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Critical care nurses' perceptions of the outcomes of working overtime in Canada

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ABSTRACT

Background: Nursing overtime is being integrated into the normal landscape of practice to ensure optimal staffing levels and addresses variations in patient volume and acuity. This is particularly true in critical care where fluctuations in either are difficult to predict.

Purpose: The goal of this study was to explore critical care nurses' perceptions of the outcomes of working overtime.

Methods: Sally Thorne's interpretive description guided the collection and analysis of data. Participants were recruited from 11 different critical care units within three large teaching hospitals in Southern Ontario, Canada. A total of 28 full- and part-time registered nurses who had worked in an intensive care unit for at least one year took part in this study. Data were collected through semi-structured, audio-recorded, individual interviews that took place in rooms adjacent to participants' critical care units. Template analysis facilitated the determination and abstraction of themes using NVivo for Mac 10.1.1.

Findings: Major themes highlighting the perceived outcomes of overtime included (a) physical effects, (b) impact on patient-centered care, (c) balancing family and work, (d) financial gain, and € safety is jeopardized.

Conclusions: Nursing managers and institutions need to be accountable for staffing practices they institute, and nurses themselves may require further education regarding healthy work–life balance. There are both negative and positive consequences of nursing overtime for nurses and patients, but nurses at large valued the option to work it.

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Nursing overtime is a global issue particularly in the United States (Berney & Needleman, 2005), Europe (Griffiths et al., 2014), the Middle East (Arsalani, Fallahi-Khoshknab, Josephson, & Lagerstrom, 2012), Africa (deBeer, Brysiewicz, & Bhengu, 2011), Japan (Primomo, 2000), and Canada. In 2014, Canadian nurses worked 267,500 hours of paid overtime per week at an annual cost of $679.4 million (Canadian Federation of Nurses'

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Unions [CFNU], 2015). This is in addition to 104,400 hours per week of unpaid overtime they worked simultaneously at an estimated value of $192.5 million (CFNU, 2015). During that year, 26% of nurses worked some overtime every week, averaging 6.1 paid hours. This amounts to 19,383,900 total hours of paid and unpaid overtime in 2014—the equivalent of 10,700 full-time positions.

Nursing overtime is the result of numerous factors including staff shortages, patient volume and acuity, hiring freezes, and fiscal constraints resulting in lower base staffing levels (Berney & Needleman, 2005). Fisher, Baumann, and Blythe (2007) suggest that these issues are more prevalent in critical care due to unpredictable fluctuations in patient volume and acuity. Despite its extensive use, the perceived effects of overtime on patient care and nursing staff remain largely unknown. Little research has been conducted about overtime within critical care units and none of it within the Canadian health care system. The purpose of this study was to explore critical care nurses' perceptions of the outcomes of overtime work in order to facilitate nurse and patient satisfaction and safety.

Background

Approximately 13% of Canadian nurses work in critical care where they require specialized assessments skills, rapid decision making, and enhanced organizational and motor skills (Fallis, McMillan, & Edwards, 2011). In these environments, patients are exposed to more treatments and medications than other environments and are also seriously ill with reduced resilience to aid in recovery in the event of nursing errors or oversight (Scott, Rogers, Hwang, & Zhang, 2006). Any additional nurse stressors, including the effects of overtime, may jeopardize patient care and resultant outcomes.

Existing research identifies perceived outcomes of overtime including decreased patient satisfaction and poor nurse-rated quality of care (Griffiths et al., 2014; Kunaviktikul et al., 2015). In their cross-sectional study of 31,627 nurses from 12 European countries, Griffiths et al. (2014) found that working overtime was associated with poor or fair quality of patient care ($p \leq .05$). Thai nurses in the study of Kunaviktikul et al. (2015) perceived increases in communication errors ($p < .05$), and patient complaints ($p < .05$) were more likely in situations of extended work hours.

These issues are indicative of compromised patient safety, which Griffiths et al. (2014) found to be significantly related to nurse overtime ($p \leq .05$). Other patient outcomes perceived to be associated with extended work hours included higher incidences of pressure ulcers ($p < .05$) and patient identification errors ($p < .001$) (Kunaviktikul et al., 2015). Studies have explored the association between overtime hours and patient outcomes with conflicting results. Although some studies related overtime to poorer patient outcomes (Olds & Clarke, 2010; Scott et al., 2006; Trinkoff et al., 2011), Berney and Needleman (2006) found it to be associated with *decreased* mortality and Stone et al. (2007) linked overtime to slightly lower rates of central line infections.

Significant outcomes of extended work hours that were self-reported by nurses included emotional exhaustion ($p = .001$) and depersonalization ($p = .002$) (Kunaviktikul et al., 2015). Significant negative correlations were found in the same study to exist between extended work hours and job satisfaction ($p = .001$) and intent to stay ($p = .042$).

There is a dearth of information regarding nurses' perceptions of the outcomes of overtime for themselves and their patients. There are only two studies that explore facets of this topic (Griffiths et al., 2014; Kunaviktikul et al., 2015), and neither reflects a Canadian or critical care perspective. Insights from this study may help to reduce turnover in critical care and equip organizations to develop safer, more efficient, and fiscally responsible staffing practices.

Methods

Interpretive description (ID) is uniquely suited to advance the nursing profession that relies on reason, philosophy, science, and theory in equal measure (Thorne, 2008). This method aims to respond to complex social and health care questions (Thorne, Kirkham, & O'Flynn-Magee, 2004). ID was developed out of a desire to discover the "so what" that drives applied disciplines and relieves the tension between theoretical integrity and utility (Thorne, 2008). It was selected for this study because of its potential to deconstruct prior knowledge (from a variety of sources) and generate insights that shape future research and have application potential (Thorne, 2008). ID draws on relatively small samples, but extends beyond description to explore meanings and underlying explanations for nurses' decisions to work overtime, so that they can be effectively and efficiently deployed.

Recruitment and Sampling

Frontline nurses from 11 critical care units within 3 teaching hospitals in Southern Ontario, Canada, were recruited for this study. Each of the facilities was unionized, and participants were bound by organization-specific contracts. Sampling was purposive, according to the following inclusion criteria: (a) a registered nurse, (b) employed in an intensive care unit (ICU) setting for at least one year, and (c) employed full or part-time. On each unit, two to four nurses were recruited using maximum variation sampling to identify individuals who self-identified as working little, moderate, or large amounts of overtime (each varied across age and gender as much as possible). Using snowball sampling, nurses who responded electronically were asked to recommend colleagues who would have