

Utah Medical Education Council
Registered Nurse Workforce Survey 2014

Demographics

1. Please indicate your gender and age: Gender: Female Male ___Age
2. What is your ethnic/racial background? (please mark only one)
 American Indian/Alaska Native African American Asian Hispanic/Latino
 Native Hawaiian/Pacific Islander White/Caucasian Other (please specify) _____
3. Please describe the area where you spent the majority of your upbringing (when you lived there):
 Rural Suburban Urban/Metropolitan Area State: _____

Licensure/Education Information

4. Did you work any of the following health related jobs before completing your initial RN education?
 No Health Related Position Before RN Education Medical Assistant
 Nursing Aide or Nursing Assistant Laboratory Technician
 Home Health Aide or Assistant Radiological Technician
 Licensed Practical or Vocational Nurse Manager in Health Care Setting
 Emergency Medical Technician (EMT) or paramedic Military Medical Corps
 Other Type of Health Related Position: (please specify) _____
5. What type of nursing degree/credential qualified you for your first U.S. nursing license?
 Vocational/Practical Certificate-Nursing Baccalaureate Degree-Nursing
 Diploma -Nursing Master's Degree-Nursing
 Associate Degree-Nursing Doctorate Degree-Nursing
6. In what state did you receive your nursing degree/credential that qualified you for your initial RN License?
State: _____
7. What year did you obtain your first U.S. RN License? Year: _____
a. Please specify any other country where you have obtained an RN license: Country: _____
8. How did you finance your initial RN education? Please mark all that apply
 Earnings From Your Health-Care-Related Employment Employer Tuition Reimbursement Plan
 Earnings From Your Non-Health-Care-Related Employment Federally Assisted Loan
 Earnings From Other Household Members Other Type of Loan
 State or Local Government Scholarship or Grant Personal Household Savings
 Other Family Resources (Parents or Other Relatives) Non-Government Scholarship or Grant
 Other Resources Educational Institution Scholarship
9. What is your highest level of education?
 Diploma-Nursing Master's Degree-Nursing
 Associate-Nursing Master's Degree-Non-Nursing
 Associate Degree-Non-Nursing Doctoral Degree-Nursing (PhD)
 Baccalaureate Degree-Nursing Doctoral Degree- Nursing practice (DNP)
 Baccalaureate Degree-Non-Nursing Doctoral Degree-Nursing Other
 Doctoral Degree- Non-Nursing

Employment Information

10. Please indicate your average number of work hours per week: *(please mark N/A if It doesn't apply)*

In Utah: _____ *(if no out of state hours, skip a. & b. below)* Out of Utah: _____ *(continue to a. below)*

a. **If you indicated Out of State hours, please list the one state where you provide the majority of services outside of Utah:** _____

b. **If you do not provide any health care services in Utah...**

i. **Please list the reason(s) you maintain a Utah license:**

ii. **Please indicate the ONE main reason why you no longer practice in Utah:**

(please provide only one reason) _____

11. Please indicate the type(s) of position(s) you hold: *(please mark all that apply)*

- Full Time Nursing
- Full Time Non-Nursing
- Faculty-Nursing
- Single Employment Position
- Part Time Nursing
- Part Time Non-Nursing
- Retired
- Multiple Employment Positions
- Contractor-Nursing
- Temporary-Nursing
- Volunteer in Nursing
- Unemployed-Seeking Work as Nurse
- Unemployed-Not Seeking Work as a Nurse

b. **If you marked above that you are a contractor, on average, how many contracts do you provide services for per month?** _____

c. **If you marked you were unemployed in the previous question, please indicate your reason for being unemployed** *(please mark all that apply):*

- Taking Care of Home
- Taking Care of Family
- Disabled
- Inadequate Salary
- Attending School
- Difficulty Finding Nursing Position
- Other *(please specify)* _____

12. Please indicate the practice Name, Zip Code of your primary practice/contracting location as well as that of any other location(s) *(if applicable)*. **Also, Please estimate the total hours worked per week** *(not including on call)* **at each practice location.**

Primary Practice/Contract	Name: _____	Zip: _____	Total hrs/wk: _____
Secondary Practice/Contract	Name: _____	Zip: _____	Total hrs/wk: _____
Other Practice/Contract	Name: _____	Zip: _____	Total hrs/wk: _____

13. Please identify the type of setting that most closely corresponds to your nursing practice position

(P-Primary Setting, S- Secondary Setting)

- | P | S | | P | S | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Hospital | <input type="checkbox"/> | <input type="checkbox"/> | School Health Service |
| <input type="checkbox"/> | <input type="checkbox"/> | Home Health | <input type="checkbox"/> | <input type="checkbox"/> | Occupational Health |
| <input type="checkbox"/> | <input type="checkbox"/> | Correctional Facility | <input type="checkbox"/> | <input type="checkbox"/> | Ambulatory Care Setting |
| <input type="checkbox"/> | <input type="checkbox"/> | Academic Setting | <input type="checkbox"/> | <input type="checkbox"/> | Insurance Claims/Benefits |
| <input type="checkbox"/> | <input type="checkbox"/> | Public Health | <input type="checkbox"/> | <input type="checkbox"/> | Policy/Planning/Regulatory/Licensing |
| <input type="checkbox"/> | <input type="checkbox"/> | Community Health | <input type="checkbox"/> | <input type="checkbox"/> | Other |
| <input type="checkbox"/> | <input type="checkbox"/> | Nursing Home/Extended Care/
Assisted Living Facility | <input type="checkbox"/> | <input type="checkbox"/> | Specify _____ |

14. Have you changed your primary work setting within the last year?

Yes *(answer a. below)* No *(proceed to next question)*

a. **Please indicate the work setting you moved FROM based on the setting categories from the previous question:** _____

15. Please rank the top three employer-offered benefits that factored in your decision to work where you are currently employed?(please place a 1,2 or 3 next to three of the following options, please only rank three of the options)

- | | | | |
|-----------------------------------|----------------------------|----------------------------|----------------------|
| ___ Paid Vacation | ___ Annual Signing Bonus | ___ Retirement Plan | ___ Health Insurance |
| ___ Base Salary | ___ Schedule Flexibility | ___ Pension | ___ Upward Mobility |
| ___ Annual Raise | ___ Reputation of Facility | ___ Shift Differential Pay | |
| ___ Other: (please specify) _____ | | | |

16. Do you precept/mentor nursing students? Yes No

If yes, how many do you mentor per academic year? _____

- a. If yes, have you experienced any of the following as a result of being a preceptor/mentor? Burnout Stress Inadequate Compensation Inconvenience
- b. If you do not currently precept/mentor students, would you like to in the future? Yes No
- c. If no, please briefly explain why not: _____

17. Please indicate what level of care or type of work that most closely corresponds to your nursing position.

- | | | | | | |
|--------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|---|
| P | S | | P | S | |
| <input type="checkbox"/> | <input type="checkbox"/> | General or Specialty Inpatient | <input type="checkbox"/> | <input type="checkbox"/> | Surgery(pre-op &post-op) |
| <input type="checkbox"/> | <input type="checkbox"/> | Critical/Intensive Care | <input type="checkbox"/> | <input type="checkbox"/> | Ambulatory Care |
| <input type="checkbox"/> | <input type="checkbox"/> | Step-down, Transitional, Telemetry | <input type="checkbox"/> | <input type="checkbox"/> | Ancillary Care |
| <input type="checkbox"/> | <input type="checkbox"/> | Sub-acute Care | <input type="checkbox"/> | <input type="checkbox"/> | Home Health |
| <input type="checkbox"/> | <input type="checkbox"/> | Emergency | <input type="checkbox"/> | <input type="checkbox"/> | Public Health/Community Health |
| <input type="checkbox"/> | <input type="checkbox"/> | Urgent Care | <input type="checkbox"/> | <input type="checkbox"/> | Education |
| <input type="checkbox"/> | <input type="checkbox"/> | Rehabilitation | <input type="checkbox"/> | <input type="checkbox"/> | Business, Administration, Case management |
| <input type="checkbox"/> | <input type="checkbox"/> | Long-Term Care/Nursing Home | <input type="checkbox"/> | <input type="checkbox"/> | Research |
| <input type="checkbox"/> | <input type="checkbox"/> | Other:(please specify) _____ | | | |

18. Please indicate the clinical specialty in which you currently practice.

(mark the specialty you spend the most time practicing in under primary. If applicable, mark the specialty you spend the next most time practicing in under secondary.) **Mark only one in each column.**

- | | | | | | |
|--------------------------|--------------------------|---------------------------------|--------------------------|--------------------------|------------------------------|
| P | S | | P | S | |
| <input type="checkbox"/> | <input type="checkbox"/> | No Patient Care | <input type="checkbox"/> | <input type="checkbox"/> | Labor and Delivery |
| <input type="checkbox"/> | <input type="checkbox"/> | General Medical Surgical | <input type="checkbox"/> | <input type="checkbox"/> | Neurological |
| <input type="checkbox"/> | <input type="checkbox"/> | Critical Care | <input type="checkbox"/> | <input type="checkbox"/> | Obstetrics |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiac or Cardiovascular Care | <input type="checkbox"/> | <input type="checkbox"/> | Occupational Health |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Care | <input type="checkbox"/> | <input type="checkbox"/> | Oncology |
| <input type="checkbox"/> | <input type="checkbox"/> | Dermatology | <input type="checkbox"/> | <input type="checkbox"/> | Primary Care |
| <input type="checkbox"/> | <input type="checkbox"/> | Emergency or Trauma Care | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric or Mental Health |
| <input type="checkbox"/> | <input type="checkbox"/> | Gastrointestinal | <input type="checkbox"/> | <input type="checkbox"/> | Pulmonary |
| <input type="checkbox"/> | <input type="checkbox"/> | Gynecology (Women’s Health) | <input type="checkbox"/> | <input type="checkbox"/> | Radiology |
| <input type="checkbox"/> | <input type="checkbox"/> | Hospice | <input type="checkbox"/> | <input type="checkbox"/> | Renal/Dialysis |
| <input type="checkbox"/> | <input type="checkbox"/> | Infections/Communicable Disease | <input type="checkbox"/> | <input type="checkbox"/> | Other:(please specify) _____ |

19. Please indicate the patient population you spend at least 50% of your patient care time with.

- | P | S | | P | S | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | No Patient Care | <input type="checkbox"/> | <input type="checkbox"/> | Newborn or Neonatal |
| <input type="checkbox"/> | <input type="checkbox"/> | Adult | <input type="checkbox"/> | <input type="checkbox"/> | Pediatric and/or Adolescent |
| <input type="checkbox"/> | <input type="checkbox"/> | Geriatric | <input type="checkbox"/> | <input type="checkbox"/> | Pre-natal |
| <input type="checkbox"/> | <input type="checkbox"/> | Multiple Age Groups(<i>less than 50% time spent with any of the above</i>) | <input type="checkbox"/> | <input type="checkbox"/> | Other: Specify: _____ |

20. Please identify the primary position title that most closely corresponds to your nursing position:

- | | | |
|---|--|---|
| <input type="checkbox"/> Consultant | <input type="checkbox"/> Nurse Manager | <input type="checkbox"/> Staff Nurse |
| <input type="checkbox"/> Nurse Researcher | <input type="checkbox"/> Nurse Educator-Clinical Setting | <input type="checkbox"/> Other-Health Related |
| <input type="checkbox"/> Nurse Executive-Clinical | <input type="checkbox"/> Nurse Educator-Academic Setting | <input type="checkbox"/> Other-Not Health Related |
| <input type="checkbox"/> Nurse Executive-Academic | <input type="checkbox"/> Advanced Practice Nurse | <input type="checkbox"/> Nurse Care Manager |

21. What is your average annual gross (before tax) income excluding benefits?

- | | | |
|--|--|--|
| <input type="checkbox"/> <\$20,000 | <input type="checkbox"/> \$50,000-\$59,999 | <input type="checkbox"/> \$90,000-\$99,999 |
| <input type="checkbox"/> \$20,000-\$29,999 | <input type="checkbox"/> \$60,000-\$69,999 | <input type="checkbox"/> \$100,000-\$109,999 |
| <input type="checkbox"/> \$30,000-\$39,999 | <input type="checkbox"/> \$70,000-\$79,999 | <input type="checkbox"/> \$110,000-\$200,000 |
| <input type="checkbox"/> \$40,000-\$49,999 | <input type="checkbox"/> \$80,000-\$89,999 | <input type="checkbox"/> >\$200,000 |

22. How many years have you been with your current primary employer? _____

23. In how many years do you plan on retiring? _____

24. Do you plan to leave your primary work setting?

- Yes, within 1 year
- Yes, in 1 to 3 years
- No plans to leave within the next 3 years
- Undecided

25. If you plan to leave your primary work position within 3 year, do you:

- Plan to move to another nursing position
- Plan to leave the nursing field temporarily but return in the future (*see a. and b. below*)
- Plan to leave the nursing field permanently (*see c. below*)

a. If you plan to leave the nursing field temporality, what is your reason for planning to leave?

b. When do you plan to return to nursing? _____

c. If you plan to leave the nursing field permanently, what is your primary reason?

- | | |
|--|--|
| <input type="checkbox"/> Retirement | <input type="checkbox"/> Skills Are Out of Date |
| <input type="checkbox"/> Taking Care of Home and Family | <input type="checkbox"/> Liability Concerns |
| <input type="checkbox"/> Salaries Too Low/Better Pay Elsewhere | <input type="checkbox"/> Inability to Practice Nursing on a Professional Level |
| <input type="checkbox"/> Stressful Work Environment | <input type="checkbox"/> Lack of Advancement Opportunities |
| <input type="checkbox"/> Scheduling/Inconvenient Hours | <input type="checkbox"/> Lack of Good Management or Leadership |
| <input type="checkbox"/> Physical Demands of the Job | <input type="checkbox"/> Career Change |
| <input type="checkbox"/> Disability | <input type="checkbox"/> Travel |
| <input type="checkbox"/> Illness | <input type="checkbox"/> To Seek More Education |
| <input type="checkbox"/> Inadequate Staffing | <input type="checkbox"/> Lack of Collaboration/Communication Between Health Care Professionals |
| <input type="checkbox"/> Burnout | |
| <input type="checkbox"/> Other:(please specify)_____ | |

THANK YOU VERY MUCH FOR YOUR PARTICIPATION. PLEASE RETURN THE SURVEY IN THE PROVIDED POSTAGE PAID ENVELOPE.