopause management and smoking cessation; site-based initiatives to provide and promote healthy food choices in cafeterias and facilities to store, heat and eat home-cooked food on the premises; roster flexibility.

These recommendations for policy and practice capitalise on study findings to promote quality of life and hence quality of care and longevity in the health workplace.