Results of the 2008 AORN Salary Survey

DONALD BACON, PHD

In August of 2008, AORN surveyed its members and some nonmembers to examine the status of perioperative nursing compensation in the United States. This market research study tracks compensation changes on a yearly basis and seeks to identify factors that influence how much perioperative nurses are presently paid. The survey also addresses the perioperative nursing shortage, focusing on perceived changes in staffing-related aspects of the perioperative nursing workplace during the last several years. Additional analyses were conducted this year to explore the differences between the acute care and ambulatory care work environments.

RESPONDENT PROFILE

For the fifth consecutive year, AORN conducted its survey online. In early August, 33,089 potential respondents—mainly AORN members—were sent an e-mail invitation to participate in the survey. By early September, 4,200 unique responses were received. Because the focus of this survey is perioperative nursing compensation, respondents who did not answer any compensation-related questions were excluded. This criterion reduced the usable sample to 3,283 individuals, for a 10% net response rate. This sample is somewhat smaller than the sample collected in 2007, but is still sufficient for the analyses that follow.

Of the respondents, 41% are staff nurses, 25% are managers, 13% are high-level managers (ie, hospital/facility administrators and vice presidents [VPs]/directors/assistant directors of nursing), 8% are educators (ie, for faculty or staff development), and 5% are RN first assistants (RNFAs) (Figure 1). The largest percentage of respondents (45%) are between 50 and 59 years of age; 28% are 40 to 49 years of age, 13% are 30 to 39 years of age, and 4% are younger than age 30. Nine percent are 60 to 69 years of age, and less than 1% are 70 years and older. Approximately 91% of the respondents are women, and 9% are men.

Hourly-paid employees comprise 64% of the sample; 36% are salaried employees. Most of the respondents work in acute care hospitals (72%), and 24% work in an ambulatory surgery center whether it be free-standing (12%); hospital-based (10%); or office-based (2%). About 1% of the respondents work in the nursing industry, in a school of nursing, or as independent consultants. About 4% are employed in other positions.

Geographically, the sample is well dispersed across the country. As shown

ABSTRACT

AORN CONDUCTED ITS SIXTH ANNUAL compensation survey for perioperative nurses in August of 2008.

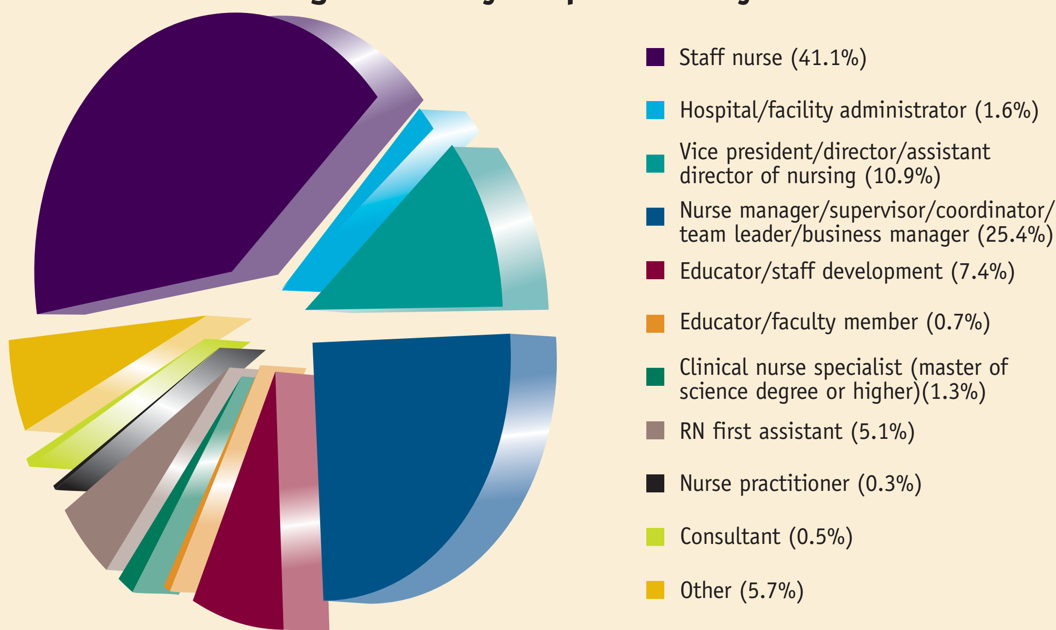
A MULTIPLE REGRESSION MODEL was used to examine how a variety of variables including job title, education level, certification, experience, and geographic region affect nursing compensation.

COMPARISONS BETWEEN THE 2008 and previous years' data are presented.

THE EFFECTS OF OTHER FORMS of compensation, such as on-call compensation, overtime, bonuses, and shift differentials on average base compensation rates also are examined. *AORN J* 88 (December 2008) 901-915. © AORN, Inc, 2008.

© AORN, Inc, 2008

FIGURE 1
Percentage of Survey Respondents by Job Title



in Table 1, 20% of the respondents live in the upper eastern coastal area (ie, New England and the Mid Atlantic), 18% reside in the South Atlantic area, and 26% are located in the East and West North Central regions. About 16% reside in the East and West South Central regions, and 21% are located in the western (ie, Mountain) and Pacific states. About 80% work in an urban or suburban area, and about 20% work in a rural location.

More than one-third of the respondents hold a bachelor's degree in nursing, and 8% have a bachelor's degree in another field. About 41% of the respondents have a diploma or associate degree. Seven percent of respondents hold a master's degree in nursing, and 7% hold a master's degree in another field. About 2% have a doctorate in another field or some other type of degree (Table 2).

About 40% of the sample have more than 20 years of experience as a perioperative nurse, and 26% have more than 25 years of experience. About 29% of the respondents have from over 10 to 20 years of experience, and about 32% have 10 or fewer years of experience as a perioperative nurse.

Overall, the respondents' demographic profile is quite similar to the 2007 and the 2006 survey samples. Figure 2 represents some of the demographic information for the sample.

BASE COMPENSATION

Statistical analyses were performed to identify which factors have the most influence on perioperative nurse compensation. It should be noted that the sample is not perfectly random because the net response rate was modest (10%). Also, the sample comprises mainly AORN members, although no significant differences in compensation were found between members and nonmembers. The sample is sufficiently representative of the perioperative nurse population that statistical tests can provide insight.

A summary of the salary findings, divided by job title and size of facility, is shown in Table 3. Facilities are categorized as small or large based on a median split of the number of ORs reported. These findings show the calculated average salary for nurses who spend an average amount of time on direct patient care for their title. As can be seen, nurses generally

receive more compensation in larger facilities.

On closer examination, it appears the relationship between facility size and compensation also may be influenced by facility type. Table 4 shows how the average number of ORs varies by facility type and how the number of ORs is related to staff nurse compensation. As shown, the university or academic facilities tend to be larger than other facilities. The ambulatory care facilities pay somewhat less than the acute care facilities.

The challenge in understanding perioperative nursing compensation is in estimating the simultaneous influence of the many different variables that can affect compensation. Multiple regression was used as the primary analytical tool in this study because so many variables are involved. The multiple regression model makes it possible to estimate the effects of one variable on compensation while statistically holding the other variables constant. The influence of each variable can then be identified independently of the others. The analysis used hierarchical regression where the variables expected to explain the most variance were entered in the model first, followed by less important variables. Several variables with related effects were entered initially and simultaneously. These variables are

- job title;
- facility size;
- facility type;
- population setting (ie, urban, suburban, rural);
- region; and
- percentage of time spent in direct patient care.

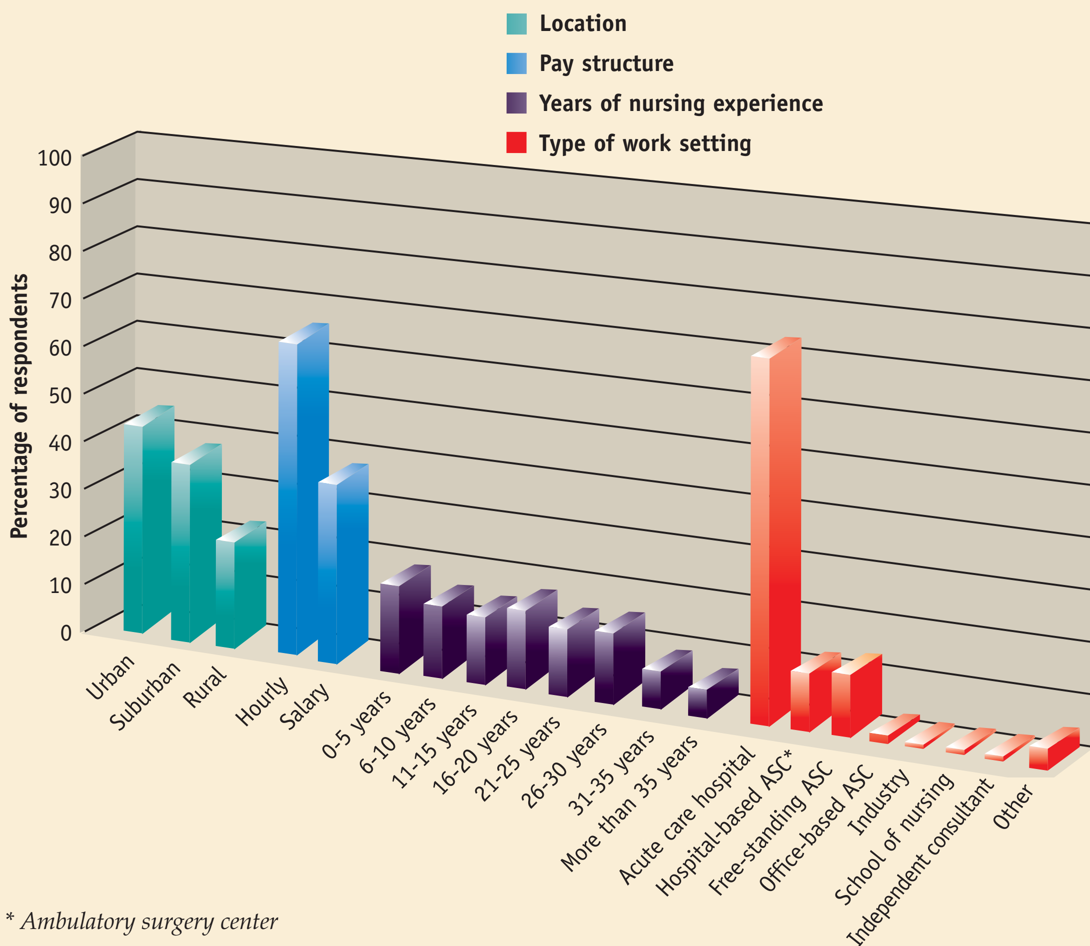
Other variables were then entered one at a

Table 1
Geographic Region

Region	Percentage
New England (ie, New Hampshire, Vermont, Maine, Connecticut, Rhode Island, Massachusetts)	5.3
Mid Atlantic (ie, New Jersey; Delaware; Maryland; Pennsylvania; New York; Washington, DC)	14.4
South Atlantic (ie, West Virginia, Virginia, North Carolina, South Carolina, Georgia, Florida)	17.7
East North Central (ie, Wisconsin, Michigan, Illinois, Indiana, Ohio)	16.9
West North Central (ie, North Dakota, South Dakota, Minnesota, Nebraska, Iowa, Kansas, Missouri)	9.0
East South Central (ie, Kentucky, Tennessee, Mississippi, Alabama)	4.9
West South Central (ie, Oklahoma, Arkansas, Texas, Louisiana)	10.8
Mountain (ie, Montana, Idaho, Wyoming, Nevada, Utah, Colorado, Arizona, New Mexico)	8.4
Pacific (ie, Alaska, Washington, Oregon, California, Hawaii)	12.4

Table 2
Respondents' Education Levels

Education	Percentage
Diploma	4.3
Associate degree	92.7
Bachelor of science in nursing	95.0
Bachelor of science in another field	47.8
Master of science in nursing	52.1
Master of science in another field	58.3
Doctorate in nursing	60.0
Doctorate in another field	21.3
Other	44.2



time. These secondary variables are

- years of work experience,
- compensation basis,
- certification,
- education level,
- participation in a collective bargaining unit,
- household status, and
- gender.

To obtain the most reliable results, the sample for the regression analyses was limited to respondents who are full-time employees and who work in the United States. Statistical outliers also were eliminated (eg, a small number of nurses who reported unusually high or low pay) to avoid skewing the results. Checks were conducted to ensure that the statistical assumptions behind the regression model were met (eg, linear relationships and normally distributed errors). The final model explains 50% of the variation in base compensation.

OVERVIEW

Following is an overview of the results concerning each variable included in the regression analysis that was found to be significantly related to base compensation level. All variables were significant at the $P \leq .05$ level. Readers can easily obtain the estimates of compensation for any particular nursing position by using the compensation calculator on the AORN web site at *http://www.aorn.org/CareerCenter.*

JOB TITLE. More than any other variable, job

TABLE 3

Estimate of Average Base Compensation by Job Title and Facility Size*

Job title	Average percentage of time spent in direct patient care	Small facility (≤ 10 ORs)	Large facility (> 10 ORs)
Staff nurse	87.2	$59,900	$62,800
Hospital/facility administrator	23.1	$94,200	**
Vice president/director/ assistant director of nursing	16.8	$85,400	$118,300
Nurse manager/supervisor/ coordinator/team leader/ business manager	38.6	$73,200	$77,000
Educator/staff development	22.3	$69,000	$72,700
RN first assistant	88.1	$67,200	**
Other	34.2	$69,500	$80,700

** The small net subsample sizes for educator/faculty member, clinical nurse specialist, nurse practitioner, and consultant resulted in their exclusion from the regression analysis. Other samples with less than 30 observations are noted with an **. Dollar amounts are rounded to the nearest hundred.*

TABLE 4

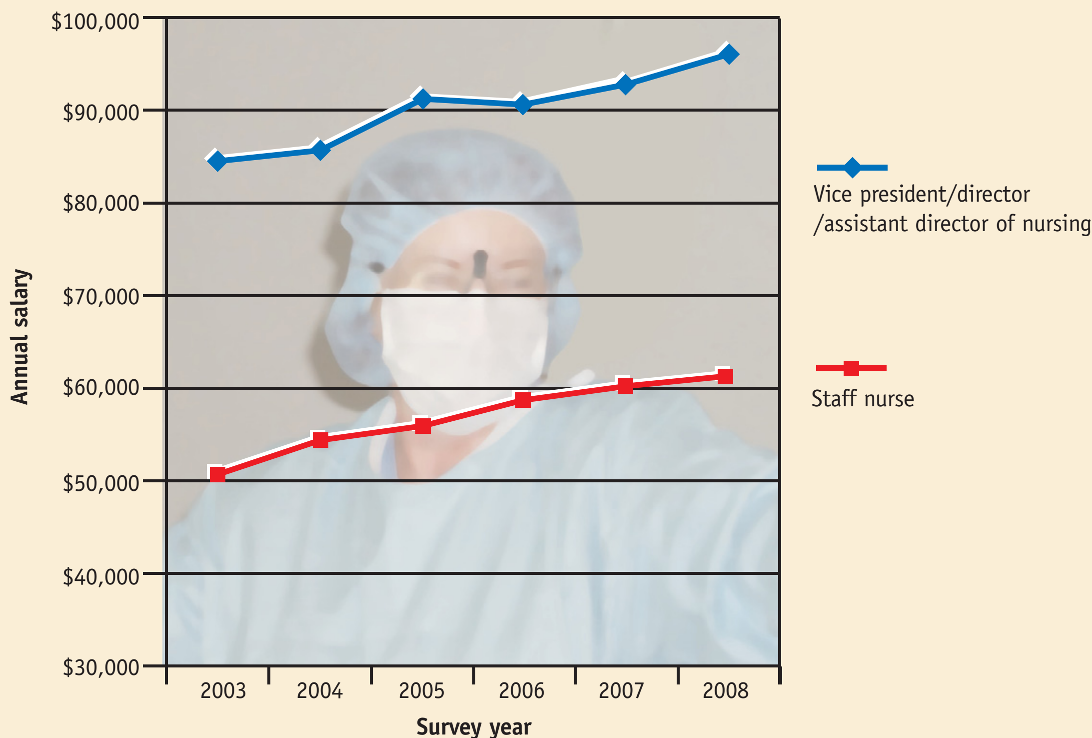
Size and Compensation by Facility Type

Facility type	Size (average number of ORs)	Average staff nurse base compensation	Count
Acute care hospital - general/community	87.2	$59,900	377
Acute care hospital - specialty	23.1	$66,800	42
Acute care hospital - university/academic	16.8	$68,600	128
Ambulatory surgery center - general/community	38.6	$55,800	47
Ambulatory surgery center - university/academic	22.3	$67,000	26

titles are linked to differences in compensation. The average staff nurse, for example, earns $61,500 ($1,100 more than in 2007), and the average VP/director/assistant director of nursing makes $97,500 ($3,700 more than in 2007). Part of the difference in salary across titles is explained by the difference in the percentage of time spent in direct patient care versus the percentage of time spent on other tasks such as management or administration.

To explore the trends in salary for nurses and nurse managers over time, data were combined from six years of AORN salary surveys. Figure 3 shows that staff nurses and VPs/directors /assistant directors of nursing have both seen increases in average compensation during this time period. The rate of growth appears to be slightly higher for staff nurses (averaging 3.9% a year) than for VPs/directors/assistant directors of nursing (averaging 2.7% a year) during this time period.

FACILITY TYPE. The regression model indicates



that nurses in university or academic facilities receive more compensation than do nurses in other types of facilities. For example, those working in university acute care hospitals average $6,700 more than others. This difference is less pronounced for those working in university ambulatory surgery centers (ASCs), where the average is $5,500 more. Nurses working in acute care specialty hospitals average $6,500 more.

These findings imply that nurses in other acute care hospitals or other ambulatory surgery centers generally receive less compensation than nurses in the facilities mentioned above. Interestingly, in addition to the differences just noted, for nurses in higher-level management positions, the average compensation is $5,400 less for those working in any kind of ASC (ie, general, specialty, university).

FACILITY SIZE. The size of facility is an important differentiator in nursing compensation. This difference is particularly pronounced for those who work in higher-level management positions. In fact, after controlling for facility type, most nurses do not receive significantly more pay for working in larger facilities, but hospital/facility administrators and VPs/directors/assistant directors of nursing earn on average $1,600 more per OR in the facility (compared to $1,650 in 2007). This difference may occur because of the greater number and range of responsibilities that these upper-level positions entail.

FACILITY OWNERSHIP. About 30% of nurses in the sample work in facilities that are private, investor-owned, for-profit organizations. Nurses in these facilities earn $4,300 less than nurses in facilities with different ownership structures (eg, nongovernment, nonprofit).

POPULATION SETTING. The location of the facility—in an urban, suburban, or rural area—substantially influences compensation. Nurses earn an estimated $7,200 less per year if they work in rural settings (the same result as was reported in 2007).

Geographic region. After controlling for all variables previously discussed, geographic region explains significant differences in compensation levels across the United States. Nurses in the South Atlantic, West North Central, East South Central, and West South Central all earn about the same income. Nurses working in the Pacific region receive $18,900 more annually. The other regions with higher annual incomes are the New England ($16,400); Mid Atlantic ($7,300); Mountain ($4,300), and East North Central ($2,900) regions.

Time spent on direct patient care. On average, staff nurses spend 87% of their time providing direct patient care, and nurse managers spend 39% of their time providing direct care. As expected, high-level managers spend a relatively small amount of time on patient care (23% for hospital/facility administrators, 17% for VPs/directors/assistant directors of nursing). Hospital/facility administrators spend 4% less time on direct patient care than was reported by the 2007 sample. The percentage of time spent on direct patient care varies among nurses with the same title. For example, some nurse managers spend as much time on direct patient care as does the average staff nurse, while some other nurse managers spend as little time on patient care as the typical director or VP.

Nurses in a particular position who spend more or less time than the average for direct patient care in that position should expect to receive compensation that differs from the average. Staff nurses earn about $320 more per year than the average staff nurse compensation for each 10% decrease in time spent on direct patient care per week and, correspondingly, for each 10% increase in time spent doing managerial tasks. This is down from $400 in the 2007 sample.

This relationship is the same for nurse managers, educators, RNFAs, nurse practitioners, private scrub nurses, and other nurses. Hospital/facility administrators and VPs/directors/assistant directors of nursing earn $300 per year more for every 10% decrease in percentage of time spent on direct patient care (the same as reported in last year's survey).

AORN members can use the compensation calculator by visiting *http://www.aorn.org/CareerCenter* and selecting "calculator."

Work experience. The polynomial regression model suggests that nurses generally see large increases related to experience early in their careers, but much smaller increases later. For example, the jump in compensation from the first to the second year is close to $900, but the jump from the 25th to the 26th year is only about $100. In this sample, the average nurse has 17 years of experience. Nurses with more or less than this amount should add or subtract some amount per year of experience to estimate their base compensation. Interestingly, hospital/facility administrators and directors/VPs/assistant directors of nursing earn about $350 per year of experience (compared to $440 last year and $470 two years ago), and this relationship continues up through 30 years of experience. On average, these individuals report 22 years of work experience.

Compensation basis. Whether a nurse is paid on an hourly basis or receives a salary is related to base compensation level, even after all of the factors mentioned above are controlled in the regression model. Salaried employees earn $3,500 more per year than do hourly employees. This amount is slightly less than the $3,900 additional compensation reported in the 2007 study.

Certification. Eleven types of certification were examined:

- BC—board certified,
- C—certified,
- CNOR—certified OR nurse,
- CRNFA—certified RNFA,
- CPAN and/or CAPA—certified perianesthesia nurse and/or certified ambulatory perianesthesia nurse,
- CPSN—certified plastic surgical nurse,
- CNA—certified in nursing administration,
- CNAA—certified in nursing administration advanced,
- ONC—certified orthopedic nurse,
- CNS—clinical nurse specialist, and
- NP—certified nurse practitioner.

This year, only one of these certifications, CNOR, is related to significant differences in

compensation. Nurses with a CNOR credential receive $2,800 more per year in compensation than do non-CNOR nurses. Interestingly, this pattern does not hold for nurses in higher-level management positions.

Of particular note, these findings are qualified by the small number of nurses in the sample who hold the 10 other types of certification. Although 59% of respondents are CNOR-certified, only a small percentage held BC, C, CRNFA, CPAN and/or CAPA, CPSN, CNA, CNAA, ONC, CNS, or NP certifications. Of these other certifications, only CRNFA and BC are held by more than 1% of the sample (CRNFA = 3.4%; BC = 1.4%). Thus, the number of some certifications was too small to render a statistically significant effect in regression analysis. In this regard, however, 38% of the respondents said that their facility pays more to those holding a nursing certification. In response to a follow-up question, of those who said their facility offers more compensation for some certifications, 81% of the respondents said they receive extra compensation for CNOR, 9% for CRNFA, and 6% for CPAN and/or CAPA. Three percent or fewer mentioned one of the other certifications. Thus, while it appears that some nurses receive extra compensation for a variety of certifications, this compensation may vary by facility. Also, nurses with some certifications such as CNOR may find work in facilities that offer more compensation, or they may spend more time on management tasks. After controlling for facility type and time spent on direct patient care, the effect of certification by itself is less pronounced.

EDUCATION LEVEL. Nurses with a master's degree in nursing add an additional $6,800 in annual base compensation (compared to $5,100 in 2007). Nurses holding a master's degree in another field make $5,800 more. When asked directly, only 27% of the respondents said that their facility pays more to those who have a degree in nursing.

It may seem surprising that education has so little impact on compensation in this analysis, but it should be noted that the analysis has already controlled for job title, and a nurse's education level may well affect the level of responsibility to which he or she may rise. Table 5 provides an analysis of education by selected job titles, including staff nurses, nurse managers, and higher-level directors or hospital/facility administrators. The table shows that those in the higher-paying jobs,

TABLE 5
Education by Selected Job Titles

Education	Staff nurse (n = 1,349)	Nurse manager (n = 834)	Director/administrator (n = 411)
Diploma	14%	12%	8%
Associate degree	35%	31%	15%
Bachelor of science in nursing	35%	36%	33%
Bachelor of science in another field	8%	7%	8%
Master of science in nursing	3%	6%	13%
Master of science in another field	4%	6%	19%
Doctorate in nursing	0%	0%	0%
Doctorate in another field	0%	0%	1%
Other	1%	1%	2%

especially directors or administrators, are less likely to have only a diploma or associate degree and are more likely than others to have a master's degree in nursing or another field. Thus, while level of education does not always have a strong direct effect on compensation for nurses with the same title, education may well affect the title each nurse holds.

Collective bargaining unit. Relatively few respondents report working in an environment with a union or collective bargaining unit (9.4% this year, 9.5% last year). However, nurses working in a unionized setting earn an average of $5,600 more in annual base compensation than do nurses employed in a nonunion workplace (compared to $5,700 more in the 2007 sample). Working in a unionized environment does not appear to affect the compensation of managers.

Household status and gender. Being married, single, or divorced is not significantly linked to base compensation. In contrast to last year's results, the variables of gender and having children under the age of 18 at home are also not significant. The varying results across the last few years of this study suggest that there may indeed be a gender effect, but the effect is inconsistent and small relative to all of the other factors that influence perioperative nursing compensation.

Other variables. As a cautionary note, the results from the regression analysis represent general patterns and do not address several variables that can affect compensation, such as the unique needs of facilities, interpersonal skills, and leadership ability. The results are generally accurate enough so that two-thirds of nurses or managers who fit a particular profile will see an annual base compensation within $16,200 of base compensation estimated by the model.

In questions unrelated to the base compensation model, 84% of the respondents report receiving a raise this year. For those receiving raises, the mean pay raise for staff nurses is 3.4% (compared to 3.5% last year). As shown in Table 6, raises are slightly higher for those with greater management responsibilities. Hospital/facility administrators received an average 5.8% pay raise (compared to 6.1% last year); VPs/directors/assistant directors of nursing averaged a 4.3% raise (compared to 4.1% last year). "Other" types of positions received a 3.9% average raise this year. Clinical nurse specialists are the one exception to the manager-pay raise relationship. They averaged a sizeable 4.6% raise (compared to 3.8% last year).

Interestingly, nurses who recently changed positions with the same employer are earning about $2,800 less than are nurses with the same position, experience, and qualifications. Thus, it appears that changing employers is one way that a nurse can increase his or her compensation.

Table 6
Mean Pay Raises by Job Title*

Job title	Percentage of pay raise
Staff nurse	3.4
Hospital/facility administrator	5.8
Vice president/director/assistant director of nursing	4.3
Nurse manager/supervisor/coordinator/team leader/business manager	4.0
Educator/staff development	3.5
Clinical nurse specialist (master of science degree or higher)	4.6
RN first assistant	3.3
Other	3.9

** Nurse practitioner, educator/faculty member, and consultant were excluded because of the small sample size.*

Other Forms of Compensation

The regression analysis previously described applies to base compensation. In the present sample, 68% of the respondents receive additional compensation from a variety of sources, including overtime, shift differential, on-call compensation, and bonuses (the same percentage as last year and up from 57% two years ago). The amount of additional pay differs

substantially by title. The average percentage of additional compensation, by title, is shown in Figure 4.

Staff nurses receive the largest additional compensation relative to base pay (16% compared to 12% last year) followed by RNFAs (15.1% compared to 14.3% last year). Educator/staff development employees receive the smallest additional compensation relative to base pay (3.6% compared to 4.4% last year) followed by VPs/directors/assistant directors of nursing (4.1% compared to 4% last year).

ON-CALL COMPENSATION. More than half of the respondents (55%) report that they take call (compared to 56% in the 2007 sample). The median number of hours per week on call is 16 (the same as was reported in the previous three surveys). Among the on-call respondents,

- 69% receive a dollar per hour amount for being on call (compared to 70% in 2007);
- 5% receive a percentage of their base pay (compared to 7% in 2007); and
- 21% receive no compensation (18% last year).

Among those who receive dollar per hour pay, the median pay is $2.75 per hour (compared to $2.57 in 2007). If called in, 59% receive time-and-a-half pay (unchanged from 2007), and 5% get straight-time pay (also unchanged from 2007). Instead of pay, 4% of the on-call respondents receive compensatory time (compared to 5% in 2007).

OVERTIME COMPENSATION. A large majority of respondents work overtime (80% compared to 83% last year), working an average of 6.8 hours each week (compared to 6.9 hours in 2007 and 6.6 hours in 2006). About 60% of those who work overtime receive time-and-a-half pay (compared to 62% last year), but 31% receive no additional compensation (compared to 29% last year).

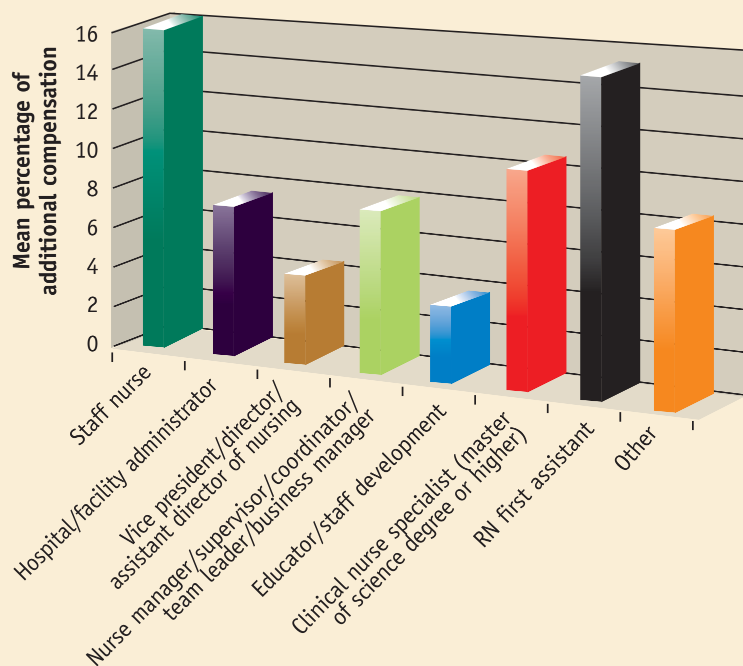
Almost all of those who are not compensated for overtime are salaried (97% compared with 96% in 2007). Registered nurse first assistants average the most overtime (7.4 hours per week compared to 7.3 hours in 2007) followed by

- VPs/directors/assistant directors of nursing (6.4 hours compared to 7.3 hours in 2007);
- clinical nurse specialists (6.1 hours compared to 7.6 hours in 2007); and
- hospital/facility administrators (6.0 hours compared with 5.7 hours in 2007).

Respondents working the least amount of overtime are educator/staff development employees (4.2 hours, which is unchanged from 2007) and those working in "other" positions (4.6 hours compared to 4.7 hours in 2007) (Table 7).

HIRING BONUSES. Relatively few of the respondents received a hiring bonus when they were hired (14%, unchanged from 2007), but 19% report that their employer now offers a hiring

FIGURE 4
Additional Compensation by Job Title*



** Educator/faculty member, nurse practitioner, and consultant were excluded because of the small sample size.*

TABLE 7
Average Overtime Hours Per Week and Percentage of Respondents Who Are Salaried*

Job title	Average overtime hours per week	Percent salaried
Staff nurse	4.8	4.6
Hospital/facility administrator	6.0	92.3
Vice president/director/assistant director of nursing	6.4	96.4
Nurse manager/supervisor/coordinator/team leader/ business manager	5.9	53.2
Educator/staff development	4.2	54.2
Clinical nurse specialist (master or science degree or higher)	6.1	30.4
RN first assistant	7.4	19.8
Other	4.6	46.1

** Educator/faculty member, nurse practitioner, and consultant were excluded because of the small sample size.*

bonus for their position (down from 21% in 2007), with half of the bonuses in the $2,500 to $7,500 range. The employees who are most likely to receive a hiring bonus are staff nurses (25%); RNFAs (22%); and clinical nurse specialists (22%); educator/staff development employees (16%); and nurse managers (16%). Hospital/facility administrators are least likely to receive a bonus, with none reporting receiving hiring bonuses this year (compared to 5% last year).

SHIFT AND OTHER DIFFERENTIALS. Among the respondents, 91% work the day shift and 5% work afternoons or evenings. Very few respondents work nights, weekend days, or weekend nights (less than 5% for the three categories combined). For those working the afternoon/evening shift, the median differential is $2.50 per hour or 10% of base pay (compared to $2.50 per hour and 12% of base pay in 2007).

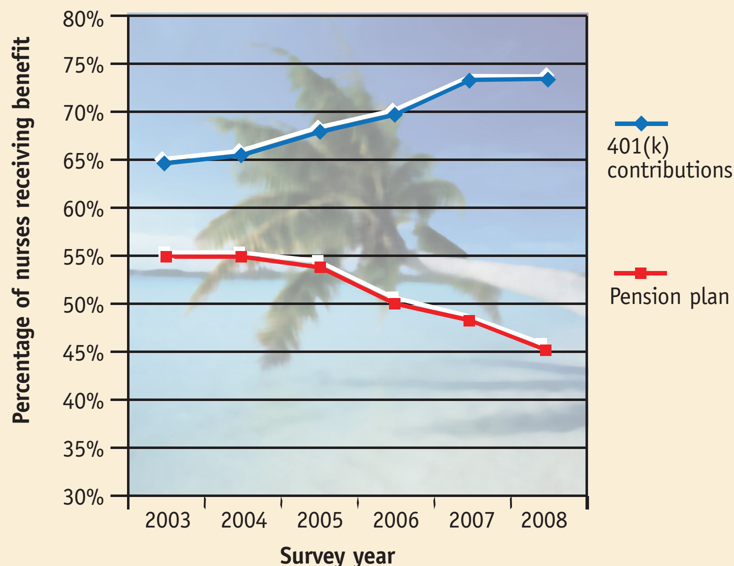
BENEFITS

Almost all of the respondents receive benefits as part of their compensation. These benefits include

- health insurance (94%);
- dental insurance (90%);
- earned time or paid time off (87%);
- life insurance (85%);
- bereavement leave (83%);
- jury duty compensation (75%);
- 401(k) contributions (74%);
- tuition reimbursement (67%);
- long-term disability (66%);
- free or discounted parking (63%);
- short-term disability (63%);
- pension plan (45%);
- paid conference travel (44%);
- paid certification exams (40%);
- employee referral bonus (37%);
- pharmacy discounts (34%);
- tax sheltered annuity plan (31%);
- flexible scheduling (25%);
- incentive bonuses (17%);
- malpractice insurance (15%);
- relocation assistance (10%);
- retention bonuses (6%);
- subsidized child/elder care (6%); and
- life quality services (eg, dry cleaning) (4%).

This year's top five benefits are the same as those reported in the previous three years.

Several of the written comments revealed that nurses were particularly concerned with retirement benefits. Data from the last several years of salary surveys were combined to explore trends in this important benefit over time. As shown in Figure 5, the trends are mixed. There has been a general increase in the percentage of nurses receiving 401(k) contributions, but a corresponding decrease in the percentage of nurses receiving a pension plan.



Another nurse agreed,

I have a really difficult time supporting my family on the low salary and low cost of living allowance. Our parking fee increased 10% this year and we got a 1% increase in pay, not to mention having to contend with the increased costs of living.

Another commented,

We are compensated far less than many manual labor jobs. It makes me angry and sad.

Several particular concerns beyond overall compensation emerged in the comments. Many nurses are frustrated that they are not compensated for earning nursing certifications or a degree. One nurse wrote,

I am currently an ADN nurse who is in the process of earning my BSN, but I will not receive any additional pay for this. There is no financial incentive for most nurses to return to school for an advanced degree or to obtain certification. Until it is tied to a financial incentive, most nurses won't feel that the cost-to-benefit ratio is worth the effort.

Related to this frustration is the need expressed by a number of respondents for their employers to provide opportunities for more training. A number of nurses suggested that perioperative nursing should be recognized as a specialty and compensated accordingly. One nurse wrote,

OR nursing is not considered by my hospital to be a specialty area while [intensive care unit] and [critical care unit] employees are paid more because they are specialty areas. However, we cannot pull nurses off any floor to work in the OR because our skills are so specialized.

Respondents were asked to provide any comments about compensation that they would like to express. More than 550 nurses offered their views. Some nurses said that they are satisfied with their compensation, but a much larger number of responders said that they are underpaid. A number of nurses commented that the pay is especially inadequate given the amount of responsibility, expertise, stress, personal risk, and daunting workloads that perioperative nursing requires. One nurse commented,

I have loved every minute of my 33-year career, but I would not recommend nursing as a career to any of my children. If I was not in a two-income family, I would have a very difficult time supporting my family. The stress, the hours, and the strain that the job puts on the family is just more than I want them to experience. And, the compensation, well, it is a shame. I could go to a tech school, get a [radiology technician] and [magnetic resonance imaging] certificate and make thousands more than I do and work less with less stress and effort. I have a family member who does the above and she makes more than I, and she has been out of school less than two years.

A Closer Look at the Acute Care Hospital Versus the Ambulatory Surgery Center (ASC) Work Environment

The base compensation model found differences in compensation related to whether a nurse worked in an acute care hospital or an ASC. On average, annual nurse compensation in acute care facilities is about $2,900 higher than in ASC facilities. Some of the most common benefits are also slightly less common in ASC facilities. For example,

- 92% of nurses in acute care hospitals receive health insurance compared to 89% of nurses in ASCs,
- 89% of nurses in acute care hospitals receive dental insurance compared to 82% in ASCs, and
- 87% of nurses in acute care hospitals receive life insurance compared to 78% in ASCs.

Surprisingly with this pay and benefit differential, the nursing shortage appears to be less severe in ASC facilities. While the median percentage of vacant positions is 4.8% in acute care hospitals, the median is 0% in ASCs—that is, more than half of ASCs have no vacant positions.

A key reason why ASCs can fill positions even at lower pay is that job satisfaction is significantly higher in ASCs. The overall satisfaction difference between acute care hospitals and ASCs is small but significant (4.8 versus 5.0, respectively, on a scale of 1 to 6, in which 6 indicates the highest satisfaction), and the difference is much larger on some issues that are very important to nurses. The biggest difference is in satisfaction with the amount of on-call time (5.2 in ASCs versus 4.1 in acute care hospitals). Ambulatory surgery center nurses appear to be on call fewer hours per week (19.1 hours in ASCs versus 22.3 hours in acute care hospitals) and work less overtime (3.9 hours in ASCs versus 5.6 hours for acute care hospitals). However, these differences did not result in a significant difference in the additional compensation as a percentage of base compensation.

Sizable differences in satisfaction also exist concerning respect from physicians (4.8 for ASCs versus 4.3 for acute care hospitals), equipment (4.5 for ASCs versus 4.1 for acute care hospitals), and the number of support staff members (4.2 for ASCs versus 3.6 for acute care hospitals). Satisfaction with pay and benefits is also slightly higher in the ASC environment, although these differences did not achieve statistical significance at the .05 level.

With these differences in work environments, do ASCs attract different types of nurses? There do appear to be some differences. Although the differences in years of experience are not substantial, there are some significant differences in qualifications and education. Ambulatory surgery center nurses are more likely to have a diploma (16% for ASCs versus 12% for acute care hospitals) or an associate degree (31% for ASCs versus 27% for acute care hospitals), and are less likely to have a master's degree in nursing (3% for ASCs versus 8% for acute care hospitals). Ambulatory surgery center nurses are also much less likely to have CNOR certification (48% for ASCs versus 61% for acute care hospitals) and are somewhat less likely to have CRNFA certification (2% for ASCs versus 4% for acute care hospitals). Thus, the lower levels of training among ASC nurses may explain the compensation differences to some degree. The ASC work environment could also simply be more enjoyable, and many nurses are willing to give up a little income to work in a more satisfying environment.

Another respondent agreed,

No nurse in the entire hospital can float to the OR because of the expertise required. So why aren't we a specialty and paid that way?"

Another commented,

We are currently receiving a $3/hour differential for working in the OR. Our administration is trying to discontinue this. It has significantly affected morale and several staff nurses have left. This means more hours for all of us. All of the other units in our facility have a "float pool" to draw from, except the OR. We are on our own.

Some respondents recommended that bonuses focus more on retaining experienced nurses than on hiring new ones. One nurse wrote,

I have suggested to my employer that it's time to look at spending some money on rewarding long-term employees with retention bonuses

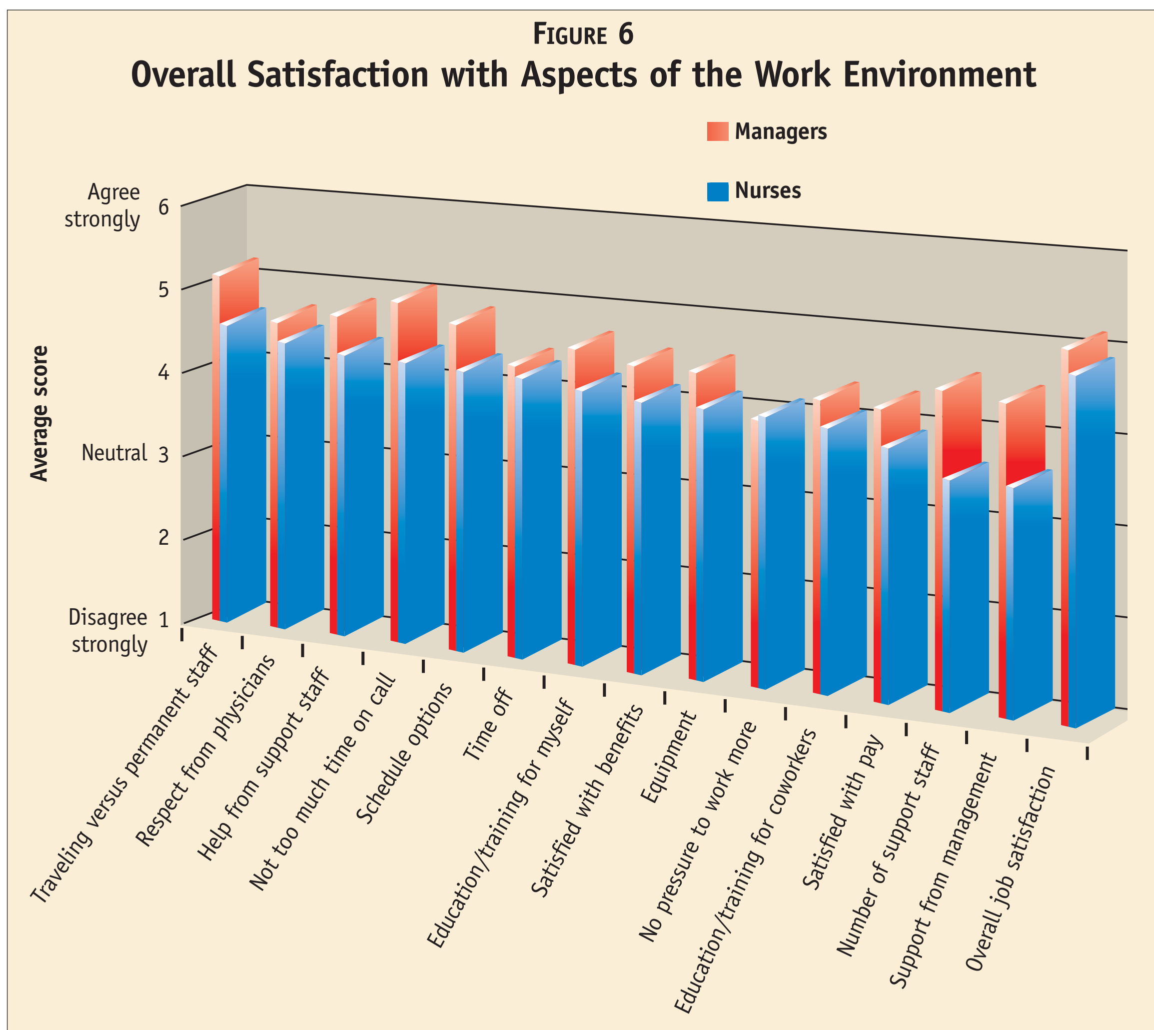
instead of spending so much on hiring bonuses. Then we could keep some of our valuable trained OR staff instead of them becoming trained and then walking away to another position. I've seen it happen time after time—after we have spent months giving a new nurse on-the-job-training, she or he takes that valuable knowledge and leaves for another position.

Shortcomings with benefits were mentioned, especially health insurance and retirement. One nurse commented,

As a health care professional, I am extremely disappointed in the fact that I will have no health care when I retire from my current position. My only health care benefit after retirement will be Medicare if it is still in existence when I reach 67+ years of age. I doubt that I will be able to retire early due to the lack of health care coverage during that period.

Frustrations with on-call compensation and requirements also were expressed. One nurse wrote,

The people who take call here work about 100 hours of first call per month and then about 40 hours of second call, which is basically for emergency [cesarean deliveries]. They generally work on call and then have to work their



regular hours. Although they feel they are compensated decently, no one wants it and call requirements alone cause the most job dissatisfaction.

A number of respondents stated that on-call hours should be reduced or eliminated for older nurses. One wrote,

There should be a way to lower call hours for older nurses so that we can be productive without wearing out. We do not bounce back as quickly as our younger counterparts, but we are able to do our fair share during the daytime hours.

Another said,

I think that all nursing staff in hospital settings are struggling with working more hours and taking more call than they would like. The compensation is good, but the work-life balance is difficult to achieve.

Update on the Perioperative Nursing Shortage

The nursing shortage is essentially unchanged in the last year. The median percentage of vacant full-time nursing positions is the same as in 2007, at 3.7% this year, down from 4.3% two years ago and 5.5% three years ago. This year, 46% of high-level managers report that the shortage has had a moderate-to-crisis level of impact on their working environment compared to 51% in 2007. Among nurses in this year's sample, 66% report a moderate-to-crisis impact, down from 72% in 2007. As expected, the shortage's impact on patient care tends to be rated more severely by those with the most patient contact. About 69% of staff nurses rate the shortage as having a moderate-to-crisis level impact compared with 60% of nurse managers, 51% of VPs/directors/assistant directors of nursing, and 12% of hospital/facility administrators.

Again this year, respondents rated their agreement with statements about their work environment. Several of these statements were phrased as satisfaction measures. The results, broken out by nurses and top managers, are shown in Figure 6. Overall, managers are more satisfied with their jobs than are nurses. Overall satisfaction ratings are similar to last year, with managers rating their satisfaction as 5.1 on a 6-point scale (the same result as in 2007), and nurses rating their satisfaction as 4.8 (compared to 4.7 in 2007). Some of the largest gaps in satisfaction between the two groups are adequate number of support staff, support from hospital administration, and the amount of on-call time. Nurses are least satisfied with the number of support staff and management support, while managers are least satisfied with the pressure they feel to work more hours than they prefer to work.

The respondents also were asked to identify their top three priorities for improving the workplace. Nurses who are not in management rate their top priorities as

- more pay (43% rated this as one of three top priorities);
- more support from management (35%); and
- more support staff (27%).

Managers rate their top priorities as

- more education and training for coworkers (38%);
- more pay (32%); and
- more respect from physicians (26%). – AORN –

Donald Bacon, PhD, is a professor of marketing at the University of Denver, CO, and a research associate at Rocky Mountain Market Research in Denver.

Editor's note: *AORN thanks Brigham and Women's Hospital, exclusive sponsor of the 2008 Salary Survey and the online AORN Compensation Calculator.*

BRIGHAM AND WOMEN'S HOSPITAL
The best place to belong.