

# Results of the 2006 AORN Salary Survey: Trends for Perioperative Nursing

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In August of 2006, AORN surveyed members and 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 presently are paid. The survey also addresses the perioperative nursing shortage and focuses on perceived changes in staffing-related aspects of the perioperative nursing workplace during the last three years.

## RESPONDENT PROFILE

For the third consecutive year, AORN conducted its survey online. In early August 2006, 21,978 AORN members and 8,150 nonmembers were sent an email invitation to participate in the survey. By early September, 4,664 unique responses were received. Since 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 3,832 individuals, for a 13% net response rate. This group represents the largest usable sample collected in the four years that AORN has been conducting the survey.

Of the respondents, approximately 42% are staff nurses; 25% are nurse managers; 11% are high-level managers (eg, directors, vice presidents [VPs], assistant directors, hospital and facility administrators); and 8% are educators, faculty members, or staff development employees (Figure 1). The largest segment of respondents are between 50 and 59 years of age (ie, 40% compared to 39% in 2005 and 37% in 2004). Thirty-three percent are between 40 and 49 years of age, un-

changed from 2005 and down from 39% in 2004, and 16% are between 30 and 39 years of age, unchanged from 2005 and compared to 15% in 2004. A total of 7% of the respondents are between 60 and 69 years of age, up from 5% in both 2005 and 2004. Of the total number of respondents, 4% are younger than 30 years of age compared to 5% last year and 4% in 2004. Lastly, less than 1% of the respondents are age 70 or older.

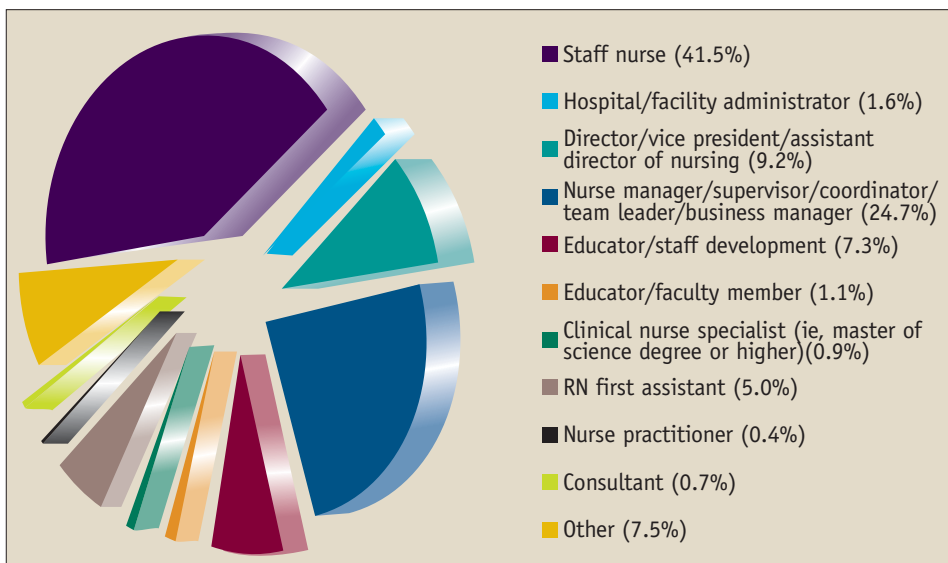
Of all the respondents, 90% are female and 10% are male. Hourly-paid employees comprise 63% of the sample, and 37% are salaried employees.

Most of the respondents work in acute care hospitals (ie, 73% compared to 75% last year), and 21% work in an ambulatory surgery center (ASC) whether it be free-standing (ie, 12%); hospital-based (ie, 9%); or office-based (ie, 1%). Approximately 2% of the respondents work in industry, in a school of nursing, or as independent consultants. Four percent are employed in other positions.

Geographically, the sample is well

## ABSTRACT

- **AORN CONDUCTED ITS ANNUAL compensation survey for perioperative nurses in August 2006.**
- **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.**
- **THIS SURVEY ALSO EXAMINES the effect of other forms of compensation (eg, on-call compensation, overtime, bonuses, shift differential) on average base compensation rates. AORN J 84 (December 2006) 952-963. © AORN, Inc, 2006.**



**Figure 1 • Percentage of survey respondents by job title.**

**TABLE 1  
Geographic Region**

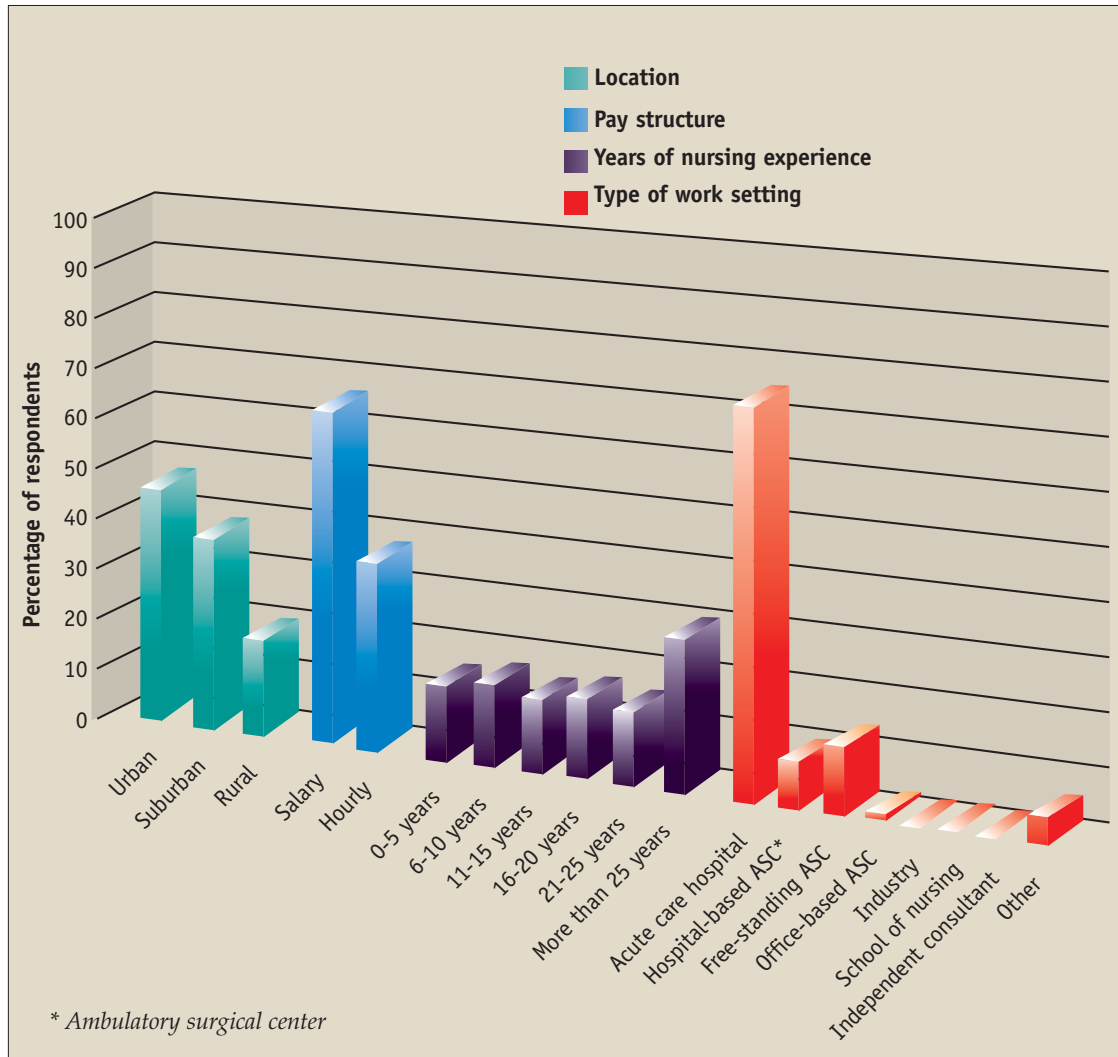
Region	Percentage
New England (ie, New Hampshire, Vermont, Maine, Connecticut, Rhode Island, Massachusetts)	5.3
Mid-Atlantic (ie, New Jersey; Delaware; Maryland; Pennsylvania; New York; Washington, DC)	12.9
South Atlantic (ie, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida)	17.1
East North Central (ie, Wisconsin, Michigan, Illinois, Indiana, Ohio)	16.7
West North Central (ie, North Dakota, South Dakota, Minnesota, Nebraska, Iowa, Kansas, Missouri)	7.8
East South Central (ie, Kentucky, Tennessee, Mississippi, Alabama)	6.5
West South Central (ie, Oklahoma, Arkansas, Texas, Louisiana)	13.6
Mountain (ie, Montana, Idaho, Wyoming, Nevada, Utah, Colorado, Arizona, New Mexico)	7.4
Pacific (ie, Alaska, Washington, Oregon, California, Hawaii)	12.6

dispersed across the country. As shown in Table 1, 18% of the respondents live in the upper eastern coastal area (ie, New England and the Mid Atlantic); 17% reside in the South Atlantic area; and 25% are located in the North Central regions. Twenty percent reside in the South Central regions, and 20% are located in the western (ie, Mountain and Pacific) states. Approximately 82% work in an urban or suburban area while 18% work in a rural location.

Regarding the educational levels of the respondents,

- 36% hold a bachelor’s degree in nursing,
- 8% have a bachelor of science degree in another field,
- 40% have a diploma or associate degree,
- 7% hold a master’s degree in nursing,
- 7% hold a master’s degree in another field, and
- 2% have a doctorate in nursing or in another field or hold some other type of degree.

More than 41% of the respondents have more than 20 years of experience as a perioperative nurse, and 28% have more than 25 years experience. Approximately 29% of the respondents have between 11 and 20 years of experience, and approximately 30% have 10 or fewer years of experience as a perioperative nurse. Figure 2 represents



some of the respondent demographic information. Overall, the respondents' demographic profile is similar to last year's sample.

**BASE COMPENSATION**

Statistical analyses were performed to identify which factors had 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 (ie, 13%). The sample also comprised mainly AORN members, though no significant differences in compensation were found between members and nonmembers. The sample was considered representative enough of the perioperative nurse population that statistical tests could provide insight.

Multiple regression was used as the primary analytical tool in this study because of the many variables affecting base compensation and the complex interactions among these variables. The multiple regression model makes it possible for researchers to estimate the effects of one variable on compensation while statistically holding the other variables constant. The influence of each variable then can be identified, independently of the others. The analysis used hierarchical regression in which the variables expected to explain the most variance are entered first in the model, followed by less important variables. Several variables with related effects were entered initially and simultaneously. These variables are

- job title;
- facility size;

**Figure 2 • A profile of the survey respondents.**

**TABLE 2**  
**Estimate of Base Compensation by Title**  
**and Facility Size for Urban or Suburban Facilities\***

<b>Position title</b>	<b>Average time spent in direct patient care (percentage)</b>	<b>Small (eg, 3 ORs)</b>	<b>Large (eg, 15 ORs)</b>
Staff nurse	88.2	\$57,700	\$63,800
Hospital/facility administrator	15.9	\$81,800	\$103,400
Director/vice president/ assistant director of nursing	18.4	\$81,400	\$103,000
Nurse manager/supervisor/ coordinator/team leader/ business manager	37.9	\$70,800	\$77,000
Educator/staff development	20.4	\$65,900	\$72,100
Educator/faculty member	29.0	\$69,800	\$76,000
Clinical nurse specialist (ie, master of science degree or higher)	15.9	\$71,000	\$77,200
RN first assistant	86.9	\$64,600	\$70,800
Nurse practitioner	82.0	\$65,000	\$71,200
Other	39.3	\$68,900	\$75,100

\* The sample inclusion criteria for the regression analysis resulted in the exclusion of consultants from the sample. Dollar amounts are rounded to the nearest hundred.

- population setting (ie, urban, suburban, rural); and
- percentage of time spent in direct patient care.

Other variables were then entered one at a time. These secondary variables are

- geographic region,
- years of work experience,
- compensation basis,
- certification,
- education level,
- facility type,
- 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, unusually high or low pay reported by very few nurses) 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 56% of the variation in base compensation. Results from the first phase of the regression analysis (ie, the simultaneous entry of primary variables) are presented in Table 2. These findings show the calculated average salary for nurses who spend an average amount of time on direct patient care according to their title and work in suburban or urban settings. The average base compensation for any particular nurse can be estimated by starting with these estimates and making adjustments for the nurse's particular setting, role, and experience.

#### OVERVIEW

Following is an overview of the results of each variable included in the regression analysis that was found to be significantly related to base compensation level ( $P = .05$ ). AORN members can obtain the exact estimates of compensation for any particular nursing position by using the compensation calculator on the AORN web site at <http://www.aorn.org/Careers>.

**JOB TITLE.** More than any other variable, differences in job title are linked to differences in compensation. The average staff nurse, for example, earns \$59,200 (ie, \$1,600 more than last year), and the average VP, director, or assistant director of nursing makes \$91,000 (ie, \$500 less than last year). 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. On average, staff nurses spend 88% of their time delivering direct patient care, and nurse managers spend 38% of their time providing direct care. As expected, high-level managers spend the least amount of time in patient care (ie, 16% for facility and hospital administrators, 18% for VPs or directors). In addition, the percentage of time spent in 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 other nurse managers spend as little time on patient care as the typical director or VP.

**FACILITY SIZE.** Facility size is another key differentiator in nurse compensation. Although all nurses earn more at larger facilities, this difference is particularly pronounced for those who work in high-level management positions. Most nurses receive approximately \$500 for each additional OR in the facility, more than double the \$200 reported last year. Hospital/facility administrators and directors/VPs/assistant directors of nursing earn on average \$1,800 per OR in the facility compared to \$1,300 last year. These differences may be a result of the greater number and range of responsibilities that these upper-level positions entail. For high-level managers, size had a significant affect on compensation up to 21 ORs, which was the largest OR size included in the survey.

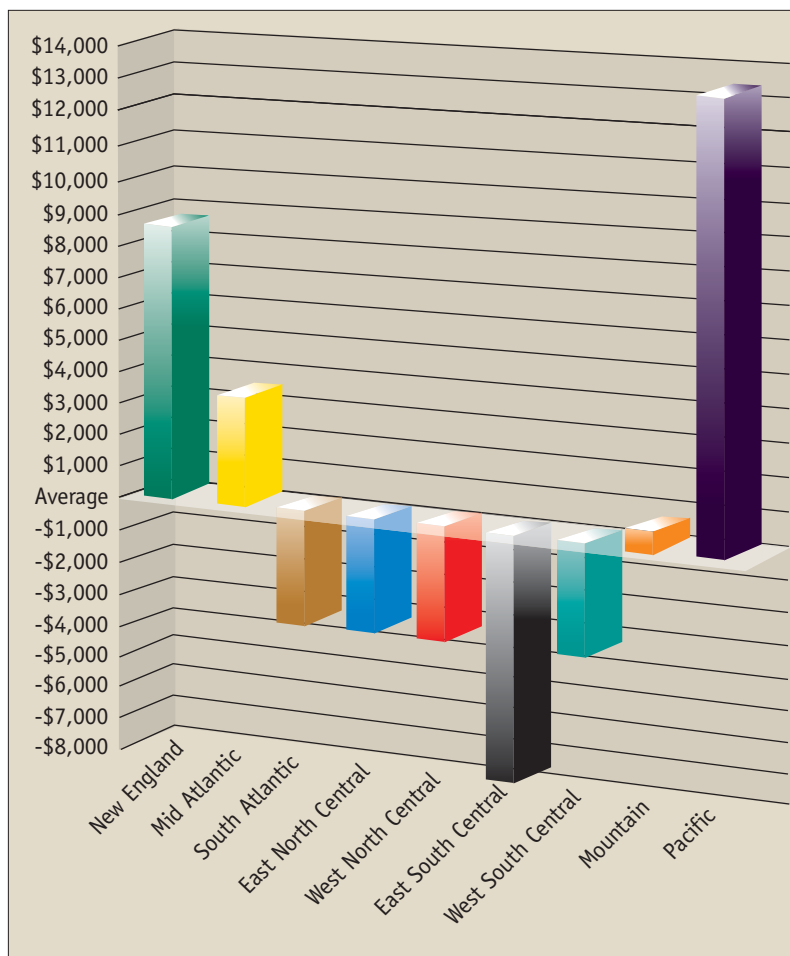
This raises the possibility that for these managers, size continues to affect pay in even larger facilities. For staff nurses, however, increasing size affects compensation up to nine ORs. Thereafter, the size/compensation relationship is not significant.

**POPULATION SETTING.** The location of the facility (ie, urban, suburban, rural) substantially influences compensation. Nurses earn an estimated \$6,600 less per year if they work in rural settings compared to \$6,100 less pay reported in last year's survey.

**TIME SPENT ON DIRECT PATIENT CARE.** 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, for example, earn about \$900 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 relationship is the same for nurse managers, educators, RN first assistants (RNFAs), nurse practitioners, private scrub nurses, and other nurses. Hospital and facility administrators and directors/VPs/assistant directors of nursing earn \$1,700 more per year for every 10% decrease in percentage of time spent on direct patient care.

**GEOGRAPHIC REGION.** After controlling for all variables previously discussed, geographic region explained significant differences in compensation levels across the United States. As shown in Figure 3, nurses working in the Pacific region

***Although all nurses earn more at larger facilities, this is particularly true for nurses who work in high-level management positions.***



**Figure 3 • Salary adjustments based on region.**

ministrators and directors/VPs/assistant directors of nursing earn about \$470 per year of experience, and this relationship continues beyond 18 years. On average, these individuals reported 20 years of work experience.

**NURSE COMPENSATION BASIS.** Whether or not a nurse is paid on an hourly basis or on salary is related to base compensation level. Salaried employees earn \$2,200 more per year than the average, while hourly employees earn about \$1,400 less per year.

**CERTIFICATION.** A total of eleven types of certification were examined:

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

Three types of certification were significantly related to compensation level. Nurses with CPAN earn \$3,800 more and CNOR-certified nurses earn \$600 more per year than average. Nurses or high-level managers with C certification made \$3,100 more. Without any of these three certifications, nurses or high-level managers earn \$750 less on average.

Of particular note is that these findings are qualified by the small number of nurses in the sample who hold eight

make \$13,300 more than the average compensation. Nurses working in New England also earn substantially more than the average (ie, \$8,500) while nurses in the East South Central region earn considerably less (ie, -\$7,800). The South Atlantic, East North Central, West North Central, and West South Central regions all show the same negative adjustment (ie, -\$3,400) to the average base compensation.

**WORK EXPERIENCE.** The regression model suggests that all nurses earn about \$660 more per year for each year of experience, up to 18 years. Beyond that point, additional experience is not related to increases in base compensation. The results for this survey are based on an average of 13 years of experience. Nurses with more or less than this amount can add or subtract \$660 per year of experience to estimate their base compensation. This adjustment is the same as was reported last year. Interestingly, hospital/facility ad-

of the types of certification. Although 56% of respondents had CNOR certification, only a small percentage held BC, C, CNA, CNA, CPAN or CAPA, CPSN, CRNFA, or ONC certifications. Of these other certifications, only BC and CRNFA are held by more than 1% of the sample (ie, BC at 2%, CRNFA at 3%). In this regard, however, 33% of the respondents said that their facility pays more for nurses holding a nursing certification. In response to a follow-up question, 77% of the respondents said they receive extra compensation for CNOR certification, 10% receive extra compensation for CRNFA certification, and 8% receive extra compensation for CPAN or CAPA certification. Four percent or fewer mentioned one of the other certifications. Although it appears that some nurses are receiving extra compensation for a variety of certifications, the number of some certifications was too small to render a statistically significant effect in regression analysis.

**EDUCATION LEVEL.** Nurses with an MS in nursing add an additional \$2,700 in annual base compensation. Nurses holding an MS in another field receive \$3,300 more in yearly pay. A BSN, BS in another field, diploma, or associate's degree was not significantly related to annual compensation. When asked directly, only one-quarter of the respondents said their facility pays more for having a degree in nursing. In most facilities, therefore, the effect of a nursing degree on compensation does not appear to be as strong as the effect of CPAN, C, or CNOR certification.

**FACILITY TYPE.** The regression model results indicate that several adjustments to base compensation based on facility type are appropriate to form the best estimate of average compensation. Nurses working in ASCs often make less money than other nurses, including those working in free-standing ASCs (ie, \$2,700 less) and those working in hospital-based ASCs (ie,

\$500 less). On average, respondents who work in an office-based ASC earn \$2900 less in base compensation. Nurses who work in an acute care general hospital earn \$500 less. Respondents working in specialty acute care hospitals, university acute care hospitals, other acute care hospitals, and university ASCs make, on average, \$2,300 more in base compensation.

**COLLECTIVE BARGAINING UNIT.** Relatively few respondents (ie, 6%) report working in an environment with a union or collective bargaining unit. Nurses who work in a unionized setting, however, earn an average of \$4,000 more in annual base compensation than do nurses employed in a nonunion workplace.

**MARITAL STATUS.** Whether nurses are married, single, or divorced did not significantly affect base compensation. Nurses with one or more children younger than age 18 living at home, however, receive \$700 less pay than do other nurses.

**GENDER.** The influence of gender on compensation level was tested after controlling for the effects of all of the aforementioned variables. As with last year's findings, the results are not statistically significant ( $P = .087$ ). These results for the last two years suggest that the gender differential observed in the first two AORN salary surveys has substantially diminished.

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 generally are accurate enough so that two-thirds of nurses or

*The influence of gender on compensation level suggests that gender differential has substantially diminished in recent years.*

**TABLE 3**  
**Mean Pay Raises by Job Title\***

Job title	Percentage of pay raise
Staff nurse	3.4
Hospital/facility administrator	4.5
Director/vice president/ assistant director of nursing	4.2
Nurse manager/supervisor/ coordinator/team leader/ business manager	3.9
Educator/staff development	3.6
Educator/faculty member	3.3
Clinical nurse specialist (ie, master of science degree or higher)	3.3
RN first assistant	3.6
Other	3.6

\* Nurse practitioners were excluded because of the small sample size (ie, 6 respondents). None of the consultants answered pay raise questions.

managers who fit a particular profile will see an annual base compensation within \$12,000 of base compensation estimated by the model.

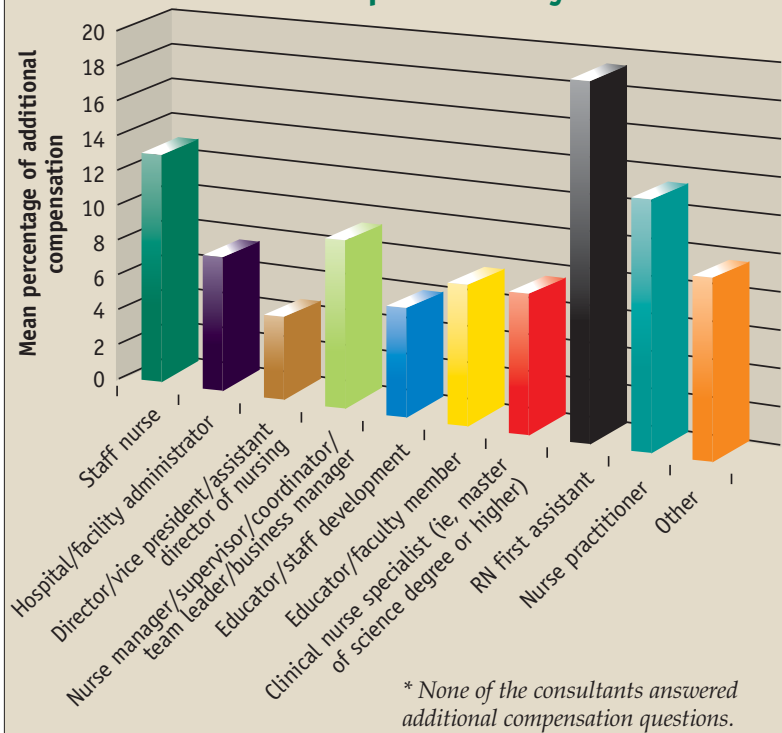
**OTHER COMPENSATION ISSUES**

In questions unrelated to the base compensation model, 83.8% of the respondents reported having received a raise this year (Table 3). For those receiving raises, the mean pay raise for staff nurses was 3.4%. Pay raises were slightly higher for those with greater management responsibilities. Hospital/facility administrators received an average 4.5% pay raise, and directors/VPs/assistant directors averaged a 4.2% pay raise.

The regression analysis previously described also applies to base compensation. In the present sample, 57% of the respondents receive additional compensation from a variety of sources including overtime, shift differential, on-call compensation, and bonuses compared to 56% last year. Although the average perioperative nurse received 10% additional compensation, the actual amount of additional compensation differed substantially and differed by title. The mean percentage of additional compensation, by title, is shown in Figure 4.

The responses show that RNFAs received the largest compensation relative to base pay (ie, 19%) followed by nurse practitioners (ie, 13%) and staff nurses (ie, 13%). These top three in rank are the same as was reported last year. As expected, directors, VPs, and assistant

**FIGURE 4**  
**Additional Compensation by Title\***



\* None of the consultants answered additional compensation questions.

**TABLE 4**  
**Average Hours Per Week Overtime and**  
**Percentage of Respondents that are Salaried\***

<b>Job title</b>	<b>Average hours per week overtime</b>	<b>Percentage salaried</b>
Staff nurse	4.9	4.4
Hospital/facility administrator	4.4	93.5
Director/vice president/ assistant director nursing	6.8	93.7
Nurse manager/supervisor/ coordinator/team leader/ business manager	6.1	50.3
Educator/staff development	4.1	56.3
Educator/faculty member	3.3	52.6
Clinical nurse specialist (ie, master of science degree or higher)	4.5	86.4
RN first assistant	7.1	22.0
Other	4.8	47.2

\* Nurse practitioners were excluded because of the small sample size (ie, 10).  
 None of the consultants answered overtime pay questions.

directors received the smallest additional compensation relative to base pay (ie, 4%).

**ON-CALL COMPENSATION.**

More than half of the respondents (ie, 56%) report that they take call. For those who take call, the median number of hours per week on call is 16. This is the same number that was reported in last year's survey. Among the on-call respondents, 72% receive a dollar-per-hour amount for being on call compared to 70% last year, 5% receive a percentage

of their base pay compared to 7% last year, and 17% receive no compensation, which is unchanged from last year. Among those who receive dollar-per-hour pay, the median pay is \$2.50 per hour. This amount also is unchanged from last year. When called in, 63% receive time-and-a-half pay compared to 59% last year, and 7% get straight time pay, which is unchanged from last year. Instead of pay, 4% of the on-call respondents receive compensation time compared to 5% last year.

**OVERTIME COMPENSATION.** A large majority of respondents work overtime (ie, 82% compared to 83% last year), and they work an average of 6.6 overtime hours each week compared to six hours in last year's findings. Most of those who work overtime receive time-and-a-half pay (ie, 62% compared to 63% last year), but 28% receive no additional compensation, which is unchanged from last year. Almost all of those who do not receive pay for overtime are salaried (ie, 97% compared to 96% last year). As shown in Table 4, RNFAAs average the most overtime (ie, 7.1 hours per week) followed closely by directors/VPs/assistant directors (ie, 6.8

hours). Respondents working the least amount of overtime are educators/faculty members (ie, 3.3 hours) and those in educator/staff development positions (ie, 4.1 hours).

**HIRING BONUSES.** Relatively few of the respondents (ie, 14%) received a hiring bonus when they were hired, but 21% report that their employer now offers a hiring bonus for their position. This percentage is the same as last year, and bonuses typically range from \$2,500 to \$5,000. The employees who are most likely to receive a hiring bonus are staff nurses (ie, 27%); nurse managers (ie, 17%); and RNFAAs (ie, 17%). Hospital administrators are least likely to receive a hiring bonus (ie, 4%). These findings differ somewhat from last year's survey, which found educator/staff development employees (ie, 17%) were among the top three jobs offering hiring bonuses.

**SHIFT AND OTHER DIFFERENTIALS.** Among the respondents, 91% work the day shift, and 4% work afternoons/evenings. Very few respondents work nights, weekend days, or weekend nights (ie, less than 1% of the sample). For those who do work

## ***Respondents voiced dissatisfaction with overall pay given the amount of expertise, responsibility, long hours, and stress that is involved in perioperative nursing.***

the afternoon/evening shift, the median differential is \$2.50/hour or 11% of base pay (compared to \$2.50 and 10% of base pay for last year).

### **BENEFITS**

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

- health insurance (ie, 95%);
- dental insurance (ie, 88%);
- life insurance (ie, 87%);
- earned time or paid time off (ie, 85%);
- bereavement leave (ie, 83%);
- jury duty compensation (ie, 76%);
- 401(k) contributions (ie, 70%);
- tuition reimbursement (ie, 69%);
- long-term disability (ie, 65%);
- free/discounted parking (ie, 64%);
- short-term disability (ie, 61%);
- pension plan (ie, 50%);
- paid conference travel (ie, 40%);
- employee referral bonus (ie, 38%);
- paid certification examinations (ie, 36%);
- tax-sheltered annuity plan (ie, 36%);
- pharmacy discounts (ie, 33%);
- flexible scheduling (ie, 28%);
- incentive bonuses (ie, 17%);
- malpractice insurance (ie, 15%);
- relocation assistance (ie, 11%);
- retention bonuses (ie, 6%);
- subsidized child/elder care (ie, 5%);
- and
- life quality service (eg, dry cleaning) (ie, 4%).

This year's top five benefits are the same as those reported last year.

### **COMMENTS ON COMPENSATION**

The survey asked respondents to provide any comments they wanted to express about compensation. Although some respondents said that they were satisfied with their compensation, most of the respondents expressed decidedly negative sentiments. Most apparent is a frustrating dissatisfaction with overall pay given the amount of expertise, re-

sponsibility, long hours, and stress that is involved in perioperative nursing and the degree of physical hazards that perioperative nurses encounter on the job. One respondent wrote, "Nursing pay seems to be the only area in which the law of supply and demand does not apply."

A nurse from Connecticut wrote:

*I have been a nurse for 30 years and feel we will never make what we should. . . . The patient's safety depends on the nurse who cares for them. I often think we should be able to bill insurance companies for our expertise. We are worth more!*

Another RN wrote, "Forget about the free lunch boxes and backpacks. We need MONEY and the support of administration."

The most frequently-cited concerns, aside from overall pay, were

- insufficient compensation for on-call,
- the failure to reward nurses for certifications and higher levels of education, and
- pay compression.

One respondent noted:

*Nurses should be compensated based on their education, experience, and certifications. . . . Nurses are not compensated based on their unique skills. Not all nurses are the same. "A nurse is a nurse" no longer works in today's health care system.*

A second commented, "I am resentful that after 30 years as an OR nurse, new nurses earn close to what I earn. How is this possible?" Another nurse wrote:

*I see hard-working, compassionate, and caring individuals who love their jobs but [who] are overworked and underpaid. Many nurses who have mandated overtime are leaving their careers due to this problem.*

**UPDATE ON THE STAFFING SHORTAGE**

The nursing shortage continues with little change from last year. The median percentage of vacant full-time employee nursing positions is 4.3% compared to 5.5% last year. This year, 49% of high-level managers reported that the nursing shortage has created a moderate- to crisis-level effect on their working environment compared to 51% last year. Among nurses in this year's sample, 72% reported a moderate- to crisis-level effect compared to 70% last year. As expected, the effect that the nursing shortage has on patient care tends to be rated more severely by those with the most patient contact. Approximately 75% of staff nurses rate the shortage as having a moderate- to crisis-level effect compared

with 65% of nurse managers, 54% of directors/VPs/assistant directors of nursing, and 23% of facility/hospital administrators. Although nurses currently appear to feel the shortage more than managers do, those in high-level management positions increasingly may be aware of the shortage problem.

**CHANGES IN THE PERIOPERATIVE WORKPLACE**

This year, respondents were asked to rate how aspects of the perioperative nursing workplace have changed during the last three years on a scale of one (ie, much worse) to five (ie, much better). As shown in Figure 5, most of the averages for nurses are above three, indicating that these situations are getting a little better. For high-level managers,

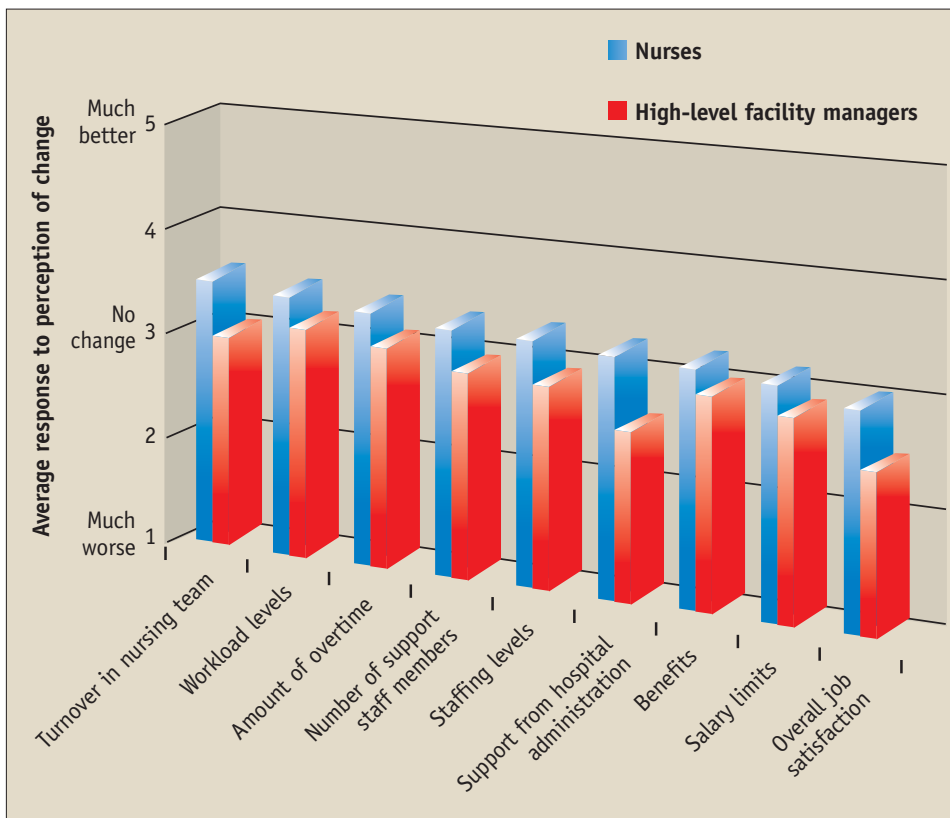
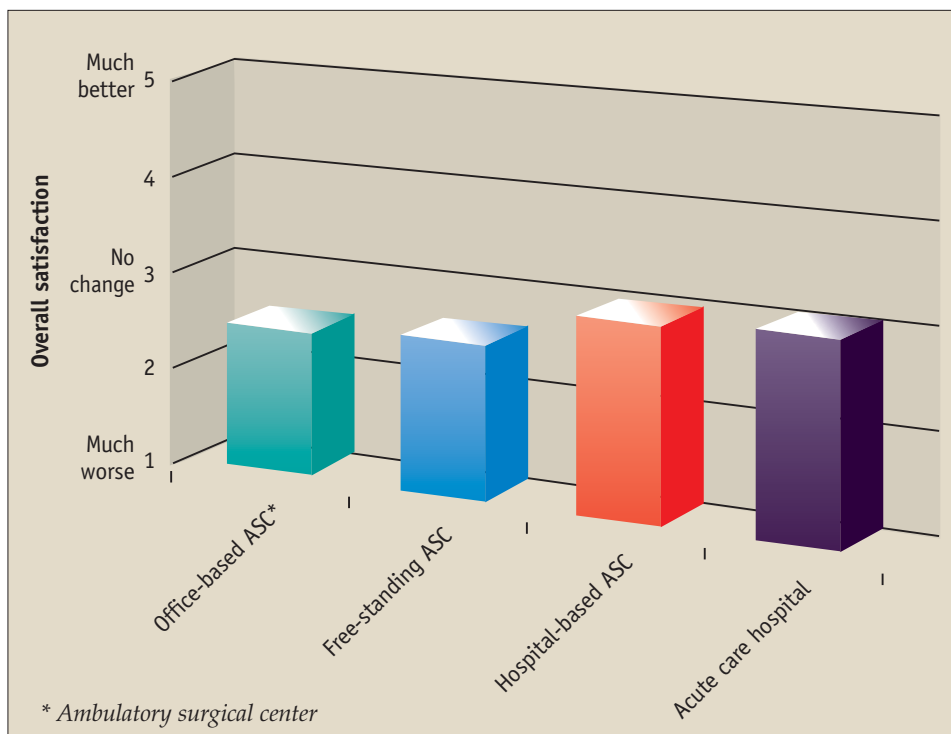


Figure 5 • Perceived change in aspects of the perioperative nursing workplace.

**Figure 6 •**  
Change in overall job satisfaction by workplace type during the preceding three years.



however, most of the averages are below three, indicating these situations are getting a little worse. For example, nurses on average believe that turnover and staffing levels are getting slightly better, while most high-level managers believe the situation is just slightly worse. Note also the difference in the means of job satisfaction changes between perioperative nurses (ie, 2.98) and high-level managers (ie, 2.48).

As Figure 6 shows, changes in overall job satisfaction during the last three years differ by workplace type. This analysis includes all respondents except those employed in workplace types with fewer than 40 respondents. Those who work in office-based and free-standing ASCs have seen a greater decline in their overall satisfaction than have respondents in acute care hospitals. It is possible, however, that the satisfaction level for the ASC respondents three years ago was

higher than for the acute care hospital respondents. Thus, one cannot generalize that acute care hospital respondents are now more satisfied with their jobs than are respondents in office-based or free-standing ASCs. ♦

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