

# **An Exploration of Factors that influence End of Career Nurses' Decision Making regarding their Workforce Participation**

**Submitted by**

**Catriona Anne Booker**

**RN, RM, BN, MNurs Leadership**

**This thesis submitted in total fulfillment of the requirements of the degree of  
Doctor of Philosophy**

**School of Educational Leadership**

**Faculty of Education**

**Australian Catholic University**

**Research Services**

**Locked Bag 4115,**

**Fitzroy, Victoria 3065**

**Australia**

**January 2011**

## STATEMENT OF AUTHORSHIP AND SOURCES

This thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma.

No other person's work has been used without due acknowledgement in the main text of the thesis.

This thesis has not been submitted for the award of any degree in any other tertiary institution.

All research procedures reported in the thesis received the approval of the relevant Ethics Committees (Appendix B and C).

Signed:  Date: 28.01.2011

Catriona Anne Booker

## ACKNOWLEDGEMENTS

Many people have afforded me a great deal of assistance and encouragement and I would like to acknowledge their contribution.

Firstly, I would like to acknowledge the nurses for their generosity and candour who unselfishly contributed to this thesis by sharing their insights through surveys and interviews.

Secondly, I am indebted to my academic supervisors at the Australian Catholic University. To my principal supervisor, Associate Professor Denis McLaughlin, who has been a constant source of wisdom as he challenged, encouraged, inspired me through offering direct and often difficult feedback in order to meet the project demands. To my associate supervisor, Associate Professor Karen Flowers for her continual guidance, encouragement and absolute professionalism given to me throughout this course of this study. To Mr. Bill Foster, who through his passion for education and diligent proof reading facilitated my exposure to the statistical aspects of research.

Thirdly, I acknowledge the support and encouragement given to me by my employer, colleagues and friends with a special thank you to Dr Yvonne Osborne who ignited my motivation to begin and consequently complete this journey through her mentorship.

My sincere gratitude is given to my children Rebecca, Nathan and Tamara whose unwavering support and encouragement allowed me to prioritise my study needs over theirs. Heartfelt thanks goes to my parents Gloria and Ian (dec.) who as my first teachers taught me about life, honesty, integrity, resilience and persistency. I look forward to regaining a sense of normality and look forward to socialising with family and friends again.

*The virtue lies in the struggle, not in the prize.*

*Richard Monckton Milnes*

## ABSTRACT

As healthcare faces a critical shortage of qualified nursing staff, the ageing nursing workforce is further challenged as the 'Baby Boomer' generation approaches retirement age by 2010. While current retention strategies are focused on recruitment, little is known about the reasons for the end of career nurses'<sup>1</sup> (EOCNs') premature retirement or their resilience to remain in the profession. For the purpose of this thesis, the term EOCN is defined as registered nurses aged from 45 years and above, regardless of their length of service in the profession.

The purpose of this research is to explore factors that influence EOCNs' decisions regarding their workforce participation. The context of this research is within an acute tertiary hospital in Brisbane, Queensland.

The following research questions emerged from a synthesis of the literature. These questions focused the conduct of the study:

- 1) How do workplace environmental factors influence the EOCNs' decision regarding workforce participation?
- 2) How do leadership factors influence the EOCNs' decision regarding workforce participation?
- 3) How do personal and professional recognition factors influence the EOCNs' decision regarding workforce participation?
- 4) How does a balance between effort and reward influence the EOCNs' decision regarding workforce participation?

Given the focus of this thesis, an interpretive approach was considered appropriate. Within a constructionist epistemology, symbolic interactionism has been adopted as the lens to inform the theoretical perspective of this study. The methodology adopted is case study. Data were collected from 218 participants (Registered Nurses (RNs) aged 45 years and over) through surveys, focus groups and in-depth semi-structured interviews.

---

<sup>1</sup> End of Career Nurses (EOCNs): Registered nurse aged 45 years and over, regardless of their length of service in the profession.

Three major conclusions drawn from this research contribute to new knowledge, practice and policy.

Contributions to new knowledge highlight the pivotal role that leaders play in the development of a shared and nurturing workplace culture which considers the work satisfaction and personal recognition of staff. However, in the absence of leadership support, staff found personal and professional friendships a strong motivator to remain in the organisation. Effort and reward balance was a critical aspect in the achievement of work satisfaction. This study highlights the complexities and diversity of effort factors together with specific reward components which leaders should honour in order to optimise a balance between effort and reward.

Contributions to practice illuminate the commitment of the experienced nurse to support their colleagues in the workplace. The commitment to support colleagues may become a reality when relevant professional development programs are accessible in order to maintain contemporary skills. In addition, a shared learning culture in the workplace fosters recognition and celebration of exchange of knowledge. Physical working conditions such as heavy workloads were also found to compromise health and wellbeing of staff. This situation has implications for leaders in the review of work practices and job design in order to promote an environment that fosters and supports a safe and healthy workplace.

Finally, contributions to policy identified a lack of organisational policy which is sensitive to the older worker. Leaders and policy developers need to support an age sensitive culture which reflects the principles of antidiscrimination, a safe and healthy environment, and pre-retirement planning opportunities.

## ACRONYMS

ABS	Australian Bureau of Statistics
AIDS	Acquired Immune Deficiency Syndrome
AIHW	Australian Institute of Health and Welfare
AIN	Assistant in Nursing
ANF	Australian Nurses' Federation
BPF	Business Planning Framework
CN	Clinical Nurse
CNC	Clinical Nurse Consultant
EDNS	Executive Director of Nursing Services
EN	Enrolled Nurse
EOCN	End of Career Nurse
ERI	Effort–Reward Imbalance
GFC	Global Financial Crisis
HIV	Human Immunodeficiency Virus
ICN	International Council of Nurses
KPIs	Key Performance Indicators
NFR	Not for Resuscitation
NM	Nurse Manager
NO	Nursing Officer
NSIs	Nurse Sensitive Indicators
NUM	Nurse Unit Manager
PDA	Professional Development Allowance
QH	Queensland Health
QNU	Queensland Nurses' Union
RN	Registered Nurse
SPSS	Statistical Package for Social Sciences (version 16.0.1 for Windows)
TOIL	Time off in Lieu
TTRP	Transition to Retirement Program
WHO	World Health Organization

# TABLE OF CONTENTS

<b>CHAPTER ONE: THE RESEARCH IDENTIFIED .....</b>	<b>1</b>
1.1 INTRODUCTION .....	1
1.2 RESEARCH CONTEXT .....	3
1.3 THE RESEARCH DESIGN .....	7
1.4 SIGNIFICANCE OF THE RESEARCH .....	9
1.5 THE OUTLINE OF THE THESIS .....	10
<b>CHAPTER TWO: DEFINING THE RESEARCH PROBLEM.....</b>	<b>12</b>
2.1 CONCEPTUALISING THE RESEARCH PROBLEM.....	12
2.2 PERSONAL CONTEXT.....	14
2.3 INTERNATIONAL NURSING SHORTAGE .....	16
2.4 QUEENSLAND HEALTH AND STUDY SITE (LOCAL) CONTEXT.....	27
2.5 THE RESEARCH PROBLEM DEFINED .....	34
<b>CHAPTER THREE: LITERATURE REVIEW .....</b>	<b>36</b>
3.1 INTRODUCTION .....	36
3.2 WORKPLACE ENVIRONMENT.....	41
3.3 LEADERSHIP.....	59
3.4 PERSONAL AND PROFESSIONAL RECOGNITION.....	74
3.5 EFFORT AND REWARD BALANCE .....	90
3.6 CONCLUSION.....	97
<b>CHAPTER FOUR: DESIGN OF THE RESEARCH.....</b>	<b>101</b>
4.1 INTRODUCTION .....	101
4.2 THEORETICAL FRAMEWORK .....	101
4.3 RESEARCH METHODOLOGY .....	106
4.4 PARTICIPANTS .....	110
4.5 DATA GATHERING STRATEGIES .....	113
4.6 ANALYSIS OF DATA .....	124
4.7 VERIFICATIONS .....	135
4.8 ETHICAL ISSUES .....	137
4.9 SUMMARY OF RESEARCH DESIGN .....	140
<b>CHAPTER FIVE: SURVEY FINDINGS.....</b>	<b>143</b>
5.1 DEMOGRAPHICS AND END OF CAREER NURSES' EMPLOYMENT HISTORY.....	144
5.2 WORKPLACE ENVIRONMENT.....	146
5.3 LEADERSHIP.....	152
5.4 PERSONAL AND PROFESSIONAL RECOGNITION.....	157
5.5 BALANCE OF EFFORT AND REWARD .....	163
5.6 OPEN-ENDED RESPONSES .....	166
5.7 SUMMARY OF SURVEY FINDINGS .....	171
5.8 SELECTION OF FOCUS GROUPS AND INDIVIDUAL INTERVIEW PROTOCOL.....	171

<b>CHAPTER SIX: FOCUS GROUP AND INTERVIEW FINDINGS .....</b>	<b>172</b>
6.1 INTRODUCTION .....	172
6.2 RESEARCH QUESTION 1.....	175
6.3 RESEARCH QUESTION 2.....	184
6.4 RESEARCH QUESTION 3.....	192
6.5 RESEARCH QUESTION 4.....	204
6.6 CONCLUSION.....	221
<b>CHAPTER SEVEN: DISCUSSION OF THE FINDINGS .....</b>	<b>223</b>
7.1 INTRODUCTION .....	223
7.2 LEADERSHIP MATURITY.....	224
7.3 LEVELS OF COMMITMENT TO WORK.....	231
7.4 SOCIAL CAPITAL .....	237
7.5 IMPACT OF CHANGE .....	242
7.6 CONSIDERATIONS OF THE OLDER WORKER.....	245
7.7 BALANCING DECISIONS.....	252
<b>CHAPTER EIGHT: CONCLUSIONS AND RECOMMENDATIONS.....</b>	<b>258</b>
8.1 THE PURPOSE OF THE STUDY .....	258
8.2 RESEARCH DESIGN.....	258
8.3 LIMITATIONS OF THE RESEARCH .....	260
8.4 RESEARCH QUESTIONS ADDRESSED.....	261
8.5 CONCLUSIONS OF THE STUDY .....	264
8.6 RECOMMENDATIONS .....	267
<b>REFERENCES .....</b>	<b>270</b>
<b>APPENDICES .....</b>	<b>292</b>
APPENDIX A: REGISTERED NURSES WORKFORCE DECISIONS SURVEY.....	292
APPENDIX B: HUMAN RESEARCH ETHICS COMMITTEE APPROVAL FORM .....	301
APPENDIX C: RBWH HSD ETHICAL APPROVAL LETTER.....	303
APPENDIX D: PARTICIPANT INFORMATION LETTER FOCUS GROUP .....	306
APPENDIX E: PARTICIPANT INFORMATION LETTER INDIVIDUAL INTERVIEW .....	311



## TABLE OF FIGURES

FIGURE 1.2:1 QUEENSLAND HEALTH: HEALTH SERVICE DISTRICTS .....	6
FIGURE 2.1:1 CONCEPTUALISATION OF THE RESEARCH PROBLEM. ....	13
FIGURE 2.4:1 SUMMARY OF VACANCIES AND RECRUITMENT OPTIONS 2008–2009 .....	29
FIGURE 3.1:1 CONCEPTUAL FRAMEWORK FOR THE LITERATURE REVIEW .....	39
FIGURE 3.5:1 EFFORT–REWARD IMBALANCE.....	93
FIGURE 4.5:1 STAGES OF DATA GATHERING STRATEGIES.....	115
FIGURE 4.6:1 INTERACTIVE PROCESS OF DATA ANALYSIS .....	127
FIGURE 5.1:1 TIMING OF INTENTIONS TO LEAVE THE STUDY SITE AND LEAVE NURSING .....	146
FIGURE 7.7:1 CONCEPTUAL VIEW OF FINDINGS .....	257

## TABLE OF TABLES

TABLE 3.1:1 SEQUENCE OF THE LITERATURE REVIEW .....	40
TABLE 3.5:1 OPTIONS OF WORKFORCE PARTICIPATION.....	90
TABLE 4.2:1 RESEARCH FRAMEWORK .....	102
TABLE 4.4:1 RESEARCH PARTICIPANTS.....	112
TABLE 4.5:1 FOCUS GROUP SCHEDULE.....	118
TABLE 4.5:2 IN-DEPTH SEMI-STRUCTURED INTERVIEW SCHEDULE.....	121
TABLE 4.5:3 SUMMARY OF ADVANTAGES, LIMITATIONS AND STRATEGIES TO ADDRESS LIMITATION OF DATA COLLECTION METHODS.....	123
TABLE 4.6:1 DATA COLLECTION AND ANALYSIS STAGES.....	126
TABLE 4.6:2 STAGE ONE INTERPRETATION OF RESPONSES FROM EXPLORATORY STAGE .....	129
TABLE 4.6:3 EXAMPLE OF INTERPRETING DATA .....	133
TABLE 4.8:1 DATA GATHERING AND ETHICAL CONCERNS AND CONSIDERATIONS.....	139
TABLE 4.9:1 OVERVIEW OF RESEARCH DESIGN AND ITS RELATIONSHIP TO THE FOUR RESEARCH QUESTIONS .....	141
TABLE 5.1:1 MATRIX OF RESEARCH QUESTIONS AND SURVEY ITEMS .....	143
TABLE 5.1:1 SUMMARY OF DEMOGRAPHIC AND EMPLOYMENT FINDINGS (N = 218).....	145
TABLE 5.2:1 WORKPLACE ENVIRONMENT ITEMS RANKED ACCORDING TO LEVEL OF AGREEMENT.....	147
TABLE 5.2:2 FACTOR ANALYSIS OF THE SEVEN WORKPLACE ENVIRONMENT ITEMS IN QUESTION 1 .....	148
TABLE 5.2:3 FACTORS EXTRACTED FROM THE SEVEN WORKPLACE ENVIRONMENT ITEMS.....	149
TABLE 5.2:4 GROUP STATISTICS: GENDER AND THE THREE WORKPLACE ENVIRONMENT FACTOR SCORES .....	149
TABLE 5.2:5 STATISTICAL TESTS OF GENDER DIFFERENCES IN THE THREE WORK ENVIRONMENT FACTOR SCORES.....	150
TABLE 5.2:6 GROUP MEANS (AND STANDARD DEVIATIONS) OF FOUR AGE GROUPS ON THREE WORKPLACE ENVIRONMENT FACTOR SCORES .....	150
TABLE 5.2:7 ANALYSIS OF VARIANCE OF AGE DIFFERENCES IN THE THREE WORKPLACE ENVIRONMENT FACTORS.....	151

TABLE 5.2:8 WORKPLACE ENVIRONMENT FACTOR SCORES AND CURRENT EMPLOYMENT (FULL-TIME OR PART-TIME).....	152
TABLE 5.2:9 T-TESTS OF THE DIFFERENCES BETWEEN FULL-TIME AND PART-TIME RESPONDENTS' SCORES ON THE THREE WORKPLACE ENVIRONMENT FACTORS.....	152
TABLE 5.3:1 LEADERSHIP ITEMS RANKED ACCORDING TO LEVEL OF AGREEMENT .....	153
TABLE 5.3:2 FACTOR ANALYSIS OF THE EIGHT LEADERSHIP ITEMS ARRANGED BY LEVEL OF AGREEMENT .....	154
TABLE 5.3:3 GROUP STATISTICS: GENDER AND THE TWO LEADERSHIP FACTORS.....	155
TABLE 5.3:4 GENDER DIFFERENCES IN THE TWO LEADERSHIP FACTOR SCORES .....	155
TABLE 5.3:5 GROUP MEANS (AND STD DEVIATIONS) OF AGE GROUPS AND THE TWO LEADERSHIP FACTOR SCORES.....	155
TABLE 5.3:6 ANALYSIS OF VARIANCE OF AGE DIFFERENCES IN THE TWO LEADERSHIP FACTORS.....	156
TABLE 5.3:7 LEADERSHIP FACTOR SCORES AND CURRENT EMPLOYMENT (FULL-TIME OR PART-TIME).....	156
TABLE 5.3:8 T-TESTS OF THE DIFFERENCES BETWEEN FULL-TIME AND PART-TIME RESPONDENTS' SCORES ON THE TWO LEADERSHIP FACTORS. ....	157
TABLE 5.4:1 PERSONAL AND PROFESSIONAL DYNAMIC ITEMS ARRANGED BY LEVEL OF AGREEMENT .....	158
TABLE 5.4:2 FACTOR ANALYSIS OF THE FIVE PERSONAL AND PROFESSIONAL ITEMS RANKED BY THE MAGNITUDE OF FACTOR LOADINGS .....	159
TABLE 5.4:3 GROUP STATISTICS: THE PERSONAL AND PROFESSIONAL DYNAMIC FACTORS BY GENDER .....	160
TABLE 5.4:4 GENDER DIFFERENCES IN THE TWO PERSONAL AND PROFESSIONAL RECOGNITION FACTOR SCORES.....	160
TABLE 5.4:5 GROUP MEANS OF AGE GROUPS AND THE TWO PERSONAL AND PROFESSIONAL DYNAMIC FACTOR SCORES .....	161
TABLE 5.4:6 ANALYSIS OF VARIANCE OF AGE GROUP DIFFERENCES IN THE TWO PERSONAL AND PROFESSIONAL DYNAMIC FACTORS.....	161
TABLE 5.4:7 HOMOGENEOUS SUBSETS .....	162
TABLE 5.4:8 PERSONAL AND PROFESSIONAL DYNAMIC FACTOR SCORES AND CURRENT EMPLOYMENT (FULL-TIME OR PART-TIME).....	162
TABLE 5.4:9 T-TESTS OF THE DIFFERENCES BETWEEN FULL-TIME AND PART-TIME RESPONDENTS' SCORES ON THE TWO PERSONAL AND PROFESSIONAL DYNAMIC FACTOR .....	163
TABLE 5.5:1 RESPONSES TO FOUR EFFORT AND REWARD ITEMS RANKED ACCORDING TO LEVEL OF AGREEMENT .....	163
TABLE 5.5:2 GROUP STATISTICS: GENDER AND THE EFFORT AND REWARD FACTOR.....	164
TABLE 5.5:3 GENDER DIFFERENCES IN THE EFFORT AND REWARD FACTOR SCORE .....	164
TABLE 5.5:4 EFFORT AND REWARD: AGE GROUP MEANS ON EFFORT AND REWARD .....	164
TABLE 5.5:5 ANALYSIS OF AGE DIFFERENCES IN THE EFFORT AND REWARD FACTOR .....	165
TABLE 5.5:6 EFFORT AND REWARD FACTOR SCORE AND CURRENT EMPLOYMENT (FULL TIME OR PART TIME).....	165
TABLE 5.5:7 T-TESTS OF THE DIFFERENCES BETWEEN FULL-TIME AND PART-TIME RESPONDENTS' SCORES ON THE EFFORT AND REWARD FACTOR .....	166
TABLE 5.6:1 THE NUMBER OF RESPONSES FOR DESCRIPTIVES FOR THE OPEN RESPONSES .....	166
TABLE 5.6:2 WHAT ARE THE MOST IMPORTANT INFLUENCES ON YOUR INTENT TO REMAIN IN NURSING? .....	167

TABLE 5.6:3 WHAT ASPECTS OF THE WORKPLACE ENVIRONMENT NOT ADDRESSED IN THIS SURVEY DO YOU CONSIDER IMPORTANT TO RETAINING NURSES LIKE YOURSELF? .....	168
TABLE 5.6:4 WHAT ASPECTS OF PROFESSIONAL RELATIONSHIPS NOT ADDRESSED IN THIS SURVEY DO YOU CONSIDER IMPORTANT TO RETAINING NURSES LIKE YOURSELF? .....	169
TABLE 5.6:5 ADDITIONAL COMMENTS ON ISSUES WHICH MAY BE INFLUENCING YOUR EMPLOYMENT IN NURSING.....	170
TABLE 6.1:1 PARTICIPANT NURSING CLASSIFICATIONS AND TERMINOLOGY .....	173
TABLE 6.1:2 KEY THEMES FROM DATA ANALYSIS .....	174
TABLE 7.1:1 ORIGIN OF KEY ISSUES AND RECONCEPTUALISING OF ISSUES THROUGH THEMES .....	224

# CHAPTER ONE: THE RESEARCH IDENTIFIED

## 1.1 Introduction

Identification of the potential problems associated with end of career nurses (EOCNs)<sup>2</sup> premature retirement from the healthcare workforce led to this research study which addresses the question: What are the factors that influence EOCNs' decisions regarding workforce participation? While minimal attention has been given to the retention of the experienced and older nurse, the research has identified a trend in retirement between 50 and 55 years (Schofield, 2007), however there is scant research documenting the reasons for this phenomenon. With approximately 46% of Queensland permanent public service employees aged over 45 years in 2008 (Office of the Public Service Commissioner, 2008), there may be an impact on workforce numbers when the older nurses begin to retire. If the trend to retire between 50 and 55 years continues among older nurses, then there are at least two potential negative outcomes. First, it is very likely that there will be a decline in the overall quality of healthcare, because of the paucity of educated and experienced nursing staff. Secondly, the education of new staff may be impeded because older nurses are unavailable to share their skills and organisational knowledge<sup>3</sup>. Such an ominous prediction invites further exploration. Consequently, this thesis focuses on the exploration of the factors that influence EOCNs' decisions regarding their workforce participation.

This chapter will explain the impetus for the study, define the EOCN, research context, research design, significance of the research and outline of the thesis.

### Impetus for this study

I had observed older nurses' increasing workloads with limited acknowledgement or utilisation of their skills and organisational knowledge in my workplace. This is a disparity, as the organisation struggled to meet staffing requirements with a lack of qualified nurses, however the older and often more experienced nurses received little

---

<sup>2</sup> End of Career Nurse: Registered nurse aged 45 years and over, regardless of their length of service in the profession.

<sup>3</sup> Organisational knowledge: A distinct attribute of an organisation that is different and distinguishable from the knowledge of individuals (Calo, 2008).

recognition for their contribution. Further, there was minimal attention given in both the study site and the literature to the retention of this experienced nurse who is likely to be contemplating their retirement.

I have been a registered nurse (RN) for approximately 30 years, and have practised in clinical, management and educational environments. Over the past 12 years, my role has been in nursing education within the study site. As an older nurse, I recognised that these issues could contribute to job dissatisfaction and ultimately resignation of this group.

One major responsibility of the nurse education team is the strategic planning and delivery of professional development opportunities to some 3060 employed nurses, ranging from assistants in nursing to Nursing Officers (NO) Grade 3 to 9. A component of building capacity in the nursing workforce has been targeted towards new RN graduates through the use of a preceptorship model<sup>4</sup> by a nominated group of experienced and purposefully prepared nursing staff.

The preferred selection of younger nurses to perform the preceptor role is seen by older and more experienced nurses as a lack of recognition for their experience and professional contribution. However, as a result of their experience, the older nurses are often required to support novice nurses, even in the absence of the relevant preceptorship training. In addition to supporting novice nurses, the older nurse practices with a normal patient case load, and may also be required to manage the shift coordination for the unit.

### **Defining the EOCN**

There is little consensus about when *end-of-career* or *retirement* begins as this varies on an individual basis for diverse reasons. The term *retirement* generally refers to the withdrawal from workforce participation. It is typically at a later stage of life and is aligned to the accumulation of accrued benefits that may or may not include a

---

<sup>4</sup> Preceptorship model: Designed to provide a supportive environment for nursing staff commencing in or moving to a new practice setting. Model includes preceptor selection, preparation, orientation and performance management (Queensland Health, 2010).

pension. While there is no statutory retirement age in Australia, there is a trend for nurses to begin their retirement between 50–55 years (Schofield, 2007).

The term *old* and *older worker* varies in the literature. One definition of the older worker is 45 years and over (Steinberg, Najman, Donald, McChesney-Clarke, & Mahon, 1994), however, official statistical documentation categorises employees 55 years and over as older workers (Australian Bureau of Statistics [ABS], 2006). In contrast, the legal definition identifies an older worker as an individual 40 years and over (Auerbach, 1994). Unfortunately, this lack of consensus is confounded by the following definitions: younger ageing worker (ages 45–54); middle ageing worker (ages 55–65); and older ageing worker (over 65) (Hatcher, Bleich, Connolly, Davis, O'Neill Hwelett, & Stokley Hill, 2006). For the purpose of this thesis, the (referred) 'older worker' is classified as an *end-of-career nurse (EOCN)* and is defined as those registered nurses aged from 45 years onwards, regardless of their length of service in the profession.

## **1.2 Research Context**

### **1.2.1 Global and Australian Context**

Quality healthcare is dependent on the adequate supply of qualified nursing staff. However, the global healthcare environment is faced with critical shortages, poor distribution and mis-utilisation of nursing staff (International Council of Nurses, 2007). This international workforce crisis is having a deleterious effect on the delivery of quality health services, both in Australia and internationally.

The World Health Organization (WHO) reports that there are 57 countries with critical healthcare worker shortages, which equates to a global deficit of 2.4 million doctors, nurses and midwives (World Health Organization, 2008). Moreover, there are considerable global variances in the nurse-to-population ratio, which range from less than 10 nurses per 100,000 population to more than 1000 nurses per 100,000 population (World Health Organization, 2006).

While Australia claimed 1095 nurses per 100,000 population in 2007, this health system is not immune to nursing shortages (Australian Institute of Health and Welfare, 2009). There is an estimated need for 13,500 additional registered nurses (RN) each year to address the predicted demand for nursing services (Australian Nursing

Federation, 2006). These nursing workforce numbers are still below predicted needs for escalating demands in healthcare (Duffield, Roche, O'Brien-Pallas, Catling-Paull, & King, 2009).

This demand for more nurses in developed countries like Australia is exacerbated due to a large increase in the ageing population who require health care services. A consequence of the ageing population is the growing number of Australians who suffer from chronic and non-communicable diseases. These additional demands on healthcare are intensified by the political decision to minimise patients' stay in hospital with rapid discharge. This policy has ironically contributed to an additional workload pressure on nurses (Duffield, Kearin, Johnston, & Leonard, 2007a). Consequently, it is not surprising that this policy has contributed to EOCNs' workload and frustration with the system generating their desire to leave the organisation.

However, the work demands on nurses are far more complex than this. The research indicates that nurses now, more than at any other time, have increased work to do with fewer resources (Buchan & Aitken, 2008). Moreover, there are insufficient new graduates entering the nursing profession and those EOCNs currently employed are opting for early retirement. The ageing workforce, demonstrated by an escalating average age of nurses and the higher proportion of nurses over 50 years old, is particularly relevant to this study. Indeed, in Australia, the oldest baby boomer cohort turned 60 years old in 2007. This implies that nursing retirement will occur in increasing numbers in the next decade and a half (Schofield, 2007).

The pending retirement of this ageing workforce may have a detrimental effect on the delivery of quality healthcare in Australia. This negative influence may manifest itself in a number of ways. First, because of the current paucity of experienced personnel, nursing teams may be devoid of the usual skill mix of the experienced professional with the newer professional. Second, it is possible that with the decline in availability of experienced practitioners in clinical nursing teams, there may be a corresponding decline in quality healthcare experienced by hospital patients (International Council of Nurses, 2007).

Organisations depend on the adequate supply of qualified nursing staff in order to provide the safe delivery of quality health services. However, as many organisations struggle to provide an adequate supply of nursing staff, increasing numbers of less qualified staff have been employed to meet staffing numbers (Duffield, et al., 2007a). This situation has the potential to place organisations at risk of legal action due to an increase in medical error and poor patient outcomes (International Council of Nurses, 2007). Errors occur more often in environments that demonstrate erosion of nurses' trust in nursing leadership, have minimal opportunity for clinical decision making, unsafe skill mix and inadequate professional development to support professional practice (Duffield & Roche, 2009). Consequently, this situation demonstrates a strong link between quality nursing staff, work environment and quality patient outcomes (Dunton & Duncan, 2010).

Not surprisingly, there are financial demands that would allow this triad to work harmoniously. Although the Australian government has planned to increase healthcare expenditure by 127% over the next three decades (Treasurer of the Commonwealth of Australia, 2010), this will not be enough to meet the increased healthcare demand and need for nursing personnel. Financial planning alone will not increase recruitment of nursing personnel (Duffield et al., 2009).

More strategic planning is necessary. For example, strategies to address the diminishing workforce pool have to date been directed towards recruitment of new graduate nurses and migrating nurses. However, minimal consideration has been given to the replacement or retention of an experienced existing resource: the EOCN. The research concerning the reasons for the older nurses' retirement or their resilience to stay is sparse, and organisations and policy makers have avoided considering this issue, preferring to engage in the recruitment of younger personnel.

### **1.2.2 Queensland Health and Study Site Context**

This research is situated in a large tertiary acute referral hospital in Queensland. The hospital provides services to patients throughout the state, northern New South Wales, the Northern Territory and neighbouring countries in the South-West Pacific (see Figure 1.2:1).



Some of the services provided by the almost 900 bed hospital include Surgical and Perioperative, Women's and Newborn, Internal Medicine, Critical Care, Mental Health, Cancer Care, Oral and Allied Health. In addition, the hospital fulfils a substantial teaching and research role with links to Queensland's major tertiary institutions.

**Figure 1.2:1 Queensland Health: Health Service Districts**



The global nursing shortage and economic considerations are similarly reflected in Queensland Health and the study site workforce. For example, in Queensland there is an estimated need for an additional 14,000 nurses by 2014 to maintain the current healthcare service (Queensland Nurses' Union, 2010a). With approximately 46% of Queensland public service employees aged over 45 years (Office of the Public Service Commissioner, 2008), there may be a negative effect on workforce numbers when the EOCNs begin to retire. Some attempts to remedy this situation by the study

site have included the employment of increasing numbers of new graduates, migrant nurses, agency and casual staff. However, there appears to be minimal forecast planning for the adequate replacement of EOCNs once they retire or reduce their workforce participation. In addition to this workforce concern is the lack of consideration for the transfer of the EOCNs' skills and organisational knowledge to the less experienced nurse.

### **1.3 The Research Design**

The focus of this thesis is the context and motivations for EOCNs to remain in or leave the workforce. The literature review (Chapter Three) generated four specific research questions which focused the conduct of the research design. They are:

- How does the workplace environment influence EOCNs' decisions regarding workforce participation?
- How does leadership influence EOCNs' decisions regarding workforce participation?
- How does personal and professional recognition influence EOCNs' decisions regarding workforce participation?
- How does the balance of effort and reward influence the EOCNs' decisions regarding workforce participation?

#### **1.3.1 Epistemology**

This research is based on a constructionist epistemology. Constructionism emphasises that meaning is socially constructed and further espouses the influence of culture in shaping the way phenomena are interpreted, providing a definite world view (Crotty, 1998). This study is an exploration of the EOCNs' decision making concerning workforce participation and seeks to understand those constructions or meanings of reality held by the EOCNs. Consequently, constructionism seems most appropriate for a study which aims to explore purposeful meaning of complex processes of EOCNs' social interaction.

#### **1.3.2 Theoretical Perspective**

The focus of this study is based on a way the EOCNs view and construct their understanding of the world (Blumer, 1998). The theoretical perspective of interpretivism aims to generate a more in-depth understanding of the specific phenomenon by exploring and analysing symbols such as language or behaviours

within a cultural context (Geertz, 1973). The particular focus of this research is an examination of the social interaction between the participants and their context in order to understand their perceptions.

### **1.3.3 Symbolic Interactionism**

Symbolic interactionism has been adopted as the lens through which to inform the theoretical perspective of this study. This perspective is appropriate, because it seeks to understand and describe the EOCN's subjective experience from the individual's view. Language and behaviours, which are in a continuous state of flux, shape the interaction and interpretation of the phenomenon (Denzin, 1989). The complexities of social interaction within the acute healthcare setting are challenged by history, culture, internal and external influences and varying interpretations and perceptions of the nurses' experiences. How these interpretations and shared meanings are constructed by the EOCN about the decisions regarding their continued workforce participation is central to this study.

### **1.3.4 Research Methodology**

A research methodology is defined as "a model, which entails theoretical principles as well as a framework that provides guidelines about how research is done in the context of a particular paradigm" (Sarantakos, 1998, p.6). The methodology provides a rationale in the orchestration of methods used to explore the phenomenon under study. The chosen methodology guides the in-depth exploration of the social interactions between the EOCN and their context. Case study is the methodology adopted for this study.

### **1.3.5 Case Study**

Case study methodology has been adopted for this research as it "investigates a contemporary phenomenon within real life context" (Yin, 1994, p.13). The study offers a voice to the experiences of the EOCNs as they interact and respond to multiple influences in and out of the acute healthcare environment. Case study allows flexibility to describe, explore and explain both the context and technical characteristics of the phenomena, which is well suited to the dynamic changes within the healthcare system (Yin, 2003). In addition to gaining understanding of the beliefs of EOCNs, further insights can be illuminated which can influence policy, procedures and future research (Merriam, 1998).

### **1.3.6 Participants**

Participant selection was purposeful and guided by the boundaries which established the case of EOCNs providing direct or indirect care or support services within an acute healthcare setting. The case study boundaries included EOCNs with a broad range of nursing classifications (Nursing Officers (NO) Grade 5–12), as it is considered that all nursing levels are exposed to experiences which may influence decisions regarding their continued workforce participation. Timeframes of work experiences are imposed and include a minimum of ten years of practice. This decision is based on the premise that practicing within such timeframes would ensure the EOCNs understand the diverse issues of the nursing profession and the healthcare environment. This purposeful selection provides the opportunity for information rich insights into the issues about the phenomenon under study.

### **1.3.7 Data gathering strategies**

The strategies chosen to collect information for this research are:

- Survey (n = 218 participants) which equated to a 30% response rate;
- Focus group interviews (n = 21 participants) and
- In-depth semi-structured interviews (n = 8 participants).

## **1.4 Significance of the Research**

This study is potentially significant for the following four reasons.

First, while previous studies have explored why nurses are leaving the profession (Queensland Nurses' Union, 2010c), there is a paucity of scholarship specifically addressing why the EOCNs are reducing their workforce participation. However, with such large numbers contemplating their retirement, the premature exit of the EOCN may have a deleterious effect on workforce numbers (Duffield et al., 2009). This is an important workforce concern, as the EOCNs have gathered workplace knowledge and expertise not specific to the organisation which is critical in the development and support of the novice nurse and the sustainability of quality healthcare. This research specifically addresses this lacuna in the scholarship of this issue.

Second, policy issues from a government and organisational perspective have an important influence on workforce participation decisions. Policies should reflect an ethical obligation for safe and quality healthcare. Imposed issues, such as economic

constraints which have been responsible for reduced training resources, particularly for the EOCN, can have a negative impact on nurses' job satisfaction, retention and the quality and delivery of safe care. By exploring this sector of the profession's personal and professional needs, policy makers and administrators may be better informed to shape future practice and policy issues through effective retention strategies.

Third, with a central role in the practice of healthcare, it is appropriate that the EOCN has a voice in the decision making of how healthcare should be delivered. It is important that their voices are heard. This study provides the opportunity to explore the salient issues and concerns of the EOCN related to workforce participation and provide a platform for their voices.

Finally, negative biases concerning the older worker and their physical and mental ability to perform effectively may override the valuable contribution this cohort brings to the workplace. While studies espouse the value of the 'knowledge worker', there is little evidence that workplace structures and environments support the EOCN and their specific needs (Hatcher et al., 2006). This study seeks to make a contribution to an area that has received minimal attention and has the potential to provide benefits to the global nursing shortage.

## **1.5 The Outline of the Thesis**

A brief outline of the structure of the thesis is given below.

**Chapter One: The Research Identified** introduces the study of the factors that influence EOCNs' decisions regarding their workforce participation within an acute tertiary hospital. This introductory chapter presents the study in terms of purpose, impetus of the study, significance and structure. In addition, the chapter outlines the development and sequential nature of the study from literature review to collection and analysis of the data, and finally to the discussion of the findings and conclusions.

**Chapter Two: Defining the Research Problem** provides structure for the context in which the EOCN considers their workforce participation. The study presents a summary of the global, national and study site contextual influences, which have shaped the life and character of contemporary nursing. This chapter documents the

influences on the nursing profession from a nursing shortage, economic rationalism and quality outcomes perspective.

**Chapter Three: Review of the Literature and Identifying the Research Questions** presents the review and synthesis of the literature and research relevant to this topic. The review of the literature identified the salient and emerging themes, which offer an explanation for understanding why EOCNs participate in the workforce.

**Chapter Four: Design of the Research** presents the research design and methodology. This chapter outlines the methods employed for data collection and the processes for the analysis of data.

**Chapter Five: Survey Findings** presents the survey findings which confirmed and discarded themes for focus groups and in-depth interviews.

**Chapter Six: Analysis of the Research Findings** presents the findings generated from the focus groups and semi-structured interviews and the emergent themes. These themes are used to sort and organise responses from participants.

**Chapter Seven: Discussion of the Research Findings** presents a discussion of the research findings under the emergent themes to interpret the findings of the research generated in Chapter Six.

**Chapter Eight: Conclusions and Recommendations** reviews the findings from the research questions. Conclusions and recommendations are presented.

## **CHAPTER TWO: DEFINING THE RESEARCH PROBLEM**

The purpose of this chapter is to articulate and justify the research problem this study intends to address.

### **2.1 Conceptualising the Research Problem**

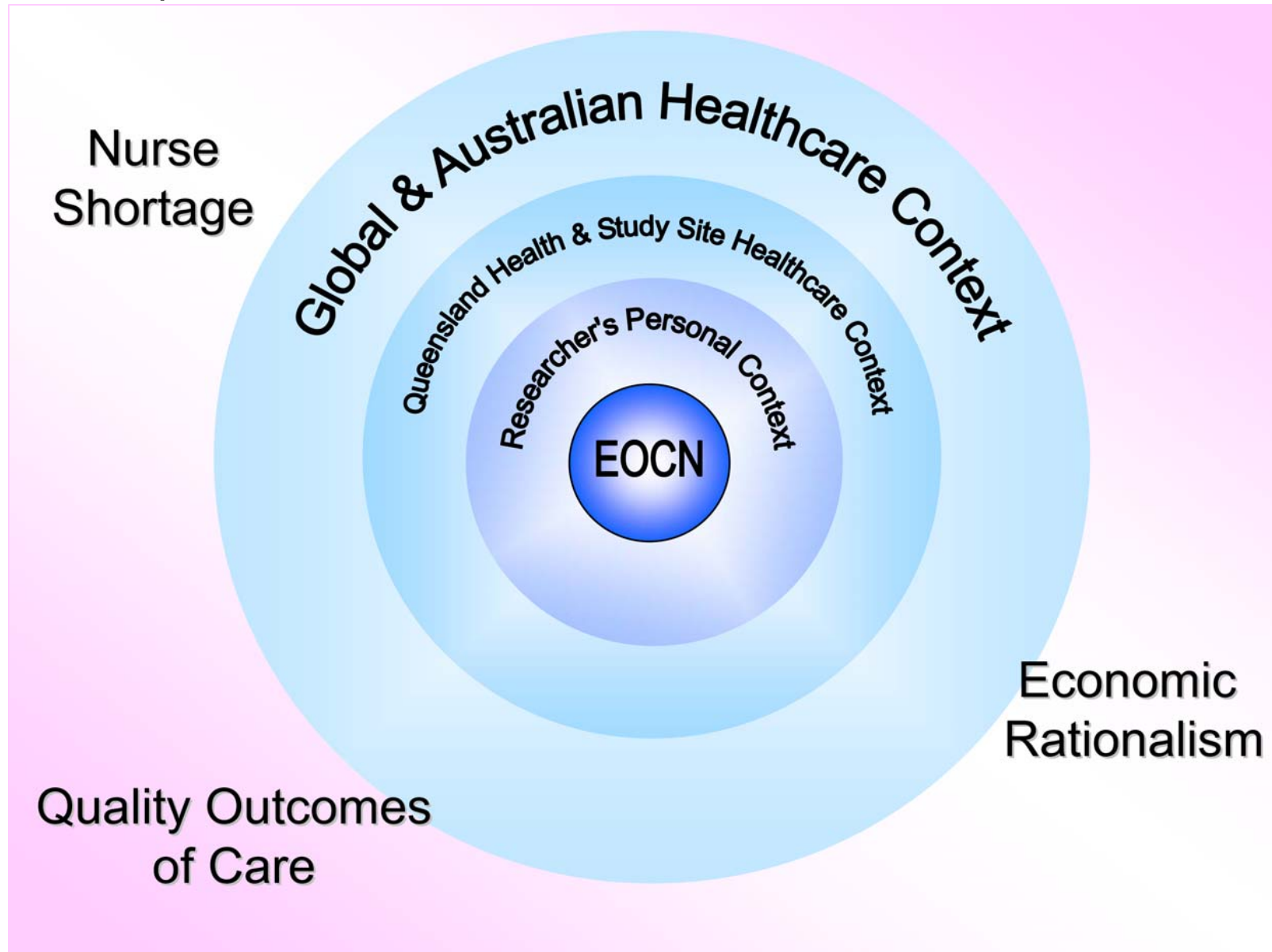
The conceptualisation of the research problem has been diagrammatically represented in Figure 2.1 to provide structure for the exploration of the context in which the EOCN makes decisions about their workforce participation. The exploration of the EOCNs' decision making commences with a broad view of the global and Australian context, which is represented in the outermost circle of the diagram. The second circle represents a view of the Queensland Health (QH) and study site context in which the EOCN practices. The third circle represents the researcher's personal context, while the innermost circle represents the EOCN as central to the global, Australian and QH influences that may impact on their decision concerning workforce participation.

In addition, the outermost circle presents three perspectives which influence each context and may ultimately influence the EOCNs' decisions about workforce participation. These three factors are:

- Nurse Shortage
- Quality Outcomes of Care
- Economic Rationalism

Each of these contexts and perspectives is explored, commencing with Personal Context.

**Figure 2.1:1 Conceptualisation of the Research Problem.**





## **2.2 Personal Context**

My involvement in the nursing profession has spanned three decades and has included practice areas such as clinical, management and educational environments. For the past twelve years, my role has been in nursing education within the largest tertiary referral hospital in Queensland. This hospital provides services to patients throughout the state, northern New South Wales, the Northern Territory and neighbouring countries in the South-West Pacific. Further, the hospital provides care in a number of specialties such as medicine, surgery, psychiatry, oncology, critical care, women's health and neonatology. Consequently, the hospital relies on a nursing workforce that is clinically experienced and has gained years of organisational knowledge.

One major responsibility for the nurse education team is strategic planning and operation of professional development opportunities to support clinical and professional practice standards. These activities are provided to some 3060 nurses (head count). The nursing classification structure within the hospital includes assistants in nursing and Nursing Officers (NO) Grade 3 to 9. Another organisational priority is the professional development of the nurse leadership team, which consists of NO Grade 7–9 culminating in the middle and upper management group. As a strategy to support and retain future nurse leaders through succession management, NO Grade 6, the lower management group, has recently been included.

These leadership teams are expected to support capacity building of staff through the facilitation and development of professional practice and standards for all nurses within the organisation in order to provide optimal patient care. One major aspect of building capacity is targeted towards new graduates through a supportive transition program. This program focuses on the consolidation and advancement of the new graduate nurses' beginning skills, which are supported through a preceptorship model over approximately twelve months (Queensland Health, 2010). Preceptor support is provided by a nominated group of experienced and purposefully trained nursing staff. However, potential preceptors are often selected from the younger cohort of experienced nurses, rather than those experienced nurses who are within a decade of possible retirement. There appears to be no organisational or professional expectation that these older and more experienced nurses would share their years of clinical and organisational knowledge with the new graduates or novice nurses.

Preceptor training is delivered over two days with other complementary programs such as *Leadership and Management*, *Mentoring*, *Preceptorship and Business Planning* being offered and attendance encouraged. However, attendance at these programs is often limited due to workloads and insufficient staff to provide backfill<sup>5</sup>, regardless of flexible program delivery times. Lack of backfill results from insufficient qualified nursing staff to meet roster requirements.

The ability to meet staffing needs on a daily basis constantly challenged Nurse Managers (NMs). One remedy to this staffing shortage frequently resulted in the employment of agency, casual staff and assistants in nursing. However, these staff members were not familiar with the work unit environment and required considerable support during the shift which was often provided by the EOCN as an experienced nurse.

Organisational data reflected poor attendance at these programs, which led to the development of performance indicators to establish required attendance standards. The younger and less experienced cohort often attended these programs leaving the work unit management and support of the remaining staff to the most experienced nurse: the EOCN. Whether given the opportunity for training as a preceptor or not, the EOCNs are frequently scheduled on the roster to perform as a preceptor during the shift as a result of their considerable knowledge and skills. The EOCNs are also expected to manage workplace issues such as perceived lack of leadership support with minimal flexibility for 'off-line time'<sup>6</sup> to attend professional development programs as their younger colleagues do.

For example, EOCNs' daily workload usually includes preceptoring or supporting new graduates, novice nurses or student nurses, a normal case load of patients and often managing the shift coordination of the unit. The lack of formal organisational recognition of the EOCNs' skills and knowledge is evident by their small nominated

---

<sup>5</sup> Backfill: refers to a Human Resource strategy to provide replacement staff when rostered staff are unavailable, i.e. professional development opportunities, sick leave.

<sup>6</sup> Off-line time: refers to authorised time provided to rostered staff in order to undertake an activity away from usual duties. The activity is, however, aligned to the roles and responsibilities of the staff member's job description.

numbers of preceptors. Further, as a result of the increasing workload demands, potential burnout and increased attrition rates for the EOCNs are a concern.

The impetus for this study came as a result of personal observation of the increasing workloads for the EOCN and limited acknowledgement or utilisation of the EOCNs' vast skills and organisational knowledge. This lack of acknowledgement highlighted a disparity, as the organisation struggled to employ sufficient registered nurses to maintain quality staffing levels. While focused on the reduction of costly use of agency and casual staff, little consideration has centred on retaining the older and more experienced nurse: the EOCN. This latter group demonstrates a trend to leave the organisation between 50 and 55 years of age, which is pertinent to workforce stability, as the EOCNs comprise a large proportion of the organisational workforce. Further, there is little research concerning the reasons for the EOCNs' premature exit. While the current global financial crisis (GFC) may have influenced retirement rates slightly, it is not known if the former retirement trend is likely to reoccur (Preston, 2009). This workforce situation is particularly relevant to the delivery of quality healthcare within the organisation as the retirement of the EOCN reduces the opportunity to not only maintain quality standards, but also support the sharing of their invaluable organisational knowledge and skills.

## **2.3 International Nursing Shortage**

Worldwide, quality healthcare is dependent on the adequate supply of qualified nursing staff, yet the World Health Organization (WHO) reports critical shortages, poor distribution and mis-utilisation of nursing staff (International Council of Nurses, 2007). As a result, this workforce crisis is having a deleterious influence on the provision of quality healthcare internationally.

The lack of qualified nursing staff is critical in both developing and developed countries. The WHO reports that there are 57 countries with critical shortages equivalent to a global deficit of 2.4 million doctors, nurses and midwives (World Health Organization, 2008). While sub-Saharan Africa claims a shortfall of more than 600,000 nurses (World Health Organization, 2008), the United States will have an estimated shortfall of 340,000 nurses by 2020 (Glazer & Alexandre, 2008). In addition, there are considerable global variances in the nurse-to-population ratio

which range from less than 10 nurses per 100,000 population to more than 1000 nurses per 100,000 population (World Health Organization, 2006).

In comparison, in 2007 Australia had 1095 full-time equivalent nurses per 100,000 population (Australian Institute of Health and Welfare, 2009). Regardless of this higher nurse–population ratio, Australia is not immune to the shortage of nurses. It is estimated that 13,500 additional registered nurses are needed each year to address predicted demand for nursing services (Australian Nurses' Federation, 2006). Despite this expected growth and the recent increases in recruitment in Australia, nursing workforce numbers are still below predicted needs for escalating healthcare services (Duffield et al., 2009).

### ***Imbalance between Supply and Demand of Nurses***

Further compromising the nursing workforce is the imbalance between supply and demand of qualified nurses for healthcare services. Nursing shortages have gained considerable attention since World War II, both nationally and internationally, as a result of increased demand exceeding a slow or static supply. However, the current shortage is unique from previous experiences as today's health systems are challenged by pressures exerted on both supply and demand (International Council of Nurses, 2006).

Factors driving an increased demand for nursing services include an ageing population, a growing burden of chronic and non-communicable diseases, and an economic and efficiency agenda to shorten hospital stays which has resulted in increased acuity. Coupled with this increased demand is a decreasing supply of nurses (National Health Workforce Taskforce, 2009). The reasons for a decreasing supply of nurses include: increased career opportunities for women; a poor image of nursing as a career; insufficient new graduates to meet service delivery needs; unfavourable work environments that include excessive workloads, violence, stress, wage disparities and minimal involvement for nurses in decision making; and an ageing workforce (Duffield et al., 2009; International Council of Nurses, 2007).

The decreasing supply of Australian nurses invites further amplification. Future projections of available staffing may further compromise the nursing shortage. This shortage is not necessarily a shortage of individuals with nursing qualifications, but a

shortage of nurses willing to work in the present conditions (Buchan & Aitken, 2008). This is a result of supply exacerbated by a shrinking workforce. In 2009, approximately 27% of Australians were aged 20–49 years, however, by 2021 this is expected to reduce to 19–20% (National Health Workforce Taskforce, 2009). Further compromising the pool of potential nurses is a decline in the number of new graduate registered nurses. This decline is demonstrated by a reduction in nursing undergraduate commencements, up to 40% attrition rates for new graduates within the first two years in the workforce and a higher average age of new graduates entering nursing programs (Schofield, 2007). While recruitment into undergraduate programs has recently increased as a means to support future health service needs, these numbers still remain short of projected requirements. This highlights the importance of building a sustainable nursing workforce through retention strategies (Duffield et al., 2009).

A further problem for the shrinking workforce pool is the ageing population of the nursing workforce, which is shown by the escalating average age of nurses and the higher proportion of nurses over 50 years old. Retirement from the workforce of this group has the potential to exacerbate the workforce shortages in future decades. Data to support these observations are unreliable as there are anomalies in the available demographic statistics. These anomalies are a result of variances in data sources and reporting mechanisms, which highlight one of the major challenges in workforce planning. The Australian Institute of Health and Welfare suggests the average age of *registered nurses* in 2007 was 43.8 years (Australian Institute of Health and Welfare, 2009), while the Australian Health Workforce Institute claims the average age of a *nurse* was 45 years in 2005 (Kronos and The Australian Health Workforce Institute, 2008). Further, the proportion of nurses aged 50 years or older increased rapidly from 28.2% to 33.0% between 2003 and 2007 (Australian Institute of Health and Welfare, 2009). It is projected that Australia will lose almost 60% of the current nursing workforce to retirement. This projected loss is estimated at an average of 15% of nursing workforce every five years, which will total 90,200 nurses between 2006 and 2026 (between 20,000 and 25,000 every five years) (Queensland Nurses' Union, 2009c). However, even if ageing nurses continue to be employed, it is demonstrated that historically their hours of work participation decrease. This reduction in workforce participation will require more nurses to provide the same level of care (Preston, 2009).

The shrinking workforce pool compromised by ageing nurses and pending retirement may pose a threat to the availability of current and future health services. As the EOCNs choose to retire, there is an increased likelihood of a negative impact on the workforce pool of experienced nurses. As the oldest of the baby boomer group turned 60 years old in 2007, nursing retirement is expected to occur in substantial numbers over the next decade and a half (Schofield, 2007).

Such a reality demands improved strategic planning. Workforce planning for the anticipated retirement of EOCNs, as well as general attrition rates, is complex due to variances in data reporting and the unpredictable nature of retention. Also, many workforce projections do not account for the reduction of new graduate numbers and backfilling requirements of staff leave and professional development opportunities. Regardless of the variances in data reporting, similar themes become apparent. The Australian Nursing Federation (2006) research has concluded that the nursing workforce will be negatively affected by:

- inadequate numbers of incoming nurses to meet the demand in terms of replacement and growth in demand for healthcare
- the ageing of the nursing workforce with the looming expected retirements of the EOCNs. This group also often decrease work hours as they age
- increased demand for health services as the general population ages and new technologies are introduced, coupled with shorter patient stays and increasing patient complexities.

As a result of these realities, strategies have included employing nurses from other countries.

### ***Strategies used to address supply and demand***

In recent times, Australia has drawn on nursing workforces from developing countries to remedy our nursing shortage. The WHO identified that few developing countries have workforce planning processes that effectively address demands for health care and provide workforce stability (2006). As a result of insufficient workforce planning processes, developing countries experience further destabilisation as their workforce is enticed to developed countries such as Australia, the United States and the United Kingdom through offers of good wages, conditions and educational opportunities. Consequently, Australia is experiencing an increase of migrating nurses which has

escalated since 2001. While this recruitment has minimised the Australian nursing shortage in the short term, it has exacerbated the nursing shortage in developing countries (Preston, 2009). From an ethical perspective, this form of recruitment from less resourced developing countries in order to support the workforce numbers in a more affluent country requires further consideration. The International Council of Nurses (ICN) warns that this form of recruitment may be viewed as exploitation as the impact reduces the numbers of qualified nursing staff within the developing country with consequences for those who are in need of the healthcare services (2007).

Another strategy used to minimise the nursing shortage is the replacement of registered nurses with cheaper and less qualified staff (Parfitt, 2009). However, this strategy has the potential to reduce the quality of patient outcomes as a result of less qualified healthcare workers providing continuous patient care which is traditionally the domain of the registered nurse (RN) (Duffield, Roche, O'Brien-Pallas, Diers, Aisbett, & King, 2007b). The additional factor of budgetary constraints in healthcare has resulted in some governments closing health facilities and freezing nursing positions despite the need to provide quality nursing services (International Council of Nurses, 2007). These budget driven strategies have placed patient outcomes at risk and highlighted attrition from the nursing workforce (Parfitt, 2009). Consequently, any further loss of registered nurses from the current workforce would exacerbate the nursing shortage.

### ***Policies to support longevity of an ageing population in the Australian workforce***

Workforce participation trends for the ageing workers and associated pension systems are becoming increasingly important to policy makers. Australia, along with Japan and Finland, has the most developed policy on age and employment. Australia's particular focus is the recognition of age as an equitable issue (Joseph Rowntree Foundation, 2002). Policies and legislation such as Equal Employment Opportunity (Commonwealth Government, 1987) and the Antidiscrimination Act (Office of the Parliamentary Counsel, 1991) support fair and equitable treatment, and opportunities for individuals regardless of their age, sex or religion. While these legislative initiatives aim to value the older worker, the intent has not been demonstrated by longevity of the EOCNs' workforce participation (Andrews,

Manthorpe, & Watson, 2005). Therefore, it is timely to consider what factors will retain the older worker in the workforce whilst recognising that all strategies are dependent on economic consideration.

### **2.3.1 Economic Rationalism**

Macroeconomic policies set the agenda for overall spending of national budgets. Health budgets and workforce comprise a large component of national budgets. While aiming to provide responsive and proactive policies and practices, all countries are facing financial challenges, which impact on workforce planning decisions. Countries dependent on external funding are facing further challenges that are impacting on their ability to meet healthcare needs (International Council of Nurses, 2006). In many countries, workforce planning has a low priority. Planning is often undertaken in occupational silos and, as such, may not be linked effectively to service planning and delivery. A factor which may inhibit workforce planning is a lack of organisational structures and information technology necessary to collect quality national labour data. Without these structures and systems in place, planning and access to quality healthcare may be compromised (Johnston, 2007). Further compromising the delivery of healthcare is the current world economy. As a result of the unpredictable situation of the GFC in 2008, healthcare may experience an additional negative impact (National Health Workforce Taskforce, 2009).

The GFC has occurred at a time of increasing demand for costly health services. As there is an enormous public investment in health care, it is important to provide an efficient and effective health service (Buchan, 2009b). Efficient and effective services are particularly relevant when the Australian health expenditure is projected to increase 127% over the next three decades, which equates to an increase of \$91 billion. Currently, the Australian Government provides 40% of the total public health funding with a proposal to increase this by 20% to meet growing healthcare demands. However, this additional funding will be dependent on facilities meeting performance criteria (Treasurer of the Commonwealth of Australia, 2010). While health authorities have engineered a wide range of strategies to reduce the demand on healthcare of stay facilities, workforce growth continues to be insufficient to meet demand (National Health Workforce Taskforce, 2009).



The need for workforce growth in healthcare is a result of demands from an ageing population, increasing consumer demands and expectations, continued expansion of new technologies and rising costs of healthcare. These factors all influence the way health leaders allocate essential services (Treasurer of the Commonwealth of Australia, 2010). As the largest professional group in Australian healthcare (40%) (P. Forster, & Queensland Health, 2005), nurses hold a unique position that places them in a continuous role beside the bed, yet they are the most vulnerable to the economic razor because of their numbers (International Council of Nurses, 2006).

Erosion of revenue streams has led to organisational restructuring and in many instances 'savings' have been made by downsizing or eliminating staff development units (Rukholm, Stamler, Bednash, Potempa, MacLeod, & Parfitt, 2009). Despite other efforts to reduce costs through shortened hospital stays and early discharge, healthcare continues to absorb a large proportion of the national budget. These increasing costs are associated with salaries, benefits and malpractice premiums (Duffield et al., 2007b). Additional costs to service provision can be attributed to the use of casual or agency staff and overtime due to insufficient quality staff. This type of staff usage increases the risk of adverse events for staff and patients, loss of productivity and continuum of care, which may attract legal costs (Tourangeau, Doran, Pringle, O'Brien-Pallas, McGillis-Hall, & Tu, 2006). While there should be a balance between allocated expenditure and a demonstration of quality outcomes, this may not be realised if qualified and experienced nurses are not retained (Buchan, 2009b).

As a result of the requirement for economic efficiency in healthcare services, there are pressures to address organisational goals and professional demands to provide a quality and cost efficient service. Most Australian hospitals are required to measure their outcomes against predetermined Key Performance Indicators (KPIs). These measures provide an opportunity to quantify healthcare outcomes and highlight the impact if insufficient registered nurses are available. Examples include bed closures, increased waiting times and admissions delays (Johnston, 2007). Additionally, working in a demanding resource depleted environment increases staff stress, which consequently increases nursing turnover rates and associated recruitment costs. Depending on the nurse's specialty, Australian costs to recruit, orientate and preceptor a registered nurse may range from \$62,100 to \$67,100 (Gess, Manojlovich,

& Warner, 2008). However, hidden costs of turnover are often not included in these estimates. The hidden costs include the cumulative effects of turnover such as staff morale and work unit productivity and may amount to an average cost of \$100,515.00 (Duffield & Roche, 2009). With escalating costs for recruitment and difficulty in attaining quality staff, a stronger focus on retention may be an economical alternative.

Furthermore, many organisations are vulnerable to criticism that economics have driven their labour policy. To overcome this image and present nursing as a desirable career, there has been an effort to provide higher wages. The introduction of higher wages to remedy the nursing shortage will not provide the sole solution as the profession is plagued with diverse organisational and professional problems that negate the effect of attractive wages. Some of these problems include better career options and the lack of input into decision making concerning patient care (McGillis-Hall & Doran, 2007). In addition, there are increasing family demands on nurses, and a 'plateau' effect on wages unless nurses transfer from the clinical area to management careers (Queensland Nurses' Union, 2009c). In contrast, another source suggests that higher wages are a strong incentive on both recruitment and retention (Thorgrimson & Robinson, 2005). In addition to an appropriate rise in the nurse-to-patient ratio, remuneration may lure nurses working outside the profession and so has the potential to rebalance shortage numbers (Lafer, 2005). However, it is unlikely that higher wages overcome the stress of working in an environment that is under-resourced and highly complex.

It does appear that business and economic principles have replaced the healthcare norms and many professional values. Ironically, the diminishing professional and human values in healthcare have not reduced healthcare costs because of increased infection rates, iatrogenic effects and litigation. Sobering statistics from the *Consumer Reports: To Err is Human – To Delay is Deadly* estimate that medical errors cost the United States between \$17 and \$29 billion each year and result in almost 100,000 lives lost each year (Consumers Union, 2009). Since reporting of incidences is ad hoc, it would be difficult to quantify more accurately, indicating this may be the 'tip of the iceberg'. This business model for healthcare has not improved access to care or enhanced quality outcomes, and has not enticed new nurses to the profession or inspired current nurses (Donley, 2005). Failure to attract new nurses to the

profession highlights the need to explore retention strategies for those experienced nurses currently in the workforce nearing retirement: namely the EOCNs.

### ***Incentives for Retaining an Ageing Australian Workforce***

Previous practices of defining the retirement age as 65 years for males and 60 years for females provided a more accurate prediction for workforce planning. This structured departure of retirees generated job opportunities for the younger generation, although scheduled retirement may have supported a perception that younger workers are more productive than older workers (Department of Communities, 2008).

With changes to legislation, there is currently no statutory retirement age in Australia (Office of the Public Service Commissioner, 2008). As not all retirees are eligible for the Age Pension, the superannuation co-contribution is an Australian Government initiative to assist with saving for retirement including both personal and government contributions. In order to manage and quarantine superannuation savings for retirement purposes, accessing superannuation can only occur once the individual has reached preservation age<sup>7</sup> (55 years if born before June 1960) and permanently retired from the workforce (Australian Government, 2009).

Prior to accessing savings, the Queensland Government Superannuation Office (QSuper) provides members with a range of retirement planning to support flexible retirement options. While there is a plethora of information available for members concerning these retirement options, there are some misunderstandings about the effects of the options on superannuation benefits. As a consequence, there is reluctance by some members to fully consider these flexible retirement options. This reluctance is evident even in light of the potential benefits to the employees. One such benefit is the accrual of additional superannuation benefits which is gained by extending member workforce participation (Queensland Government, 2009). The benefits of extended employment for the EOCN may be an economic option for both employee and employer while having a positive influence quality outcome.

---

<sup>7</sup> Preservation age: The age at which the individual can take a preserved benefit as a lump sum (once permanent retirement from the workforce). The preservation age rises progressively from age 55 years to 60 years according to the individual's date of birth.

### **2.3.2 Impact of Nursing Shortage on Quality Outcomes**

The ICN purports that quality healthcare depends on adequate supply of qualified committed nursing staff in order to provide an appropriate skill mix, and safe delivery of quality health services. As many organisations are unable to provide an adequate skill mix on a shift by shift basis, they may face an increased risk of legal action due to error and poor patient outcomes (International Council of Nurses, 2007). In addition, registered nurses are at risk of liability. This situation is a result of increasing numbers of less qualified workers who are employed to meet staffing numbers. With an inability to employ sufficient qualified staff within a nursing shortage environment, patient safety is at risk of being reduced (Duffield et al., 2007b). While programs such as orientation and preceptorship education may assist to reduce the errors made by staff, these initiatives are expensive with costs escalating due to high turnover. However, these programs are often not offered in all facilities (Laschinger & Leiter, 2006).

The Institute of Medicine also suggests that work environments may in fact support error making (2001). Errors occur more often in environments that demonstrate erosion of nurses' trust in administration, lack of nursing leadership, minimal opportunity for clinical decision making, unsafe skill mix, working extended hours and inadequate professional development to support clinical and professional practice (Duffield & Roche, 2009). Consequently, this demonstrates a strong link between quality nursing staff, work environment and quality patient outcomes (Duffield et al., 2007b; Dunton & Duncan, 2010).

Another feature of a reduced nursing workforce is the need to work overtime or extended hours. While overtime may be unavoidable in emergency situations where patient acuity demands are high and experienced staff numbers are low, it is recognised that overtime has the potential to pose an increased safety risk to staff and patients. Nurses working 12.5 hour shifts as opposed to 8.5 hour shifts are at risk of increased musculoskeletal and needle stick injuries and have twice the risk of a motor vehicle accident as a result of drowsiness (Geiger-Brown & Trinkoff, 2010). Further, a study of nurses who worked at least a 12.5 hour shift showed they were three times more likely to make an error than those who worked an 8.5 hour shift (Rogers, Hwang, Scott, Aitken, & Dinges, 2004). Ironically, the costs of hiring additional quality nurses may be offset if patients have fewer complications and

adverse events, therefore leaving the hospital sooner and in better health (Dunton & Duncan, 2010).

As nursing shortages continue, many facilities have opted to increase the use of agency staff and to employ migrating nurses to meet staffing numbers. This means using nurses who are unaware of corporate culture and organisational norms, and may not stay long enough to adjust to the workflow and standards of the facility. This can compromise patient care and add to turnover expense and training costs (Buchan, 2009a). Other attempts to remedy the shortage have included increased use of unlicensed assistant personnel. However, contemporary healthcare facilities have increased in patient complexity and acuity, which requires more skilled nurses rather than substitution with unskilled workers, which brings concerns of increased medical errors (Garling, 2008).

Medical errors are costly for the organisation and for the patient. Certainly, a number of recurrent issues exacerbate the incidence of medication errors including interruptions and distractions, poor communication, inadequate staffing levels, high patient acuity and heavy workloads (U.S. Department of Health and Human Services, 2008). Given the current health environment, these factors should to be considered in future workforce planning.

In conclusion, while it is recognised that nursing shortages are cyclic, this global phenomenon is creating a crisis in terms of adverse impacts on healthcare delivery. The challenges for policy makers and leaders are unprecedented in both under-developed and developed countries. Not only are the demands for quality health services increasing under fiscal constraints, but there is also a shrinking supply of quality nursing staff to meet these healthcare demands. As a result of the shrinking supply of nurses, the 'quality' of healthcare has, in many instances, caused patient harm. Strategies to address this have to date been directed towards recruitment of new graduate nurses and migrating nurses, yet minimal effort or consideration has been directed towards retention of an experienced nurses who are currently employed: the EOCN.

## **2.4 Queensland Health and Study Site (Local) Context**

### **2.4.1 Nursing Shortage: Queensland Health and Study Site Context**

Nursing shortages that are being experienced globally are similarly reflected in the Queensland Health (QH) nursing workforce. With Australia's average nurse-to-patient ratio at 1107 full-time equivalent nurses per 100,000 population in 2006, Queensland's ratio fell well below this figure at 1025.3 nurses per 100,000 people. To maintain current service status, there is an estimated need for an additional 14,000 nurses in Queensland by 2014. These forecasts, while conservative, do not include the large predicted retirements from the profession, backfill requirements for leave and training or the anticipated increases in healthcare service (Queensland Nurses' Union, 2010b). With approximately 46% of Queensland's permanent public service employees aged over 45 years in 2008 (Office of the Public Service Commissioner, 2008), there may be an impact on workforce numbers when the EOCNs begin to retire.

Within this context, there is an increased demand for healthcare services, with one scheduled initiative for QH to increase bed numbers by 1700 from 2015–2016. This increase in beds is planned at a time when nurse retirement rates are expected to be escalating and the requirements for additional nurses are becoming even more critical (Queensland Nurses' Union, 2010c). In addition, there appears to be little planning for adequate replacement of EOCNs once they retire or reduce their workforce participation. The pool of expected replacements for the EOCNs is decreasing as the new graduates are experiencing attrition rates as high as 40% within the first two years of employment (Duffield et al., 2009).

Similar to the overall QH situation, nursing shortages have negatively impacted on the study site's ability to provide sufficient qualified staff to cover shift by shift requirements. One major barrier to planning for staffing needs is the lack of collation of accurate and timely workforce data. Information on, and management of, the recruitment strategies has been compromised by a lack of consistent or systematic collation and reporting of this data. Additionally, data sets were not consistently defined across all Service Lines within the organisation.

### ***Study Site Strategies to Overcome Nursing Shortages***

Prior to 2008, strategies adopted to support the reduction of large vacancies included employment of increasing numbers of new graduates and, to a lesser degree, sponsorship of migrating nurses. Additionally, agency and casual staff were employed on a shift by shift basis to support unit staffing and patient requirements. These strategies were considered short term and proved to be an expensive approach to managing the shortages of qualified nurses. Since 2009, as a result of the cost implications, there has been an active drive to recruit permanent qualified nursing staff to the affordable full-time equivalent level of vacancies<sup>8</sup>. In order to support this strategy, a standardised data system and processes have been operationalised. The standardised systems have resulted in successful reduction of agency, casual staffing and migrating nurses' employment with minimal permanent nursing vacancies by 2009. These strategies invite further explanation.

The first strategy to fill vacancies left by resignation of staff with diverse skills was to recruit from the new graduate group. These new graduates required preceptorship and support over an extended period in order to become an effective member of the healthcare team. These programs drew on more experienced nurses to support the graduate nurses. The new graduate employment data reflected discrepancies as not all Service Line Nurse Managers consistently accessed the central database, but rather often employed through other employment networks. However, the available data highlighted the numbers of new graduates employed over the two reported periods remained constant with a slight increase in the numbers employed in 2009 (217) compared to 2008 (180).

The second strategy included the recruitment of migrating registered nurses and demonstrated a number of problems. Complexities included issues such as visa and sponsorship access. In addition, language, comprehension and comparative education standards proved complex and resource intensive concerns. These concerns required that experienced staff support the professional development and cultural integration of the migrating nurses into the country and organisation. As a result of these complexities and their resultant demands on the existing workforce,

---

<sup>8</sup> Affordable full-time equivalent: Relates to the staffing full-time equivalent which has been negotiated and budgeted through using the principles of Business Planning Framework

the facility reduced employment of the migrating registered nurses from 2008 (117) to 2009 (44).

Regardless of the employment of new graduates and migrating registered nurses, vacancy rates remained high for January to June 2008. As a consequence, a third strategy involved employment of agency staff to meet the requirements of service delivery (1769.80 RNs in 2008). Simultaneously, employment of registered nurses to the Casual Pool occurred to support service delivery (1604.05 RNs in 2008). However, as a result of the high costs of agency staff and the resultant financial burden, workforce improvement strategies changed. In 2009, a model for staffing using Business Planning Framework principles was revised and implemented (Queensland Health, 2008). Hence, hiring of agency staff was reduced by 35.8% from 2008 to 2009 and casual staff usage, which was the preferred fiscal option, remained consistent from 2008 to 2009.

The fourth and final strategy to support recruitment gained funding from the Australian Government with financial incentives offered as a 'Return to Work' program for nurses not working in the profession. Acceptance of this initiative remained minimal at the study site due to insufficient nurses to support the transition of this cohort. However, some of these 'Return to Work' positions were accepted by mature aged nurses. This could also be viewed as a short-term solution as they are potential retirees which could exacerbate the nursing shortage projected to occur around 2020 (Drury, France, & Chapman, 2008). Table 2.1 provides a summary of study site trends in vacancy and employment strategies.

**Figure 2.4:1 Summary of Vacancies and Recruitment Options 2008–2009**

Staffing option	January to June 2008	January to June 2009
Vacancy rates	743.12 (1550.01 for 2008)	481.32
New Graduate RNs	180	217
Migrating RNs	117	44
Agency RNs	944.92 (1769.8 for 2008)	338.98
Casual RNs	829.75 (1604.05 for 2008)	766.54
Return to Work	2 (QH 30)	6 (QH 56)



### ***Exit Interview Findings from Registered Nurses (RNs) 45 years and over***

While the collection of vacancies and recruitment data provided information on workforce trends for the facility, minimal information was available concerning the reasons for nursing staff leaving the organisation. As a consequence, voluntarily Exit Interviews were initiated to inform retention strategies.

An environment tool formed the basis for the Exit Interviews with five priority areas including flexibility; professional development; ability to do your job; feeling valued; and feeling safe (Webster, Flint, & Courtney, 2009). Over the period of March to July 2008, data highlighted a response rate of 37% with 22 EOCNs resigning, five EOCNs retiring and four EOCNs transferred within the facility. Currently, the Exit Interview systems and processes are under review as information systems do not support the timely or accurate receipt or retrieval of data. To date, this strategy has not provided sufficient information which could be employed to inform strategies that support the retention of EOCNs.

#### **2.4.2 Economic Rationalism: Queensland Health and Study Site Context**

At a time when hospitals are struggling to meet increasing healthcare demands, there is a need to improve efficiencies to minimise fiscal pressure. These efficiencies may support the funding for resources to meet the increasing healthcare demand. The Productivity Commission estimates that some public hospitals throughout Australia may be operating with up to 20% inefficiency when compared to best practice (Australian Government, 2010). These inefficiencies and their impact have generated much discussion and planning for performance monitoring of facility activities.

Further, without major changes to healthcare delivery, rising health costs will outstrip revenue growth, and state budgets may be at risk of running a deficit, adding to the workload of already overstretched staff. To strive for the delivery of world-class healthcare, the Australian Government aims to undertake major structural reforms of Australia's health system. One of the major proposed structural reforms includes changes to the way hospitals are funded (Australian Government, 2010).

Currently, the Commonwealth supports the delivery of free public hospital services through block grant funding to the states and territories. Allocation of the funding is then determined for each facility (Australian Government, 2010). However, new

proposed reforms are moving to a form of activity-based funding according to services provided. This funding comes at a price, as the states and territories may be required to commit to system wide reform to improve public hospital governance, performance and accountability (Australian Government, 2010). Improvements may only be realised with strong leadership, safety and quality systems, and processes to support best practice.

QH receives a large proportion of the Queensland state budget. It is unrealistic to assume that it can continue to consume such a large and growing portion of the budget, however, the monitoring of performance is expected to support efficiencies and rationalisations (Garling, 2008). One method of performance improvement is the implementation of the QH nursing workload management tool, Business Planning Framework (BPF). This tool is used throughout all facilities to align demand and supply for nursing resources and promote efficiencies (Queensland Health, 2008). While further refinement of the tool is expected to take place over the next few years, many areas are still to fully implement the principles into their management processes.

### ***Economic Policy to Support Transition to Retirement Program***

One method to support the balance of supply and demand is the implementation of the Transition to Retirement Program (TTRP). As facilities are now recognising the need to keep pace with the ageing workforce, flexibility in retirement is acknowledged as vital. Many employees who are eligible to retire intend to remain in full-time employment for a number of years, while others, due to reasons such as health and family commitments, may not be able to maintain their current work hours. Retirement options such as phased retirement, part-time or part-year work are important strategies in retaining and transferring the skills and knowledge within the public sector. This also provides an opportunity for the employee to ease into retirement, rather than an abrupt move from full or part-time work to full-time retirement (Department of Employment and Industrial Relations, 2009). In addition, this change in attitude to working beyond retirement offers an opportunity to retain experienced and knowledgeable nurses in the workforce past planned retirement age.

The Queensland Nurses' Union undertook three surveys on nurses over a seven-year period (scheduled 2001, 2004 and 2007) concerning career breaks and nurses' intentions for retirement. The final results highlighted nurses taking fewer and shorter career breaks and expecting to work longer. Over 60% of forty to sixty-year-old nurses in 2007 expected to remain in nursing well into their mid-sixties, compared to 30% in previous years (Eley, Parker, Tuckett, & Hegney, 2010). This represented a broad cross-section of nurses in Queensland.

In recognition of supporting the extension of the EOCNs' workforce participation, QH progressed with an initiative to formalise the TTRP which incorporated the principles of phased retirement. Initially, this program was trialed at a pilot site within the same Health Service District as the study site. An advantage for staff to consider this transition to retirement strategy after reaching their preservation age included a move towards more flexible work arrangements. Flexibility in work arrangements may include a reduction of hours worked and alteration of duties. In addition, the program could boost superannuation before fully retiring, minimise income tax, reduce debt or increase income as nurses move from full-time to part-time work. These incentives are aimed at retaining the EOCNs in the nursing workforce. However, regardless of the indicated benefits to the employee of delaying retirement, post-implementation evaluation indicated minimal uptake within the pilot site. Further, the study site program introduction claimed no participants (Northside Health Service District, 2008). Previous studies have demonstrated that while the intention of flexible retirement policy was to retain mature skilled workers, the effects are minimal (Parish, 2007). Similarly, a Canadian study confirmed the lack of participation, which may suggest that the reasons for early retirement are multifaceted and pension benefits are but one strategy in a complex decision to retire (Blakeley & Ribeiro, 2008). This highlights the need for further exploration of factors which may influence EOCNs retention in the workforce.

Retirement income policies have the potential to be a strong motivator in extending retirement for nurses. However, the minimal data from Northside Health Service District suggests that a possible barrier could be a general lack of financial preparedness, especially among women. Lack of compulsory superannuation funds prior to 1992 and the high level of part-time work are contributing factors to being financially unprepared to retire (Eley et al., 2010). As a result, a lack of financial

preparedness and the effects of the GFC may influence EOCNs to extend their workforce participation void of other reasons for intended retirement or resignation (Preston, 2009).

#### **2.4.3 Impact of Nursing Shortage on Quality Outcomes of Care: *National and Study Site Context***

As healthcare facilities focus on more economic and patient-focused efficiencies, robust safety and quality frameworks and strategies to measure outcomes are being refined to provide best practice information with the available resources. Of particular interest is consideration to generating Nurse Sensitive Indicators(NSI) <sup>9</sup> to measure strategy efficiencies (Swan, 2008). The refinement of these indicators is critical for the measurement of actual nursing work and the supporting structures and processes. These data are often shared internally and between facilities as a benchmarking activity to compare practice effectiveness (Moss, 2009).

While measurement tools support evaluation of practice, studies indicate that where registered nurses provide continuous patient care, there are better patient outcomes (Duffield et al., 2007b). A skill mix with a higher proportion of registered nurses demonstrated a statistically significant decrease in rates of adverse patient outcomes. This is demonstrated by examples of NSI which include decreasing rates of patients experiencing decubitus ulcers, pneumonia, sepsis and patient falls when a higher proportion of registered nurses provided care (Dunton & Duncan, 2010). Further studies indicate that adverse events occur more frequently when nursing activities such as medication administration are undertaken in a distractive work environment (Coombes, Heel, Stowasser, Reid, Henderson, & Mitchell, 2005; Garling, 2008). In addition, systems and supports in the work unit, such as the availability of a nurse educator, have been shown to decrease adverse events (Duffield et al., 2007b). Therefore, in a time of nursing workforce shortages and the need for quality health outcomes, it is critical to investigate the possibilities of retaining experienced and qualified nurse such as the EOCNs within the healthcare system.

---

<sup>9</sup> Nurse Sensitive Indicators: Reflect the structure, process and outcomes of nursing care, e.g. patient falls, pressure ulcers

## **2.5 The Research Problem Defined**

The achievement of quality outcomes is dependent on an adequate supply of qualified, committed nursing staff. The premature attrition of the EOCNs potentially contributes to the nursing shortage which influences quality outcomes. The premature retirement of EOCNs is expected to have a negative impact on the numbers of qualified nursing staff in the near future. The withdrawal of this cohort from the nursing workforce may reduce the distribution of organisational knowledge within the nursing profession and so contribute to diminished quality in health outcomes. Therefore, the retention of the EOCN is a critical workforce challenge and should be considered if leaders are to effectively manage the debate between economic efficiencies and quality outcomes (Duffield, et al., 2007b). Reforms to reduce barriers to prolong workforce participation, particularly for the EOCN, may support and increase economic growth, thus reducing future staffing, quality and economic pressures (Treasurer of the Commonwealth of Australia, 2010).

Reduction of experienced nurses in healthcare is a particular contemporary problem in the second decade of this century. Almost all of the baby boomers' group, to which the EOCN belongs, will be at prime retirement age by 2010 (Preston, 2009). While the average age of a registered nurse was 43.8 years in 2007, the proportion of those 50 years and over increased to 33% in the same year (Australian Institute of Health and Welfare, 2009). There is also a trend for the EOCN to retire between 50 and 55 years of age, with a preference for work hour reduction prior to actual retirement. Recently, there has been some evidence to suggest delays to this retirement trend as a result of the GFC, however, reversal of the broader economic conditions may see this be a short-term trend. The challenge is to identify what can entice the EOCNs to extend their workforce participation. There is little known about the reasons for the EOCNs' premature retirement or their resilience to stay, and organisations and policy makers have skirted this issue in preference for diverse recruitment drives.

Factors contributing to the need for retention of EOCNs during nursing shortages are insufficient numbers of new graduates to replace potential retiring EOCNs and a disillusionment with nursing as a profession, have contributed to nurses often choosing other more satisfying career options (Norman, Donelan, Buerhaus, Willis, Williams, & Ulrich, 2005). While numerous government reports have recommended

strategies to address the current shortage (Australian Health Ministers' Conference, 2004), none have recognised the value of retaining the most experienced practitioners who are on the brink of retirement – the EOCNs (The Lewin Group, 2009a). Retention of the EOCN may not only rebalance the registered nurse population in a time of shortage, but also, if given the opportunity may opportunistically support the development of lesser experienced nurses prior to the EOCNs' retirement.

The pressure to provide efficient and effective services with fewer resources will continue. In tandem, employers face an older and smaller registered nurse workforce, and the increasing demands weigh heavily on this ageing cohort. While older, experienced nurses may represent a more stable workforce; specific reasons why EOCNs prematurely leave are not known (International Council of Nurses, 2007; Johnston, 2007).

Consequently, the problem that this research intends to address is the phenomenon of EOCNs prematurely retiring from the healthcare workforce.

### **2.5.1 Purpose of the Research**

The purpose of this study is to *explore factors that influence EOCNs' decisions regarding their workforce participation.*

### **2.5.2 The Major Research Question**

The major research question that focuses the conduct of this research is:

*How do particular factors influence EOCNs' decisions regarding workforce participation?*

## CHAPTER THREE: LITERATURE REVIEW

### 3.1 Introduction

The purpose of this thesis is to *explore the factors that influence EOCNs' decisions regarding their workforce participation*.

The purpose of this chapter is to generate a review of the literature that identifies and amplifies issues underpinning the purpose of the thesis.

#### 3.1.1 Conceptual Framework

The conceptual framework of *Factors which influence EOCNs' decisions regarding their workforce participation* evolved during the process of reviewing the literature in light of the research problem. (Figure 3.1:1).

A synthesis of the literature generated four key themes:

1) *Workplace Environment*; 2) *Leadership*; 3) *Personal and Professional Recognition* and 4) *Effort-Reward Balance*. These themes are the foundation for the conceptual framework which offers an explanation for understanding why EOCNs continue to participate in the workforce.

In addition, two distinct perspectives are represented within the conceptual framework. The left side of Figure 3.1:1 indicates the themes that influence the EOCNs' decisions regarding workforce participation. The right side of the diagram indicates the decision outcomes regarding workforce participation made by the EOCN as a result of the impact of the influencing themes. Lines and arrows indicate the direction of these influences towards the EOCNs' decision. Within the construction of this conceptual framework, there is an implicit acknowledgement that the EOCN's decisions regarding workforce participation will have a consequential and rebounding influence on the contextual factors.

#### **Contextual Factors**

Contextual factors including the Nursing Shortage, Economic Rationalism and Quality Outcomes of Care have an influence on the context in which EOCNs practice. These factors are depicted by lightly shaded waved lines at the extreme left of the

conceptual framework diagram. The shaded patterns and dotted lines represent the indirect influences that these contextual factors have on the decisions regarding the EOCNs' workforce participation.

### **Major Concepts**

Three major themes are depicted as yellow shapes to represent the major influences on the EOCN decision making. The first theme of **Workplace Environment** is a compilation of issues found within the organisation. It includes *workload levels*, *the skill mix ratio* of registered nurses, enrolled nurses and unlicensed carers, and *personal risk factors* such as workplace injury, occupational stress and workplace violence.

The second theme of **Leadership**, which includes issues such as the effectiveness and *cohesiveness of communication* between team members, *flexibility* of management issues and *work-life balance*, the *commitment* to the organisation and the profession, the leadership team's ability to provide the opportunity for EOCNs to perform *autonomously* within their role.

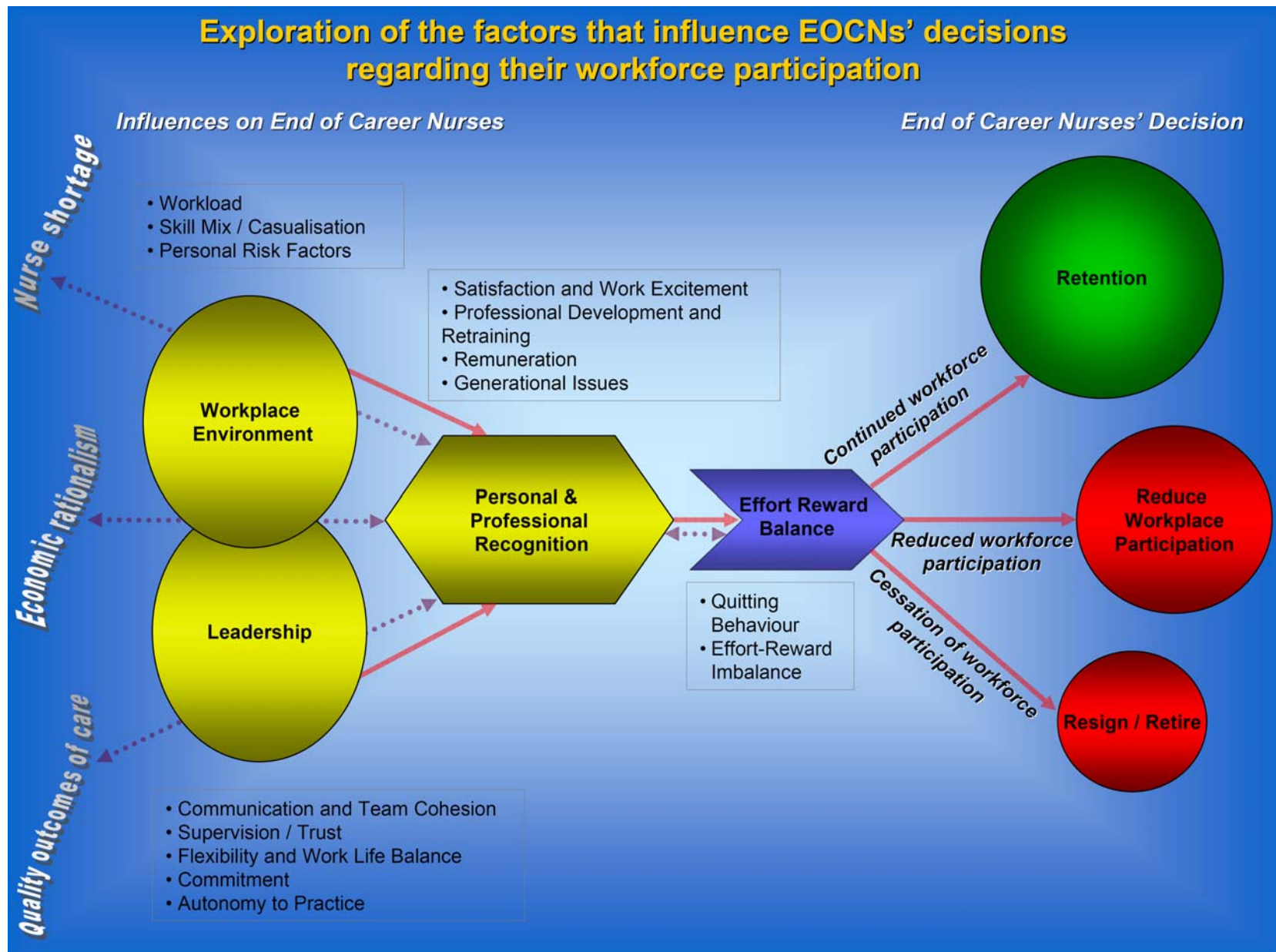
The third theme of **Personal and Professional Recognition** includes *job satisfaction and work excitement* specific to the EOCN, opportunities for ongoing *training and retraining*, *multigenerational interactions* and *remuneration* comparative to educational requirements of other professional occupations. There is a degree of overlay between themes one and two. This third theme involves a personal focus and therefore involves syntheses and interpretation of the previous contexts prior to the final EOCN's decision making, which occurs following the fourth theme.

The fourth and final theme of the **Effort-Reward Balance** is represented as dark solid lines and is influenced by associations with contextual factors and the three previous themes. This juncture is depicted as a blue arrow indicating action to progress. The EOCN's process for decision making on workforce participation considers factors such as '*quitting*' behaviours and considers this decision through the *effort-reward imbalance model*. The EOCNs' decision on workforce participation is shown as taking one of three directions. The EOCN may: 1) continue their workforce participation without change (retention); 2) reduce workforce participation or 3) cease workforce participation (retire or resign).



It is through the exploration of these major themes and their relationships that their significance in relation to the research problem can be determined. This chapter explores workforce participation of the EOCN in relation to features of the workplace environment in which they practice, the behaviours and characteristics of organisational leadership and the value of the EOCN as demonstrated through personal professional recognition and reward.

Figure 3.1:1 Conceptual Framework for the Literature Review



### **3.1.2 Sequence of the Literature Review**

To demonstrate the conceptual framework, key concepts identified through the literature review are listed in Table 3.1:1. Although these concepts are presented in a linear manner within the conceptual framework, they are discussed as interrelated concepts throughout this review.

***Table 3.1:1 Sequence of the Literature Review***

#### **3.2 Workplace Environment**

3.2.1 Workload

3.2.2 Skill Mix / Casualisation

3.2.3 Personal Risk Factors

3.2.4 Summary and Research Question

#### **3.3 Leadership**

3.3.1 Communication and Team Cohesion

3.3.2 Supportive/Trust

3.3.3 Flexibility and Work–Life Balance

3.3.4 Commitment

3.3.5 Autonomy to Practice

3.3.6 Summary and Research Question

#### **3.4 Personal and Professional Recognition**

3.4.1 Job Satisfaction and Work Excitement

3.4.2 Professional Development and Retraining

3.4.3 Remuneration

3.4.4 Baby Boomers versus Other Generations

3.4.5 Summary and Research Question

#### **3.5 Effort–Reward Balance**

3.5.1 Quitting Behaviours

3.5.2 Effort–Reward Imbalance

3.5.3 Summary and Research Question

#### **3.6 Conclusion**

## **3.2 Workplace Environment**

Workplace environments have the capacity to influence the EOCN's decision to stay within their employing organisation and the nursing profession. In particular, environmental factors such as heavy workload, workplace injury, skill mixes and increasing casualisation can impact on nursing staff and may be the cause of undesirable health outcomes such as workplace stress (Duffield & Roche, 2009). Additionally, there is evidence that heightened risk of violence such as harassment or disruptive behaviour also contributes to workplace stress, rendering the health workplace a volatile and hostile environment in which to practice (Eley et al., 2010). Collectively, these environmental complexities project an image of a profession in chaos, resulting in nursing being viewed as an unstable and unsafe career option. As a consequence of this volatile environment and potentially undesirable work environment, nurses may be influenced to reduce their workforce participation, retire from the organisation or leave the profession permanently (Smith, Oczkowski, & Smith, 2008). Decisions of EOCNs to prematurely reduce their workforce participation as a result of negative workplace environments may have serious long-term effects on a professional already challenged with a critical nursing shortage (Australian Nursing Federation, 2008).

### **3.2.1 Workload**

As a result of a more complex and challenging healthcare sector, nursing workload has increased over the past decade (Hegney, Tuckett, Parker, & Elay, 2008). Current nursing shortages result in poor skill mixes and heavy nursing workloads, and contribute to attrition from the nursing workforce. Changes such as increasing patient complexities and increased acuity, reduced patients' length of stay, nursing shortages, restructuring of services and cost containment initiatives contribute to increasing nursing workload undertaken on a shift by shift basis (Duffield et al., 2006). Heavy nursing workload has been shown to increase turnover; however, of particular concern to this review is the influence that excessive workloads may have on the EOCN's decision to prematurely reduce their workforce participation. Heavy nursing workload is a major cause of stress and dissatisfaction with the profession and, together with the nursing shortage, has reduced the available number of qualified nurses, forcing the profession to utilise other less qualified staffing options to support service provision (Buchan & Aitken, 2008).

Healthcare services are dependent on appropriate numbers of competent skilled nurses to provide quality care. Furthermore, a study across five countries suggested there were insufficient registered nurses to provide quality care and complete the necessary work due to excessive workload causing increasing dissatisfaction (Aiken, Clarke, Sloane, Sochalski, Busse, Clarke, 2001). It is suggested that unsustainable workload levels, exacerbated by an increase in unqualified workers and a reduction in the number of qualified nurses, may be one of the reasons for the reduction in quality care outcomes (Forster & Queensland Health, 2005). Currently, experienced EOCNs may find that they are expected not only to manage heavy workloads in the patient care environment, but also manage the shift coordinator role while holding a preceptor and/or mentor portfolio to support junior and unqualified staff (Hegney, Plank, Buistra, Parker, & Eley, 2005). These multiple roles are a further workload burden for the EOCN.

In addition to managing multiple roles, the EOCN faces the challenges of short-term and often detrimental strategies such as paid or unpaid overtime, double shifts, increased hours for part-time staff, cancelling services and bed closure that are often implemented (Johnston, 2007). As a result, there is a reduction in the quality of health services that has been demonstrated by increased nursing errors as nurses deal with the challenges of balancing workload and service provision. Risks of error have been found to be three times higher when nurses work overtime, twelve hour shifts and/or over 40 hour weeks (Rogers et al., 2004). Additionally, the probability of making an error in this context was unaffected by age or experience of the nurse (Rogers et al., 2004). While this report may have limitations due to reliance on staff self-reporting, the staff reported a significantly higher response rate than the formal hospital reporting system. While the collection of accurate data demonstrated inherent difficulties, this study does show an association between errors and long work hours and heavy workload.

Quantifying nursing workload is difficult due to the lack of a common definition or objective measure of nursing work. Any measurement tool will not be comprehensive due to the “invisible nature of nursing work” (Duffield et al., 2006 p. 21). Further, the inconsistent collection of workload data has rendered it impossible to determine if nursing workload levels have increased or to quantify nursing outcomes (Cox, Teasley, Zeller, Lacey, Parsons, Carroll, 2006; Duffield et al., 2006;). As the current

nursing shortage is predicted to escalate to critical levels (Forster & Queensland Health, 2005), workload is not likely to diminish due to increasing patient acuity, decreasing numbers of qualified staff and insufficient resources. Consequently, consideration of nursing workload is paramount as the EOCN contemplates retirement or reduction of work hours, both of which will further exacerbate the nursing shortage.

Determining appropriate staffing allocations has been made more difficult because of the type of data used to quantify nursing workload (Twigg & Duffield, 2009). Historical data on nurse–patient ratios were often used for staff allocation and seldom reflected changing skill mix requirements or patient needs (Forster & Queensland Health, 2005). Due to nurses lobbying for appropriate staffing allocations, initiatives such as workload committees were developed. However, these committees and aligning processes were perceived to be ineffectual by the majority of participants in a 2003 survey on nursing workload (Hegney, Plank, & Parker, 2003). A survey in 2007 by the Queensland Nurses' Union reconfirmed these perceptions with the majority of participants indicating workloads remained 'heavy' (Hegney et al., 2008). Consequently, without a common method of measuring nursing workload or determining staffing allocations, nurse managers may have to defend appropriate recruitment needs (Forster & Queensland Health, 2005). However, one study did suggest that it was insufficient to use patient acuity in isolation to measure nursing workload (Spence, Tarnow-Mordi, Duncan, Jayasuryia, Elliott, & King, 2006). Organisational factors could be a more powerful influence on nursing workload than patient acuity as effective team processes and the manager's organisational ability were shown to decrease the nurse's workload (Spence et al., 2006).

The importance of quantifying of nursing workload is highlighted by the projected dearth of nursing numbers. Queensland requires an additional 14,000 nurses by 2014 to maintain current service status; however, this estimate is conservative as it is not inclusive of the increasing demands on healthcare services, backfill for professional development or predicted retirements from the EOCN cohort (Queensland Nurses' Union, 2010b). From 2006 to 2026, the total population is expected to grow by 24% and the population aged 65 years or more by 79%. This growth in the aged population, even when offset by policies for reduced hospital stay, has been projected to increase demand for hospital bed days by approximately 40%

from 2005 to 2025 (Schofield, 2007). Furthermore, the Queensland public health sector continues to have the lowest number of health professionals per capita of any Australian State or Territory except for Tasmania (Forster & Queensland Health, 2005), which will increase workload in the health system and consequently increase workplace stress. These figures strongly suggest a critical nursing workforce shortage in the future which will make it impossible to meet increasing demands for healthcare services. Therefore, retention of EOCNs in the workforce supports a strategy for maintaining a stable and sufficient nursing workforce into the middle of the 21<sup>st</sup> century.

Initiatives to improve the imbalance in nursing workload and service provision have included the development of the Business Planning Framework (BPF) (Queensland Health, 2008). This framework was designed to support leaders and managers in the complex task of ensuring financial integrity while providing sufficient resources to support work unit requirements. Some facilities have employed the BPF with the intention of balancing supply and demand of nursing ratios and financial budgets. However, the emphasis for many organisations has been on meeting budget integrity rather than managing a nursing workload (Queensland Nurses' Union, 2009a). Consequently, some authors have been critical of the supply and demand approach to predicting required nursing resources due to its lack of complexity and rigour in understanding future nursing needs and quality outcomes (Duffield et al., 2006). It appears that heavy nursing workload, exacerbated by inappropriate staffing allocations, has a direct impact on the nursing shortage through attrition for various reasons (Duffield et al., 2009).

Furthermore, an Australian nursing review identified dissatisfaction and discontentment with the current workplace environment as nurses' personal and professional needs were unmet due to heavy nursing workload (Department of Education Science and Training, 2002). In addition to unsustainable workload, the review highlighted an unsupportive workplace environment which included experiences such as "endless shift work, low pay, horizontal violence, social isolation, risk of injury and disease" (Department of Education Science and Training, 2002 p.180). Because this review was limited by a population of nurses with no specific age cohort, the findings may not be generalisable to the EOCN cohort. Unsustainable workload is also a major cause of stress and dissatisfaction within the nursing

profession, which in turn increases the likelihood of turnover or reduced workplace participation (Duffield et al., 2009). Therefore, the association between unsustainable nursing workload, increased stress levels and job dissatisfaction supports the notion that the EOCNs are at risk of reducing their workforce participation.

Additionally, an unsupportive workplace with increased workload reduces the time available for staff to meet both personal and professional needs (Forster & Queensland Health, 2005). Overall, nurses choose the profession to care for patients rather than high professional status or remuneration. However, nurses' personal and professional needs are often unmet when unsustainable workload eliminates one of the most rewarding components of their role, resulting in attrition as a favourable option (Day, 2007). Over 43% of nurses in the aged care sector and 42% of nurses in the acute care setting in Queensland reported difficulties meeting patients' needs. Further, 32% of these nurses suggested that these difficulties in meeting patients' needs were due to insufficient staffing levels (Hegney et al., 2008). While this study was extensive and the response rate was high, only financial members of the Queensland Nurses' Union were included in the sample. A non-response bias may exist if the attitude of respondents and non-respondents differed on selected issues (Polit & Beck, 2008). In summary, the EOCN and their patients' needs are at risk of not being met in a climate of heavy workload and staffing shortages.

Nurses may be required to prioritise and eliminate components of their work as a result of heavy workload. Changes to healthcare over the past decade have impacted on the work that nurses undertake and how they use their time and skills. Increasing amounts of documentation and reporting consumes considerable amounts of nurses' time, which reduces the time spent on direct patient care (Duffield, Gardner, & Catling-Paull, 2008). Increasing patient acuity and complexity, reduced length of patient stay, increased technology and risk of litigation have increased the requirement for documentation with duplication of data a common occurrence (Gugerty, Maranda, Beachley, Navarro, Newbold, & Hawk, 2007). Further compromising the time available for patient care is the need for nurses to undertake non-nursing duties such as housekeeping, cleaning beds and collecting equipment (Tourangeau, Cummings, Cranley, Ferron, & Harvey, 2009). This situation remains in some facilities as a consequence of hospital 'downsizing' where support staff have been reduced. Australian nurses were found to allocate 9% of their time to



performing clerical duties, filing and delivering messages (Duffield, Forbes, Fallon, Roche, Wise, & Merrick, 2005). This situation has the potential to impact on the quality of patient care, decrease job satisfaction and increase turnover in a time of nursing shortages (Tourangeau et al., 2009).

Prioritising components of nurses' work may further lead to unmet personal and professional needs. This situation is often managed by sacrificing 'invisible' work such as emotional support for more obvious tasks (Duffield et al., 2008). Rather than reducing expected tasks such as medication administration, nurses compensate for unmanageable workloads by donating their own time. Furthermore, measurements of workload do not reflect the complexity of the patient situation or the unpredictable patient events which directly impact on the EOCN's work situation (Twigg & Duffield, 2009). There is a dissonance between organisational priorities and values and those of the nurse. This may result in the nurse being left to compensate their work for this inadequate system (Duffield et al., 2008). This situation may cause fatigue, burnout or moral distress leading to premature reduction of workforce participation for the EOCN.

The advancing age of the EOCN may combine with the heavy nature of nursing workload to influence the EOCN's decision about continuing in the workforce (Forster & Queensland Health, 2005). While not a nursing study, the productivity and health and safety of the general older worker was found not to be problematic in the workplace (Department of Communities, 2008). Function loss has been associated with the ageing, however, this can be minimised by regular physical activity. Furthermore, the EOCN age group often has a greater level of mechanical skill than the younger employee, which may enable them to compensate for any muscular weakness. This confirms the EOCN's equal value with regard to their physical contribution to the workplace. In contrast, heavy workload may be simply tiring and in some cases may be the cause of permanent injury in all age groups (Department of Industrial Relations, 2005). Moreover, while permanent injury is a risk, it is suggested that support for the injury is often non-existent, which may influence the EOCN in their decision of continued workforce participation.

As the EOCN cohort prepares to retire, heavy workload may cause them to consider whether or not to remain in the workforce, causing increased workforce shortages in

an already compromised healthcare system. Further, an increased number of ageing individuals accessing the healthcare system may contribute an additional strain on service provision. Simultaneously, a reduction of workforce participation of the experienced EOCN will cause a reduction of the largest nursing cohort (Duffield et al., 2006), which may further compromise inappropriate skill mixes, nursing allocations and quality outcomes.

### **3.2.2 Skill Mix / Casualisation**

Providing an appropriate skill mix of nurses over a 24-hour period seven days per week is made more complex due to an international nursing shortage (Garling, 2008). As a consequence of the limited supply of qualified nurses and the resultant consistently high workload, nurses are choosing part-time or casual employment over full-time employment or are permanently leaving the profession. This situation contributes further to an inappropriate skill mix of qualified staff to less qualified staff (Hart, 2006). The lack of qualified staff is responsible for adding to the current nursing workload by placing extra supervisory responsibilities on the experienced nurse. These additional responsibilities are a result of the need to clinically support casual or agency staff through long and inflexible shifts (Norman et al., 2005). Due to inadequate staffing and excessive demands placed on the EOCN's time by unqualified staff, there is a potential for quality of care to be compromised with consequential increased stress.

The trend towards casualisation has increased the workload of experienced and permanently employed nurses as they are required to support a floating population of casual, agency or migrating nurses. This floating population is casually employed to bridge the shortages in the workforce (Lee & Mills, 2005). Reasons for seeking casual employment vary and may include: 1) combining paid work with family responsibilities; 2) studying and pursuing other interests; 3) gradually reducing of workforce participation as retirement nears or 4) supplementing the family income (Batch, Barnard & Windsor, 2009). The fifth reason for the trend to casualisation is multigenerational differences, which requires further amplification. As Generation 'X' and 'Y' favour a healthy work-life balance, they are likely to be attracted to casual employment to met these needs (Henry, 2007). This reduction in workforce participation may then result in an increase to the EOCN's workload as they are left to juggle commitments of work and a range of diverse family issues. The EOCN, who

commonly belongs to the 'Baby Boomer' generation, places a priority on fulfilling work commitments; however, this will be challenged as other registered nurses move to casual shift work to retain a work-life balance (Hatcher et al., 2006). Dissatisfaction with this imposed workload may prompt the EOCN to reduce workforce participation by adopting casualisation as a short-term strategy and a way to maintain their work-life balance; however, equity of leave and financial benefits may be a point of consideration.

Illustrated by equity issues, casual employees are disadvantaged as they receive lower long-term financial and leave benefits. Additionally, the ability to access organisationally offered professional development opportunities is reduced for the casual worker, which may impact on their ability for innovation, continuity of service provision and quality outcomes (Buchan, 2009b). In contrast to limited employment opportunities, casualisation may be favoured as a benefit to the employee. Compensation or remuneration strategies which have developed as a response to the nursing shortage may reverse the intent by supporting nurses to reduce their hours of workforce participation (Batch et al., 2009). While increased penalty rates have been granted for hours of peak demand or less favourable shifts, nurses may choose to work at these times to receive the higher remuneration benefits. This allows them to reduce the hours worked per week while maintaining the same income (Zeytinoglu, Denton, Davies, Baumann, Blythe, & Boss, 2006). Organisations may lose the expertise of the EOCN if they are disadvantaged by financial equity issues or their personal and professional needs are not met.

Consequences of selecting to work casually can impact on the EOCN's decision to reduce workforce participation if disadvantages outweigh the benefits. Additionally, the EOCN's decision to reduce their hours from full-time to casual employment may disadvantage them if they are placed in non-career positions and therefore have reduced opportunities for career progression (Hatcher et al., 2006). As a result, there may be difficulty in retaining this cohort at least until their preservation age of 55 years. Consequently, placement in non-career positions could be considered as devaluing the EOCN's skills and knowledge. With no career prospects and a consistently heavy workload exacerbated by inappropriate skill mixes, there seems little to encourage retention of the EOCN in the workplace.

Currently, the effort to increase staffing numbers has seen unregulated workers increasingly being employed – a strategy that is not without risk from a quality perspective (Forster & Queensland Health, 2005). Due to cost containment, unregulated workers are most commonly being employed in the aged care sector (Hegney et al., 2008). As a result of there being no minimum standard for these workers, it is impossible to establish standards for their work practices. Consequently, there is no professional alignment, which places additional stress on the supervisory role of the experienced registered nurse. This has a direct impact on the workload of the EOCN (Queensland Nurses' Union, 2009b). Concern has been raised that a minimum health worker educational standard of Certificate III is required to promote best practice (Garling, 2008). However, at this point, the standard remains a workforce regulation of the employing organisation rather than a national imperative. As a result of increasing employment of unregulated workers, the EOCNs' workload responsibilities escalate.

Studies have supported the need for a well qualified nursing workforce by demonstrating an association between higher levels of staffing by registered nurses, better outcomes and lower rates of adverse events (Duffield et al., 2007b). For example, a large study of 799 hospitals over 11 states in the United States of America (USA) found consistent evidence that a higher proportion of hours of nursing care provided by registered nurses and a greater number of registered nurse hours per day were associated with better outcomes for hospitalised patients (Needleman, Buerhaus, Mattke, Steward, & Zelevnsky, 2002). Some organisations compromise staff allocations with potential risk of liability as a result of increasing numbers of less qualified workers delivering care without the level of skill required to work unsupervised (Tourangeau et al., 2006). The risks associated with inappropriate skill mix may cause the EOCN to resign or reduce workforce participation due to increased stress related to extended supervisory responsibilities for unqualified staff and reduced quality patient outcomes.

Despite higher proportions of registered nurses being associated with fewer adverse events, the healthcare sector is increasing the proportion of unregulated workers to support staff numbers in the work units (Duffield et al, 2007b). The staffing complexities of increasing employment of agency and casual staff are further complicated by increasing workplace dissatisfaction with workload issues. In a

climate of nursing shortage, skill mix changes and heavy workload, the EOCN may feel challenged to reconsider their ability to achieve quality outcomes for patients.

### **3.2.3 Personal Risk Factors**

Personal risk factors have the potential to influence the EOCN's decision about workforce participation and come at considerable cost to the organisation and the nurse. These risk factors include workplace injury such as musculoskeletal injuries (Norman et al., 2005; Zaloshnja, Miller, & Waehrer, 2006); organisational stress (Cyr, 2005); and workplace harassment and violence (Hegney, Eley, Plank, & Buikstra, 2006a) and may lead to a decrease in physical or mental wellbeing. For the EOCN, this situation may place them at risk of harm and cause them to consider reducing their workforce participation or leaving the profession permanently.

#### **3.2.3.1 Workplace Injury**

Jobs with high demand and low control factors have been identified as having an association with adverse physical and mental health outcomes for women in healthcare (Letvak, 2005). This is relevant as the nursing profession is predominately a female population (90.4%) (National Health Workforce Taskforce, 2009). Specifically, heavier workload and longer shift hours, aggravated by nursing shortages can lead to workplace injury (Australian Nursing Federation, 2008). Work related injuries range from mental health problems to coronary disease (Letvak, 2005) with nurses often leaving the workplace or profession as a consequence (Australian Nursing Federation, 2008). While older registered nurses employed in the hospital setting are more likely to report job-related injuries than their younger counterparts, organisations lack policies to address the needs of the older worker (Letvak, 2005).

Due to the heavy workload related to caring for patients in chaotic conditions, nurses from all age groups are increasingly susceptible to musculoskeletal injuries at great costs to the organisation and the individual. Increasing age when combined with years of nursing is a precursor to reduced physical health, with the majority of nurses suffering from recurrent episodes of neck, shoulder or back pain (Chang, Daly, Hancock, Bidewell, Johson, Lambert, 2006). Further, a 2007 study found nurses described that heavy workloads, excessive tiredness, lack of support and high stress level contributed to their chronic back problems (Gabrielle, Jackson, & Mannix,

2007). While workplace health and safety policies mandate the use of supportive equipment such as manual handling devices, their use is minimised as a result of lack of time and access, which leads to back injuries. Back injuries are the most frequently documented workplace injury for nurses and are a contributor to staff turnover (Norman et al., 2005). The Victorian Government has demonstrated success in the implementation of a 'no lifting' policy in the public health sector in 2000, which reduced manual handling injuries by 48%, compensation claims by 54% and decreased work days lost by 74% (Australian Nursing Federation, 2004). In response, the Australian Federal Government has proposed funding a 'no lifting' policy across all public health facilities at a cost of \$60 million over three years (Australian Nursing Federation, 2008).

An additional major personal injury risk is contracting Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or hepatitis from a needlestick injury. This danger of this injury is illustrated by a report of an almost 200% increase in the likelihood of needlestick injury when workload is high, staffing levels are inappropriate and morale is poor (Clarke, Rockett, Sloane, & Aiken, 2002). However, the introduction of a needle-less system throughout many Australian healthcare facilities has minimised the risk of this injury. Although transmission of blood-borne pathogens is largely preventable through the use of universal precautions and safe needle equipment, the highest cohort reporting injuries are those between 41 and 50 years (Ulrich, Buerhaus, Donelan, Norman, & Dittus, 2005). With only one in four needlestick injuries reported to hospital authorities, underreporting of these and other workplace injuries may be an organisational problem (Clarke et al., 2002). The rationale for the higher reporting of workplace injuries by the older cohort may be a result of recognising the importance of incident reporting as a means to promote and maintain quality outcomes. As retirement is looming, the EOCN may alternatively view reporting as less intimidating to the hospital authorities than their younger cohort; however, there is minimal recognition for the EOCN's contribution to health and safety issues in the workplace (Letvak, 2005).

Finally, research on shift work indicates that fatigue can result from a loss of regular sleeping times, and an increase in age also contributes to the resultant fatigue (Letvak, 2005). Older nurses report delayed recovery from sleep deprivation compared with their younger years and, as a result, often returned to work exhausted

(Gabrielle et al., 2007). This poses a particular risk for the EOCN. Ageing decreases the speed of circadian rhythms to night work, increasing the risk of sleep disorders and aggravating other conditions such as diabetes, psychiatric conditions and epilepsy (Letvak, 2005). The risk of fatigue-related car accident following a shift was similarly cited by 18.8% of nurses as a safety concern (American Nurses Association, 2001). The long and potentially tiring shifts demanded by organisations from their nursing workforce would need to be reconsidered if the EOCN is to choose to remain in the workforce and preserve their health and safety.

Heavy workload and nursing shortages impact on the health and wellbeing of nurses (Garling, 2008). While the nursing workforce is ageing, there is little known about the health and safety aspects of the older nurse. However, a survey of nurses over 50 years of age found that almost 25% experienced a job-related injury in the past five years and over 30% experienced job-related health problems. Despite these injuries, this study found that collectively, older nurses reported higher levels of physical and mental health than the national norm (Letvak, 2005). As a result, the EOCN may consider the implications of workplace injury as a component within their decision of workforce participation. Healthcare organisations are therefore obliged to make an effort to maintain the physical and mental health of the EOCN in order to support their retention within the workforce.

### **3.2.3.2 Workplace Stress / Burnout**

Heavy nursing workload with resultant risk of workplace injury is further complicated by the inability to recruit and retain experienced nurses. The work environment may not be conducive for nurses to meet their personal and professional needs as a result of the current nature of nursing work. Nurses are at high risk for experiencing emotional stress as exhaustion, frustration and stress are commonly described as the 'normal daily routine' (Lafer, 2005). Nurses suffering from continual emotional stress have an increased chance of suffering from burnout (Cyr, 2005) with other damaging effects causally connected to mental health problems, elevated blood pressure and asthma (DeVries & Wilkerson, 2003). Burnout may be defined as "the syndrome of physical and emotional exhaustion, involving the development of negative self concept, negative job attitudes and loss of concern and feelings for clients" (Pines & Maslach, 1978 p. 233). Additionally, burnout is an outcome of lower levels of autonomy and micro-management, which may result from a dissonance between the

individual nurse's expectations to fulfill their professional role and organisational structure (Norman et al., 2005). Poor working conditions, inadequate resources, increased stress levels and disillusionment with the management of their personal and professional life often results in nurses leaving organisations (Human Resources, 2005). A Queensland study conducted on three occasions from 2001 to 2007 identified that 95% of nurses rated job stress as 'high' in their workplace (Hegney et al., 2008), which places staff wellbeing at risk.

As a result of burnout, the nurse may lose all concern and emotional feeling for colleagues and/or patients, treating them in a detached or even depersonalised manner (Maslach, 1976). Depersonalisation is defined as "the development of negative, cynical attitudes towards recipients of one's service or care" (Demerouti, Bakker, Nachreiner, & Schaufeli, 2000, p. 455). As a result of detached behaviour, nurses' feelings may be demonstrated by cynical or negative view points, or derogatory comments (Leiter, Harvie, & Frizzell, 1998; Pines & Kanner, 1982;). It follows that burnout may be associated with a reduction in quality of care (Erickson & Grove, 2007). Nursing is a caring role and there is a professional and personal need to achieve quality patient outcomes. Burnout and associated symptomatic behaviours may not allow nurses to meet their personal and professional needs, thus rendering continued participation in the workforce an unlikely option.

Nurses with high job demands such as intense interactions with patients, and high physical and cognitive workloads may have strong associations with emotional exhaustion, energy depletion or draining of emotional resources (Lafer, 2005). Each additional patient per nurse has been shown to be associated with a 23% increased risk of burnout and a 15% increased risk of job dissatisfaction (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002). In addition, poor reward systems, inability to participate in decision making and disillusionment with work can increase staff turnover (Duffield et al., 2009). In contrast, reward initiatives and sound communication processes are associated with health and wellbeing for nurses (Gelsema, van der Doef, Maes, Janssen, Akerboom, & Verhoeven, 2006). As satisfied employees rise to the challenges of the workplace and are more resistant to job strain and burnout, nurse leaders are well placed to foster EOCN satisfaction within the work environment (Gelsema et al., 2006).



Job demands, lack of job control and lack of social support from leaders and colleagues are associated with burnout and health problems for nurses (Gelsema et al., 2006). If the social environment is supportive, burnout is not likely to occur, even if the work is stressful (Lafer, 2005). Lowering the work pressure and physical demands, and providing sufficient time to provide quality care may prevent serious health consequences for nurses, improving job satisfaction and ultimately nurse retention (Gelsema et al., 2006). Even so, it has been argued that job demands may become too high to be buffered with ordinary supporting networks (Lindholm, 2006). The concept of organisational and collegial support within a stressful environment is equally relevant to the EOCN regardless of the length of service or experience within the profession. If this social support is not forthcoming, the EOCN may reduce their workforce participation.

Women in roles with high demands, low control and low social support show the greatest decline in health status (Ulrich et al., 2005). Consequently, the personal cost of potential declining health status as a result of high stress levels or burnout may have a direct impact on the inability to recruit and retain experienced nurses (Lafer, 2005). In the United Kingdom, excessive costs to the individual and the organisation resulting from job stress are estimated to be in excess of £4 billion (~\$A6.8 billion) (Wright, 2005) and cause a loss of approximately 13 million work days per year (Laurence, 2003). As a result of continued stress or burnout, there is a strong correlation between sick leave and overtime (Norman et al., 2005), which is negatively associated with satisfaction and turnover (Erickson & Grove, 2007). The nursing profession is already challenged with difficulties in recruitment and retention. To offer employment which is further compromised by high stress levels and burnout will not be viewed favourably as the EOCN contemplates their workforce participation. A Swedish survey of nurses working in aged care studied the relationship between staff satisfaction with work and perceived stress levels (Engstrom, Ljunggren, Lindqvist, & Carisson, 2006). The findings suggested that staff who reported lower levels of stress symptoms were older and this same cohort was more satisfied with their current workload (Buerhaus, Donelan, Ulich, Norman, & Dittus, 2006). Similarly, the notion that older nurses were less likely to experience agitation or burnout may be a positive consideration for the EOCN in providing emotional mentorship to their younger colleagues.

However, healthcare can not afford to lose any staff through declining health status when the development of management practices are well placed to reduce occupational stressors and should be seen as a fundamental part of leadership (Anderson, Manno, O'Connor, Gallagher, 2010). It is evident from the increasing turnover rates that current strategies to address this major health risk are not successful. However, strategies to manage the effects of stress are only part of the puzzle as the workplace environment is also likely to be exacerbating the causes of stress. Work relationships influencing retention decisions for the EOCN are pivotal in evolving a working culture that engenders trust and encourages creativity in an emotionally intelligent environment (Anderson et al., 2010).

### **3.2.4 Workplace Harassment**

The healthcare setting is particularly susceptible to workplace harassment and violence, and owes its increasing attention to increased media attention and attempts to reduce the inherent stress in traditional hierarchical structures (Sweet, 2005; Forster, 2006). Presenting as a variety of titles including workplace violence, harassment, bullying or aggression, workplace harassment is defined as “any incident where an employee is abused, threatened or assaulted in circumstances arising out of, or in the course of their employment” (Dent, 2006, p.3). As a result of a stressful environment, the associated violence may range from intimidation to stabbings with perpetrators including colleagues, physicians, patients and family members (Hegney et al., 2008).

Workplace harassment or violence also varies by facility. Work relationships can be compromised as a result of internal violence and are most common in organisations where dominant/subordinate hierarchical interactions exist. Additionally, workplace violence has gender differences with female victims experiencing higher levels of verbal and sexual abuse, while male victims tend to receive more overt threats and physical assaults. Comparatively, the incidence of violence in the workplace has increased for women and decreased for males (Hegney et al., 2008). This is of particular relevance for the EOCN as nursing is a predominately female led profession (National Health Workforce Taskforce, 2009).

A form of workplace harassment is commonly found in dominant/subordinate hierarchical interactions such as the nurse–physician relationship. This is evidenced

by physicians' disruptive behaviours having a negative impact on job satisfaction and morale of nurses (Gordon, 2005). These disruptive behaviours are commonly demonstrated by disrespect, verbal abuse and condescending actions often in the presence of colleagues, patients or family members. The cause of the 'nurse / physician predicament' is a perceived variance in the role of nursing and a failure to effectively communicate (Hegney et al., 2006a). Regardless of an endorsed organisational code of conduct (Tuschke, 2006) or zero tolerance policies (Forster, 2006), a Queensland study reported 50% of public acute nurses experienced workplace violence in the last three months (Hegney et al., 2008). Additionally, the physician dominant role and the nurse subservient role are reinforced by gender, education and remuneration. As a consequence of this interrelationship, collaboration raises concerns of erosion of power and authority for the physician. However, while the quality of nurse–physician relationships has improved in recent decades, many barriers remain which hinder effective collaboration (Morinaga, Ohtsubo, Yamauchi, & Shimada, 2008). These barriers may influence the EOCN to reconsider their workforce options if their experience and knowledge is not valued in collaborative interactions.

Bullying and intimidation of nurses by nurses is also prevalent in some areas of nursing and through all nursing levels (Garling, 2008). This form of workplace harassment is found to be more stressful for nurses than aggression from other sources. Bullies form cliques to assist with the demise of vulnerable colleagues, resulting in a range of outcomes from resignations to suicide (Mather, 2006). Although avenues for reporting disruptive behaviours were available, barriers such as intimidation, fear of retaliation and lack of confidentiality were reported by Queensland Nurses Union members indicating that reporting of violence of any degree was complex (Hegney et al., 2008). Consequently, it is difficult to accurately quantify the extent of workplace violence as many incidents are not reported and do not result in time off work. Recordings of some incidents are cited in the patient's file, but not recorded for WorkCover purposes (Forster, 2006). Further, reporting barriers may be partly responsible for the continuance of the disruptive behaviours. In Australia, it has been estimated that one in four healthcare employees are affected by harassment with costs incurred including poor morale, productivity losses, increased absenteeism and turnover, and law suits estimated at \$12 billion per year

(Mayhew & Chappell, 2001). This is an unnecessary cost to any organisation and individual which may negatively impact on retention.

Client-initiated violence is more common for workers who have face-to-face contact with clients and families, particularly if the clients are distressed, frightened or in pain. Therefore, nurses working in emergency departments and mental health settings are at high risk of physical injury, although this risk is evident in all nursing workplaces (Tuschke, 2006). Some patients may behave in a violent manner as a result of their medical condition, however, being in care does not absolve perpetrators from the legal consequences of their actions (Dent, 2006; Tuschke, 2006). As a healthcare professional, one of the most difficult situations is to be confronted by one of the patients for whom they have dedicated their career to assisting (Hegney et al., 2006a).

As previously identified, sources of violence may vary by perpetrator; however, a variance may also occur with the type of healthcare facilities. To clarify, a survey among members of the Queensland Nurses' Union identified that the major source of violence in the public health sector originated from patients (29.7%), followed by other nurses (19%), and visitors and relatives (16.4%) (Hegney et al., 2008). This study also found that inexperienced nurses are more likely to report violence than experienced nurses and the latter group perceived workplace policies and procedures to be ineffective (Hegney et al., 2008). What this study does not reveal is the influence the violence has on the EOCN. While this study population was 3000 nurses with a response rate of 44.6%, one limitation was that the target group was limited to Queensland Nurses' Union members and may not reflect the opinion of all nurses in Queensland. However, the reluctance to report workplace violence conceals the actual extent of the problem and risks desensitising the nurse to accept the violence as part of the job (Lanza, Zeiss, & Rierdan, 2006).

The nursing profession is particularly susceptible to workplace harassment due to a stressful and complex environment. A recent Australian study identified that more than one-third of nurses reported experiencing emotional abuse and about one in five nurses reported threats of physical harm. More than one in ten reported actual physical harm with the source of violence nearly always from patients and families (Duffield et al., 2007b). However, while nurses are better placed to cope with

workplace violence with good social support, it has been shown that nurses are more concerned about aggression from colleagues than other sources (Baltimore, 2006). As a consequence, the EOCN may perceive they have little support, which is shown as researchers have identified the reluctance of more experienced nurses to report harassment events. The EOCN may also perceive the structures developed to support them against disruptive behaviours to be ineffectual.

### **3.2.5 Summary and Research Question**

The physical environment for the EOCN incorporates factors such as workload, skill mix, scheduling, resources and equipment. Additionally, factors such as workplace harassment and violence add to the complexities of health care delivery with the possibility of culminating in stress or burnout for the nurse. The nurses' workplace environment is a greater predictor of satisfaction than other factors such as pay and benefits (Garling, 2008). Structural factors such as unreasonable expectations of employees, and undesirable hours and shifts have been negatively associated with job satisfaction. While there is a plethora of literature recommending strategies to support nurses in the workplace, much of the data have been taken from descriptive studies and questionnaires yet to be viewed through evaluation. Furthermore, the available literature refers to a general nursing population with minimal data being specific to the EOCN.

The EOCN is already contemplating and planning their future workforce participation. If the workplace environment is not aligned to the EOCN's professional and personal needs, options may include the premature reduction or cessation of workforce participation. This would be a great cost to the profession and healthcare organisations. The loss of decades of organisational knowledge and intuitive practice prior to transference to less experienced nurses is detrimental to the continued development of the profession. Additionally, in an environment where the profession is struggling with a nursing shortage that is forecasted to escalate, nursing can not afford to lose the EOCN through factors which can be controlled. It is necessary to be informed by specific research which is focused on the EOCN's workforce participation decision in order to develop appropriate strategies to ensure their retention and sustainability. Therefore, in light of these considerations, the following research question aims to elicit relevant data.

## **Research Question:**

***How does the workforce environment influence EOCNs' decisions regarding workforce participation?***

### **3.3 Leadership**

It has been suggested that nurses do not leave hospitals, they leave leaders (O'Brien-Pallas, Duffield, & Hayes, 2006). Leadership attributes and behaviours have the ability to influence the professional environment in which EOCNs practice, yet they can not be contained within a discrete and comprehensive list. While transformational leadership behaviours are those associated with effective leaders (Bally, 2007), leadership factors such as communication and team cohesiveness, supervision attributes including trust (Daly, Speedy, & Jackson, 2005) and flexibility (Gess et al., 2008) contribute to the EOCN's decision to stay in the organisation or profession. Also, the ability to exercise factors such as mentorship, autonomy of practice and organisational commitment (Bally, 2007) will influence employment decision making for the EOCN. Effective management attributes and leadership skills enhance job satisfaction, sustain organisational commitment and encourage retention (Hayes, O'Brien-Pallas, Duffield, Shamian, Buchan, & Hughes, 2006). However, the profession is not only challenged by the nursing shortage crisis, but is also moving towards a nurse leadership crisis (Wolf, Bradle, & Nelson, 2005). A contributing factor in the looming leadership shortage is cost containment, which has reduced the middle manager cohort and cutback the formal training and development of this group. As a result of these reductions, nurse leaders may be ill prepared or reluctant to perform successfully in their complex roles which will undoubtedly impact on the EOCN.

A range of leadership approaches, modified to meet the needs of different groups or individuals, may energise staff to excel within their work environment (Gess et al., 2008). Leadership is understood in this context as the behaviours, knowledge and skills that are pivotal to the development of a social climate which is sensitive and supportive of the need to nurture and retain quality staff. Additionally, these leadership behaviours may create a sense of ownership for the nurse without being fearful of risk-taking in a constantly changing environment. Higher levels of nurse satisfaction and reduced turnover have been reported when associated with an emphasis on communication between leadership and staff, professional autonomy

and commitment to flexibility in a decentralised organisational structure (Lavoie-Tremblay, O'Brien-Pallas, Viens, Brabant, & Gelinas, 2006). It is important to identify the degree of influence these leadership factors have on the EOCN's decision on workforce participation in order to better understand their professional and satisfaction needs.

### **3.3.1 Communication and Team Cohesion**

The importance of sound communication abilities and listening skills are core concepts in building trusting relationships and are often overlooked by leaders (Tveiten & Severinsson, 2006). Supportive communication from leaders and colleagues buffers nurses from job stressors and provides them with informational and emotional resources to cope with workplace stressors (Duffield & Roche, 2009). In addition, supportive communication assists in the enhancement of an environment in which nurses build communication skills that enable them to perform effectively in their role (Henry, 2007). As a result of exemplary communication skills, a sense of belonging and identification with a group or organisation is established, enabling the nurse to learn desirable identity characteristics and make decisions congruent with group norms and values (Armstrong-Stassen, 2005). Through interaction between experienced and less experienced nurses, the latter group is able to identify with the role and what it means to be a nurse (Apker, Ford, & Fox, 2003). The successful leader will encourage genuine communication with all employees, developing a sustainable workforce that views problems as an opportunity to create innovative initiatives (Armstrong-Stassen, 2005). The enrichment of the less experienced nurse's identity and professional skills highlights the potential value of the EOCN and their ability to contribute to the education and socialisation of their colleagues. Additionally, when nurses identify with a particular reference group, they are more likely to stay with that group. Identifying with a group may have retention benefits for all nurses but specifically, it may positively influence EOCNs and their continued workforce participation.

Nurturing a culture conducive to open communication and safety in challenging the status quo without fear of repercussions may extend the EOCN in their role and realise their value as a healthcare professional (Edens, 2005). Many leaders do not believe that clinical staff have the ability to create innovative ideas at an organisational level, nor are they given an opportunity to develop through

participation (Al-Hussami, 2008). Specifically, due to continuous care responsibilities, the nurse is optimally placed of all healthcare professionals to develop a therapeutic relationship with the patient. However, the nurse's professional relationship capability and knowledge is rarely recognised in consultation with other healthcare workers (Tourangeau & Cranley, 2005). This ineffective communication may influence the ability or willingness of nurses to develop interactive relationships and information flow which contribute to better outcomes (Anderson, Corazzini, & McDaniel, 2004). Leadership climate and communication can affect turnover; however, research shows that patterns of communication alone do not create either effectiveness or ineffectiveness in minimising turnover rates (Duffield et al., 2009). Further, leaders can influence turnover by addressing climate and communication patterns and by encouraging stable leadership (Gess et al., 2008). If lack of collaboration is present for the EOCN, a reduction in effort to interact may result, affecting the quality of patient outcomes and devaluing the EOCN's contribution within the work group.

Higher levels of group cohesiveness and lower job stress were reported when a nursing practice environment was modelled to investigate the effectiveness of a participatory leadership style (Bally, 2007). Other leadership studies confirm the positive influences that communication, autonomy and group cohesion have on reducing job stress and increasing job satisfaction, which in turn is directly linked with the intent to stay (Hayes et al., 2006). Nurses who perceived that they were valued team members may more effectively tolerate additional frustrations within a complex environment (Lavoie-Tremblay et al., 2006). Being a valued team member will confirm job satisfaction and, as a result, the nurse is more likely to remain in the current role, minimising turnover costs and increasing quality patient outcomes (Gess et al., 2008). This was demonstrated through the formation of a care model which focused on enhancing the expertise of the experienced nurse (Batcheller, Burkman, Armstrong, Chappell, & Carelock, 2004). Enhancement of leadership role of experienced staff provided improvements in team cohesion which lead to reduced staff turnover, increased job satisfaction, physician confidence and patient safety (Batcheller et al., 2004). Additionally, it is reasonable to assume that as a result of revised model, the inexperienced nurse was supported appropriately and the experienced nurse was valued for their expertise, resulting in a 64% reduction in nurse turnover one year post unit redesign (Batcheller et al., 2004). While the study did not categorise the nurses who remained by experience, the valuing of expertise



and resultant benefits may positively influence the EOCN by providing a cohesive situation in which to practice.

In addition, Magnet hospital leaders identified that collaborative team building increased efficiency and productivity while enhancing staff and patient satisfaction (American Nurses Credentialing Centre, 2010). Staff communication and job satisfaction were shown to be positively linked with effectively functioning teams and higher quality of nursing care (Amos, Hu, & Herrick, 2005). However, there is a challenge in the development and sustainability of the team as illustrated by an examination of the leadership practices of hospital administrators (Farrell, 2003). This study found that doctors, nurses and unions were in power conflicts related to inadequate allocation of resources by governments, resulting in a constant struggle for control between stakeholders, with management and clinical professionals in opposition (Farrell, 2003). This style of leadership is unlikely to facilitate change, sustain continued commitment of employees or manage conflict which is common within changing organisations (Bally, 2007).

Furthermore, healthcare is undergoing major changes due to social, patient-related and economic stressors and conflict is an inevitable result. Healthcare, with its diversity of disciplines, has a long history of less than cohesive relationships, particularly between employees and employers (Cooper, 2003). While loyalty to organisations may be diminishing, this is not true of collegial loyalty. Staff may not hesitate to leave an organisation, but may find it difficult to leave their team mates. Teams can build on the commitment theme of working hard so as not to let down the remaining team members (Tourangeau & Cranley, 2005). It follows that strong ownership of, and accountability for, outcomes creates greater peer pressure for members to make sacrifices for the team. Leaders are well placed to implement strategies which create cohesive work teams and encourage social ties among key employees such as the EOCN, ultimately reducing turnover.

Leadership behaviours which provide motivation and an environment for staff to develop require meaningful, consistent communication through multiple forms; acting with integrity; and treating staff with respect and dignity. These behaviours engender improved levels of trust and mutual understanding which are integral to team work (Lavoie-Tremblay et al., 2006). Teamwork not only combines the strengths of each

member, but also delivers benefits such as reduced job stress and turnover, increased job satisfaction and autonomy of practice (Shirey, 2006). These behaviours may be responsible for not only assisting in providing positive support for the EOCN, but also providing a work environment conducive to nurturing trusting relationships.

### **3.3.2 Supportive / Trust**

Lack of consistency and credibility of healthcare leaders dealing with labile budgets further compromise the supportive and trusting relationship needed to retain quality staff (Shirey, 2009). Nurses struggle to provide quality care within cost constraints, supervise increased numbers of unlicensed care givers and yet continue to have little influence in their practice setting (Forster & Queensland Health, 2005). As a result of the demands placed upon the EOCN, trust in leadership has become an increasingly critical element in influencing the organisational culture, employee performance and commitment to the organisation (Anderson et al., 2010). Most available literature concerning the influence of leadership on nurses is limited to descriptive studies (Cyr, 2005), and few studies specifically focus on the EOCN.

A supportive workplace environment that considers the professional and personal needs of the individual is vital to ensure a sustainable workforce (Armstrong-Stassen, 2005). Creating a practice environment in which nurses feel supported is a priority for nurse leaders (Lavoie-Tremblay et al., 2006). Without this environment, multidisciplinary collaboration and quality of patient outcomes may be compromised and a patient-centred environment can not exist. To sustain trust, leaders should be responsive to the EOCN and their personal and professional needs.

Trust in leadership and management is an essential component in supporting a sound employee performance and commitment to the organisation (Shirey, 2009). Public trust and respect for nurses has never been questioned, although this can not be said for the relationship between nurses and their leaders (Donelan, Buerhaus, DesRoches, Dittus & Dutwin, 2008). Issues such as lack of consistency in leadership and financial limitations may reduce the ability to build trusting relationships, particularly as the winning side in a compromise is often the business component of healthcare rather than clinical needs (Elovainio, Forma, Kivimaki, Sinervo, Sutinen, & Laine, 2005).

Trust is found to be the best predictor of feelings of autonomy and empowerment (Sikma, 2006). One method of developing a trusting relationship is for nurse leaders to express their trust and allow the EOCN to develop and make mistakes in a non-judgemental and learning environment (Sikma, 2006). If nurse leaders can create a work environment that fosters trust, provides support and empowers nurses to accomplish their goals, this will increase job satisfaction and organisational commitment. This increased satisfaction and commitment will in turn positively affect retention (Al-Hussami, 2008).

However, the philosophy of some nurse leaders is to 'do to' rather than to 'work with' staff. This type of assertion can generate anger and mistrust with minimal creativity or initiative being demonstrated, resulting in employee resignation (Sikma, 2006). Alternatively, the leader who is able to communicate a genuine need for success will empower the nurse to excel past all expectations. Success is credited to the leader's ability to clearly define the expected outcomes and provide a supportive, trusting, motivating and coaching environment (Bally, 2007).

Additionally, the social support from the leader or colleague is crucial in positively influencing coping mechanisms and wellbeing. Empowerment is a means of social support to reconcile stress in the workplace. As staff perceive a decrease in their level of leader or collegial support, they perceive an increase in job stresses (Gess et al., 2008; Laschinger, Finegan, Shamian, & Wilk, 2001). However, the quantity of social support is not important but rather the actual presence and quality of the network. Conversely, too much support may adversely affect the nurse's feelings of control (Laschinger et al., 2001). It is shown that satisfied nurses are choosing to work in environments that value social support and empowered nursing practice (Gess et al., 2008).

One of the greatest challenges for nurse leaders is to build trusting relationships in a resource constrained climate; however, the EOCN may have an expectation that their leader will provide the appropriate resources to deliver quality of care. It is also an expectation that the leader will provide an environment which demonstrates flexibility to meet both the organisation's and nurses' needs. If this workplace climate is not made available, the EOCN may reconsider their continued workforce participation.

### **3.3.3 Flexibility and Work–Life Balance**

Most healthcare is delivered in the acute hospital setting and these facilities are commonly described as bureaucratic hierarchical organisations. Criticised as inflexible and lacking in innovation, a bureaucratic structure and leadership style will prevent nurses from responding appropriately to the continually changing environment (Forster & Queensland Health, 2005). Further, this structure risks missing the opportunity to embrace a more open and flexible approach which will bring healthcare into the 21<sup>st</sup> century (Duffield et al., 2007a). Australia's healthcare system faces the same challenge as our international counterparts, which is to review how services can be delivered most effectively while balancing the work and life commitments of the healthcare worker. Nurse leaders will therefore require specific characteristics to guide the profession.

As a female dominant profession (90.4%) (National Health Workforce Taskforce, 2009), nursing struggles with an increase in work and life demands which call for greater flexibility in scheduling practices (Storey, Cheater, Ford, & Lesse, 2009). With projected increases in the demand for healthcare and the concern that the nursing supply will be insufficient to cope with the demand, there is a focus on retention strategies and more efficient utilisation of nursing resources. However, due to nursing shortages and increased numbers of unregulated workers and heavy workload, roster scheduling is constantly challenged. By enabling nurses to combine work and non-work commitments, staff turnover concerning these issues could be positively influenced (Duffield et al., 2009). The most attractive employer provides a flexible work environment which recognises the nurse's personal and professional needs. This environment is created by the nurse leader with consideration to the match of staffing in a patient-centred approach (Christmas, 2009). Much attention is given to the younger nurse to support their family and work–life balance, yet the 'Baby Boomer' or 'sandwich generation' is not granted similar consideration (Hart, 2006). The EOCN, who is likely from the 'Baby Boomer' generation, may not only be caring for offspring attending university or grandchildren, but also may be taking a major role in the care of their older family members. Other family situations, such as single parent families, also impact on the work and life balance for the EOCN (Hart, 2006). In addition, the EOCN may require flexibility to access of educational programs, take sabbaticals or a 'phased' approach to retirement (Forster & Queensland Health, 2005). A study of the older worker, 50 years and over, found flexible working

conditions and approaches to retirement favourable for retention (Storey et al., 2009). To have the flexibility to choose workforce participation options is a preference for the older worker and would be similar for the EOCN if leadership strategies were conducive to providing these choices.

Lack of communication between nurses and leaders attempting to fulfill scheduling needs may lead to nurses working with inflexible rosters which results in nurse resentment, burnout, low morale, increasing absenteeism and turnover (Duffield et al., 2009). Shiftwork and night work have been found to impact on a range of health outcomes such as increased risk of stress, anxiety, insomnia, breast cancer and cardiovascular disease (Levtak, 2005) which may cause an increase in turnover including retirement (Blakeley & Ribeiro, 2008). Shift work, linked with increasing age, is responsible for the continuous and increasing frequency of sleep disturbances and is a significant predictor of all sleep difficulties (Levtak, 2005). The reduction in sleep quality and quantity from ages 32 to 52 years was found to be significant and these disturbances persisted long after the cessation of shift work (Marquie & Foret, 1999). While it is more common for nurses over 55 years old to work daytime hours, there is a small but increasing percentage working a variety of shift schedules (Gabrielle et al., 2007) which may be responsible for health concerns.

The degree of choice the nurse has over their work schedules is a key component in the relationship between working and their health (Andrews et al., 2005). Working long and unpredictable shifts has a negative impact on the health and wellbeing of the nurse due to increased social isolation and impaired interpersonal relationships (Shermont & Krepcio, 2006). However, the extent to which the nurse perceives their control over the balance of work and home life has been found to affect the health of the nurse and organisational outcomes in terms of productivity, absenteeism, staff morale and turnover (Pryce, Albertsen, & Nielsen, 2006). While the benefits of achieving work–life balance are recognised by organisations, nurses continue to experience difficulties balancing work and family responsibilities (Forster & Queensland Health, 2005). To remedy this imbalance, healthcare organisations have focused interventions on working hours and work scheduling. Nurses in a Danish hospital trialed and evaluated a self rostering system and found enhanced job satisfaction and significant increase in work–life balance, which was largely due to the ownership and choice over work–rest schedules (Pryce et al., 2006).

Self-scheduling is defined as a process by which nurses within the unit “collectively decide and implement a monthly work schedule” (Kilpatrick & Lavoie-Tremblay, 2006, p. 6). The line manager would determine the criteria for adequate staffing and staff mix for each 24-hour period and each nurse then chooses which day and shift they will work. While unit scheduling may be described as the most autocratic method (Silvestro & Silvestro, 2000), self-scheduling is conducive to staff empowerment, motivation, scheduling effectiveness and staff satisfaction (Shermont & Krepcio, 2006). Regardless of this strategy, one review found that rostering practices in Queensland public hospitals were inflexible and inequitable, and negatively affected recruitment and retention of nurses (Hegney et al., 2008). Issues raised included unreasonable demands with self-rostering processes; full-time staff felt disadvantaged through undesirable scheduled shifts; lack of availability of backfill meant study or special leave was not possible; lack of experimentation with varying shift lengths; and lack of rostering principles or guidelines. These inflexible and inequitable issues may be responsible for the reduction or exit of workforce participation for the EOCN.

To remedy the inflexible issues, effective rostering is required to ensure nurses’ personal and professional needs are met. These needs are also aligned with the staffing requirements to ensure patients’ needs are met while maintaining a principle of equity (Freeney & Tiernan, 2009). Following recommendations from a Taskforce Report (Department of Education Science and Training, 2002), rostering trials were established in Queensland hospitals to address the inequity issues of rostering practices. The *Best Practice Framework for Rostering Nursing Personnel* (the Rostering Framework) has been developed as an outcome of these trials and is designed to provide nursing staff with a comprehensive guide to best practice rostering (Queensland Health, 2003). Queensland Health nurses were encouraged to use this framework in conjunction with the *Business Planning Framework: Nursing Resources* to facilitate the appropriate allocation of nursing resources required to deliver quality care (Queensland Health, 2008). However, regardless of these support strategies, rostering issues continue to plague work unit management (Hegney et al., 2008).

Nurses continue to report overwork and poor working conditions in a climate which is stressful due to high patient expectations. The balance of work and home life becomes increasingly important as nurses age and, as a result, the EOCN may opt to reduce workforce participation or leave the profession (Storey et al., 2009). The increasing turnover rates indicate that nurses are not willing to work within the current healthcare system. The work environment is fundamental to the retention of nurses, particularly those who possess the accumulated knowledge and skills of decades of experience (Storey et al., 2009). While reports indicate the inflexibility of management practices, turnover data indicate that attempts to implement recommendations are generally unsuccessful and may additionally be responsible for a decrease in organisational commitment.

### **3.3.4 Commitment**

Organisational commitment is a more stable predictor of turnover and group-level performance than job satisfaction (Al-Hussami, 2008), and it has been determined that effective management attributes and leadership skills sustain organisational commitment and encourage retention (Gess et al., 2008). Defined as “the strength of an individual’s identification with and involvement in the goals and values of the organisation” (Porter, Steers, Mowday, & Boulian, 1974, p. 604), organisational commitment is relevant in a healthcare environment where registered nurses are in short supply and turnover rates are high (Leach, 2005). Conversely, lack of organisational commitment was found to be a result of nurses feeling unappreciated and unsupported by their nurse leader (Gess et al., 2008). Therefore, as nurses work in a challenging environment with heavy workload, a better understanding of the nature of their commitment may support strategies to satisfy and retain them (Bennett, Davey, & Harris, 2009).

Further, the intent to stay, turnover, job effort and satisfaction have been identified as outcomes of commitment (Al-Hussami, 2008). One study combined these associations to examine the relationship between nurse leadership and organisational commitment among hospital based registered nurses (Leach, 2005). The study results demonstrate that nurse executive leadership has an effect on the type and degree of commitment experienced by registered nurses. Additionally, nurse executives with transformational leadership styles have a direct influence on registered nurses that inversely affects ‘alienative commitment’, which occurs when a

nurse wants to leave the organisation but feels trapped for a variety of reasons (Leach, 2005, p. 236). The value of leadership in this situation is to engage the nurse, reduce the feelings of alienation and maintain a productive existence, thus increasing the nurse's organisational commitment (Nielsen & Munir, 2009).

The psychological link between the individual and the decision to continue in an occupation can be described through the Three-Component Model of Occupational Commitment (Meyer & Allen, 1991). The first component of this model is affective commitment, which is related to the nurse's connection with the organisation. Affective commitment was found to be positively associated with job satisfaction, involvement, performance and organisational citizenship behaviour (Allen & Meyer, 1996). Research using this model to study job withdrawal intentions, turnover and absenteeism found affective commitment to be the most consistent predictor of these outcomes and was the only view of commitment that was related to turnover and absenteeism (Somers, 1995). The model's second component, continuance commitment, reflects a nurse's acknowledgement of the costs of leaving the organisation. If continuance commitment is high, the nurse believes the benefits of staying with the organisation outweigh the consequences of leaving. The third component of the model, normative commitment, is the nurse's sense of obligation for remaining with the organisation (Allen & Meyer, 1996). Normative commitment, in conjunction with affective commitment, was found to be positively related to intent to remain (Somers, 1995). It is suggested that each nurse has an individual "commitment profile reflecting his or her degree of desire, need, and obligation to remain" with the current organisation (Meyer & Allen, 1991, p. 83).

This model of occupational commitment was tested by Nogueras to predict the registered nurses intent to leave the profession (2006). The study found that the higher the level of education and number of years of experience for the registered nurse, the greater the occupational commitment and lower the intent to leave the profession. What is also relevant for the EOCN is that as the registered nurse's age increased, so too did their occupational commitment (Nogueras, 2006). Limitations of this study included a voluntary non-randomised group and the use of self-report measures which may not accurately represent the national American profile. If these findings are considered in relation to the EOCN, their commitment levels would be expected to be high with little consideration of reducing workforce participation. It is



therefore relevant to determine why EOCNs are leaving organisations and the profession. This cohort has the potential to be a committed member of the profession with the potential to extend their workforce participation if the environment remains conducive to their needs.

Loyalty to the organisation can also be enhanced without requiring organisational commitment (Cappelli, 2000). One strategy is to delegate the control of practice to the nurses. This acts as a catalyst to increasing their commitment. The resultant benefits are satisfaction, recognition and status (Cappelli, 2000). Nurses are more likely to commit to an organisation if their leader challenged relevant aspects of the job, questioned the status quo, managed stress effectively and took risks within their practice (Shirey, 2009). One Swedish study of emergency nurses contradicted this notion of enhanced organisational commitment without loyalty, indicating that both job involvement and organisational commitment are directly related to turnover intent, however, only indirectly related to actual turnover (Sjoberg & Sverke, 2000). If nurses could work autonomously, it may be assumed that there would be a level of job involvement and commitment to the role. Factors which influence nurses' organisational commitment include: 1) personal factors such as stability and meeting their needs; 2) opportunities for learning; 3) job satisfaction; 4) plans to retire from the organisation; 5) remuneration; 6) ability to provide quality care; 7) support system from coworkers; 8) cultural factors including work values; 9) job security (McNeese-Smith, 2001). However, a limitation of this qualitative study of nurses is the restricted ability to generalise the results due to nonexperimental methodology, the setting and the relatively small sample size.

An additional factor which may influence how employees offer their commitment is the multigenerational issue. Generation X and Y do not share the same work ethic and sense of employer loyalty as the Baby Boomers (Thorgrimson & Robinson, 2005). Baby Boomers, which include the EOCN cohort, generally have unquestioning commitment to the organisation, as long as organisations actively assist them to juggle personal and work commitments (Hart, 2006), and publicly recognise innovative ideas. If leaders support the EOCN in meeting their personal and professional responsibilities, organisations may enhance the strong commitment from an experienced cohort (Stuenkel, Cohen, de la Cuesta, 2005) which may extend their workforce participation.

In addition to the generation factor, the stage of an employee's career has an impact on commitment level. One study identified that employees in their last career stage have the highest commitment levels (Morrow & McElroy, 1987). Further, these employees were the most satisfied with their work and colleagues, and the least satisfied cohort in relation to promotional opportunities. This notion was confirmed more recently in a study of nurses 45 years and over (Bennett et al., 2009). These nurses described a need for high standards in patient care and would forgo promotion if they lost the opportunity for direct patient care. Furthermore, there was a strong commitment to their less experienced colleagues in a desire to mentor and support their ongoing development (Bennett et al., 2009). These qualities could benefit both the patient and the less experienced nurse and highlight the value in retaining the EOCN in supporting quality patient outcomes.

### **3.3.5 Autonomy to Practice**

In addition to organisational commitment, autonomy is a strong predictor of organisational and professional identification. Nurses who perceive that their role allows autonomy of practice are more likely to experience feelings of belonging and loyalty towards their employer in the short term and the profession in the longer term (Apker et al., 2003). Professionals are expected to maintain autonomy over their practice which results in the stimulation of personal and professional development of employee (Bennett et al., 2009). Opportunities for autonomous practice enable nurses to become critical and reflective thinkers.

Leaders are often guilty of not developing or valuing knowledge. Subsequently, the work environment does little to promote autonomy of practice as clinical decision-making is often determined away from the practice area (Ritter-Teitel, 2003). EOCNs who have developed expertise in their chosen field expect increased autonomy, recognition and opportunities; however, autonomous practice is the exception rather than the rule. In contrast, nurses working in Magnet hospitals were found to be more involved in decision making and consequently gained more autonomy over their practice (Gordon, 2005). These nurses had higher levels of job satisfaction and experienced less burnout than nurses in other environments. Autonomy is therefore the strongest correlate of job satisfaction and retention (Nedd, 2006). Nevertheless, competence is a prerequisite for autonomy, and it is necessary that nurse leaders

provide opportunities for nurses to maintain and advance their knowledge and skill levels. It seems important that nurse leaders develop an environment which enables nurses to further develop skills in their clinical practice to support autonomous practice. While the expansion of professional autonomy can be gained through continuing education, research and shared governance (Gess et al., 2008), the EOCN is not routinely offered this opportunity regardless of their expertise.

Regardless of education and research, unless the leader demonstrates genuine trust in their staff, opportunities to practice autonomously are unlikely (Hayes et al., 2006). Given this prerequisite, the leader may embrace the challenge to empower or enable employees to practice in an autonomous manner by taking risks and engaging in innovative activities without layers of approval (Christmas, 2009). However, exacerbated by time constraints, resource cutbacks and high patient acuity, autonomous practice has decreased as demonstrated by the limiting of nurse inclusion in decision making (Hayes et al., 2006). An Australian review corroborated these results, suggesting nurses had little influence over the health system or involvement in decision making (Department of Education Science and Training, 2002). Numerous layers of bureaucracy may be responsible for the lack of decision making by nurses in organisations (Forster & Queensland Health, 2005). Bureaucratic organisations commonly have convoluted and prolonged reporting processes which slow down the nurse's ability to mobilise resources in order to meet organisational goals in an effective and timely manner (Garling, 2008).

Empowerment is the single most critical component of effective change within organisations, and it is pivotal that leaders empower nurses across the spectrum of generations, considering each individual nurse's needs (Moye & Swan, 2009). The clinician understands empowerment as a tool to critically think about their practice and to move beyond performing as they always have done. Empowerment does imply granting the power through delegation, although delegating alone does not empower (Lee & Cummings, 2008). Self-efficacy has been associated with enabling as a crucial stage of the empowerment process. As a result of enabling, increased professional practice behaviours and the guidance of strong leadership are promoted (Manojlovich, 2005). Moreover, strong facilitative leaders who have the capacity to revitalise staff to become committed, accountable employees were found to be

essential in a climate aiming to retain quality experienced staff such as the EOCN (Elloy, 2005).

The leader who can communicate a genuine need for success will likely empower the team members to excel past all expectations (Elloy, 2005). Success is credited to the leader's ability to clearly define the expected outcomes and provide a nurturing, motivating and coaching environment (Bally, 2007). An Australian review reported that nurses "often find they belong to a profession controlled in a paternalistic manner and one that is not held in high regard by other health care team members" (Department of Education Science and Training, 2002, p. 80). This environment may lead to minimal creativity and dissatisfaction leading to decreased retention (Kerfoot, 2000). One method to engender trust within the profession is to attract and retain staff with the promise to empower nurses to develop and utilise their professional skills (Hayes et al., 2006). Even though practicing autonomously has a positive effect on satisfaction and retention, the literature does not reveal that this is common practice for the experienced nurse or the EOCN.

### **3.3.6 Summary and Research Question**

Further challenges to the nursing profession include a shortage of nurse leaders and a demonstrated shortage of exemplary leadership knowledge and skills to support the depleting and ageing workforce. Nurse leaders are critical to the success of managing these organisational challenges through the provision of appropriate skills and resources to enable nurses to deliver quality patient care. Furthermore, nurses require a conducive environment in which the provision of quality care can be delivered (Wolf, 2006).

The current nurse turnover problem and associated challenges are influenced by leadership style and behaviours (Hayes et al., 2006; Manojlovich, 2005). In particular, transformational leadership behaviours are predominately associated with effective leaders (Nielsen & Munir, 2009) and components of these behaviours have been demonstrated to influence nurses' decision to remain in the organisation. Effective leadership behaviours engender nurses who are committed to their organisation (Luthans & Jensen, 2005). Additionally, nurse leaders who provide a nurtured culture of open communication, supportive trust and flexibility, promote an environment which ensures nurses feel enabled to practice in an autonomous manner (Storey et

al., 2009). In the absence of transformational leadership behaviours, retention of experienced nurses will be compromised (Hayes et al., 2006). Consequently, if leadership nurtures an environment which meets the EOCN's personal and professional needs, the cost to the organisation and profession of prematurely losing the EOCN (both a financial and quality issue) is minimised.

**Research Question:**

***How does leadership influence EOCNs' decisions regarding workforce participation?***

### **3.4 Personal and Professional Recognition**

A workplace culture that demonstrates genuine value of their most prized human resource is a hallmark of a cutting edge organisation. Corporate cultures which value end of career nurses describe them as a “resource to be cherished rather than a liability to be minimised” (Hatcher et al., 2006, p. 44). Factors that influence recruitment and retention in nursing are individually specific for diverse reasons. However, job satisfaction (Erickson & Grove, 2007) and work excitement opportunities (Sadovich, 2005) are positively linked to continuation of workforce participation. Further, nurses' personal and professional needs will influence their decision making in regard to workforce participation. These needs may be reflected in the interrelationships of multigenerational groups, with the potential for workplace conflict due to differing values and ethics (Hart, 2006). While labelling is a superficial way of describing the multigenerational groups, it does allow some understanding of different characteristics between the groups (Donley, 2005; Stuenkel et al., 2005). Furthermore, personal and professional needs such as life-long learning highlight the value of continued training opportunities throughout the nurse's career not only to revitalise and challenge the EOCN, but also to promote quality outcomes and increased retention (Armstrong-Stassen, 2005). Lastly, despite varied views on remuneration as a recruitment and retention strategy, it remains an important consideration concerning decisions to remain in the workforce (Storey et al., 2009). However, there is minimal research which identifies specific and effective strategies for retention of the EOCN.

### **3.4.1 Job Satisfaction and Work Excitement**

Job dissatisfaction and turnover are recurring themes in nursing literature and have regained interest due to the international nursing shortage (Bennett et al., 2009). Moreover, nurses who report overall dissatisfaction with their jobs have a higher probability of intending to leave than nurses who report satisfaction (Storey et al., 2009). As job satisfaction decreases, the likelihood of nurses leaving the organisation or profession increases, exacerbating the nursing shortage. However, a one size fits all solution to retention will not work (Hegney et al., 2006b) and previous satisfaction studies have not recognised the competing interests and specific predictors for the EOCN to stay. Issues which may be relevant to job satisfaction and its influence on the EOCN's decision on workforce participation include progressive job stages, work excitement, retirement and life satisfaction.

The disparity between the desire to meet professional needs and reality contributes to disengagement and withdrawal from the profession (Prescott, 1989). However, much of the research concerning job satisfaction assumes that nurses merely respond to the work environment rather than to a relationship between the individual and the work environment (Takase, Maude, & Manias, 2005). Each nurse will have unique professional needs and preferences that influence their interpretations of the work environment, their behaviour and their emotional responses to the job or organisation. It has been identified that job satisfaction would be increased by strategies such as enhanced autonomy, shared governance, recognition and respect, and professional growth and development opportunities (Duffield et al., 2009). Workplace environments that have these features are conducive to practice that is consistent with nurses' professional and personal needs and expectations (Storey et al., 2009).

Considering the issues which lead to the EOCN's career may provide an understanding of the workforce participation decision making process. One approach would be to view the different job stages. The journey through an individual's career has been identified by three stages: 1) entry; 2) mastery; and 3) disengagement (Graham, 1973). These stages are associated with time on the job, skill enhancement and attitudes, and are levels of identification of the self and ego with the work environment (McNeese-Smith, 2000). This identification with the work environment and the 'ideal' job commences in the entry stage, continues to increase

through the mastery stage and begins to depolarise at the onset of the disengagement stage. While the time nurses disengage will vary due to individual and organisational circumstances, the strongest negative associations have been found to be job satisfaction and organisational commitment (McNeese-Smith, 2000). Additionally, the predictors for disengagement increase with time on the job due to boredom and indifference, rather than age or years within the profession (McNeese-Smith, 2000). The stage of mastery is described as advanced beginning skills moving towards advanced practice. As a result, nurses at mastery stage describe themselves as feeling a sense of accomplishment, challenge and purpose (McNeese-Smith, 2000), which may be an optimal position for EOCNs to avoid the likelihood of premature retirement.

Preparation for retirement specific to finances and planned activities may produce higher retirement satisfaction (Armstrong-Stassen, 2005). As the population and workforce ages and life expectancy increases, nurses face longer retirement periods if retirement begins at 50–55 years (Hatcher et al., 2006). As a result of the abandonment of compulsory retirement ages, the prediction of retirement is an important issue for leaders to maintain a qualified workforce. A study of retirement satisfaction among retired civil servants identified that health was an important factor in the individual's satisfaction with their retirement status and overall life satisfaction. Additionally, the notion of high job involvement was associated with dissatisfaction with retirement activities (Schmitt, White, Coyle, & Rauschenberger, 1979). The results of this study are based only on the group of state civil servants who responded to the questionnaire and, as such, the possibility of sample bias is real. However, the study does highlight some issues that are rarely considered from the employers' perspective. Complementary to retirement satisfaction, hospitals that offered Retirement System plans had a higher level of satisfaction and developed institutional loyalty and long-term financial security as key elements of a recruitment and retention strategy (Ma, Samuels, & Alexander, 2003). Identification of the degree of influence these satisfaction factors have on the EOCN's decision on workforce participation may lead to better understanding of their unique professional and satisfaction needs.

Job satisfaction is the most important indicator of a nurse's decision on workforce participation (Al-Hussami, 2008; Duffield et al., 2009), however, to obtain a broader

view, factors other than job satisfaction need consideration. To provide further insight into the interrelationships of job satisfaction, factors such as work frustration and work excitement may be considered (Sadovich, 2005). Defined as “personal commitment and enthusiasm for work evidenced by creativity, receptivity to learning, and ability to see opportunity in everyday situations”, work excitement espouses a new dimension in nursing practice and is a prerequisite to quality outcomes (Simms, Erbin-Roesemann, Darga, & Coeling, 1990, p. 178). Leaders may have a direct influence on perceptions of work by modelling work excitement behaviours. One study supported the potential impact of a work excitement conceptual model by demonstrating that due to increased autonomy, responsibility and opportunities for growth and development through a variety of experiences, nurse executives were more excited about their work than nurse administrators (Zavodsky & Simms, 1996). In contrast to work excitement, disengagement has been associated with an increase in years of service (McNeese-Smith, 2000) and may be more likely to occur in the EOCN, as this cohort tend to stay longer in the same employment (Hart, 2006). It may then be deduced that increased levels of work excitement may influence the reduction of boredom in the workplace and lead to continued or extended workforce participation of the EOCN.

Much research has focused on the reasons for dissatisfaction, turnover and burnout with little attention to the exciting nature of nursing practice. As an organisational model, work excitement is conceived to be the catalyst essential to the provision of care and optimal outcomes that reduce or eliminate the effects of burnout, which is one of many influences prompting nurses to leave organisations (Sadovich, 2005; Simms et al., 1990). The opportunity for learning and a supportive work environment have been positively correlated to work excitement (Erbin-Roesemann & Simms, 1997; Lickman, Simms & Greene, 1993). Four predictors of work excitement include: 1) work arrangements; 2) a learning environment that fosters individual growth and development; 3) variety of experiences; 4) positive working conditions (Simms et al., 1990). In addition to a stimulating environment of continuous learning, an internal locus of control is a key component in the creation of empowered work environments which are positively associated with work excitement (Erbin-Roesemann & Simms, 1997). Therefore, the opportunity for nurses to be nurtured in a learning environment may lead to a more fulfilling work life and work excitement. This learning environment



provides nurses with the skills and knowledge to practice effectively, regardless of the length of service within the organisation (Al-Hussami, 2008).

The value of continuous learning has been further reinforced after reviewing registered nurses' assessment of their daily work activities (Hallin, 2007). This qualitative study showed that registered nurses' work situation fluctuated between stimulation as the ideal situation and strain as the negative experience. While the ability to effectively manage this situation was reduced due to increasing numbers of patients and skill mix difficulties, support was found to be necessary through education and life-long learning (Hallin, 2007). Additionally, the level of work excitement is raised when the nurse's work environment ensures a positive perception of working conditions and the minimisation of work frustration (Sadovich, 2005). The EOCN's work environment can potentially encourage them to seek and use life-long learning opportunities, which may add to the work excitement of their role (Sadovich, 2005).

### **3.4.2 Professional Development and Retraining**

Providing relevant professional development not only supports quality outcomes, but also has positive links to retention (Al-Hussami, 2008). Further, the availability of training opportunities and life-long learning has a stronger impact on nurse turnover than workload or pay (Cowin, Johnson, Craven, & Marsh, 2008). If nurses intend to remain in the clinical arena providing quality care as they progress towards the end of their career, education and professional development are a necessity (Giorgianni, 2005). This continual professional development is particularly relevant around the nurse's mid career, bringing a new and revitalising challenge in preparation for the next twenty years of their working life (Giorgianni, 2005). While many nurses are commencing nursing training at a later age, continual professional development remains relevant, particularly for the EOCN in the provision of quality care and challenge to their role.

High-quality professional development is one of the most effective ways to attract, motivate and retain talented staff (Al-Hussami, 2008), yet this is not afforded to nurses across all development stages and age levels (Giorgianni, 2005). Professional development for the EOCN has numerous barriers and has received minimal attention. Development opportunities are an organisational priority for the new

graduate and the less experienced nurse; however, the same opportunities are not offered to the EOCN (Rambur, McIntosh, Val Plumbo, & Reinier, 2005). Training resources are disproportionately targeted at workers between the age of 25 and 44 years. Additionally, stereotypes or doubts about older workers' ability to master skills, fear of failure and approaching retirement may undermine any training advantages available to them (Rix, 1996).

Generally, older workers are interested in job-related training with 88% of workers between the ages of 45 and 77 years reporting their ideal job would include the opportunity to learn new skills (Giorgianni, 2005). The minority who reported disinterest in training were on the threshold of retirement (Rix, 1996). These findings about disinterest are problematic if they reinforce the employer's belief that older workers would not be receptive to training opportunities or that they are less trainable. On average, learning time does appear to increase with age, nevertheless, the ability to learn continues well into the upper years, particularly if the learning environment is conducive to the learner's needs (Department of Industrial Relations, 2005). Decisions about training are therefore based, in part, on employer attitudes about worker flexibility, ability to learn and receptivity to training (Andrews et al., 2005). Additional barriers to receiving professional development opportunities include the inability to be released due to insufficient staff for backfilling (Forster & Queensland Health, 2005). While mature-aged nurses (50 years and over) were cognisant of the need for life-long learning, they were also concerned about the personal cost of education (North Queensland Workforce Unit, 2005).

The specific stage of the EOCN's personal and professional development is often not taken into consideration by nurse leaders. Nurses with years of experience, which may not include postgraduate qualifications, need specific attention as they have the professional memory that organisations count on for quality outcomes and that novice nurses depend on for support through preceptorship (Hatcher et al., 2006). An Australian review suggested that there was a lack of commitment by employers to ensure that nurses maintained education to support best practice (Department of Education Science and Training, 2002). Additionally, the clinicians felt disempowered, their skills and knowledge undervalued and organisations reported "inadequate training and professional development opportunities and insufficient time for teaching and research" (Forster & Queensland Health, 2005, p. 205). Regardless

of the nurse's practice role or length of time within the role, there is a personal and professional need to maintain contemporary skills and knowledge through career development and life-long learning activities (Armstrong-Stassen, 2005). Consequently, organisations are challenged to offer personal and professional development opportunities for EOCNs to meet their needs while ensuring that the employer's needs are also met (Al-Hussami, 2008).

Further, the nursing shortage has provided opportunities as broader educational foundations allow nurses to accept the challenge of more advanced roles such as the nurse practitioner (Heartfield, 2006; Queensland Nursing Council, 2005). If professional challenges are not available for nurses, dissatisfaction and increased turnover will result. Additionally, the development of advanced nursing and new or extended nursing roles are being redesigned to align skill level with task complexity and improved patient outcome (Forster & Queensland Health, 2005). Role expansion and advancement of practice for the nurse may cause overlap with the roles of other healthcare workers, particularly in settings such as primary healthcare and midwifery. The issues of role substitution highlight the cost of educating nurses and other health professionals. This would be less expensive than training medical officers, however, this continues to be a contentious issue within the current professional hierarchy (Duckett, 2005). While an assumption, a large number of EOCNs will be working at an advanced level due to their collective experience and knowledge. The opportunity for equal access to professional development in support of role substitution may challenge the EOCN and increase work excitement and organisational commitment ensuring the EOCN will be more likely to remain within the workforce (Duckett, 2005).

Nurse leaders have advocated clinical ladder programs to address salary compression of experienced nurses. Clinical ladder programs are based on Benner's work on professional development, use of preceptors and mentors to facilitate career development, peer review of performance and enhancement of autonomy through role negotiation (Riley, Rolband, James, & Noron, 2009). Pay differentiation was defined by varying levels of clinical practice (Corley, Farley, Geddes, Goodloe, & Green, 1994). While nurses on the clinical ladder held slightly more positive attitudes about job satisfaction, promotional opportunities and work rewards, they also had a lower intent to leave (Everson-Bates, 1992). Additionally, reduction in sick leave, lower vacancy rates and decreased agency usage was found where clinical ladder

programs were in place. However, while one study evaluated the clinical ladder programs favourably (Riley, Rolband, James, & Norton, 2009), others do not support that the program per se increases job satisfaction (Bjork, Samdal, Hansen, Torstad & Hamilton, 2007). This latter study supported the notion that nurses who were older and had opportunities for professional development have a higher intent of staying in the organisation. The intent to advance clinical practice with incentives, mentorship and supportive education is a sound principle which can be adopted from the program (Riley et al., 2009). Transfer of the knowledge of experienced nurses to the younger or less experienced nurse can not be replicated in programs; however, this does highlight the value of the experienced nurse and the challenge to transfer their experiences.

#### **3.4.2.1 Mentorship**

As a result of limited resources, nurse leaders struggle with the challenge to provide development opportunities for their staff. Other industries have worked towards a supportive and self-sufficient model of a mentorship framework, yet the nursing profession has been reluctant to embrace this strategy (Reid Ponte, Gross, Galante, & Glazer, 2006). The mentoring relationship aims to value and develop staff and is associated with satisfaction, higher levels of commitment, productivity and reduced turnover (Bally, 2007). Additionally, mentoring reflects the development of culture and values from one whom the mentee aspires to resemble. Mentorship is an enabling relationship which facilitates another nurse's personal growth and development, and assists with career development by guiding the mentee through organisational, social and political networks (Morton-Cooper & Palmer, 1993). Earlier applications of this model were used to improve performance deficits, however, mentorship is now more commonly undertaken by progressive leaders who value leadership development and continuous learning (Reid Ponte et al., 2006). There are alternative terms that are used to describe the supporting role of staff which may cause confusion when used interchangeably. Preceptorship is one such term. As a short-term relationship, preceptorship focuses on clinical and task-orientated skills in predetermined levels of competence (Morton-Cooper & Palmer, 1993). Comparatively, a mentoring relationship is generally a long-term personal relationship based on encouragement, constructive comments, openness, mutual trust, respect and willingness to learn and share (Morton-Cooper & Palmer, 1993).

Much of the literature on mentorship is targeted towards the new graduate (Nelson, Godfrey & Purdy, 2004), which may be more closely related to the preceptor model. However, the nurse executive has gained attention as a recipient of the mentoring relationship, but there are no studies or recommendations targeted towards the EOCN. This may be due to definition confusion (Leners, Wilson, Connor & Fenton, 2006). However, there is an opportunity for leadership to value and utilise the professional knowledge of the EOCN as they may have gathered much workplace knowledge during their practice years. One mentorship model was trialled using the experienced registered nurse as a mentor to provide expert advice and guidance to the novice or less experienced nurse (Reid Ponte et al., 2006). Outcomes from the trial included a 64% reduction in registered nurse turnover, a 77% reduction in medication error and culminated in greater nurse job satisfaction, physician confidence and patient safety (Reid Ponte et al., 2006). While theoretical and clinical learning is essential, the nurturing, guidance and wise counsel of a mentor is more than a complementary role. Mentorship is an opportunity to professionally strengthen both the mentee and the mentor as well as the profession itself (Bally, 2007). Improving the work environment through professional mentoring offers a unique opportunity to invest in the professional socialisation of the nursing profession (Leners et al., 2006) and the EOCN is best placed to provide this expertise.

Support of a mentor relationship should be balanced with available resources to achieve the goal of professional development and retention. Recognition of the mentor role by some facilities has included increased remuneration, job redesign and professional status (Greene & Puetzer, 2002). However, this has not routinely been the case and, in many instances, this role is in addition to an already heavy workload (Tourigny & Pulich, 2005). The mentor role is not one of remedial intervention, but rather is a tailored approach to professional development which assists the mentee. Mentoring aims at individually negotiated targets and successful outcomes are reached in a way that classroom learning cannot match (Bally, 2007). The already strained workforce can limit the leader's ability to roster experienced nurses such as the EOCN away from patient care to facilitate, preceptor or mentor new staff (Stein & Deese, 2004). Accordingly, there is a need for graduate nurses to be better prepared prior to entering the workforce.

The flow of new graduate mentees can negatively impact on the EOCN, with burnout often the result (Storey et al., 2009). A model and framework to support both preceptorship and mentoring has been developed. While the preceptorship model is focused towards the new and less experienced clinician, the mentor relationship is targeted towards the clinicians aiming to extend their professional and organisational skills (Morton-Cooper & Palmer, 1993). Throughout a nurse's career, work skills and attitudes are developed through experiences which can not be replicated for the new nurse through training. Mentorship may provide this opportunity through role modelling and counselling (Leners et al., 2006). While the EOCN is aptly qualified to provide this developmental opportunity, little or no mentorship training is provided in preparation for the role.

The opportunity for the EOCN to enter a mentor relationship in a mentee capacity is limited. The literature indicates positive correlation between satisfaction and mentor relationships, therefore the opportunity to be involved in such a relationship may influence the EOCN's decision to stay in the organisation and the profession. While mentoring relationships recognise and value the expertise of the nurse, remuneration also demonstrates recognition for their expertise.

### **3.4.3 Remuneration**

Research on the links between remuneration, job satisfaction and retention has had inconsistent results. The inconsistencies concerning the importance of remuneration are evident at different stages of the nurse's decision about retention. While it has been suggested that pay does not have as strong an influence on job satisfaction as work environment, it does have an influence on retention (Zeytinoglu et al., 2006). Additionally, there are specific issues which have been documented as important when considering remuneration and work participation issues. Some of these issues include fair reward for provision of care, a comparative wage for similar positions outside of the profession, penalty rates and career path anomalies.

Fair and comparative reward for provision of care will influence a nurse's decision to remain in the current organisation (Department of Medical Sociology, 2008). Nurses who had resigned from the profession commented through focus groups held by the New South Wales (NSW) Nurses' Association that positions outside nursing were associated with higher pay and lower levels of responsibility and stress (Buchanan &

Considine, 2002). These nurses suggested that the rates of pay anomalies were due to the profession not keeping pace with the changing nature and complexities of nursing work. For example, a mistake made by an executive may cause organisational and economic problems, however, a mistake from a nurse providing patient care may cause death (Fochsen, Sjogren, Josephson, & Lagerstrom, 2005). A perception of poor monetary rewards and lack of recognition for demanding and complex roles contributes to decreased satisfaction and consequently increased turnover (Al-Hussami, 2008).

In addition to comparative pay rates and provision of care, nurses raise concern over the relationship between professional development factors and remuneration. Payment of penalty rates cause frustration among nurses as a less qualified nurse with less responsibility can earn more money on night duty than an experienced nurse on day duty (Cowin, 2002). Further, limited career pathways for nurses wishing to continue in clinical practice rather than transfer into a management stream has resulted in lower remuneration (Forster & Queensland Health, 2005). Survey participants expressed dismay at the level of qualifications and lack of salary incentives for experience and knowledge (Cowin, 2002).

There are limited opportunities for advancement for highly skilled and advanced nurses, such as the EOCN, beyond the highest paypoint of the nurse practitioner. The nurse practitioner is able to function in more complex situations while providing support and direction to registered nurses and other non-registered nursing personnel (Heartfield, 2006). Additionally, nurses in the NSW Nurses' Association study were concerned about the extra expenses required to maintain professional competence. The extras may include the obligation to undertake professional development courses in their own time and expense which could require Government Fee Assistance. In close proximity to their retirement, the EOCN may reconsider the value of fee paying professional development with its associated financial burden. Due to nurses' dissatisfaction with professional development factors, a nursing qualification allowance has been offered as an incentive for nurses choosing to work within the clinical environment (Forster & Queensland Health, 2005). In addition to the qualification allowance, enterprise bargaining in Queensland public hospitals has awarded nurses the first annual professional development allowance of \$1500 in 2005 (Queensland Health Integrated Resource Manual, 2006). To highlight

professional comparison, Senior Medical Officers have been awarded a similar professional development allowance to the value of \$20,000 per annum as from 2005, and Resident Medical Officers received the same amount as of 2006. The Medical Officers receive an allowance approximately 13 times greater than that of the nursing profession (Medical Interest Based Bargaining, 2005). This imbalance between professional development allowances highlights a lack of recognition and value for the nurse. This may prompt the EOCN to reconsider any desire to progress with additional studies.

Remuneration appears to be more influential to nurses who are considering leaving than those who have already left, according to a Queensland survey (Hegney et al., 2008). The level of remuneration, however, is traded off in lieu of a conducive and supportive work environment. In addition to work environment, the economy may also influence the EOCN's decisions concerning remuneration and workforce participation. In a strong economy, numerous alternative career options may appeal to potential nursing students if the remuneration was competitive (Minnick, 2000). Even though strategies such as promoting nursing as a challenging professional role aim to attract and retain nurses, the economy has an influence on nursing employment. Reviewing the United States labour market demonstrated hospital registered nurses wages increased 5% above inflation rates in 2002 and 1.8% in 2003. Subsequently, there was a surge of employment of registered nurses over the age of 50 years together with international nurses (Minnick, 2000). Moreover, a weakening of the national economy which threatened employment of many registered nurses' spouses, promoted nursing work as a favourable option (Buerhaus, Donelan, Ulrich, Norman, & Dittus, 2005). As most nurses are not considered primary income workers, it is more likely that nurses respond to the total family income and the general economy (Zeytinoglu et al., 2006). In tandem with an international demand for nurses, there is a risk of nurses seeking employers who pay higher rates outside the profession. If stagnation or minimal increases in nurses' wages continue, there is little reason to believe that the profession can make a strong economic case to retain those considering retirement such as the EOCN (Buerhaus et al., 2005).

Premature exit of EOCNs as a result of low or inequitable remuneration concerns presents a financial burden on western countries, as many nurses retire at 50 to 55



years (Schofield, 2007). The burden consists of high societal costs through loss of tax revenues, increase of retirement costs and the growing healthcare needs due to continued increase in life expectancy (Australian Government, 2010). If the EOCN extended their workforce participation past their preservation age, they may ease this potential economic strain. However, insufficient remuneration coupled with work environment issues such as heavy workload and emotional demands may lead nurses to question their intent to stay within the profession (Capuano, Bokovoy, Hitchings, & Houser, 2005).

#### **3.4.4 Baby Boomers Versus Other Generations**

Multigenerational factors are considered in relation to recruitment and retention strategies as each generation holds different core values and priorities (Hart, 2006). The nursing profession consists of several distinct generational groups with diversity in work and life issues. This diversity has the potential for workplace conflict due to differing values and work ethics (Stuenkel et al., 2005). These differences may cause a lack of peer cohesion which is associated with nurse 'burnout' (Henry, 2007). How the generational issues are managed may influence the EOCN's perception of job satisfaction and hence workforce participation.

Born in the baby boomer generation between 1946 and 1964, the EOCN will often have multiple responsibilities (Hart, 2006). For the purpose of this section, 'baby boomer nurses' will be referred to as 'the EOCN'. Characteristically, the EOCN will absorb themselves in work, but strive for early retirement and financial freedom (Weston, 2006). They seek an environment which provides the flexibility to manage their personal responsibilities, while continuing to meet their professional needs (Hart, 2006; Weston, 2006). Additionally, this cohort claims their strength as process-orientated, team and consensus builders and mentors (Henry, 2007). Considering their attributes, extended employment for the EOCN up to and past the preservation age would make a substantial contribution to the quality and quantity of the workforce (Tourangeau et al., 2009).

'Generation Xs' were born between 1965 and 1978 and consider work as just one component of their life with leisure and family as their priorities (Hart, 2006). In contrast to the EOCN, 'Generation Xs' have determined that "long time commitment to one organisation and hierarchical reverence are to be avoided" (Kupperschmidt,

2006, p. 4). With a preference to work as individual contributors rather than team members, this cohort will not remain with the same organisation throughout their career if their needs are unmet (Henry, 2007). Similar to 'Generation Ys' characteristics, they are typically technologically smart and productive, and prefer to work alone with minimal direction (Hart, 2006).

'Generation Ys' were born from 1979 to 1999 and have core values which include confidence, achievement, diversity and recognition of professional status (Kupperschmidt, 2006). Once employed, this group expect immediate authority with influential decision making. Additionally, this generation are cooperative team players, work hard and expect recognition for their efforts (Henry, 2007). While 'Generation Ys' are predicted to seek employment in the helping professions, they are intolerant of colleagues and leaders who are not technically competent. This group is empowered by competence with the internet (Kupperschmidt, 2006).

The healthcare system is being challenged to provide equilibrium between unique and separate generations in an already stressful environment. Generational differences or conflicts can increase stress and disharmony within the workplace which may manifest as increased absenteeism or resignation (Kupperschmidt, 2006). Initially, bureaucratic structures followed hierarchical lines of interaction dictating that the younger generation at entry level reported to the next generation. This meant that older nurses held the senior positions (Weston, 2006). While a hierarchical structure may still be common, appointments by merit and continuous quality improvement have brought a more team-based approach to structures, which endorse the various generations to interact as peers. Team approaches may be effective, but may also cause conflict between the various generations as their values and priorities differ.

The EOCN views nursing as a professional career and 'marries' their self-worth to their work ethic (Kupperschmidt, 2006). Conversely, Generation X and Y, as the future nursing workforce, do not share the same work ethic and sense of loyalty to the employer (Donley, 2005; Hart, 2006; Thorgrimson & Robinson, 2005). Consequently, the EOCNs perceive that they carry the greatest workload of the generations and experience high levels of role overload and stress (Kupperschmidt, 2006). This perception is highlighted when the 'Xs' have a tendency to place their personal priorities ahead of work obligations by responding less than eagerly to

overtime requests (Henry, 2007). Additionally, EOCNs have laboured throughout their professional life to gain experience and credibility, yet 'Generation Xs' expect success from short-term employment (Weston, 2006).

Changing roles may be the foundation of additional differences between the generations. If the EOCN is to embrace the preceptor or mentor role to support the less experienced nurse with their application of knowledge, generational differences will need to be managed (Stuenkel, 2005 #36). In addition, there is a dissonance between Generation X and Y when considering the preferred work environment. While Generation X prefers to work alone, Generation Y will favour work within a team (Kupperschmidt, 2006). Also, the 'Information Age' has reduced the support required by the younger generation from the more senior generation (Weston, 2006). Historically, the older nurse would act as the clinical teacher, however, due to ease of access to information and evidence and the technical expertise of this generation, this may not be the case today. The younger generation may in fact provide professional educational support to the older generation for accessing the computer for information or documenting their work (Weston, 2006). While these subtle work changes may support the sharing of skills between generations, they are potential sources of misunderstandings and conflict.

The nearing retirement of many EOCNs has the potential to have a significant impact on the labour market (The Lewin Group, 2009b). The reduced workforce participation or retirement of the EOCN will impact on the supply of registered nurses within the healthcare system. Multigenerational characteristics have the potential to cause workplace conflict due to the diversity of each generation's values and ethics. If Generation Xs and Ys elect to work casually in order to maintain the balance of work and lifestyle (Thorgrimson & Robinson, 2005; Stuenkel et al., 2005), the EOCNs will be left to accept the responsibility. This may contribute to the EOCN's decision to leave while the other generations balance their lives (Donley, 2005; Stuenkel et al., 2005).

### **3.4.5 Summary and Research Question**

As a result of the nursing shortage, reasons for job dissatisfaction and turnover have gained increasing interest in the literature (Duffield et al., 2009); however, there remains a lack of satisfaction studies which specifically identify predictors of dissatisfaction for the EOCN. Additionally, while research has focused on reasons for dissatisfaction, little attention has been given to the exciting nature of nursing practice. Although work excitement is a catalyst for the provision of quality care and assists to eliminate many of the effects of dissatisfaction (Sadovich, 2005), minimal strategies have recognised the need to support the addition of work excitement in the EOCN's professional practice.

Evidence suggests that nurses access professional and continuing education to maintain skills and knowledge relevant to providing quality care (Giorgianni, 2005). This principle of accessing knowledge is important to nurses across all age groups and is not limited to early career nurses. As the workforce ages, it is important to recognise the need to provide professional development relevant to the EOCN, who has the organisational knowledge to support less experienced staff (Armstrong-Stassen, 2005). How the EOCN is offered training and support to manage this transfer of knowledge and their own continued development is crucial.

Remuneration does not have as strong an influence over nurse retention as the work environment, however, the perception of fair remuneration for the provision of care has strong influences over nurses' decision to remain in the organisation (Al-Hussami, 2008). Much of the perception of fair remuneration is based on comparative information of other professions and their expected workload, responsibility and knowledge requirements (Al-Hussami, 2008). Finally, multigenerational diversity and priorities are partially responsible for workplace disharmony and misunderstandings (Hart, 2006). The workplace disharmony and misunderstandings may be viewed by the EOCN as a lack of personal and professional recognition, causing premature reduction of workforce participation for the EOCN.

## Research Question:

***How does personal and professional recognition influence EOCNs' decisions regarding workforce participation?***

### 3.5 Effort and Reward Balance

The EOCN's decision on workforce participation has been discussed under *Workplace Environment*; *Leadership*; and *Personal and Professional Recognition* concepts. The fourth and final concept of Effort and Reward Balance is categorised under three headings: 1) retention; 2) reduced workforce participation; 3) resignation or retirement. The category of *retention* is defined as the employment status remaining the same number of contracted work hours per fortnight and may include casual or agency, part-time, full-time employment. *Reduction of workforce participation* is a negotiated reduction of contracted work hours per fortnight. Finally, *resignation* is defined as the withdrawal from workforce participation with the current employer, while *retirement* is the withdrawal from workforce participation, typically at a later stage of life with the collection of accrued benefits such as the pension (refer to Table 3.5:1). The individual may retire at any age or may retire from one job or career and accept another.

***Table 3.5:1 Options of Workforce Participation***

Category	Definition
Retention	The employment status remaining as the same number of contracted work hours per fortnight; may include casual or agency, part-time, full-time employment.
Reduction of work-force participation	A negotiated reduction of contracted work hours per fortnight.
Resignation	The withdrawal from workforce participation with the current employer.
Retirement	The withdrawal from workforce participation, typically at a later stage of life with the collection of accrued benefits such as the pension.

### 3.5.1 Quitting Behaviour

As a result of the international nursing shortage, the 'quitting behaviour' of nurses has gained considerable attention. The Australian age range for retirement has no specific limit; however, it is commonly between 55 and 65 years. While the preservation age is 55 years, labour participation commonly begins to reduce at 50 years for the nurse (Schofield, 2007). The EOCN may require different retention strategies than their younger counterparts due to differing values and needs (Armstrong-Stassen, 2005); however, there is little evidence which supports trialed and effective organisational retention strategies. A longitudinal survey by the British National Health Service (NHS) identified issues which were important to the decision making relating to 'quitting' or leaving the organisation or nursing profession (Frijters, Shields, & Price, 2003) and has been corroborated by other researchers (Bennett et al., 2009; Camerino, Conway, Heijden, Estryn-Behar, Costa, & Hasselhorn, 2008; Mion, Hazel, Cap, Fusilero, Podmore, & Szweda, 2006).

A contributor to the nurse's decisions about workforce participation is the health status of the individual. Nurses who reported a long-term health condition are more likely to exit the organisation or profession (Frijters et al., 2003; Leavitt, 1996). In addition to the nurse's health status, financial viability will also contribute to the 'quitting' decision. An individual who is financially viable will not extend their work participation even though the retirement age may no longer be fixed. Housing tenure also appeared to be a predictor of resignation, with those holding a mortgage the least likely to leave due to their greater financial responsibility (Hatcher et al., 2006).

Nurses were found to be much less likely to resign if they were employed in a large organisation (Frijters et al., 2003). Together with seniority, workplace size is the most significant predictor of resignation. This may be due to the ability of larger organisations to have some characteristics which improve the work environment for nurses. Examples of these favourable work environment characteristics may be the ability to offer more flexible working schedules or better internal career opportunities (Frijters et al., 2003). Also, nurses who were employed at higher levels were more likely to leave than the junior staff, which may reflect the high transferability of the managerial skills to the outside market (Frijters et al., 2003). Younger nurses are more likely to leave organisations than the older nurses (Kupperschmidt, 2006), however, this will only occur if the work environment conditions were flexible and met

the older nurses' individual and professional needs of the EOCN (Armstrong-Stassen, 2005).

Remuneration may not compensate for a unfavourable workplace environment. National Health Service (NHS) nurses who received 23% more pay when compared to outside employment, and worked 1.5 hours per week less, continued to leave the NHS. These nurses stated that their reason for resignation was that they were less likely to engage in shift work than when they were employed at NHS.

While many of these findings have been supported in other studies, evidence suggests that few organisational strategies have been implemented or trialed to support their effectiveness or relevance, particularly for the EOCN. Further, much of the literature concerning 'intention to leave', particularly for the nurse nearing retirement, discusses the imbalance between the effort required and the reward received in the workplace (Siegrist, 1996).

### **3.5.2 Effort–Reward Imbalance Model**

There have been many factors identified which may influence the decision making of the nurse contemplating reduction in workforce participation or retirement. While individual circumstances will be pivotal in the decision, the personal review or consideration of the effort a nurse must expend compared to the reward received is relevant. This consideration is relevant for nurses of all ages and may be a useful tool to view and begin to understand the processes the EOCN undertakes to arrive at a decision about their employment. The effort–reward imbalance (ERI) model considers high cost/low gain conditions in the workplace to be stressful (Siegrist, 1996). This theoretical approach is:

focused on the notion of social reciprocity which is characterised by mutual cooperative investments based on the norm of return expectancy where efforts are equalised by respective rewards (Department of Medical Sociology, 2008, p. 1).

Recurrent high effort demonstrated at work in combination with low reward may cause negative emotions and sustained stress reactions with adverse long-term effects on physical and mental health. Conversely, positive emotions evoked by appropriate social rewards promote wellbeing, health and sustainability (Siegrist,

1996). Two components of effort and reward are distinguished in this model: 1) an *extrinsic component* which reflects distinct job conditions (effort: work demands, obligations; rewards: remuneration, esteem, career opportunities and security), and 2) the *intrinsic component* which depicts the personal coping style termed 'over-commitment'. Over-commitment defines a set of attitudes, behaviours and emotions that reflect excessive striving combined with a strong desire for approval (Hasselhorn, Tackenberg, & Peter, 2004). Some nurses will manage stress more effectively than others, for example nurses with over-commitment or high intrinsic effort will over-emphasise their efforts as they need approval. This group will find the dissonance between efforts and rewards stressful (Kuper, Singh-Manoux, Siegrist, & Marmot, 2002). Rewards are the degree to which nurses feel they have been recognised and congratulated for their job performance. The level of reward should match the level of the performance or the inequity may cause withdrawal from extra effort by the nurse (Lavoie-Tremblay et al., 2006).

**Figure 3.5:1 Effort–Reward Imbalance**



[original Effort-Reward Imbalance Model (Siegrist, 1996) cited in Department of Medical Sociology, 2008, p. 3]

According to the ERI model, effort at work is given as part of a social contract that reciprocates effort with adequate reward. Rewards are offered by three methods: 1) remuneration 2) esteem and 3) career opportunities which may include job security. Receipt of any of these rewards was demonstrated to positively effect personal



health (Department of Medical Sociology, 2008). The reward component of the ERI model was explored from differing nursing work settings. This study found that nurse compensation varied considerably across employment settings and that non-monetary rewards (motivators) may be critical determinants to job retention (Hughes & Marcantonio, 1991). This result has been confirmed with other studies through different methodologies (Storey et al., 2009; Tourangeau et al., 2009). If the EOCN's work environment demands high effort, this group will consider the balance of work with the reward they receive. If remuneration is poor, particularly when compared with other similar professions, or there is minimal recognition for work effort through career progression or additional training opportunities, there is risk of withdrawal from effort by the nurse (Al-Hussami, 2008).

High-level effort and insufficient reward is demanding attention within the current healthcare environment. In the 1990s, healthcare restructuring was a planned strategy to increase productivity and reduce expenditure while maintaining quality of care (Aiken, Clarke, Sloane, 2000). The result has been long lasting for healthcare, leaving nurses feeling devalued and 'burnout' (Duffield et al., 2008). Comparatively, the current work environments describe heavy work load, skill mix challenges which may compromise quality outcomes (Forster & Queensland Health, 2005) and personal risk to nurses such as violence (Forster, 2006) or burnout (Cyr, 2005). The ERI model has been used to review the effects of the current healthcare system. A study that explored the nursing profession across seven (7) European countries found a strong association between ERI and burnout as well as intention to leave the profession (Hasselhorn et al., 2004). This has implications for the management of nursing staff, but particularly the EOCN, who may be considering their employment options.

An imbalance between (high) effort and (low) reward is maintained under particular conditions (refer to Figure 3.5:1). These conditions are discussed with relevance to the EOCN's decision about workforce participation (Department of Medical Sociology, 2008). The first condition is *work contracts are poorly defined or employees have little choice of alternative workplaces* (Department of Medical Sociology, 2008). The EOCN is a valuable component in the workplace as they have the organisational knowledge and experience to support quality outcomes in patient care. Additionally, the EOCN has the knowledge to provide support and guidance to

the new or less experienced nurse as long as they have the appropriate training to provide this facilitation role. As a result of the nursing shortage, nurses are a valuable and marketable commodity with little to interrupt the mobility to an alternative employment site. The nurse's skill level as determined by state or national competencies would ensure the nurse had the ability to perform at a minimum competency level ensuring employability in organisations of choice. The ERI for the nurse may present in unclear boundaries of the job description and is dependent on the effectiveness of the organisational and leadership factors.

The second condition concerned employees accepting this imbalance for strategic reasons (Department of Medical Sociology, 2008). Commonly, the ERI may be chosen as an anticipatory investment which may lead to improved future work prospects. This strategy would be an individual choice for the nurse, however, it may be a more likely direction for the nurse with more years to serve. Consideration would include the current employment situation and possible future benefits. The third and final condition concerned the fact that the experience of high cost/low gain at work is common in staff who exhibit a specific cognitive and motivational pattern of coping with demands characterised by excessive work-related commitment (over-commitment) (Department of Medical Sociology, 2008).

Overcommitted nurses suffer from inappropriate perceptions of demands and of their own coping resources more often than their less involved colleagues, because perceptual distortion prevents them from accurately assessing cost-gain relationships (Department of Medical Sociology, 2008, p. 2).

Age relevance of the ERI model was demonstrated by an examination of Japanese workers, which found that the ERI was most prevalent in the 25–30 year old employees (Tsutsumi, Kayaba, Nagami, Miki, Kawano, Ohya, 2002, p. 3). Additionally, while the ERI decreases with age, the level of over-commitment increased with age. If the EOCN who is 'over-committed' or has high intrinsic effort does not manage work stress effectively, they will over-emphasise their efforts in order to receive recognition for their work (Kuper et al., 2002). The EOCN will find a dissonance between effort and reward stressful and this may influence their decision on workforce participation.

Organisational empowerment may be a useful strategy for reducing job stress. A relationship study between nurses' empowerment and their perception of ERI found that having access to supports, autonomy, opportunity, information and resources may result in a positive match between self-appraised efforts and perceived rewards and prevent the effort–reward imbalance (Kluska, Laschinger, & Kerr, 2004). Nurses' perception of access to resources was a key component in the amount of ERI experienced by the nurse. While lack of resources added to the workload, increased access to resources was related to higher perceived rewards. If the organisation provided appropriate resources, it may be assumed that the work provided was valued and so rewarded adequately for the effort (Department of Medical Sociology, 2008). Nursing leadership is well placed to support EOCNs in providing resources and opportunities to empower them to accomplish their work in meaningful ways. When EOCNs are educated to provide optimal care, they are more likely to do so if their work efforts are sufficiently rewarded (Manojlovich, 2005).

As many EOCNs prepare for retirement within a nursing shortage environment, the healthcare sector will have to compete with other sectors for staff. This may necessitate improving measures to not only recruit but also to retain staff, specifically the EOCN. These strategies will only succeed when the workplace environment is improved to allow for the provision of professional practice and reduce the likelihood of occupational stress (Gelsema et al., 2006).

### **3.5.3 Summary and Research Question**

The EOCN is exposed to factors such as workplace environment, leadership and personal and professional needs which influence their decision on workforce participation. Additional personal and situational factors such as the nurse's age and financial security, health status and current job satisfaction will further influence the decision about work continuation (Barclay, 2006). Studies into the 'quitting behaviours' of nurses identified that while the effect of remuneration is statistically significant, the predicted impact of an increase in nurses' pay on retention rates is small. What was more influential from a retention perspective was the effect of workplace environment. Age, seniority, job and employer characteristics are all found to be important predictors of nurse's quitting decisions (Department of Medical Sociology, 2008).

In addition to the 'quitting behaviours', failure of reciprocity between work efforts and rewards received may cause negative emotions and sustained stress reactions with adverse long-term effects on physical and mental health. If, however, appropriate rewards balanced the work effort, the effort–reward balance would be reduced and promote wellbeing, health and sustainability (Siegrist, 1996). The EOCN's decision concerning workforce participation will culminate in one of three directions which include: 1) continued retention; 2) reduction of workforce participation; or 3) resignation or retirement.

**Research Question:**

***How does the balance of effort and reward influence the EOCNs' decisions regarding workforce participation?***

### **3.6 Conclusion**

This chapter presented a review of the literature which amplified the factors influencing the trend towards decreasing workforce participation by the EOCN. Withdrawal of EOCNs from the current workforce will impact upon staffing numbers and quality of healthcare services. Although considerable savings can be achieved if healthcare organisations could reduce the current high and costly rate of turnover and reliance on temporary staffing, little recognition is given to the benefits of retaining EOCNs. Organisations continue to invest their efforts into recruiting new staff rather than retaining or delaying the retirement of the EOCN cohort. As a result, little research has been done to evaluate which recruitment and retention strategies are effective for this group. However, use of effective strategies to retain the EOCN would result in cost savings and/or increased revenue for the employer, in addition to benefiting the profession and healthcare sector (Hatcher et al., 2006). This literature review has addressed four major concepts in relation to EOCN's workforce participation. These concepts are Workplace Environment; Leadership; Personal and Professional Recognition; and Effort-Reward Balance.

The majority of EOCNs are from the 'Baby Boomer' generation which now faces choices of retirement or continuing on in the workforce at reduced hours. Consequently, the nursing profession will potentially lose considerable numbers of highly skilled and experienced nurses as they consider their workforce employment

or retirement options with a trend toward retirement at age of 50 and 55 years (Schofield, 2007). The knowledge and experience lost if the EOCN reduces or exits from workforce participation is irreplaceable as evidenced by the escalating costs of replacement of specialty nurses (Hatcher et al., 2006). The literature review highlights that a 'one-size fits all' approach has been taken in planning workforce replacement initiatives, with few studies exploring strategies for retention of different age cohorts. This approach risks over-generalising data or making assumptions with regard to benefits of retaining the EOCN in a highly technical and demanding context. While this generalised approach continues to be implemented, organisations are ignoring the potentially large cohort of highly skilled nurses available if 'best-fit' retention strategies were practised (Armstrong-Stassen, 2005). There are a few descriptive studies of issues influencing retention which provide recommendations on strategies specifically for the EOCNs. However, there is little evidence to demonstrate the effectiveness of outcomes or benefits of these strategies to the healthcare system as they have not been evaluated specifically for the EOCN cohort.

### ***Work Environment***

The general nursing literature consistently reports dissatisfaction concerning workplace environmental factors such as heavy workload, inappropriate skill mixes and workplace injury. These factors are responsible for permanent injury and increased workplace stress levels which often results in nurse burnout (Hegney et al., 2008). Consequently, poor health has been cited as a major influence for encouraging premature retirement (Cyr, 2005; Hatcher et al., 2006). Turnover data indicates dissatisfaction and reducing tolerance to work under these conditions. Even though the negative impact of environmental factors is common for all age groups, the impact of these factors upon the decisions of EOCNs to remain or leave the workforce has not been evaluated.

### ***Leadership***

Within the context of demanding and complex healthcare systems, the leadership role of the nurse manager is important in retaining staff. Together with the workplace environment, nurse leaders are required to balance conflicting demands from both the administration and the clinical staff, and reconcile these in the best interests for all concerned. Within this context, the nurse leader plays a pivotal role in team building and in creating a culture of collaboration that demands and rewards safe,

high quality patient care. In order to meet the requirements of patient acuity and resource constraints, the nurse leader is expected to delegate responsibilities to nursing staff. For nurses, this delegation can be perceived as a reflection of the nurse leader's confidence in staff competence. Appropriate delegation provides nurses with a sense of empowerment by acknowledging their role as decision-makers at the point of care. Delegations of responsibility create a perception of being a valued team member and assist the EOCN to be more tolerant of the complexities and frustrations of the work environment. More specifically, the EOCN would feel motivated, committed and more connected to their workplace (Somers, 1995). Leadership strategies such as nurturing a supportive and cohesive team environment allow nurses to practice autonomously. This strategy has demonstrated benefits for nurses regardless of age, however, no approaches which are specifically targeted at the EOCN have not been identified, evaluated or documented (Hatcher et al., 2006).

### ***Personal and Professional Issues***

In the light of the effects of positive team development, recognition of the EOCN's personal and professional issues potentially influences their decision concerning workforce participation. Evidence suggests that this cohort of nurses is largely ignored in the area of professional development opportunities offered within organisations. Organisations also fail to tap into the EOCNs as human resources. The EOCNs hold the organisational and professional knowledge because of their length of service, and these attributes cannot be substituted and can support the development of less experienced nurses. Strengthening the transfer of this knowledge has many avenues for utilisation such as career promotion, preceptorship or mentorship, however, little if any opportunities are made available to the EOCN to access skill development or retraining. While increases in wages are seen by EOCNs as recognition of professional contributions and are a potential enticement to stay in the workforce, they do not influence their decision with regard to retention. Rather than monetary reward being the primary motivator for retention, EOCNs value the opportunities to demonstrate creativity, flexibility and adaptability within their practice environment. Reports indicate that the bureaucracy of acute healthcare is ignoring the strengths of its most valuable asset, the nurse, which is causing dissatisfaction. This lack of recognition is demonstrated by the exodus of nurses of all ages from the system. Therefore, it is critical and timely to identify specific factors which further reduce workforce participation for the EOCN.

### ***Effort–Reward Balance***

It is anticipated that in the light of current workplace conditions, the EOCN will consider their decision on workforce participation. The effect of their decisions could potentially result in the retirement of large numbers of baby boomers, which will impact on the labour market. This impact may influence the quality of healthcare as the demand for qualified and experienced nurses outweighs the supply. It is known that the final decision to reduce participation or resign from the workforce involves multifaceted processes and is dependent on the individual's personal and professional circumstances. Quitting behaviours have significant influence on the decision of workforce participation and include factors such as health and financial status. Another pivotal influence in the workforce participation decision may be best explained by the balance or imbalance of effort and reward for the EOCNs. Examination of this balance may reduce workplace stress and demonstrate value for the nurse if the environment and leadership provide a workplace conducive to the provision of quality care.

In conclusion, the four research questions generated from the review of literature are:

- How does the workplace environment influence EOCNs' decisions regarding workforce participation?
- How does leadership influence EOCNs' decisions regarding workforce participation?
- How does personal and professional recognition influence EOCNs' decisions regarding workforce participation?
- How does the balance of effort and reward influence the EOCNs' decisions regarding workforce participation?

The next chapter, Chapter Four, explains and justifies the research design for the thesis.

## **CHAPTER FOUR: DESIGN OF THE RESEARCH**

### **4.1 Introduction**

The purpose of this research is to explore factors that influence EOCNs' decisions regarding their workforce participation. This chapter explains and justifies the research design adopted in pursuit of the research purpose.

The research questions which focus the conduct of the research design are:

- 1) How do workplace environmental factors influence the EOCNs' decision regarding workforce participation?
- 2) How do leadership factors influence the EOCNs' decision regarding workforce participation?
- 3) How do personal and professional recognition factors influence the EOCNs' decision regarding workforce participation?
- 4) How does the balance between effort and reward influence the EOCNs' decision regarding workforce participation?

### **4.2 Theoretical Framework**

A theoretical framework offers a philosophical foundation which justifies and gives direction and structure to the research design. From an epistemological perspective, constructionism has been chosen as the theoretical framework to explore and provide meaning of the phenomenon (Crotty, 1998), as constructed in this case by the EOCNs' decision making regarding their workforce participation. A theoretical perspective of interpretivism is employed as this study aims to draw an in-depth understanding (Verstehen) of the social life-world (Charon, 2001; Crotty, 1998) from the EOCN's standpoint. Specifically, the theoretical perspective adopts symbolic interactionism as the theoretical lens in exploring the influences that impinge upon EOCNs' decisions regarding their workforce participation (Bassey, 1999).

A case study approach is the methodology adopted. It is consistent with the research purposes' epistemology and theoretical perspective. A case study approach provides a rationale in the orchestration of methods used to explore the phenomenon under study (Merriam, 1998).



Data gathering strategies employed included a survey, focus group and semi-structured interviews.

Table 4.2:1 presents an overview of the research framework. Each element informs the other and is addressed in detail through the subsequent text within this chapter.

**Table 4.2:1 Research Framework**

<b>4.2 Theoretical Framework</b>	
<b>4.2.1 Epistemology</b>	Constructionism
<b>4.2.2 Theoretical Perspective</b>	Interpretivism <ul style="list-style-type: none"> <li>• Symbolic interactionism</li> </ul>
<b>4.3 Research Methodology</b>	Case study
<b>4.5 Data Gathering Strategies</b>	Survey Focus groups Interviews: Semi-structured and informal – purposeful selection

### **4.2.1 Epistemology**

Epistemology captures the nature of knowledge through the study of “how knowledge is generated and accepted as valid” (O'Donoghue, 2007, p. 9). The focus of epistemology is that knowledge is legitimate and adequate (Crotty, 1998). The epistemological framework chosen for this study is constructionism, as it seeks to provide understanding of reality from the participants' perspective at a particular time and considers the legitimacy of that knowledge (Creswell & Plano Clark, 2007). Constructionism offers flexibility in the exploration of ‘ways of knowing’. Rather than providing a prescriptive formula of what should be studied, constructionism suggests directions along which to explore emerging concepts and theories to describe and explain a phenomenon (Crotty, 1998).

Constructionism emphasises that meaning or reality is not constructed by each individual at the instance of each phenomenon, but rather it is socially constructed (Barkway, 2001). Further, constructionism espouses the influence of culture in

shaping the way phenomena are interpreted by individuals, providing a definite view of the world (Crotty, 1998). As individuals live in different worlds, there are diverse ways of knowing and varying ways of constructing meaning and realities. Benner's opinion in the following quotation aligns with constructionism by suggesting that the social constructions of understanding worldviews are sufficient to guarantee their 'trustworthiness'.

No higher court for the individual exists than meaning or self-interpretations embedded in language, skills and practices. No laws, structures, or mechanisms offer higher explanatory principles or greater predictive power than self-interpretations in the form of common meanings, personal concerns and cultural practices shaped by a particular history (Benner, 1985, p. 5).

Constructionism rejects that the 'truth' is waiting to be found, but rather meaning is negotiated or constructed through social interaction. The researcher and the researched, while different, are united to construct meaning (Crotty, 1998). The inquirer is described as 'connoisseur-turned-critic' by reconstructing a perception that "illuminates, interprets, and appraises the qualities of the experience" (Schwandt, 1994, p. 129). This reconstruction facilitates the re-education of the reader's perception. 'Truth' then is the negotiated outcome of best-informed construction of the phenomenon upon which there is consensus (White, 2004). In this case, the consensus is the EOCNs' interpretation of their experience at a particular time of their work-life.

Constructionism assumes that "what is real is a construction of the minds of individuals" (Lincoln & Guba, 1985, p. 83). The constructed assumptions suggest that individuals seek understanding of the world in which they interact. This is undertaken by the negotiating of subjective meanings of experience that are reflected upon (Creswell, 2002). Individual differences in the construction of meaning may be multiple or even conflicting, however, these meanings or 'knowledges' offer a meaningful interpretation of experiences. The meaning is subject to continuous revision with changes most likely to occur when relatively different constructions emerge as meaning becomes more informed and sophisticated (Guba & Lincoln, 1994). These constructed assumptions or meanings of the individual's experience guide this study through choice of methodology and methods (Creswell & Plano Clark, 2007).

The study's focus is the meaning or reality the EOCNs construct from their experiences concerning decisions about workforce participation. At different times and places, alternate and legitimate interpretations of the same phenomenon occur (White, 2004). Regardless of how varied the interpretations of meaning may be, these interpretations rely on the EOCNs' view of their situation (Schwandt, 1994). Therefore, the chosen theoretical framework for this study aims to support the exploration of making sense of the meanings EOCNs have about their world (Creswell, 2002). Consequently, constructionism is well suited for a study which aims to explore purposeful meaning of complex processes of the social factors that influence the EOCNs' decision making.

#### **4.2.2 Theoretical Perspective**

##### ***Interpretivism***

A theoretical perspective provides an epistemological foundation on which the direction and structure of the research is undertaken (Blumer, 1998). A theoretical perspective is a set of interrelated assumptions about the nature of society and of social behavior (O'Donoghue, 2007). The theoretical perspective for this study is within an interpretive paradigm which is based on a way of viewing and constructing an understanding of the world (Blumer, 1998). As a theoretical perspective, interpretivism aims to generate a more in-depth understanding of the specific phenomenon within the EOCNs' natural world (Merriam, 1998). Access to this in-depth understanding is gained by exploring and analysing symbols such as language or behaviours within a cultural context (Geertz, 1973). Constructionism and interpretivism, therefore, are in synergy as they focus on how understandings are constructed, negotiated, maintained and readjusted within a specific context of human interaction (Schwandt, 1994).

Interpretivists accept that this understanding or meaning is constructed by individuals in community through their experiences, rather than reality being 'out there' to be discovered (Sarantakos, 1998, p. 35). Meaning may be constructed differently by each EOCN as they make sense of their perceptions through social interaction (Crotty, 1998).

The theoretical perspective chosen guides the research direction. This perspective also addresses the influences and meanings of the EOCN and researcher as they

construct an understanding of the phenomenon of decisions on workforce participation. Symbolic interactionism is the lens through which interpretivism is perceived as this study aims to construct meaning of EOCNs' complex social interactions.

### ***Symbolic Interactionism***

Symbolic interactionism has been adopted as the lens to inform the theoretical perspective of this research, as it is concerned with the study of humans in their social worlds (Stake, 1994).

Four principles provide an understanding of the fundamentals of symbolic interactionism (Blumer, 1998):

- a) *Individuals act towards a phenomenon on the basis of the meanings that it has for them.* It is therefore relevant to view the phenomenon in this study from the perspective of the EOCN. Methodological implications guide issues of concern to be collected through observations of EOCNs and critical discussion by the informed group (Blumer, 1998). Symbolic interactionists are prepared to accept the meanings that individuals give to their interactions, recognising that their understandings of reality may differ. In this case, the EOCNs develop their symbolic interactions, such as language and other symbolic tools, on these foundations (Crotty, 1998).
- b) *The meaning constructed from the phenomenon is derived from the social interaction with others.* Social interaction is an evolving process which is directing, checking and modifying their actions in the light of their interactions with others (Blumer, 1998). Social interactions are influenced by culture and so are acknowledged and observed in an effort to 'experience' the interactions from the perspective of the individual (Crotty, 1998).
- c) *Social acts, whether individual or collective, are constructed through a process in which the individuals monitor, interpret and assess the particular situation.* Social activities require interviewing and observing EOCNs 'acting' in their environment, and determining the interpretation process (Charon, 2001). As a consequence, the collating and construction of this observed experience may be problematic due to differing perceptions, language and interpretations (Bassey, 1999).
- d) *The complexities of interactions within organisations are not static affairs.*

Symbolic interactionism acknowledges the ongoing interception between groups of individuals within organisations as a result of their actions. Symbolic interactionism seeks an explanation of this action by exploratory and inspection processes, respecting the nature of the environment. This stance is reflected in the choice of methodology and methods adopted (Blumer, 1998).

Symbolic interactionism is critical of an over-reliance on traditional scientific methods due to the inherent complexities of human interaction. These complexities present difficulties in reviewing the phenomenon in isolation. As social interactions are complex, consideration is given to symbols such as language and behaviours within cultural environments, which are in a continuous state of change (Denzin, 1989). These interactions are particularly acknowledged in the development of study recommendations. While the recommendations are based on a careful and systematic investigation, there is an appreciation that the findings offer no absolutes (Blumer, 1998).

The adoption of symbolic interactionism as a theoretical perspective for this study is appropriate because it seeks to understand and describe the EOCN's subjective experience from the individual's perspective. Language or other symbols shape the interaction and the interpretation, guiding the methodology which will explore the phenomenon. The complexities of social interaction within the acute healthcare setting are challenged by history, culture, internal and external influences, and varying interpretations and perceptions of the nurses' experiences.

Symbolic interactionists accept the meanings that individuals give to phenomena and continue by developing systematic interpretations of those meanings (Denzin, 1989). How these interpretations and shared meanings are constructed for EOCNs concerning their workforce decision-making is pivotal to this study.

### **4.3 Research Methodology**

A research methodology is defined as "a model, which entails theoretical principles as well as a framework that provides guidelines about how research is done in the context of a particular paradigm" (Sarantakos, 1998, p. 6). The methodology provides a rationale in the orchestration of methods used to explore the phenomenon under study (Merriam, 1998). Case study is the methodology adopted for this study

### 4.3.1 Case Study

Case study is described as a unit of human interaction (the phenomenon) embedded in the natural world (Scholz, 2002). The phenomenon is studied or understood within its context in a given timeframe (Gillham, 2004). The merging of contextual conditions and the phenomenon implies that precise boundaries are difficult to determine (Gillham, 2004). As the phenomenon and the richness of the context are not always distinguishable in real-life situations, case study research:

- a) copes with the technically distinctive situation in which there will be many more variables of interest than data points;
- b) relies on multiple sources of evidence, with data needing to converge in a triangulating fashion;
- c) has benefits for the major development of theoretical dispositions which guide data collection and analysis (Yin, 2003, p. 13-14).

Case study methodology is undergoing a resurgence in healthcare research, possibly due to the rapid and dynamic changes and continuing developments within the healthcare system (Buchan, 2002). This continual state of flux justifies inquiry methodologies that allow flexibility to describe, explore and explain both the context and technical characteristics of the phenomena (Yin, 2003). These conditions favour the use of case studies over other methodologies, as case studies may offer the sensitivity to appreciate the real-life phenomena (Gillham, 2004).

Studying a phenomenon in its real-life context offers problems of operationally defining the phenomenon or the 'case' being studied. The case is explained as a specific, complex, 'bounded system' that has working parts, and is purposeful and often has a self (Stake, 1995, p. 2). However tentative, it is necessary to define the case operationally at the outset of the study. An inadequate definition may lead to the problem that the findings do not reflect the presumed case (Yin, 1999). Further, the definition of the case (unit of analysis) is aligned to the formulation of the research question and suggests that the case is the primary focus of the research question (Yin, 2003). These considerations are congruent with the purpose and research questions in this study, which seek to explore factors that influence EOCNs' decisions regarding workforce participation in one particular hospital setting.

There are five characteristics of case study that make it particularly appropriate for this research.

The first characteristic is the intense focus on a single phenomenon within its real-life context, which gains insight and interpretation into complex 'mega-systems' (Yin, 1999, p. 1210). The complexities of the phenomenon generate multiple variables of interest which outnumber the data points (Yin, 2003). *The phenomenon of interest for this study is the workforce participation decision-making of the EOCN.*

The second issue is the natural world, which is bounded by space and time, and provides the study context. To understand the complex phenomenon, the 'bounded system' allows the researcher to retain holistic and meaningful characteristics of real-life situations. Additionally, case study tolerates the condition where the boundary between a phenomenon and its context is not clear (Yin, 2003). A complication noted in conducting case studies is that both the 'case' and its context may be changing over time, adding immeasurably to the number of variables and the complexity of any analysis (Yin, 1999). This methodology has sufficient flexibility to cope with this uncertainty. *The 'bounded system' or context for this study incorporates the factors that influence EOCNs' workforce decision-making within an acute healthcare setting in a predetermined timeframe.*

The third characteristic of case study research is that it is richly descriptive due to the inquiry embedded in varied sources of information. An additional strength is the ability to deal with these multiple and diverse sources of evidence to explore common and unique features of the case (Gillham, 2004). This enables presentation of interpretations of the observed phenomenon (Bassey, 1999).

The fourth characteristic, while generally more exploratory than confirmatory, seeks to identify the themes or categories of behaviour and events rather than prove relationships or test hypotheses (Yin, 2003).

Finally, a desirable feature of case studies is to present the case study evidence separate from the investigator's interpretations of the evidence. Traditional study presentations of narrative nature do not typically distinguish between evidence and interpretation. This has led to criticism that case study investigations are only

presenting evidence which supports their interpretations; a possible criticism of any research design (Yin, 1999). However, this criticism is contested by the ability of case study research to focus on the detail of “real-life situations and test views directly in relation to phenomena as they unfold in practice” (Flyvbjerg, 2004, p. 425).

Case study inquiry is sometimes viewed as demonstrating less-scientific character than alternative approaches (Yin, 2003). However, this criticism has become less relevant as a result of public awareness of the shortfall of a science of social life (Hammersley & Gomm, 2004). Nevertheless, to utilise case study methodology, criticisms must be acknowledged and addressed accordingly.

Concern has been raised over the lack of rigour of case study research as a result of not following systematic procedures, or allowing biased views to influence the direction of the findings and conclusions (Yin, 2003). However, bias is also a reality in the conduct of experiments (Yin, 2003). In addition, it has been claimed that case study research takes too long and results in a plethora of unreadable documents. However, for this study, considerations of these risks are made and alternative ways of writing are employed with the study timeframe predetermined in design stages (Yin, 2003).

Finally, there are concerns that case study research provides little basis for scientific generalisation. Some researchers suggest that the capacity to make general conclusions is unnecessary or impossible, arguing in favour of thick description, naturalistic generalisations or transferability (Donmoyer, 2004; Lincoln & Guba, 2004; Stake, 2004). The focus of case study research is on particularisation, rather than generalisation. There is an emphasis on uniqueness of the case which implies in-depth knowledge of the phenomenon and understanding of the case itself (Stake, 1995). The aim of case study research is to ‘give voice’ to the participants and represent their case authentically, which is the core to discovering ‘symbolic truths’. The notion of authenticity is considered with regard to the legitimacy of researchers speaking on behalf of others, or challenging the idea that collectively people have but one perspective (Hammersley & Gomm, 2004). The study outcomes will be suggestive rather than conclusive and will not provide one perspective of seeing the phenomenon (Crotty, 1998).



In summary, case study methodology is selected for this research as it “investigates a contemporary phenomenon within real-life context” (Yin, 1994, p. 13) – in this case, the EOCNs’ workforce decision-making. The study offers a voice to the experiences of the EOCNs as they interact and respond to multiple influences in and out of the acute healthcare environment. In addition to gaining insight into the beliefs of EOCNs, further insights can be illuminated which can influence policy, procedures and future research (Merriam, 1998).

## **4.4 Participants**

Participant selection is purposeful and guided by the boundaries which established the case of EOCNs providing direct or indirect patient care or support services within an acute healthcare setting.

### **4.4.1 Selection of Participants**

Purposeful selection gives access to participants whose knowledge and opinions may provide ‘information-rich insights’ to the research questions (Hancock & Algozzine, 2006) – in this case, EOCNs. Consequently, this data source, which is judiciously chosen, enables gathering of potentially rich data on issues central to the those nurses experiencing the study phenomenon (Merriam, 1998). To obtain access to information-rich participants, inclusion criteria influenced by the case are Registered Nurses (RN), who:

- a) have a minimum of 10 years (collective) experience working within healthcare systems as a registered nurse;
- b) are aged 45 years and over, regardless of their entry age into the profession;
- c) are currently part-time or full-time employees at the study site: an acute tertiary metropolitan hospital located in Brisbane, Queensland;
- d) practises within the classifications of nursing officer levels {Nursing Officer (NO) 5 to 12} and provide direct or indirect patient care or support services. No exclusion by gender is applied.

The case study boundaries include only those EOCNs whose nursing classifications are broad (NO Grade 5–12) as it is considered that all nursing levels are exposed to experiences which may influence decisions regarding their continued workforce

participation. Timeframes of work experience are imposed and include a minimum of ten years' experience. This decision is based on the premise that practising within such timeframes would ensure the EOCNs understand the diverse issues of the nursing profession and healthcare systems. This provides the opportunity for greater information insights into the issues central to the phenomenon.

Initially, all EOCNs meeting the inclusion criteria were invited to participate in a survey, which sought to generate insight from their shared beliefs and attitudes about influences concerning their workforce participation. The insights provide direction for the following data gathering strategies, which include focus groups and in-depth semi-structured interviews.

Focus groups utilise predetermined purposeful selection through inclusion criteria to review and study all cases illuminated from the survey and research questions (Patton, 1990). In addition to purposeful selection, the focus group selections were determined by allocating EOCNs to similar nursing classification groups. These homogenous groups provide a relatively safe environment in which to share their experiences and dilute the power imbalance, therefore stimulating discussion and facilitating comparison between groups (Barbour, 2005; Krueger, 1994). Purposeful selection determines which groups of people are likely to have different views or experiences and these categorisations guide recruitment and group composition. Selection considerations also highlight ethical issues such as exposing vulnerable individuals to others, or even bringing together individuals from different levels in an organisation (Barbour, 2005).

In-depth semi-structured interviews utilise theoretical sampling as a preferred option. The data are simultaneously collected, coded and analysed in order to determine what data to collect next and from whom it should be collected (Polit & Beck, 2004). Participants were selected based on the analysis of information or theoretical relevance offered within the focus group interviews, for example, emerging preliminary themes, rich data discussed or negative response/s given by focus group participants. Selection of these participants for in-depth semi-structured interviews offers the optimal opportunity for information-rich insights into issues central to the phenomenon. Table 4.4:1 summaries the participants involved in the study.

**Table 4.4:1 Research Participants**

<b>Data Gathering Strategy</b>	<b>Nursing Officer (NO) Classification of Registered Nurses</b>	<b>Numbers of Participants</b>
Survey	NO Grade 5 to 12	n = 218
Pilot group	No classification used as review of the questions is the intent of pilot group	n = 6
Focus group 1	NO Grade 5 and 6	n = 8
Focus group 2	NO Grade 7	n = 9
Focus group 3	NO Grade 9 to 12	n = 4
In-depth semi-structured interviews	NO Grade 5	n = 1
	NO Grade 6	n = 4
	NO Grade 7	n = 3
<b>Total</b>		<b>n = 247</b>

\* Note: RN Classification commences at NO Grade 5. Additionally, there were no classification NOs Grade 8 or 11 employed at the study site at time of interview.

### **Participant Identification**

As a means to identify the data sources and maintain confidentiality, the following coding was applied to the data. Data which most informed the theme were extracted from either focus groups or in-depth semi-structured interviews. In order to ensure the ability to track data to the original source, names were replaced by pseudonyms with the classification level and data source maintained. A data list of original participant names with aligned pseudonyms is secured for confidentiality purposes.

#### *Nurses' Names*

Pseudonyms have been provided which denotes the gender suitable name of the participant.

### *Focus Groups and In-depth Semi-Structured Interviews*

The number of focus group carries the appropriate chronological number with the code FG. For example, the first focus group is coded FG(1). Similarly, the in-depth interviews were coded by IDI. The pseudonym given aligns to the original name of the participant and denoted their gender. Therefore, an example of Sue IDI denotes the participant's name by gender and in-depth interview.

## **4.5 Data Gathering Strategies**

Case study methodology accommodates data gathering strategies that involve a broad variety of techniques, rather than just a single technique (Patton, 1990). Directed by the research design, the evidence of this study is strengthened by data gathering strategies while remaining sufficiently open and flexible to permit in-depth exploration of the phenomenon.

The strategies chosen for this research are:

- Survey
- Focus group interviews
- In-depth semi-structured interviews.

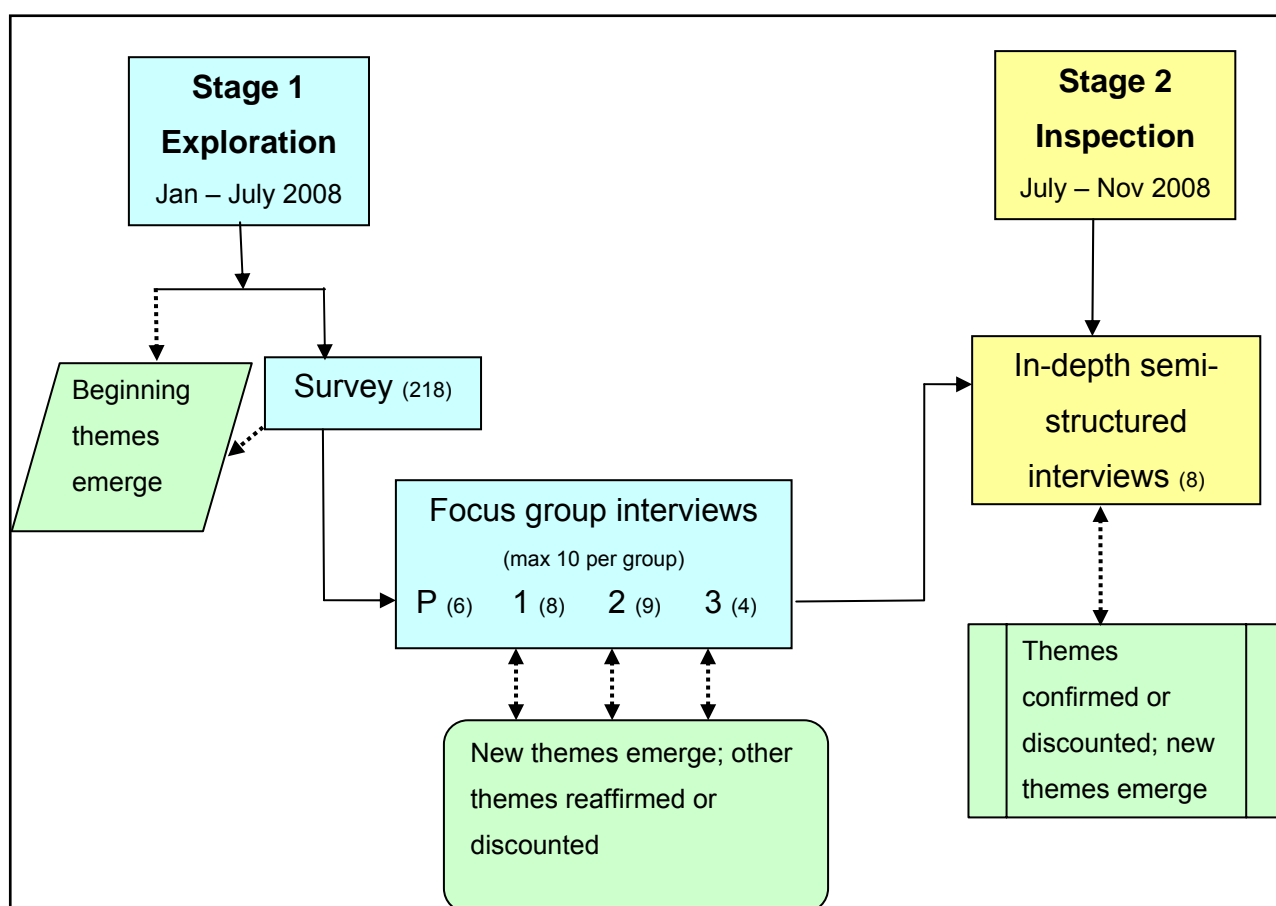
Influenced by the study's theoretical perspective of symbolic interactionism, the data gathering adopts a rigorous two-part analysis: exploration and inspection (Blumer, 1998). While it is recognised that there are numerous stages to any research process, adopting this two-staged process provides a framework for data gathering and analysis. The first stage of *exploration* forms a "comprehensive acquaintance with a sphere of social life that is unfamiliar" or alternatively gives meaning to the "developing and sharpening" of the inquiry resulting in interpretations remaining "grounded in the empirical life under study" (Blumer, 1998, p. 40). The exploratory stage accommodates flexibility as modifications in lines of inquiry occur resulting from emerging themes, reaffirming themes and discounting of 'redundant' themes being illuminated. Case studies permit the use of any ethically allowable data gathering strategies, as there are no boundaries or predetermined data gathering methods. This flexibility of data gathering methods is supportive of the provision of 'information-rich' data (Charon, 2001). In summary, the exploratory stage was undertaken through a survey and focus group interviews spanning January–July 2008. The collective use of these methods aims to strengthen the inquiry giving a focused research direction.

At the completion of the exploratory stage, significant questions are developed to direct stage two: inspection.

*Inspection* is an 'intensive focused examination' of influences concerning decision-making of EOCNs' workforce participation, which is uncovered through in-depth semi-structured interviews (Blumer, 1998, p. 43). While inspection is flexible and creative, this stage explores fewer and more focused issues of the phenomenon, which were identified as a result of the exploratory stage (Charon, 2001).

Equal consideration is given to an in-depth analysis of the environment, which offers a platform to understand the 'information-rich' data provided by the participants (Scholz & Tietje, 2002). Additionally, the study design is strengthened as a result of using a combination of methods to study the single phenomenon. These varied methods provide different types of data giving the opportunity for cross-checking the data. Using varied methods of data gathering provides a more robust understanding of the phenomenon and strengthens the trustworthiness of findings (Patton, 1990). While internal consistency of each approach or paradigm diminishes the value of methodology mixing (Lincoln & Guba, 1985), it may be argued that "purity of method is less important than dedication to relevant and useful information" (Patton, 1990, p. 193). Figure 4.5:1 provides a summation of the stages of data gathering strategies. Each strategy is addressed.

**Figure 4.5:1 Stages of Data Gathering Strategies**



### **Stage 1 Exploration**

#### **Survey (Appendix A)**

The survey approach is a research strategy “to view comprehensively and in detail” (Denscombe, 2003, p. 6). Survey, as a component of the overall study, provides insights into the design of a more focused exploration through focus groups and in-depth semi-structured interviews. Not only do the survey findings provide an opportunity to cross-check with data from other sources, thereby increasing the trustworthiness of the study, but they also provide a ‘snapshot’ of a large number of EOCNs’ beliefs and attitudes concerning aspects of the phenomenon (Patton, 1990).

The survey is based on the research questions and designed for a particular site rather than intending generalisation across hospitals. In addition to demographic information, the survey included relevant and specific items to explore the EOCNs’ perspectives concerning: workplace environment and culture; organisational and workunit leadership; personal and professional recognition; and effort and reward balance.

A pilot of the survey instrument was scheduled to establish content validity, avoid poor style, flow and clarity of questions, and recognise potential problems. The pilot stage included a trial of the survey, which was scheduled for January 2008 with five participants who were not otherwise involved in the study. The processes and outcomes of the pilot study were evaluated and modifications to the survey instrument were made.

Surveys were advertised and distributed to all workunits in February 2008 requesting voluntary participation by RNs 45 years and over within the study site. The total number of surveys sent to workunits across the facility was 730. An adequate response rate was achieved (30%) by implementing the advertising process across workunits for a second time (March 2008). Returned surveys were reviewed and only those participants meeting the inclusion criteria as outlined in the Section 4.4 were retained for analysis. Seven of the returned surveys were discarded because of substantial incompleteness or apparent mischievousness. The data from the survey offered insight into the EOCNs' shared beliefs and attitudes, and provided direction for the subsequent data gathering strategies, focus groups and interviews. Of the surveys returned, 75% (163) agreed to be contacted for participation in the follow-up focus groups.

### ***Focus Group Interviews***

Focus group interviews are employed to elicit insight into the participants' feelings and opinions, while exploring aspects which would otherwise prove inaccessible (Barbour, 2005; Webb, 2001). An inherently flexible method, focus groups are designed to ensure that the questions being asked are contextually relevant and easily understood by participants (Webb, 2002). Specifically, the questions in this research explored aspects concerning the influence that workplace environment, leadership, personal and professional recognition concepts, and effort and reward have on their workforce participation decision-making.

Focus group interviews give voice to socially constructed meanings, while focusing on the refinement of current and emerging themes and categories (Barbour, 2005) collected from the literature and other data gathered strategies. Although this type of interview may not provide in-depth information, this risk is minimised through purposeful selection to provide a safer environment in which the EOCN may disclose

in-depth thoughts and perceptions with their peers (Webb, 2002). A focus group interview is not intended to facilitate a rigid debate; however, it is important to maintain a focused discussion. Open-ended questions were used to provide members with an opportunity to share their individual experiences and minimise the introduction of 'group think'. Below is an example of the process of individual experiences.

***Example: Focus Group 1 – Individual experiences rather than group think***

Q: Is it common that the older and more experienced nurse is more available than the younger generation and therefore picks up a heavier workload?

*Grace FG(1): I feel that the more experienced nurses are more willing to follow through on things than the less experienced staff. It's not so much a formal expectation but it's maybe because of the way we were trained.*

*Docie FG(1): I've been in nursing for 45 years.. a little bit older, but honestly, I beg to differ a little bit. I honestly think we are working harder mentally. I think that we worked harder back in '63. I think there is more documentation. Years ago there was more cleaning and things like that. I think that's more the mental thing because we are now seeing patients that have a lot more complicated illness.*

With the aid of an interview plan of proposed questions, the interviewer has the flexibility to explore further in order to provide rich information about the phenomenon (Patton, 1990). Questions were progressively modified from previous focus group interviews as themes emerged and were confirmed or discarded. Providing all interviewees with an *aide-memoire* two (2) weeks prior to the scheduled interview allowed reflective time in which to consider the concepts for discussion giving optimal opportunity for rich data collection (O'Donoghue, 2007). Table 4.5:1 documents the focus group schedule.



**Table 4.5:1 Focus group schedule**

<p>The survey results indicated that work environment is a significant factor which impacts on nurses.</p> <p><i>* How does your work environment influence how you feel about staying in nursing, reducing your hours or leaving nursing altogether?</i></p>
<p>The survey results indicated that financial remuneration was not a key motivator for work, however when given the opportunity to offer additional considerations to remaining within the organisation, many responses included financial considerations as important.</p> <p><i>* How important is financial remuneration in your decisions about remaining in nursing?</i></p>
<p>Survey results indicated that professional development opportunities were afforded equally to all staff regardless of age. However, comments included an expectation for personal and professional recognition, professional advancement and succession management.</p> <p><i>* What are your thoughts on this expectation for personal and professional recognition?</i></p>
<p>We have heard about the challenges to nursing such as shortages of staff, ageing workforce, heavy workloads and leadership, however, despite the challenges, there is a strong tie to remain in nursing.</p> <p><i>* What is it about nursing that keeps you at the study site?</i></p>
<p>You have given me a chance to ask you questions related to retention issues so:</p> <p><i>* Is there anything you would like to add concerning issues which impact on your decision about staying, reducing your work hours or retirement from nursing?</i></p>

As the focus group discussion progressed, an escalation of questions challenged the EOCNs to rationalise their thoughts and views. Additionally, the EOCNs were asked to consider the perceptions of their colleagues that are not necessarily in line with their views (Webb, 2002). Interaction is the key to the method, giving a high level of face validity through the confirming, reinforcing or contradicting of views within the group discussion (Krueger, 1994). As participants are modeled by relationships and interactions, they may be influenced by colleagues within the group. A particular benefit of using focus groups is the ability to probe for more in-depth data to better understand the EOCNs' beliefs and attitudes. This method can support the exploration and clarification of views, which is less accessible in an in-depth semi-structured interview or survey (Krueger, 1994).

A pilot test of the focus group and the in-depth semi-structured interview method is scheduled to avoid poor style and flow of questions, inappropriate interactions and recognise potential problems. The first focus group became a pilot study with six participants. The process and outcome of the pilot study was evaluated with a view to refocus and modify if required for the subsequent focus group interviews. The data produced from the pilot group was discounted (Krueger, 1994). The focus groups were audiotaped and conducted in a series of three groups (Amick, Kawachi, Coakley, Lerner, Levine, & Colditz, 1998) following the pilot group, having similar participants to detect patterns and trends across groups. Each focus group had maximum of ten participants and progress continued for approximately 60–90 minutes with the group defining closure (Patton, 1990). As previously stated, of the surveys returned, 75% agreed to be contacted for participation in the follow-up focus groups.

## ***Stage 2 Inspection***

### ***In-depth semi-structured interviews***

The second stage of inspection allows for closer exploration of themes and involves “isolating the important elements within the situation and describing the situation in relation to those elements” (Blumer, 1998, p. 42). Relevant themes and questions which emerge from previous strategies and particularly focus group data provide the framework for the semi-structured interviews. The researcher’s role was to use a participatory style through open-ended questions while probing to seek an in-depth understanding of the influences on EOCNs’ workforce decision-making. The following extract from an in-depth interview provides an example of probing for the purpose of in-depth understanding.

**Example: Probing for in-depth understanding during in-depth interview.**

Q: Can you tell me about the generational issues in the work unit?

*Janine (IDI 8): I love working with them [Generation X and Y], but I do see the way they get treated sometimes.*

Q: How so?

*Janine (IDI 8): A brand new student was giving handover. Now it wasn't quite right... there were a few gaps, but it was her first time, so we said 'Well done'. I looked over and saw two older nurses rolling their eyes.*

Q: So do you think, given that experience, that there are some issues between the generations?

*Janine (IDI 8): I don't know if the older nurses feel threatened by the younger nurses... their knowledge is superb, but they have a different way of doing things.*

Q: Can you unpack that a bit more?

*Janine (IDI 8): Well, I wouldn't dream of looking after a post-natal patient all day without giving her a wash, whereas I don't think that is a big issue for them. You know, they think that it's more important to have the notes written absolutely superbly, all the observations done whereas we probably have different priorities.*

Important insights into the phenomenon are interpreted from the perspective of selected, well-informed EOCNs (O'Donoghue, 2007; Yin, 2003). Interviewing provides another viewpoint as their feelings, thoughts and intentions can not be observed. These insights and perceptions are collated over multiple interviewees (Stake, 1995).

To maintain integrity of the interpretive perspective of the study, in-depth semi-structured interviews pursued a consistent line of inquiry guided by the four (4) questions central to the study (Yin, 2003). Further exploration therefore includes issues concerning workplace environment, leadership, personal and professional recognition concepts, and effort–reward balance. Similar to focus group interviews, questions are designed to give structure, while allowing the interviewer flexibility to explore, probe and ask questions that provide rich information about the

phenomenon (Patton, 1990). This approach is consistent with the epistemological assumption that there are multiple realities and so uses loosely defined questions for guiding the conduct of the interviews, giving interviewees the freedom to recall and expand on events (O'Donoghue, 2007). Questions therefore are progressively modified from previous interviews. Providing all interviewees (8) with an *aide-memoire* two (2) weeks prior to the scheduled interview allows reflective time in which to consider the concepts for discussion giving optimal opportunity for rich data collection (O'Donoghue, 2007). Selected interviewees who agreed to being contacted were invited from the focus group participants. The selection process for the participants for in-depth interviews focused on the achievement of information-rich data from those who agreed to participate in further interviews. Table 4.5:2 provides an in-depth semi-structured interview schedule.

**Table 4.5:2 In-depth semi-structured interview schedule**

<p>You indicated in the FG that work–life balance was a consideration for you to remain in the workforce.</p> <p><i>Can you tell me more about how you determine the balance that is acceptable to you?</i></p>
<p>There was a lot of discussion in the FG about commitment to the job, i.e. finishing work before going home and so working extended hours gratis. There seems to be a perceived expectation to do this either from management or your own expectations of yourself.</p> <p><i>Can you tell me more about this acceptance to work extra? Why tacit acceptance?</i></p>
<p>Another theme which was evident from the FG was the different way of thinking and behaving between the varying generations of nursing staff (younger versus older nurses).</p> <p><i>Can you tell me more about how this impacts on you as an older and more experienced nurse?</i></p>
<p>Finally, the intent of this study is to understand how you make the decision to stay or leave the workforce.</p> <p><i>Can you tell me more about how you actually make this decision with regard to the balance between the reward/recognition you receive and the effort you put into your work?</i></p> <ul style="list-style-type: none"> <li>▪ <i>How important is job satisfaction to you in the decision of whether you stay or go?</i></li> <li>▪ <i>How do you actually evaluate or make your decision to stay or go? What is the Achilles heel for you?</i></li> </ul>

Throughout the focus groups and in-depth semi-structured interviews, observation provided a broader dimension to the interviewees' reactions as the interview progressed to a conversational style (Patton, 1990). Observation can enhance the understanding of the phenomenon by creating a sense of being there. Adding to data collection, elements such as relevant behaviours or environmental conditions can contribute to the description for further analysis evidence (Stake, 1995; Yin, 2003). Field notes were recorded immediately following all interviews to record further collaborating information which may otherwise not be captured. An example is provided below. Additionally, all in-depth interviews were audiotaped to provide the interviewer with the flexibility to focus the direction of the interview and provide a means of transcription.

#### **Example: Participant observation during focus group (2)**

Q: So, in closing, is there anything anyone would like to add that's had an impact on their decision about staying in the organisation or leaving?

*Leonie FG(2): Well, I've really made my decision. I'm so tired, so burnt out. I'm taking twelve months without pay in October. I'm going to be a ski instructor so I'm going from \$40 an hour to \$10 an hour but the money doesn't count... I'm tired, I'm really tired.*

Observation: While not obvious from the text, the atmosphere provided a more intense experience. All the participants, for the first time during the course of the focus group were silent. Expressions of absolute surprise and disappointment due to the loss of this participant became a reality. There was a sense of appreciation for the enormous contribution Leonie had given to the profession.

While there are numerous advantages concerning the data gathering methods proposed, there are also criticisms. Consideration of these criticisms and strategies to minimise these effects will be addressed. Table 4.5:3 provides a summary of these considerations.

**Table 4.5:3 Summary of advantages, limitations and strategies to address limitation of data collection methods**

Advantages	Limitations	Strategies to address limitations
<b>Survey</b>		
Tolerates large numbers of participants (Patton, 1990)	Response rate commonly low	Maximise the number sent to potential participants
	Structured nature does not allow for exploration of emerging and unanticipated issues	Utilise focus group interviews
<b>Focus Group Interviews</b>		
Held in natural setting as opposed to experimental situations (Yin, 2003).	Less control over group	Use in-depth interviews
Flexibility to explore unanticipated issues not possible in more structured questioning such as a survey (Krueger, 1994).	Difficulty of analysis and interpretation of results	Maintenance of focus on research questions and purpose
'High face validity' Increase sample size without increase of interview time (Barbour, 2005)	Difficulty in distinguishing between individual and group views	All participants encouraged to contribute to discussion Confirm by summary as to consensus or not of discussion points
Observe behaviours or environmental conditions adding to data sources Reality – covers events in real time Context – covers context of events (Yin, 2003 #545)	Event may progress differently because it is being observed	Interviewer used a respectful manner in a safe working environment.
<b>In-depth Semi-structured Interviews</b>		
Additional topics may emerge during interview, not listed explicitly, therefore would not be explored with each participant (Krueger, 1994)	Unable to capture dynamic nature of group interaction	Utilise focus group interview where capture is possible
Allow interviewer to be highly responsive to individual differences (Patton, 1990)	Possibility of bias, poor recall or inaccurate articulation (Patton, 1990)	Corroborating interview data with information from other sources
Observe behaviours or environmental conditions adding to data sources Reality – covers events in real time Context – covers context of events (Yin, 2003)	Event may progress differently because it is being observed	Interviewer uses a respectful manner in a safe working environment.

## 4.6 Analysis of Data

The collection of data and its analysis are two processes that occur simultaneously with interpretative data (Patton, 1990). Constant comparison analysis was the method of choice to inductively analyse the qualitative data (Maykut & Moreouse, 1994).

Systematic processes directed the data analysis in two stages. The first stage of *exploration* included the collection of data through a survey and focus group interviews. The survey provided an opportunity to gather baseline data from a large participant group within a short timeframe. Surveys were coded and analysed to provide trends within the data using the Statistical Package for the Social Sciences (SPSS version 16.0.1 for Windows). The data collected from the survey provided beginning themes which were further explored within the three focus group interviews. Initial analysis of the data enabled the emergence of new themes, reaffirming of some themes and discounting of irrelevant themes. As the data analysis became more intensive, further inspection was required through in-depth semi-structured interviews, forming stage two – *inspection* (Blumer, 1998). The challenging task of making sense of large quantities of data from focus groups and interviews was managed manually. Collectively, analysis of the data illuminates patterns, themes and idiosyncrasies.

### 4.6.1 Organising the Data

#### ***Stage 1: Exploration***

##### *Survey*

One method of gathering organisational data, such as workplace environmental concepts, leadership perceptions, personal and professional recognition issues, and effort–reward balance, is through a survey. This organisational data gathering method provided a venue to confirm and explore emerging themes from which focus group questions and discussion points were determined. Simple descriptive statistics were used to analyse the data to determine the trends and themes.

The findings of the survey were enhanced by the use of a specifically designed instrument for this study site. The scores nominated on the Likert scales were collated, coded and transferred to SPSS for statistical analysis (Coakes & Steed, 2001). The SPSS software was used to generate descriptive data and to provide the

frequency of responses expressed in percentages, mean score, standard deviation and number of valid cases for each item. A valuable component of the data analysis involved the exploration of the significance of the relationships between scale scores and specific characteristics of the participants.

### *Focus Groups*

The challenge for focus group interviews was to maintain systematic and thorough processes in order to explain the emerging themes identified in the data (Scholz & Tietje, 2002). Focus groups were audiotaped with consent from the participants and notes were taken during the conversations in order to capture the issues which are unable to be recorded on tape, i.e. behaviours and expressions. Notations further enhanced the interpretation from the participant's perspective. The recorded focus groups were transcribed verbatim to provide a rich database for analysis (Merriam, 1998). Progressively, transcripts and notes were read and re-read to refine, confirm or discard themes in preparation for subsequent focus groups. As the manual transcription and data analysis progressed, themes were highlighted.

## ***Stage 2: Inspection***

### *In-depth Interviews*

The themes generated from the focus groups were questioned if they had not emerged during the interview process to elicit deeper understanding. The new themes or issues which emerged were clarified at the interview time. Similarly to focus group processes, the interviews were tape recorded, notes taken and verbatim transcription occurred (Merriam, 1998). As data collection and analysis are undertaken simultaneously, themes were modified, accepted or rejected according to their validation or repetition in the existing data. Table 4.6:1 summarises the stages of data collection and analysis.



**Table 4.6:1 Data Collection and Analysis Stages**

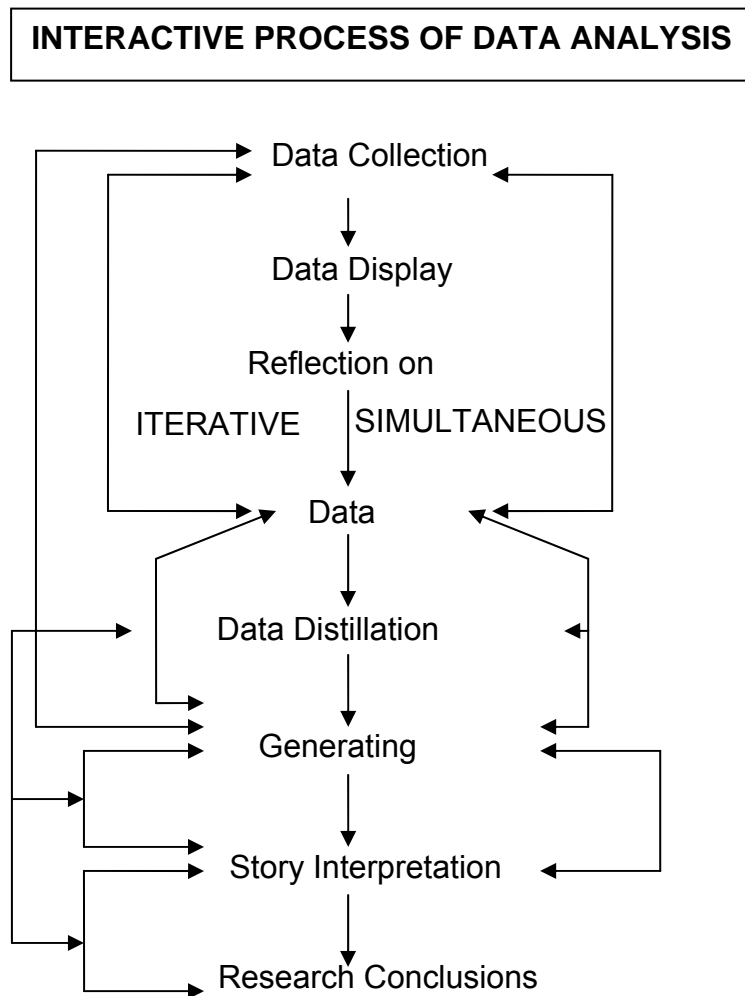
Data Collection Techniques	Stages for Data Collection and Analysis	
Exploration Stage	Step 1a	Pilot survey Conducted January 2008
	Step 1b	Survey Conducted February 2008. Reminder sent March 2008
	Step 2	Analyse data collected from step 1b which will assist to design questions for focus groups together with research questions
	Step 3	Select sample from step 2 according to predetermined inclusion criteria for focus groups (purposeful selection)
	Step 4a	Pilot focus group to trial relevance of designed questions (FGP n = 6) This data is not included in data analysis. Conducted June 2008
	Step 4b	Analyse data collected in pilot focus group and questions modified for future focus group interviews as required
	Step 5	Three focus groups conducted at acute tertiary site (FG1 n = 8; FG2 n = 9; FG3 n = 4). Conducted June to July 2008
	Step 6	Constant comparative method and coding of data collected
Inspection Stage: In-depth semi-structured Interviews	Step 7	Select sample from step 6 according to predetermined inclusion criteria for focus groups (purposeful selection and thematic sampling)
	Step 8	In-depth semi-structured interviews conducted (n = 8). Questions refined from data collected in focus groups. July–November 2008
Final analysis	Step 9	Constant comparative method and coding of analysis of data collected
	Step 10	Final analysis by constant comparative method and coding of analysis of data collected throughout the research process.

### 4.6.2 Managing and Analysing Data

As the research design guides the data collection and simultaneous data analysis for this study, techniques for data analysis were adopted from both case study and grounded theory traditions to best fit the interpretivist design (Creswell & Plano Clarke, 2007). Specifically, a constant comparative method was applied as it reduces the large volumes of data to emergent and reoccurring themes (Lincoln & Guba, 1985). Coding procedures supported the aligning and synthesis of the data to effectively illuminate the research purpose and research questions to develop emergent understandings of the phenomenon (Creswell & Plano Clarke, 2007; Merriam, 1998).

The systematic processes for data analysis illuminate rich descriptions of the phenomenon is summarised in the Figure 4.6:1.

**Figure 4.6:1 Interactive Process of Data Analysis**



The constant comparative method generates and confirms theory by simultaneously coding and analysing data to generate themes (Glaser & Strauss, 1967). This systematic approach to analysing data combines coding with a simultaneous comparison of concepts or themes. Each concept is compared to all other concepts and subsequently grouped with similar concepts. Throughout the data collection process of focus groups and in-depth interviews, identified themes are refined with new themes emerging and others are made redundant or fully developed (O'Donoghue, 2007). Additionally, by continually comparing specific themes, exploration of their relationships to one another were made and integrated into a coherent theory (Boeije, 2002). The aim is to determine “conceptual similarities to refine the discriminative power of categories and to discover patterns” (Tesch, 1990, p. 96).

For this study, transcripts and notes are manually generated and analysed to assist with the management of qualitative data through processes of memo writing, re-reading, coding, categorising and identifying items.

### ***Coding***

Coding procedures are applied in a flexible manner to reflect the changing situations throughout data gathering, analysis, and theory development. Three coding procedures were utilised and included open and selective coding. Initially, *open-coding* orchestrated the breaking down of data to allow close examination and comparison of similarities and differences (Charmaz, 2005; O'Donoghue, 2007). The first stage of the analysis process began with the gathering all the data (focus groups and interviews). All transcripts were coded by notations and organised chronologically to assist with ease of access in analysis and writing up the findings (O'Donoghue, 2007). Following transcription of each focus group or interview, the scripts were repeatedly read using iterative set of procedures (Huberman & Miles, 1994). Comparisons were made between participant interactions and these informed the next event of data collection. Additionally, cross analysis of data from other data gathering events and methods was undertaken to identify regularly occurring concepts and make comparisons with already emerging concepts (O'Donoghue, 2007). The final list of Stage one interpretation of responses that emerged from the exploration stage focus group interviews is presented in Table 4.6:2.

**Table 4.6:2 Stage One Interpretation of Responses from Exploratory Stage**

<p>Job satisfaction</p> <ul style="list-style-type: none"> <li>• negative</li> <li>• positive</li> <li>• burnout</li> <li>• motivated</li> <li>• various reasons impact</li> </ul>	<p>Nursing role</p> <ul style="list-style-type: none"> <li>• enjoy</li> <li>• love</li> <li>• dislike</li> <li>• disillusioned</li> <li>• way of life</li> <li>• always done this and too old to change</li> <li>• consistently changing</li> </ul>	<p>Autonomy</p> <ul style="list-style-type: none"> <li>• ability to practise autonomously (freedom to work autonomously)</li> <li>• inability to practise autonomously (lack of freedom)</li> <li>• trust from leaders to do the role</li> </ul>
<p>Work environment</p> <ul style="list-style-type: none"> <li>• friendly</li> <li>• non-friendly</li> <li>• socially warm</li> <li>• socially cold</li> <li>• human interaction</li> <li>• physical environment</li> <li>• comfort</li> <li>• reflective area / process work</li> <li>• resources to do the job</li> <li>• chaos and consistently changing</li> </ul>	<p>Acknowledge / listen to staff</p> <ul style="list-style-type: none"> <li>• positive</li> <li>• negative</li> <li>• professionally value staff</li> <li>• professionally devalue staff</li> <li>• personally value staff</li> <li>• personally devalue staff</li> <li>• value by government</li> <li>• devalued by government</li> <li>• lack of acknowledgement by medical staff</li> <li>• acknowledgement by medical staff</li> </ul>	<p>Value of staff</p> <ul style="list-style-type: none"> <li>• positive</li> <li>• negative – underestimate</li> <li>• punish</li> <li>• reward</li> <li>• value clinicians</li> <li>• devalue support staff</li> <li>• lack of understanding from colleagues</li> <li>• reason for staying</li> </ul>
<p>Fairness of work practices</p> <ul style="list-style-type: none"> <li>• equitable of same NO levels</li> <li>• inequitable of same NO levels</li> <li>• comparative</li> <li>• non-comparative</li> <li>• transparent</li> <li>• non-transparent</li> <li>• resources to do the job</li> <li>• no resources to do the job</li> <li>• variances in work practices between NO levels</li> <li>• perception of control</li> <li>• perceptions of no control</li> </ul>	<p>Leadership behaviours/traits</p> <ul style="list-style-type: none"> <li>• visible leader</li> <li>• invisible leader</li> <li>• approachable</li> <li>• not approachable</li> <li>• progressive leadership</li> <li>• non-progressive leadership</li> <li>• encouraging</li> <li>• non-encouraging</li> <li>• understanding</li> <li>• lack of understanding</li> <li>• supportive</li> <li>• non-supportive</li> <li>• helpful</li> <li>• non-helpful</li> <li>• perception disparity between levels concerning leadership worth</li> </ul>	<p>Credibility of leadership</p> <ul style="list-style-type: none"> <li>• clinically competent</li> <li>• competent leadership skills</li> <li>• incompetent leadership skills</li> <li>• competent management skills</li> <li>• incompetent management skills</li> <li>• resultant respect for leadership</li> <li>• resultant lack of respect for leadership</li> <li>• value leadership</li> <li>• devalue leadership</li> <li>• invisible</li> <li>• consider staffs' needs</li> <li>• flexible</li> </ul>

Flexibility of leadership practices <ul style="list-style-type: none"> <li>• positive</li> <li>• negative</li> <li>• inflexible rostering practices</li> <li>• flexible rostering practices</li> <li>• flexible work practices</li> <li>• inflexible work practices</li> </ul>	Feelings of older staff as result of colleague behaviour <ul style="list-style-type: none"> <li>• resentment</li> <li>• abuse</li> <li>• self self-worth <ul style="list-style-type: none"> <li>• reduced</li> <li>• supported</li> </ul> </li> <li>• resignation</li> <li>• retention</li> </ul>	Staff reliability <ul style="list-style-type: none"> <li>• positive</li> <li>• negative</li> <li>• younger – no dependents</li> <li>• younger – dependents</li> <li>• older – no dependents, however responsibilities for older parents and children</li> </ul>
Patient outcomes <ul style="list-style-type: none"> <li>• adverse /poor</li> <li>• optimal</li> <li>• compromise patient care</li> <li>• patient outcome</li> <li>• task focused</li> </ul>	Leadership <ul style="list-style-type: none"> <li>• negative impact on retention <ul style="list-style-type: none"> <li>• non-fulfillment of role</li> </ul> </li> <li>• positive impact on retention <ul style="list-style-type: none"> <li>• fulfillment of role</li> </ul> </li> </ul>	Assertiveness <ul style="list-style-type: none"> <li>• positive</li> <li>• negative</li> <li>• forced assertion</li> <li>• forced submission</li> </ul>
Workload <ul style="list-style-type: none"> <li>• heavy</li> <li>• unrealistic</li> <li>• stressful</li> <li>• acceptable</li> <li>• unacceptable</li> <li>• high acuity</li> <li>• increased complexity</li> <li>• reduce shifts to cope</li> <li>• accept 12 hr shifts to reduce days</li> <li>• expectation high</li> <li>• expectation low</li> <li>• healthcare system expectations</li> <li>• disparity between colleagues</li> <li>• disparity between leadership</li> <li>• self generated / imposed</li> <li>• control over workload</li> <li>• lack of control over workload</li> <li>• variance of perception between levels</li> </ul>	Feelings of older staff as result of leadership behaviour <ul style="list-style-type: none"> <li>• inequity of expectations</li> <li>• equity of expectations</li> <li>• resentment</li> <li>• value</li> <li>• abuse</li> <li>• self-worth</li> <li>• lack of recognition</li> <li>• used by date</li> <li>• redundant</li> <li>• not worth developing further</li> <li>• ageism mentality</li> <li>• avoidance – increased sick leave</li> <li>• feeling of reduced support</li> <li>• feeling supported</li> <li>• resignation</li> <li>• retention</li> </ul>	Changing role <ul style="list-style-type: none"> <li>• increasing role</li> <li>• more complex</li> <li>• increasing demands</li> <li>• increasing non-nursing duties</li> <li>• keeping pace with changing role</li> <li>• not keeping pace with changing role</li> <li>• disparity of perception of RN role by older nurse</li> <li>• disparity of perception of RN role by younger nurse</li> <li>• ability to perform the role</li> <li>• inability to perform the role</li> <li>• lack of understanding the role</li> <li>• resources to do the role</li> </ul>
Reward versus effort <ul style="list-style-type: none"> <li>• equal</li> <li>• inequitable</li> <li>• fair</li> <li>• unfair</li> <li>• just accept</li> </ul>	Personal responsibilities <ul style="list-style-type: none"> <li>• older nurse – diverse (children; parents)</li> <li>• younger nurse – child care</li> <li>• simple requirements</li> <li>• high requirements</li> </ul>	Work ethics <ul style="list-style-type: none"> <li>• high – older nurse</li> <li>• low – younger nurse</li> <li>• high – younger nurse</li> <li>• low – older nurse</li> </ul>

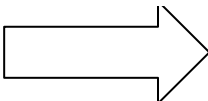
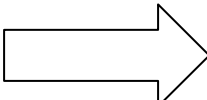
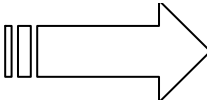
<p>Social interaction</p> <ul style="list-style-type: none"> <li>• positive interaction</li> <li>• collegial support</li> <li>• negative interaction</li> <li>• networking opportunities</li> <li>• lack of networking opportunities</li> <li>• companionship</li> <li>• lack of companionship</li> <li>• human interaction</li> <li>• common social area</li> <li>• lack of common social area</li> <li>• lack of understanding</li> <li>• lack of nurses' collective voice (political pressure)</li> <li>• collective voice of medical officers (political pressure)</li> </ul>	<p>Team work</p> <ul style="list-style-type: none"> <li>• leadership support of team processes</li> <li>• leadership non-support of team processes</li> <li>• collegial support for team processes</li> <li>• collegial non-support for team processes</li> <li>• medical support for team processes</li> <li>• medical non-support for team processes</li> <li>• allied health support for team processes</li> <li>• allied health non-support for team processes</li> <li>• interpersonal skills</li> </ul>	<p>Commitment to organisation</p> <ul style="list-style-type: none"> <li>• high</li> <li>• older nurse <ul style="list-style-type: none"> <li>• younger nurse</li> </ul> </li> <li>• low <ul style="list-style-type: none"> <li>• older nurse</li> <li>• younger nurse</li> </ul> </li> <li>• commitment self-enforced by nurse <ul style="list-style-type: none"> <li>• older nurse</li> <li>• younger nurse</li> <li>• expected of older nurse</li> <li>• not expected of younger nurse</li> </ul> </li> </ul>
<p>Responsibility acceptance of staff</p> <ul style="list-style-type: none"> <li>• positive</li> <li>• negative</li> </ul>	<p>Workplace cultural</p> <ul style="list-style-type: none"> <li>• positive interaction</li> <li>• negative interaction</li> <li>• old culture – do it this way</li> </ul>	<p>Personal recognition</p> <ul style="list-style-type: none"> <li>• acknowledged</li> <li>• not acknowledged</li> <li>• personal respect</li> <li>• personal disrespect</li> </ul>
<p>Changing models of care</p> <ul style="list-style-type: none"> <li>• traditional (as previous for older nurse)</li> <li>• contemporary</li> <li>• care holistically</li> <li>• team nursing</li> </ul>	<p>Personal responsibilities</p> <ul style="list-style-type: none"> <li>• older nurse – diverse (children; parents)</li> <li>• younger nurse – child care</li> <li>• simple requirements</li> <li>• high requirements</li> </ul>	<p>Use of staff</p> <ul style="list-style-type: none"> <li>• effective skill mix</li> <li>• non-effective skill mix</li> <li>• value professional expertise</li> <li>• non-value of professional expertise</li> </ul>
<p>Professional recognition</p> <ul style="list-style-type: none"> <li>• not understanding professional role</li> <li>• understanding professional role</li> <li>• role identity</li> <li>• role erosion</li> <li>• professional relationships</li> <li>• acknowledged by leadership</li> <li>• not acknowledged by leadership</li> <li>• acknowledged by clinical abilities</li> </ul>	<p>Professional recognition (cont)</p> <ul style="list-style-type: none"> <li>• not acknowledged by clinical abilities</li> <li>• professional maturity</li> <li>• professional immaturity</li> <li>• succession management opportunities</li> <li>• lack of succession management opportunities</li> <li>• lack of support for succession management</li> <li>• lack of support for succession management in clinical area</li> </ul>	<p>Professional recognition (cont)</p> <ul style="list-style-type: none"> <li>• support for succession management in clinical area</li> <li>• support for succession management opportunities</li> <li>• multidisciplinary respect</li> <li>• multidisciplinary disrespect</li> <li>• professional respect</li> <li>• professional disrespect</li> <li>• professional value</li> <li>• professional devalue</li> <li>• community respect</li> <li>• community disrespect</li> </ul>

Shift work / night duty <ul style="list-style-type: none"> <li>• ability to cope</li> <li>• inability to cope</li> <li>• compromise health</li> <li>• non-compromising to health</li> <li>• prefer</li> <li>• not prefer</li> <li>• inequitable allocation</li> <li>• equitable allocation</li> </ul>	Professional development <ul style="list-style-type: none"> <li>• valued by leader</li> <li>• not valued by leader</li> <li>• valued by nurse</li> <li>• not valued by nurse</li> <li>• equitably distributed</li> <li>• inequitably distributed</li> <li>• new graduate needs</li> <li>• older, experienced nurse needs</li> <li>• professional development need</li> <li>• continuous</li> <li>• ad hoc</li> </ul>	Rewards/recognition <ul style="list-style-type: none"> <li>• not acknowledged</li> <li>• acknowledged</li> <li>• free/subsidised parking</li> <li>• material rewards</li> <li>• professional respect</li> <li>• incentives (barbeques)</li> <li>• lack of incentives</li> <li>• healthcare system inhibits recognition/ reward</li> <li>• balance</li> <li>• imbalance</li> </ul>
Work–life balance <ul style="list-style-type: none"> <li>• achieved</li> <li>• not achieved</li> <li>• acceptable</li> <li>• unacceptable</li> <li>• extensive extra activities (compromise WLB)</li> <li>• leadership support WLB</li> <li>• individual need to achieve WLB</li> <li>• individual perception</li> <li>• expectation for extra hours</li> </ul>	Financial remuneration <ul style="list-style-type: none"> <li>• insufficient compensation</li> <li>• sufficient compensation</li> <li>• comparative</li> <li>• not comparative</li> <li>• balance pay with the complexity of the role and responsibility</li> <li>• imbalanced pay, i.e. lower level receives more pay than higher level if working shift work</li> <li>• disparity between professions</li> <li>• retirement benefits</li> </ul>	Communication <ul style="list-style-type: none"> <li>• positive</li> <li>• negative</li> <li>• open</li> <li>• forced, closed</li> <li>• interpersonal skills</li> </ul>
Safety priority <ul style="list-style-type: none"> <li>• supported</li> <li>• not supported</li> <li>• available equipment</li> </ul>	Support <ul style="list-style-type: none"> <li>• collegial support</li> <li>• leadership support</li> <li>• lack of support</li> </ul>	Physical work capacity <ul style="list-style-type: none"> <li>• inability to mange</li> <li>• manageable</li> <li>• shift work and night duty compromise</li> </ul>
Acknowledgement for effort <ul style="list-style-type: none"> <li>• positive</li> <li>• negative</li> </ul>	Harassment <ul style="list-style-type: none"> <li>• colleagues</li> <li>• patients</li> <li>• leadership</li> </ul>	Accountability <ul style="list-style-type: none"> <li>• accepting</li> <li>• non-accepting</li> </ul>
Financial security <ul style="list-style-type: none"> <li>• important</li> <li>• not important</li> </ul>	Respect <ul style="list-style-type: none"> <li>• received</li> <li>• not received</li> </ul>	Decision making <ul style="list-style-type: none"> <li>• individual</li> <li>• group</li> <li>• minimal for experience</li> </ul>

The second method, *axial coding*, identified the connectedness between the identified categories in an attempt to build rich data concepts of relationships (Strauss & Cheater, 1990). Further exploration is considered through the context in

which the category is identified, the strategies by which this category is managed and the end result of those strategies. Areas of agreement and disagreement may emerge between the various levels of nursing classifications (Bogdan & Biklen, 1998). These categories provide a focused view for data analysis. An example of this process is the issue of workload and disparate expectations between the various nursing classifications. The initial responses were grouped as presented in the Table 4.6:3.

**Table 4.6:3 Example of Interpreting Data**

Data		Interpretation
<div> <b>Clinical Nursing Officers</b>  Heavy workload  Unrealistic  Stressful and unacceptable workload  High acuity of patients </div>	Reduction 	<div> Unacceptable workload </div>
<div> <b>Leadership Nursing Officers</b>  Healthcare expectations  Self-generated / imposed  Expected high workload for senior </div>	Reduction 	<div> Acceptable workload </div>
	Comparative Reduction 	<div> Opposed perceptions of workload between NO levels </div>

The third and final method, *selective coding*, is the integration of categories generated and developed through open and axial coding, and ultimately results in theory building. This coding process selects a core category and systematically relates it to other categories, reviews relationships for validation and explores further those categories which require additional development (Strauss & Cheater, 1990; Dey, 1993). Additionally, interim feedback is a valuable component to assist with the ongoing processing of the phenomenon to re-establish the focus of analysis (Patton, 1990). Table 4.6:4 presents the themes that emerged from the four research questions.



**Table 4.6:4 Third Stage – Selective Coding: Key Themes from Data Analysis**

<b>Q1: How does the workplace environment influence the EOCNs' decisions regarding workforce participation?</b>	<b>Q2: How does leadership influence the EOCNs' decisions regarding workforce participation?</b>	<b>Q3: How does personal and professional recognition influence the EOCNs' decisions regarding workplace participation?</b>	<b>Q4: How does the balance of effort and reward influence the EOCNs' decisions regarding workforce participation?</b>
<p>Mounting challenges of increased workload</p> <ul style="list-style-type: none"> <li>Escalating supervisory responsibilities</li> <li>Increasing workload necessitates managing additional work hours</li> </ul>	<p>Credibility of leader</p> <ul style="list-style-type: none"> <li>Leader visibility</li> <li>Credible management and clinical skills</li> </ul>	<p>Feeling valued for personal and professional contribution</p> <ul style="list-style-type: none"> <li>Respect for professional and personal experience</li> <li>Valuing commitment</li> <li>Age concerns</li> </ul>	<p>Effort</p> <ul style="list-style-type: none"> <li>Demands (workloads), obligations (expectations)</li> </ul>
<p>Risk factors impact</p> <ul style="list-style-type: none"> <li>Shift work: part. night duty</li> <li>Harassment and violence</li> <li>Burnout</li> </ul>	<p>Interaction, team and social cohesion promoted by leadership</p> <ul style="list-style-type: none"> <li>Interaction cohesion</li> <li>Team and social cohesion</li> </ul>	<p>Recognition through comparative remuneration</p> <ul style="list-style-type: none"> <li>Fair and comparative pay</li> <li>Financial security</li> </ul>	<p>Reward</p> <ul style="list-style-type: none"> <li>Remuneration, esteem, career opportunities and security</li> </ul>
<p>Competing work and life commitments</p>	<p>Support, flexibility and trusting relationships demonstrated by leadership</p>	<p>Opportunity for professional development (PD) and advancement</p> <ul style="list-style-type: none"> <li>Accessing PD</li> <li>Implied value of PD</li> <li>Professional advancement</li> </ul>	<p>Results</p> <p>Behaviours, attitudes and emotions</p>
		<p>Dissonance between the generations</p> <ul style="list-style-type: none"> <li>Sense of loyalty and commitment</li> <li>Inequity and different expectations</li> <li>Generational interaction compromising learning</li> </ul>	

## 4.7 Verifications

Data quality is achieved through trustworthiness (Polit & Beck, 2004) and confirms the case study methodology as being a legitimate and justifiable research methodology. Collectively, criteria for establishing the trustworthiness of qualitative data are: Credibility; Dependability; Confirmability; and Transferability (Lincoln & Guba, 1985). These criteria not only assess trustworthiness of qualitative data, but are also concerned with evaluation of interpretations and conclusions of the data (Polit & Beck, 2004).

### 4.7.1 Credibility

Credibility refers to the reader's confidence in the truth and interpretation of the data. The research process is designed to increase the believability of the findings. To enhance the overall credibility of the research, the following steps were taken: a) Prolonged Engagement and Persistent Observation, b) Verification, c) Peer Debriefing, d) Member Checks (Lincoln & Guba, 1985; Polit & Beck, 2004).

#### *Prolonged Engagement and Persistent Observation*

In order to gain an in-depth understanding of the culture, language, beliefs and attitudes of the EOCN, time was dedicated to collection of relevant rich data and to cross-check for misinterpretations or distortions. Rapport building with participants enhanced the potential for gathering rich and accurate data (Lincoln & Guba, 1985; Merriam, 1998). Persistent observation is the focus on components of a situation that are relevant to the phenomenon under study. This value added strategy is confirmed as 'prolonged engagement provides scope, persistent observation provides depth' to the study (Lincoln & Guba, 1985, p. 304). During focus groups and in-depth semi-structured interviews, direct observation provided more depth to information by including behaviours and attitudes which are unable to be collected by other methods.

#### *Verification*

Verification aims to overcome the intrinsic bias associated with a single data source, thus discrediting the findings due to the weaknesses of any single method. From a theoretical framework perspective, purity of method is less important than dedication to relevant and rich information (Lincoln & Guba, 1985, p. 304). Two (2) types of verification were used within this study: data verification and method verification.

*Data verification* involves the use of multiple data sources. This study incorporated time verification which is the collecting of relevant data concerning the EOCN at different stages, determining the congruence of the phenomenon over time. Additionally, person verification was used through the collection of data from different organisational levels of EOCNs to validate data through multiple perspectives of the phenomenon (Lincoln & Guba, 1985; Patton, 1990). The second method, *method verification*, uses multiple methods of data collection which provides the opportunity to evaluate the internal consistency of the emerging themes. In this study, multiple methods including survey, focus groups and in-depth semi-structured interviews provided the richest blend of information and determined reality from error or biased viewpoint.

#### *Peer Debriefing*

Peers had the opportunity to critique data quality and interpretative issues following focus groups and in-depth interviews. Interview data, once coded and categorized, was offered to peers for review and cross-check. This strategy not only provides and confirms direction for the research, but also enhances the credibility of the data (Polit & Beck, 2004; Yin, 2003).

#### *Member Checks*

Participants had the opportunity to review and make comment on the data and interpretations within a report following all focus groups and in-depth interviews. When issues presented themselves, the researcher reflected and modified as necessary. This substantially increased the accuracy of the findings by providing an opportunity to modify as relevant (Lincoln & Guba, 1985; Webb, 2002).

### **4.7.2 Dependability**

Another method of ensuring the trustworthiness of the study from a dependability perspective is an internal audit. This audit involved a review of the data and the supporting documents by an external reviewer and was undertaken at predetermined check points during the study (Bassegy, 1999; Webb & Kevern, 2001). The external reviewers in this study were the two research supervisors and specifically selected workplace peers.

### **4.7.3 Confirmability**

This study established and maintained an audit trail of systematically collected materials which is available for audit by an independent auditor. This checking process provides confidence that the research undertaken is in fact trustworthy (Lincoln & Guba, 1985).

### **4.7.4 Transferability**

The goal of qualitative research is 'transferability' of findings, rather than statistical generalisability (Lincoln & Guba, 1985; Polit & Beck, 2004; Yin, 2003). Focus groups have high 'face validity' due to the credibility of comments from participants (Barbour, 2005). If colleagues study the research and believe it to be relevant to their situation, the findings may be transferable. The decision of transferability is the responsibility of the individual considering the findings as opposed to the researcher of the original study (Barbour, 2005).

## **4.8 Ethical Issues**

Exploration of thoughts and perceptions of the EOCN is central to this study and so the fundamental principle is to safe guard the human rights of these participants. Considerations for this study include not only the safe guarding of the participants, but also obtaining informed consent and communicating the role of the researcher to participants. Data storage and confidentiality are also components of the role of the researcher.

EOCNs who met the inclusion criteria were invited to participate in the research by letter. The invitation outlined the purpose of the study, the criteria for participation in the study and explained the research design and data collection methods. The length of the study, steps taken to ensure confidentiality, expectations of the study and how findings would be communicated to the participants, hospital, university and wider community were also explained. Details of ethical clearances obtained from both the health facility's Research Ethics Committee and Australian Catholic University Human Research Ethics Committee, including information and consent forms, are included in Appendices B, C, D and E.

Informed consent empowers the potential participant to take part at their choice, with the exclusion of any element of fraud, duress or similar unfair manipulation (Webb,

2002). Consent is ensured in writing through informed consent slips of a written statement of potential risks and benefits. The slips were dated and signed by both the potential participant and the researcher (Berg, 2004). Survey consent is assumed by voluntary return of the completed survey form by the participants.

Precautions to ensure that information is appropriately secured include strategies such as participant coding and data security. Data collected is stored as a hard copy in a locked filing cabinet and on the researcher's laptop and data stick in the home environment. Additionally, a copy of the data is secured in the principal supervisor's office and retained for five (5) years past the completion date of the study. Consent forms and transcripts, while stored as previously described, are secured separately. Participant confidentiality is protected by removal of any identifiable elements from the research records (Berg, 2004; Glesne, 2006). As a means to identify the data sources and maintain confidentiality, participant coding is applied to the data. Data which most informed the theme were extracted from either focus groups or in-depth interviews. In order to ensure the ability to track data to the original source, names were replaced by pseudonyms denoting gender and data source. A data list of original participant names with aligned pseudonyms is secured for confidentiality purposes. Ethical concerns and considerations are summarised in Table 4.8:1.

**Table 4.8:1 Data Gathering and Ethical Concerns and Considerations**

<b>Data Gathering Strategy</b>	<b>Strategies to support Ethical Concerns and Considerations</b>
Survey	A letter of introduction and explanation informed the participants, and response return would confirm agreement. As there are no identifying codes on the survey, the information gathered will assist with emerging and confirming themes.
Focus Groups	<p><i>Participant identification:</i> Pseudonyms will be provided which denote the gender of participant.</p> <p>The number of focus groups chronologically carried the appropriate letter or number. The allocated name aligns to the original name of the participant. Therefore, Ann (FG1) denotes the participant's name by gender, focus group 1.</p> <p>Additionally considerations include:</p> <ul style="list-style-type: none"><li>• information and consent forms are written clearly and concisely</li><li>• expectations are clearly explained</li><li>• opportunity for all participants to review and modify transcripts as relevant post-interview</li><li>• ensure individuals are not professionally compromised by non-participation</li><li>• acceptable to withdraw at any stage without compromise to self.</li></ul>
In-depth Interviews	<p>Consent of the interviewee to proceed with the interview and clarify issues of confidentiality was sought.</p> <p><i>Participant coding:</i> The letter sequence allocated to participants involved in in-depth interviews was IDI. Therefore an example of Sue (IDI) denotes the participant's name by gender, in-depth interview.</p>
Observation	Conducted with awareness of those being observed by using informed consent so as not to violate legal or ethical protections.

(Berg, 2004).

Additionally, as the researcher is known to a number of participants, confidentiality may be compromised. Professional integrity of the researcher together with ethical strategies promotes participants' trust in the research process. Consideration is also given to the organisational status of the research, which may intimidate potential participants. This is addressed by following guidelines for interviewing and demonstrating respect for participants.

## **4.9 Summary of Research Design**

An interpretive approach for the research design is adopted because this is consistent with the exploration of in-depth understanding of the EOCNs' decisions regarding their workforce participation. This chapter discusses the application of strategies which is viewed through constructionism and social interactionism, and informed data collection and analysis stages. As a methodology, case study orchestrated the collection of rich and meaningful data from a bounded system from which most could be learned about the phenomenon.

Table 4.9:1 provides a general overview of the research design.

**Table 4.9:1 Overview of Research Design and its Relationship to the Four Research Questions**

<b>PURPOSE: To explore factors that influence EOCNs' decisions regarding their workforce participation.</b>				
<b>Research Questions</b>	<b>Stages of Research</b>	<b>Data Gathering Strategy</b>	<b>Sources of Data and Analysis</b>	<b>Timeline</b>
<p><b>Quest 1:</b> <i>How does the workplace <b>environmental</b> influence the EOCNs' decision regarding workforce participation?</i></p> <p><b>Quest 2:</b> <i>How does <b>leadership</b> influence the EOCNs' decision regarding workforce participation?</i></p> <p><b>Quest 3:</b> <i>How does <b>personal and professional recognition</b> influence the</i></p>	Exploratory	<ul style="list-style-type: none"> <li>Survey return 31.03.08</li> </ul>	<ul style="list-style-type: none"> <li>Validated instruments concerning workloads, safe working environment, i.e. harassment, bullying <i>Collated, analysed and verified</i></li> </ul>	Jan–March 2008
		<ul style="list-style-type: none"> <li>Focus Group Interview Pilot (n = 6) scheduled 24.06.08</li> </ul>	<ul style="list-style-type: none"> <li>Questions / concepts informed by literature review and survey trends</li> </ul>	April–May 2008
		<ul style="list-style-type: none"> <li>Focus Group Interviews               <ul style="list-style-type: none"> <li>Focus Group 1 (NO Grade 5 and 6) (n = 8) scheduled 27.06.08</li> <li>Focus Group 2 (NO Grade 7) (n = 9) scheduled 1.07.08</li> <li>Focus Group 3 (NO Grade 9 to 12) (n = 4) scheduled 8.07.08</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Questions / concepts informed by literature review, survey trends and pilot focus group interview. Each consecutive focus group was modified as a result of information taken from previous data gathering strategies, i.e. emerging and confirming themes, discontinued themes <i>Constant comparative method, coding of data</i></li> </ul>	May–July 2008



<b>PURPOSE: To explore factors that influence EOCNs' decisions regarding their workforce participation.</b>				
<b>Research Questions</b>	<b>Stages of Research</b>	<b>Data Gathering Strategy</b>	<b>Sources of Data and Analysis</b>	<b>Timeline</b>
<p><i>EOCNs' decision regarding workplace participation?</i></p> <p><b>Quest 4:</b></p> <p><i>How does a the balance of <b>effort and reward</b> influence the EOCNs' decision regarding workforce participation?</i></p>	Inspection	<ul style="list-style-type: none"> <li>In-depth semi-structured interviews (n = 8) scheduled August 2008</li> </ul>	<ul style="list-style-type: none"> <li>Semi-structured interview plan developed by reviewing information from previous data gathering strategies, i.e. emerging and confirming themes, discontinued themes</li> </ul> <p><i>Constant comparative method, coding of data</i></p>	July–Nov 2008

## CHAPTER FIVE: SURVEY FINDINGS

The purpose of this chapter is to present survey findings from the Exploratory Stage of this study: that is exploration of factors that influence EOCNs' decisions regarding workforce participation. The Exploratory Stage included recruitment of participants for the survey and focus groups; however only the survey findings will be presented in this chapter. Chapter Six will present the focus group findings and the Inspection Stage which includes interview findings collectively.

The survey was designed specifically to address each of the four research questions and once coded and analysed, supported the formulation of the questions for the three focus groups and subsequent individual interviews. Table 5.1:1 provides a matrix of the four research questions and the aligning survey items.

***Table 5.1:1 Matrix of Research Questions and Survey Items***

Research Questions	Survey Items
	Demographics Section 1 Question 1; 2; 3; 4; 5; 6; 7; 8; 9; 10.
Research Question 1: How does the workplace environment influence EOCNs' decisions regarding workforce participation?	Section 2 Question 1a; 1b; 1c; 1d; 1e; 1f; 1g
Research Question 2: How does leadership influence EOCNs' decisions regarding workforce participation?	Section 2 Question 2a; 2b; 2c; 2d; 2e; 2f; 2g; 2h.
Research Question 3: How does personal and professional recognition influence EOCNs' decisions regarding workplace participation?	Section 2 Question 3a; 3b; 3c; 3d; 3e
Research Question 4: How does the balance of effort and reward influence EOCNs' decisions regarding workforce participation?	Section 2 Question 4a; 4b; 4c; 4d
	Open-ended responses Question 5a; 5b; 5c; 5d.

There were 730 registered nurses (RN) aged 45 years and over (EOCNs) employed at the study site. Of this group of registered nurses, 218 EOCNs provided completed survey forms, representing a response rate of 30%. Data were collated then coded and analysed using the Statistical Package for the Social Sciences (SPSS version 16.0.1 for Windows).

## **5.1 Demographics and End of Career Nurses' Employment History**

Table 5.1:1 provides a summary of the demographics and EOCN's employment history. Respondents were 137 full-time (62.8%) and 81 part-time (37.2%) nurses. Most respondents were female 198 (91%) with 137 (63%) of female respondents reporting full-time employment and 104 (48%) being shift workers at the time of survey. This division between full-time and part-time is relevant when considering the intention to change current hours. Most respondents (172, 79%) had not recently changed their hours of employment. Of the 45 respondents (21%) that had done so, 21 (47%) had reduced their hours of employment. Thirty respondents reported changing their work status, 7 of these reported transfers (23.3%) and 5 (16.6%) reported secondment to projects or higher duties, while 12 respondents (40.0%) reported avoiding shift work or ill health.

The number of years worked as an RN at the study site ranged from 1 to 48 years. The majority (52%) had worked for 29 years or fewer (as reported in Table 5.1:1). The most experienced group, those who had worked for 40 years or more constituted the oldest 7% of respondents.

Respondents nominated their current work area from a total of 10 categories (Section 1, Question 9) with the most common ( $n = 41$ , 18.8%) being Internal Medicine Service Line. The large number (31, 14.2%) listed in 'Other' includes a further eight categories which included Nursing Education, Research, Quality, Nursing Administration and Community. The qualification reported most frequently (Section 1 Question 10) was a Hospital Certificate (46.8%). Higher degrees (Masters, Doctorates) occurred with a low frequency (16.6%).

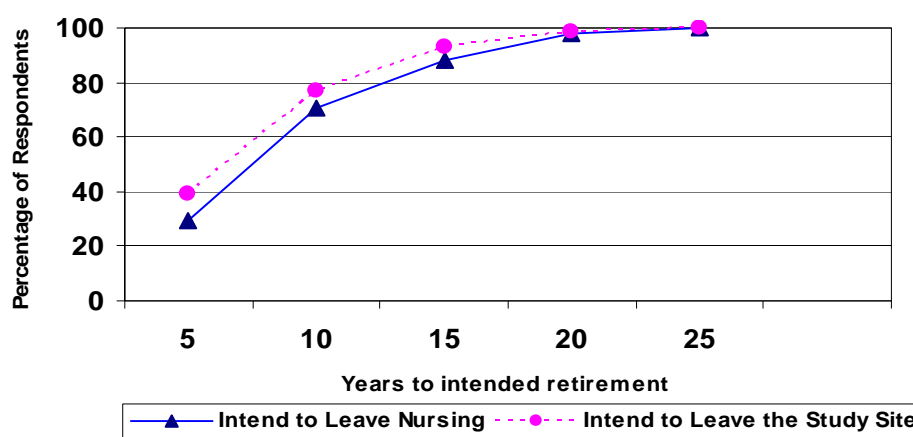
**Table 5.1:1 Summary of Demographic and Employment Findings (n = 218)**

Demographic Items	Freq	%	Demographic Items	Freq	%
<b>Gender</b>			<b>Years worked as RN at Study Site</b>		
Female	199	91.3	1–4	49	22.5
Male	19	8.7	5–10	29	13.3
<b>Age Range</b>			11–15	27	12.4
45–50	96	44	16–20	48	22.0
51–55	54	24.8	21–25	24	11.0
56–60	46	21.1	26–30	29	13.3
61–65	21	9.6	30+	11	5.0
<b>Current Employment</b>			<b>Reason for Changes in Work Status</b>		
Full-time	137	62.8	Decreased as a result of ill health	7	23.3
Part-time	81	37.2	Transfer	7	23.3
<b>Shift work</b>			To avoid night duty and/or shift work	5	16.6
Shift work	104	47.7	Project or higher duties	5	16.6
Non shift work	114	52.3	Work–life balance	3	10.0
<b>Current Work Areas</b>			Increased due to increasing finances	2	6.6
Internal Medical	41	18.8	Changed due to inflexible rosters	1	3.3
Surgical	30	13.8	<b>Professional Qualifications and Awards</b>		
Women's Health	30	13.8	Hospital Certificates	102	46.8
Neonatology	18	8.3	Bachelor of Nursing	53	24.3
Cancer Care	17	7.8	Graduate Certificate	50	22.9
Critical Care	16	7.3	Graduate Diploma	44	20.2
Mental Health	16	7.3	Bachelor Degree	42	19.3
Perioperative	16	7.3	Masters (Course Work)	32	14.7
Casual Pool	3	1.4	TAFE Certificates	18	8.3
Other	31	14.2	Masters (Research)	3	1.4
			Professional Doctorate	1	0.5

### ***Intention to Leave***

Respondents were asked to report whether they intended to leave nursing (Q11) or whether they intended to leave the study site and continue nursing in another setting (Q12). Responses to these two questions tended to peak at 5-year intervals indicating a simplifying response bias towards this year interval as identified in Figure 5.1:1. Many respondents (30%) intend to retire from nursing within 5 years and a further 40% within 10 years. In addition, many respondents intend to retire from the study site (30% within 5 years and a further 40% within 10 years). It is notable that to a great extent those who intend to retire from the study site intend to retire from nursing, which is illustrated in Figure 5.1:1.

***Figure 5.1:1 Timing of Intentions to Leave the Study Site and Leave Nursing***



## **5.2 Workplace Environment**

The first research question that focuses the conduct of the research is:

**How does the workplace environment influence end of career nurses' (EOCNs') decisions regarding workforce participation?**

Section 2 Question 1a–g explored the issues embedded in the above question. The seven items dealt with aspects of the work environment in relation to decisions about remaining in nursing. A 5-point Likert type scale was used from 1 (strongly disagree) to 5 (strongly agree) with findings presented in Table 5.2:1. Across the seven aspects of work environment (Q1a to 1g) the lowest level of agreement (mean = 2.6) was obtained for Q1e (Workplace harassment within my area), while the highest level of

agreement (mean = 4.0) was recorded for Q1c (Experienced nurses have heavier workload due to supervisory workload).

Responses to the survey questions concerning workplace environment provided in Table 5.2:1 indicated that most respondents agreed that they were able to complete necessary workload to meet patient's needs (Q1b, mean = 3.50) and were satisfied with the workload allocation (Q1a, mean = 3.39). Experienced nurses agreed that they have a heavier workload due to their supervisory responsibilities (Q1c, mean = 3.90) and have marginally considered reduction in employment status to avoid heavy workload (Q1d, mean = 2.62). The descriptive statistics also indicated that the study site provided safety equipment (Q1g, mean = 3.95) and there were effective processes to address workplace harassment (Q1f, mean = 3.44).

**Table 5.2:1 Workplace Environment Items Ranked According to Level of Agreement**

Item	Mean	Standard Deviation
Q1g. The organisation provides safety equipment	3.95	1.00
Q1c. Experienced nurses have heavier workload due to supervisory workload	3.90	0.95
Q1b. Able to complete necessary workload to meet patients' needs	3.50	1.05
Q1f. Effective processes to address workplace harassment	3.44	1.14
Q1a. Satisfied with workload allocated	3.39	1.05
Q1e. Workplace harassment within my work area	2.76	1.32
Q1d. Considered reducing employment status to avoid heavy workload	2.62	1.35

Note: 1 = Strongly disagree; 3 = Neutral; 5 = Strongly agree

The seven Workplace Environment items were subjected to a principal component analysis. Table 5.2:2 ranks the findings according to correlation coefficients. A three-factor solution accounting for 68.5% of the variance was accepted. The Varimax rotated solution is presented in Table 5.2:3. The factors were identified as (1) Workload Issues; (2) Organisational Provisions regarding Safety; and (3) Contribution of Supervisory Duties to Workload.

In the rotated solution presented in Table 5.2:2, three items have substantial loadings on the first factor. These were Workload Issues including the ability to complete work which meets patient needs (Q1b, factor loading = .91), being satisfied with the workload allocation (Q1a, factor loading = .90) and a negative factor loading (–.41) on Q1d, indicating that respondents were not considering reducing employment status to avoid heavy workload. Organisational Provisions includes items: the organisation provided processes to address workplace harassment (Q1f, factor loading = .80), the organisation effectively provides safety equipment (Q1g, factor loading = .77) and a negative factor loading (–0.51) for item Q1e indicating that there was a low incidence or absence of workplace harassment. Contribution of Supervisory Duties to Workload includes the following items: experienced nurses have heavier workload due to supervisory workload (Q1c, factor loading = .84) and consideration of reduced employment status to avoid heavy workload (Q1d, factor loading = .66).

**Table 5.2:2 Factor Analysis of the Seven Workplace Environment Items in Question 1**

	Component		
	1	2	3
Q1b. Able to complete necessary workload to meet patients' needs	.91		
Q1a. Satisfied with workload allocated	.90		
Q1f. Effective processes to address workplace harassment		.80	
Q1g. The organisation provides safety equipment		.77	
Q1e. Workplace harassment within my work area		–.57	.45
Q1c. Experienced nurses have heavier workload due to supervisory workload			.84
Q1d. Considered reducing employment status to avoid heavy workload	–.41		.66
Extraction Method: Principal Component Analysis Rotation Method: Varimax with Kaiser Normalisation <sup>a</sup>			
Note: a. Rotation converged in 4 iterations.			

\*Factor loadings with an absolute value smaller than .30 (implying less than 10% of the variance associated with an item of the item) have been omitted for clarity.

From this analysis the three factor scores were computed and saved as three additional variables in the data file.

**Table 5.2:3 Factors Extracted from the Seven Workplace Environment Items**

Factors Extracted		Factor Loadings
1	Organisational Provisions Regarding Safety	
	Effective processes to address workplace harassment	.80
	The organisation provides safety equipment	.77
	Workplace harassment within my work area	-.57
2	Workload Issues	
	Able to complete necessary workload to meet patients' needs	.91
	Satisfied with workload allocated	.90
	Considered reducing employment status to avoid heavy workload	-.41
3	Contribution of Supervisory Duties to Workload	
	Experienced nurses have heavier workload due to supervisory workload	.84
	Considered reducing employment status to avoid heavy workload	.66
	Workplace harassment within my work area	.45

There were no significant gender differences on the three Workplace Environment factor scores as reported in Table 5.2:4 and Table 5.2:5. The results of the three t-tests were: (Organisational Provisions Regarding Safety ( $t_{(216)} = -.889$ ,  $p = .375$ , *ns*); Workload Issues ( $t_{(216)} = -.304$ ,  $p = .672$ , *ns*); Contribution of Supervisory Duties to Workload ( $t_{(216)} = .544$ ,  $p = .587$ , *ns*).

**Table 5.2:4 Group Statistics: Gender and the Three Workplace Environment Factor Scores**

Group Statistics				
	Gender	n	Mean	Std Deviation
Organisational Provisions Regarding Safety	Female	199	-.02	1.00
	Male	19	.20	1.05
Workload Issues	Female	199	-.01	1.00
	Male	19	.07	1.00
Contribution of Supervisory Duties to Workload	Female	199	.01	1.01
	Male	19	-.12	.9



**Table 5.2:5 Statistical tests of Gender Differences in the Three Work Environment Factor Scores**

	t-test for Equality of Means		
	t	df	p (2-tailed)
Organisational Provisions Regarding Safety	-.89	216	.375
Workload Issues	-.30	216	.762
Contribution of Supervisory Duties to Workload	.54	216	.587

There were no statistically significant differences in the responses in the three Workplace Environment factors among the four age groups. Table 5.2:6 presents the age group means (and std deviations). There are three Workplace Environment factors: (Safety Provision by the Organisation ( $t_{216} = -.889$ ,  $p = .375$ , *ns*); Workload Issues ( $t_{216} = -.304$ ,  $p = .762$ , *ns*); Workload Supervisory Load ( $t_{216} = .544$ ,  $p = .587$ , *ns*)) as provided in Table 5.2:7.

**Table 5.2:6 Group Means (and Standard Deviations) of Four Age Groups on Three Workplace Environment Factor Scores**

Descriptives				
	Age Range	n	Mean	Std Deviation
Organisational Provisions Regarding Safety	45–50	96	-.04	.95
	51–55	54	-.18	.99
	56–60	46	.11	.99
	61–65	21	.44	1.13
	Total	217	.01	1.00
Workload Issues	45–50	96	-.02	1.02
	51–55	54	-.10	1.03
	56–60	46	.21	.84
	61–65	21	-.13	1.12
	Total	217	.00	1.00
Contribution of Supervisory Duties to Workload	45–50	96	-.03	1.03
	51–55	54	.14	.96
	56–60	46	-.13	1.06
	61–65	21	.02	.84
	Total	217	.00	1.00

**Table 5.2:7 Analysis of Variance of Age Differences in the Three Workplace Environment Factors**

ANOVA						
		Sum of Squares	df	Mean Square	F	p
Organisational Provisions Regarding Safety	Between Groups	6.41	3	2.14	2.17	.093
	Within Groups	209.93	213	.99		
	Total	216.34	216			
Workload Issues	Between Groups	2.84	3	.95	.94	.421
	Within Groups	214.16	213	1.01		
	Total	217.00	216			
Contribution of Supervisory Duties to Workload	Between Groups	1.90	3	.63	.63	.599
	Within Groups	215.02	213	1.01		
	Total	216.92	216			

There was a statistically significant difference between factor scores of full-time and part-time respondents for Safety Provision by the Organisation ( $t_{216} = -1.98$ ,  $p = .05$ , sig.) as shown in Table 5.2:8 and Table 5.2:9. The part-time group had a higher mean score (mean = .17, sd = .94) than the full-time group (mean = -.10, sd = 1.02). The difference between full-time and part-time respondents was not significantly different for Workload Issues ( $t_{216} = 1.40$ ,  $p = .16$ , ns), nor for Workload Supervisory issues ( $t_{216} = -1.41$ ,  $p = .16$ , ns).

**Table 5.2:8 Workplace Environment Factor Scores and Current Employment (Full-Time or Part-Time)**

	Current employment status	n	Mean	Std Deviation
Organisational Provisions Regarding Safety	Full-time	137	-.10	1.02
	Part-time	81	.17	.94
Workload Issues	Full-time	137	.07	.92
	Part-time	81	-.12	1.10
Contribution of Supervisory Duties to Workload	Full-time	137	-.07	.92
	Part-time	81	.12	1.10

**Table 5.2:9 t-Tests of the Differences between Full-Time and Part-Time Respondents' Scores on the Three Workplace Environment Factors.**

	t	df	p (2-tailed)
Organisational Provisions Regarding Safety	-1.99	216	.048
Workload Issues	1.4	216	.163
Contribution of Supervisory Duties to Workload	-1.41	216	.159

### 5.3 Leadership

The second research question that focuses the conduct of the research is:

**How does leadership influence end of career nurses' (EOCNs') decision regarding workforce participation?**

Section 2 Question 2a–h explored the issues embedded in the above question. The eight items dealt with aspects of the leadership in relation to nurses' decisions about remaining in the profession. A 5-point Likert type scale from 1 (strongly disagree) to 5 (strongly agree) was used with findings being ranked according to level of agreement as presented in Table 5.3:1. Across the eight aspects of leadership (Q2a to Q2h) the lowest level of agreement was obtained for Q2d (Team processes are a priority,

mean = 3.52), while the highest level of agreement was recorded for Q2e (Trusted by leadership team to do my job, mean = 4.22).

Most respondents agreed that they felt trusted by the leadership team to do their job (mean = 4.22) and were able to practice with a high level of autonomy (mean = 4.10). Respondents also felt that they were listened to when they voiced their concerns and the leadership team responded appropriately when they voiced their opinions. Team processes are a priority (mean = 3.52) and the leadership team provided flexible rostering to similarly meet personal and professional needs (mean = 3.85 and 3.79 respectively).

**Table 5.3:1 Leadership Items Ranked According to Level of Agreement**

Item	Mean	Std Deviation
Q2e. Trusted by leadership team to do my job	4.22	.83
Q2h. I feel able to practice autonomously	4.10	1.03
Q2f. Leadership team provides flexible rostering to meet my personal needs	3.85	1.12
Q2g. Leadership team provides flexible rostering to meet my professional needs	3.79	1.11
Q2b. Supported by leadership	3.71	1.11
Q2a. Leadership team listens to my concerns	3.68	1.08
Q2c. Leadership team responds appropriately when I voice my opinions	3.57	1.05
Q2d. Team processes are a priority	3.52	1.01

Note: 1 = Strongly disagree; 3 = Neutral; 5 = Strongly agree

The eight Leadership items were subjected to a principal component analysis. A two-factor solution accounting for 71.8% of the variance was accepted. The Varimax rotated solution is presented in Table 5.3:2. The factors were identified as (1) Perceived Valuing by Leadership and (2) Roster Flexibility. Perceived Valuing by Leadership include items such as Q2a 'the leadership team listens to my concerns', factor loading = .90; Q2b 'being supported by leadership', factor loading = .89; Q2c 'the leadership team responds appropriately when I voice my concerns', factor loading = .86.

Roster Flexibility includes Q2f ‘the leadership team provides flexible rostering to meet my personal needs’, factor loading = .93; and Q2g ‘the leadership team provides flexible rostering to meet my professional needs’ factor loading = .90. Question 2h ‘feeling able to work autonomously’ relates to both factor 1 ‘Perceived Valuing by Leadership’, factor loading = .60, and factor 2 ‘Roster Flexibility’, factor loading = .32.

**Table 5.3:2 Factor Analysis of the Eight Leadership Items Arranged by Level of Agreement**

	Component	
	1	2
Q2a. Leadership team listens to my concerns	.90	
Q2b. Supported by leadership	.89	
Q2c. Leadership team responds appropriately when I voice my opinions	.86	
Q2d. Team processes are a priority	.73	
Q2e. Trusted by leadership team to do my job	.71	
Q2h. I feel able to practice autonomously	.60	.32
Q2f. Leadership team provides flexible rostering to meet my personal needs		.93
Q2g. Leadership team provides flexible rostering to meet my professional needs		.90
Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization.		
Note: a. Rotation converged in 3 iterations.		

\*Factor loadings with an absolute value smaller than .30 (implying less than 10% of the variance associated with an item) have been omitted for clarity.

From this analysis the two factor scores were computed and saved as two additional variables in the findings file.

There were no statistically significant differences between the factor scores for the male and female respondents as reported in Table 5.3:3 and Table 5.3:4. The t-test result for Valuing by Leadership was  $t_{(209)} = -1.181$ ,  $p = .238$ , *ns*. In the test for gender differences in the importance of Roster Flexibility, the t-test result ( $t_{(209)} = 1.247$ ,  $p = .228$ , *ns*) was not significant.

**Table 5.3:3 Group Statistics: Gender and the Two Leadership Factors**

Group Statistics				
	Gender	n	Mean	Std Deviation
Valuing by Leadership	Female	193	-.02	.98
	Male	18	.27	1.17
Roster Flexibility	Female	193	.04	.94
	Male	18	-.41	1.48

**Table 5.3:4 Gender Differences in the Two Leadership Factor Scores**

t-test for Equality of Means			
	t	df	p (2-tailed)
Valuing by Leadership	-1.19	209	.239
Roster Flexibility	1.25	209	.228

There were no statistically significant age group differences (Valuing by Leadership ( $F_{(3,206)} = .47$ ,  $p = .71$ , *ns*); Roster Flexibility ( $F_{(3,206)} = 1.98$ ,  $p = .14$ , *ns*)) in the scores obtained on the two Leadership factors. These results are reported in Table 5.3:5 and Table 5.3:6.

**Table 5.3:5 Group Means (and Std Deviations) of Age Groups and the Two Leadership Factor Scores**

Descriptives				
	Age range	n	Mean	sd
Valuing by Leadership	45–50	93	.00	1.09
	51–55	52	-.11	1.04
	56–60	45	.08	.812
	61–65	20	.15	.882
	Total	210	.00	1.002
Roster Flexibility	45–50	93	-.03	1.017
	51–55	52	-.14	1.192
	56–60	45	.04	.783
	61–65	20	.47	.711
	Total	210	.00	1.002

**Table 5.3:6 Analysis of Variance of Age Differences in the Two Leadership Factors**

ANOVA						
		Sum of Squares	df	Mean Square	F	p
Valuing by Leadership	Between Groups	1.41	3	.47	.47	.706
	Within Groups	208.30	206	1.01		
	Total	209.71	209			
Roster Flexibility	Between Groups	5.58	3	1.86	1.87	.135
	Within Groups	204.13	206	.99		
	Total	209.71	209			

The variance difference is not statistically significant between full-time and part-time respondents for Valuing by Leadership ( $t_{209} = -1.18$ ,  $p = .24$ , *ns*). The full-time group had a higher mean score (mean = 0.09, sd = .99) than the part-time group (mean =  $-.15$ , sd = 1.00).

The part-time group had a higher mean score (mean = 0.14, sd = .96) than the full-time group (mean =  $-.08$ , sd = 1.02). There is no statistically significant difference in full-time and part-time factor scores for Roster Flexibility ( $t_{209} = 1.81$ ,  $p = .072$ , *ns*) as shown in Table 5.3:7 and Table 5.3:8.

**Table 5.3:7 Leadership Factor Scores and Current Employment (Full-Time or Part-Time)**

	Current employment status	n	Mean	Std Deviation
Valuing by Leadership	Full-time	132	.09	.99
	Part-time	79	$-.15$	1.00
Roster Flexibility	Full-time	132	$-.08$	1.02
	Part-time	79	.14	.96

**Table 5.3:8 t-Tests of the Differences Between Full-Time and Part-Time Respondents' Scores on the Two Leadership Factors.**

	t-test for Equality of Means		
	t	df	p (2-tailed)
Valuing by Leadership	-1.18	209	.239
Roster Flexibility	1.81	209	.072

## 5.4 Personal and Professional Recognition

The third research question that focuses the conduct of the research is:

**How does personal and professional recognition influence end of career nurses' (EOCNs') decision regarding workplace participation?**

Section 2 Question 3a–e explored the issues embedded in the above question. These five items dealt with aspects of the personal and professional recognition in relation to decisions about remaining in nursing. A 5-point Likert type scale was used ranging from 1 (strongly disagree) to 5 (strongly agree). This data is presented in Table 5.4:1. Across the five aspects of personal and professional recognition (Q3a to Q3e) the lowest level of agreement was obtained for Q3d (Younger or less experienced staff are provided with more professional development opportunities, mean = 2.47), while the highest level of agreement was recorded for Q3e (Relate well with different generations at work, mean = 4.19).

Most respondents agreed that they had a high level of job satisfaction (mean = 3.86) and financial remuneration was not a key motivator (mean = 3.00). Most respondents agreed that professional development opportunities were provided equally to all staff (mean = 3.67). Many of the respondents did not consider that younger or less experienced staff are provided with more professional development opportunities (mean = 2.47). The majority of respondents suggested that they related well with different generations (mean = 4.19).



**Table 5.4:1 Personal and Professional Dynamic Items Arranged by Level of Agreement**

Item	Mean	sd
Q3e. Relate well with different generations at work	4.19	.76
Q3a. High level of job satisfaction	3.86	1.00
Q3c. Professional development opportunities are afforded equally to all staff	3.67	1.13
Q3b. Financial remuneration is key motivator	3.00	1.13
Q3d. Younger or less experienced staff are provided with more professional development opportunities	2.47	1.22

Note: 1 = Strongly disagree; 3 = Neutral; 5 = Strongly agree

The five personal and professional recognition items were subjected to a principal component analysis. The analysis of Q3a to Q3e is reported in Table 5.4:2. A two-factor solution accounting for 58.11% of the variance was accepted. The Varimax rotated solution is presented in Table 5.4:2. The factors were identified as (1) Professional Development Opportunities and (2) Importance of Remuneration. Professional Development Opportunities factors includes four items: equally afforded professional development opportunities (Q3c, factor loading = .79). There was a negative loading (–.73) for item Q3d indicating that younger or less experienced staff were not provided more professional development opportunities. Professional Development Opportunities issues also included the ability to relate well with different generations (Q3e, factor loading = .61) and high level of job satisfaction (Q3a, factor loading = .44). The Importance of Remuneration factor includes financial remuneration is a key motivator (Q3b, factor loading = .86), relating well with different generations at work (Q3e, factor loading = .30),. There was a negative loading (–.57) for Q3a indicating that a low level of job satisfaction is associated with a high level of importance being assigned to remuneration.

**Table 5.4:2 Factor Analysis of the Five Personal and Professional Items Ranked by the Magnitude of Factor Loadings**

	Component	
	1	2
Q3c. Professional development opportunities are afforded equally to all staff	.79	
Q3d. Younger or less experienced staff are provided with more professional development opportunities	-.73	
Q3e. Relate well with different generations at work	.61	.30
Q3b. Financial remuneration is key motivator		.86
Q3a. High level of job satisfaction	.44	-.57
Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalisation.		
Notes: a. Rotation converged in 3 iterations. b. Small values being omitted		

\*Factor loadings with an absolute value smaller than .30 (implying less than 10% of the variance associated with an item) have been omitted for clarity.

From this analysis the two factor scores were computed and saved as two additional variables in the findings file (Professional Development Opportunities and the Importance of Remuneration).

There were no statistically significant differences between the factor scores for male and female respondents in their responses to the one of the Personal and Professional Recognition factors which included PD Opportunities ( $t_{(213)} = .449$ ,  $p = .654$ , *ns*) as reported in Table 5.4:3 and Table 5.4:4. There was also no statistically significant difference between gender groups in their factor scores on the Importance of Remuneration ( $t_{(213)} = 316$ ,  $p = .752$ , *ns*).

**Table 5.4:3 Group Statistics: The Personal and Professional Dynamic Factors by Gender**

Group Statistics				
	Gender	n	Mean	Std Deviation
PD Opportunities	Female	196	.01	1.01
	Male	19	-.10	1.02
Importance of Remuneration	Female	196	.01	1.01
	Male	19	-.07	.95

**Table 5.4:4 Gender Differences in the Two Personal and Professional Recognition Factor Scores**

	t-test for Equality of Means		
	t	df	p (2-tailed)
PD Opportunities	.45	213	.654
Importance of Remuneration	.32	213	.752

There was a statistically significant difference in the factor scores for Importance of Remuneration among the four age groups ( $F_{(3,210)} = 3.106$ ,  $p = .027$ , sig.). These are reported in Table 5.4:5 (Age Group Means) and Table 5.4:6 (Scheffe tests). The source of this difference was investigated by undertaking Scheffe Post Hoc tests of the differences among pairs of the age group means. The mean for the 61–65 age group was significantly lower than those of the other younger age groups. There was no statistical difference among the three younger age groups.

**Table 5.4:5 Group Means of Age Groups and the two Personal and Professional Dynamic Factor Scores**

Descriptives				
	Age Group	n	Mean	sd
PD Opportunities	45–50	94	.01	.93
	51–55	54	–.23	1.07
	56–60	46	.19	.90
	61–65	20	.22	1.22
	Total	214	.01	.10
Importance of Remuneration	45–50	94	.08	.97
	51–55	54	.08	1.01
	56–60	46	–.01	.98
	61–65	20	–.64	1.00
	Total	214	–.01	.10

**Table 5.4:6 Analysis of Variance of Age Group Differences in the Two Personal and Professional Dynamic Factors**

ANOVA						
		Sum of Squares	df	Mean Square	F	p
PD Opportunities	Between Groups	5.31	3	1.77	1.81	.146
	Within Groups	205.10	210	.98		
	Total	210.39	213			
Importance of Remuneration	Between Groups	9.01	3	3.00	3.11	.027
	Within Groups	203.09	210	.97		
	Total	212.10	213			

## Scheffe Post Hoc Tests

**Table 5.4:7 Homogeneous Subsets**

Remuneration			
Scheffe			
Age range	n	Subset for alpha = 0.05	
		1	2
61–65	20	–.65	
56–60	46		–.01
51–55	54		.08
45–50	94		.08
Sig.		1.00	.99
Means for groups in homogeneous subsets are displayed.			

There was a statistically significant difference in factor scores for Professional Development Opportunities between full-time and part-time respondents ( $t_{213} = 2.955$ ,  $p = .003$ , sig.) as shown in Table 5.4:8 and Table 5.4:9. The full-time group had a higher mean score (mean = 0.152, sd = .95,  $n = 135$ ) than the part-time group (mean = –.257, sd = 1.04,  $n = 80$ ).

There was no statistically significant difference in the Importance of Remuneration factor scores between full-time and part-time respondents ( $t_{213} = -.053$ ,  $p = .958$ , *ns*).

**Table 5.4:8 Personal and Professional Dynamic Factor Scores and Current Employment (Full-Time or Part-Time)**

	Current employment status	n	Mean	Std Deviation
PD Opportunities	Full-time	135	.15	.95
	Part-time	80	–.26	1.04
Importance of Remuneration	Full-time	135	–.00	.98
	Part-time	80	.01	1.05

**Table 5.4:9 t-Tests of the Differences between Full-Time and Part-Time Respondents' Scores on the Two Personal and Professional Dynamic Factor**

	t-test for Equality of Means		
	t	df	p (2-tailed)
PD Opportunities	2.96	213	.003
Importance of Remuneration	-.053	213	.958

The values reported in Table 5.4:8 indicate a significant difference between full-time and part-time respondents concerning the issue of access to professional development with full-time respondents assigning a higher rating to this issue (mean = .15) than part-time respondents (mean = -.26).

## 5.5 Balance of Effort and Reward

The fourth research question that focuses the conduct of the research is:

**How does the balance of effort and reward influence end of career nurses' (EOCNs') decisions regarding workforce participation?**

Section 2 Question 4a–d raises issues to be explored within the above question. The four items dealt with aspects of effort and reward at work in relation to decisions about remaining in nursing. A 5-point Likert type scale was used ranging from 1 (strongly disagree) to 5 (strongly agree); results are presented in Table 5.5:1. Across the four aspects of effort and reward at work (Q4a to Q4d), the lowest level of agreement was obtained for Q4c (Rewarded for efforts I make, mean = 3.02), while the highest level of agreement was recorded for Q4b (Recognised for my efforts, mean = 3.43).

**Table 5.5:1 Responses to Four Effort and Reward Items Ranked According to Level of Agreement**

Item	Mean	sd
Q4b Recognised for my efforts	3.43	1.05
Q4d Leadership team recognises staff efforts	3.36	1.12
Q4a Balance between effort and recognition	3.31	1.11
Q4c Rewarded for efforts I make	3.02	1.06

Note: 1 = Strongly disagree; 3 = Neutral; 5 = Strongly agree

The descriptive statistics for the items concerning Effort and Reward questions 4a to 4d showed that the means were somewhat above 3, which is the 'neutral' value on the 5-point Likert type scale. Respondents reported that there was a balance between effort and recognition (Q4a, mean = 3.31) and that they were rewarded for their efforts (Q4c, mean = 3.02).

The four Effort and Reward items (Q4a–Q4d) were subjected to a principal component analysis. The factor scores were saved in the data file as a variable named Effort and Reward.

**Table 5.5:2 Group Statistics: Gender and the Effort and Reward Factor**

Group Statistics				
	Gender	n	Mean	Std Deviation
Effort/Reward	Female	195	-.02	.10
	Male	19	.16	1.06

**Table 5.5:3 Gender Differences in the Effort and Reward Factor Score**

t-test for Equality of Means			
	t	df	p (2-tailed)
Effort/Reward	-.716	212	.475

There was no statistically significant difference in the Effort and Reward factor scores between the male and female respondents as reported in Table 5.5:2 and Table 5.5:3 ( $t_{(212)} = -.716$ ,  $p = .475$ , *ns*).

**Table 5.5:4 Effort and Reward: Age Group Means on Effort and Reward**

Descriptives				
	Age range	n	Mean	SD
Effort/Reward	45–50	96	-.10	1.08
	51–55	52	-.11	.93
	56–60	44	.23	.93
	61–65	21	.25	.92
	Total	213	.00	1.00

Note: This is the one variable derived to represent the four Effort/Reward items.

There were no statistically significant differences among the age groups in their responses to the Effort and Reward factor ( $F_{(3,209)} = 1.72$ ,  $p = .163$ , *ns*) as reported in Table 5.5:5.

**Table 5.5:5 Analysis of Age Differences in the Effort and Reward Factor**

ANOVA					
Effort/Reward					
	Sum of Squares	df	Mean Square	F	p
Between Groups	5.143	3	1.71	1.72	.163
Within Groups	207.855	209	.10		
Total	212.998	212			

The Effort/Reward scores for the part-time and full-time groups are presented in Table 5.5:6. There was no statistically significant difference in Effort and Reward factor scores obtained by these groups ( $t_{212} = .613$ ,  $p = .54$ , *ns*) as reported in Table 5.5:6. The part-time group had a lower mean score ( $n = 80$ , mean =  $-.054$ ) than the full-time group ( $n = 134$ , mean =  $.32$ ).

**Table 5.5:6 Effort and Reward Factor Score and Current Employment (Full Time or Part Time)**

Group Statistics				
	Current employment status	n	Mean	Std Deviation
Effort/Reward	Full-time	134	.03	1.03
	Part-time	80	-.05	.95



**Table 5.5:7 t-Tests of the Differences between Full-Time and Part-Time Respondents' Scores on the Effort and Reward Factor**

	t-test for Equality of Means		
	t	df	p. (2-tailed)
Effort/Reward	.61	212	.540

## 5.6 Open-ended Responses

Section 2 Question 5 contained four open-ended response questions (Q5a–d). Each of the four questions related to influences concerning decisions about remaining in nursing and offered respondents the opportunity to comment on any issues they considered relevant and important. The number of respondents varied from 163 to 216 over the four questions. The minimum number of responses for each question part was three. In addition, 130 persons responded to all items. Questions 5a–d required open-ended responses only. The comments from each of the four parts of Question 5 were coded into categories which were produced post hoc. Reduction of the large volumes of data to a number of tentative themes or categories was systematically managed through a constant comparative method which generated and confirmed theory by simultaneously coding and analysing data. Table 5.6:1 summarises the findings.

**Table 5.6:1 The Number of Responses for Descriptives for the Open Responses**

Descriptive Statistics					
	n	Min.	Max.	Mean	sd
5a. What are the most important influences on your intent to remain in nursing?	216	3	18	10.52	4.53
5b. What aspects of the workplace environment not addressed in this survey do you consider important to retaining nurses like yourself?	187	3	19	9.51	4.55
5c. What aspects of professional relationships not in this survey do you consider important to retaining nurses like yourself?	170	3	19	9.08	4.19
5d. Please add any additional comments on issues which may be influencing your employment in nursing	163	3	20	10.47	4.89
Valid n (listwise)	130				

Note: Table 5.6:1 contains the exact wording used in the survey instrument.

### **Question 5a**

Question 5a asked for *aspects of the most important influences on your intent to stay in nursing*. A total of 216 aspects were reported. These were coded into 18 categories. The 18 categories are reported in Table 5.6:2. The most frequently occurring response concerned 'financial issues' (24.5%) and a similar number of respondents (24.1%) indicated that 'they enjoyed what they do / being a nurse'. 'Feeling valued', 'availability of parking facilities' and 'dissatisfaction with work' (0.5%) were least reported items for retaining nurses.

There was a minimum of three responses per person across all four items. While 49 respondents did not answer 5d, of the 163 respondents who did respond, all of them provided 3 or more responses. Of those who responded (minimum of 163), an average of 10 responses were provided.

**Table 5.6:2 What are the Most Important Influences on Your Intent to Remain in Nursing?**

	<b>Freq</b>	<b>Percent</b>
Financial	53	24.3
Enjoy what I do / enjoy being a nurse	52	23.9
Personal and professional recognition	28	12.8
Make a difference / positive influence	23	10.6
Physical challenges of the work / night duty / shift work / personal health	15	6.9
Professional advancement / succession management	12	5.5
Leadership	11	5.0
Social interaction	7	3.2
Workplace environment	6	2.8
Quality outcomes	3	1.4
Respected / professional recognition	3	1.4
Feeling valued	1	.5
Parking facilities	1	.5
Dissatisfaction	1	.5
No response	2	.9
<b>Total</b>	<b>218</b>	<b>100.0</b>

### Question 5b

Question 5b asked for *aspects of workplace environment not addressed in the survey* which the respondents considered important to retain nurses like themselves. A total of 187 aspects of the workplace environment were reported. These were coded into 19 categories. The 19 categories are reported in Table 5.6:3. The most frequent response reported 'influence by the workplace environment' (15.1%). 'Effort and reward balance' (0.9%), 'enjoy being a nurse' (0.9%) and 'quality outcomes' (0.5%) were least reported. Of similar frequency was 'leadership' (12.8%) and 'physical challenges of work which included night duty, shift work and personal health' (12.8%).

**Table 5.6:3 What Aspects of the Workplace Environment Not Addressed in this Survey do You Consider Important to Retaining Nurses Like Yourself?**

	Freq	Percent
Workplace environment	33	15.1
Leadership	28	12.8
Physical challenges of the work / night duty / shift work / personal health	28	12.8
Respected / professional recognition	19	8.7
Parking facilities	16	7.3
Personal and professional recognition	14	6.4
Professional advancement / succession management	10	4.6
Financial	9	4.1
Feeling valued	7	3.2
Social interaction	6	2.8
Make a difference / positive influence	5	2.3
Dissatisfaction	4	1.8
Job share to work less hours however maintain higher position [i.e. Nursing Officer 4]	3	1.4
Enjoy what I do / enjoy being a nurse	2	.9
Effort reward balance	2	.9
Quality outcomes	1	.5
No response	31	14.2
<b>Total</b>	<b>218</b>	<b>100.0</b>

### **Question 5c**

Question 5c asked for *aspects of professional relationships not addressed in this survey which the respondents considered important to retain nurses like themselves*. A total of 170 aspects of the professional relationships were reported. These were coded into 14 categories. The 14 categories are reported in Table 5.6:4. The most frequent of the 170 responses was 'personal and professional recognition' (21.6%). 'Being professionally respected' (16.1%) and 'leadership' (14.7%) were also frequently mentioned influences. 'Quality outcomes' (0.5%) and 'effort and reward balance' (0.5%) were least reported as influences for retaining nurses within the nursing profession.

**Table 5.6:4 What Aspects of Professional Relationships Not Addressed in This Survey do You Consider Important to Retaining Nurses like Yourself?**

	<b>Freq</b>	<b>Percent</b>
Personal and professional recognition	47	21.6
Professionally respected	35	16.1
Leadership	32	14.7
Professional advancement / succession management	15	6.9
Make a difference / positive influence	7	3.2
Social interaction	7	3.2
Feeling valued	7	3.2
Workplace environment	6	2.8
Financial	4	1.8
Parking facilities	3	1.4
Job share to work less hours however maintain higher position [i.e. NO 4]	3	1.4
Physical challenges of the work / night duty / shift work / personal health	2	.9
Effort–reward balance	1	.5
Quality outcomes	1	.5
No response	48	22.0
<b>Total</b>	218	100.0

### **Question 5d**

Question 5d asked for *any additional comments on issues which may influence their employment in nursing*. A total of 163 aspects were reported. These were coded into 20 categories. The 20 categories are reported in Table 5.6:5. The most frequent of the 163 responses concerned ‘financial issues’ (13.3%) and ‘leadership’ (11.9%), while the least reported influence concerned ‘feeling too old to change jobs’ (0.5%).

**Table 5.6:5 Additional Comments on Issues Which may be Influencing Your Employment in Nursing**

	<b>Freq</b>	<b>Percent</b>
Financial	29	13.3
Leadership	26	11.9
Personal and professional recognition	18	8.3
Dissatisfaction	16	7.3
Enjoy what I do / enjoy being a nurse	13	6.0
Physical challenges of the work / night duty / shift work / personal health	11	5.0
Workplace environment	9	4.1
Make a difference / positive influence	8	3.7
Professional advancement / succession management	8	3.7
Respected / professional recognition	8	3.7
Parking facilities	5	2.3
Effort–reward balance	4	1.8
Social interaction	3	1.4
Quality outcomes	2	.9
Feeling valued	2	.9
Feel too old to change jobs at this stage of work life	1	.5
No response	55	25.2
<b>Total</b>	<b>218</b>	<b>100.0</b>

## **5.7 Summary of Survey Findings**

In conclusion, the majority of respondents were full time employees of the facility (62%) with 48% being shift workers and not surprisingly, 91% were females. Additionally, there was evidence of a stable employment as 79% had not recently changed their hours of employment. Of the 45 respondents (21%) that had changed their employment hours, 21 (47%) had reduced their hours of employment with almost half of this group (40%) reporting avoidance of shift work or ill health.

The respondents reported the highest influence concerning the workplace environment to be that experienced nurses have heavier workload due to supervisory workload. This was found to contribute to consideration of reduced employment status to avoid heavy workload.

Most respondents agreed that they felt trusted by the leadership team to do their job and were able to practice with a high level of autonomy. In addition, most respondents agreed that they had a high level of job satisfaction and financial remuneration was not a key motivator to remain at work. Professional development opportunities were provided equally to all staff and most respondent reported that they related well with different generations.

Finally, there was a neutral value reported concerning the balance between effort and recognition and that being rewarded for their efforts.

## **5.8 Selection of Focus Groups and Individual Interview Protocol**

The survey results, once coded and analysed supported the formulation of questions used to prompt discussion in the three focus groups and subsequent individual interviews as nominated in Table 4.5:1 and Table 4.5:2. The results from the focus groups and the interviews will be presented in the following chapter (Chapter Six).

## **CHAPTER SIX: FOCUS GROUP AND INTERVIEW FINDINGS**

The purpose of this chapter is to present findings generated from focus groups and semi-structured interviews that explored the factors that influence EOCNs' decisions regarding workforce participation.

### **6.1 Introduction**

The four research questions provide a framework for presentation of findings from analysis of focus group and interview data:

1. How does the workplace environment influence the EOCNs' decisions regarding workforce participation?
2. How does leadership influence the EOCNs' decisions regarding workforce participation?
3. How does personal and professional recognition influence the EOCNs' decisions regarding workplace participation?
4. How does the balance of effort and reward influence the EOCNs' decisions regarding workforce participation?

In order to maintain consistent terminology, Table 6.1:1 contains definitions for titles and classifications of nursing officers used within the text.

**Table 6.1:1 Participant Nursing Classifications and Terminology**

<b>Term Used</b>	<b>Term Definition</b>
Clinical participants	Nursing Officer Grade 5 (Gr 5): Registered Nurse 1 (RN1)
Clinical participants	Nursing Officer Grade 6 (Gr 6): Clinical Nurse (CN)
Line Manager	Perform as a Line Manager and may include any of the following nursing roles:  Nursing Officer Grade 7 (Gr 7): Clinical Nurse Consultant (CNC); Nurse Manager (NM); Nurse Unit Manager (NUM); Nurse Educator (NE); Nurse Researcher (NR)  Nursing Officer Grade 9.1–9.3 (Gr 9.1–9 3): Assistant Nursing Director (AND); Nursing Director (ND);  Nursing Officer Grade 12 (Gr 12): Executive Director of Nursing (EDNS)
Leadership Team (LT)	Nursing Officer Grade 7 (Gr 7): Could include any combination of the following: Clinical Nurse Consultant; Nurse Manager; Nurse Unit Manager; Nurse Educator; Nurse Researcher
Senior Leadership and Management Team (SLMT)	Nursing Officer Grade 9–12 (Gr 9–12) Assistant Nursing Director (Gr 9.1); Nursing Director (Gr 9.2 or 9.3); Executive Nursing Director (Gr 12)

Table 6.1:2 presents the key themes that emerged from the data analysis. The themes are tabulated under the heading of each question and are numbered to correspond with the section within this chapter.



**Table 6.1:2 Key Themes from Data Analysis**

Q1: How does the workplace environment influence the EOCNs' decisions regarding workforce participation?	Q2: How does leadership influence the EOCNs' decisions regarding workforce participation?	Q3: How does personal and professional recognition influence the EOCNs' decisions regarding workplace participation?	Q4: How does the balance of effort and reward influence the EOCNs' decisions regarding workforce participation?
<p>6.2.1 Challenges of increasing workload:</p> <ul style="list-style-type: none"> <li>Escalating supervisory responsibilities</li> <li>Increasing workload necessitates managing additional work hours</li> </ul>	<p>6.3.1 Credibility of leader</p> <ul style="list-style-type: none"> <li>Leader visibility</li> <li>Credible management and clinical skills</li> </ul>	<p>6.4.1 Feeling valued for personal and professional contribution</p> <ul style="list-style-type: none"> <li>Respect for professional and personal experience</li> <li>Valuing commitment</li> <li>Age concerns</li> </ul>	<p>6.5. Effort and reward balance per participant through:</p> <p>Effort:</p> <ul style="list-style-type: none"> <li>Demands (workloads) and obligations (expectations)</li> </ul> <p>Reward:</p> <ul style="list-style-type: none"> <li>Remuneration, esteem, career opportunities and security</li> </ul> <p>Results:</p> <ul style="list-style-type: none"> <li>Behaviours, attitudes and emotions</li> </ul>
<p>6.2.2 Risk factors impact</p> <ul style="list-style-type: none"> <li>Shift work: particularly night duty</li> <li>Harassment and violence</li> <li>Burnout</li> </ul>	<p>6.3.2 Interaction, team and social cohesion promoted by leadership</p> <ul style="list-style-type: none"> <li>Interaction cohesion</li> <li>Team and social cohesion</li> </ul>	<p>6.4.2 Recognition through comparative remuneration</p> <ul style="list-style-type: none"> <li>Fair and comparative pay</li> <li>Financial security</li> </ul>	
<p>6.2.3 Competing work and life commitments</p>	<p>6.3.3 Support, flexibility and trusting relationships demonstrated by leadership</p>	<p>6.4.3 Opportunity for professional development (PD) and advancement</p> <ul style="list-style-type: none"> <li>Accessing PD</li> <li>Implied value of PD</li> <li>Professional advancement</li> </ul>	
		<p>6.4.4 Dissonance between the generations</p> <ul style="list-style-type: none"> <li>Sense of loyalty and commitment</li> <li>Inequity and different expectations</li> <li>Generational interaction compromises learning</li> </ul>	

## 6.2 Research Question 1

The first research question is: How does the workplace environment influence EOCN's decisions regarding workforce participation?

The three findings concerning research question 1 are:

1. Challenges of increased workload
  - Escalating supervisory responsibilities for EOCN
  - Increasing workload necessitates managing additional working hours
2. Risk factors
  - Impact of shift work: particularly night duty
  - Impact of harassment, violence and burnout
3. Competing work and life commitments

Each of these findings is now discussed.

### 6.2.1 Challenges of Increasing Workload

*Escalating supervisory responsibilities for EOCN: Consequence of skill mix*

The participants identified that they were experiencing increasing work demands. As numbers of experienced clinicians were reducing, it became increasingly difficult for line managers to meet shift requirements. In order to support staffing numbers, increasing numbers of less experienced staff were allocated to work. This imbalance in skill mix placed additional demands on the experienced clinician, as they were required to support the clinical practice of these novice nurses. This phenomenon was particularly illustrated by Janine:

I have worked harder now than I ever worked even as a student nurse. I don't think that it's the patient care that's making it harder. It's keeping an eye out for the colleague that's a new grad. [graduate] (*Janine: FG1 p. 10*)

Indeed, the lack of experience of novice nurses with their associated rudimentary clinical knowledge was identified as a major concern for experienced clinicians. In order to address such deficiencies, EOCNs engaged in additional supervisory roles exercised through formal preceptorship<sup>10</sup> relationships as well as through other informal strategies such as buddying<sup>11</sup> relationships.

---

<sup>10</sup> Preceptorship: a short-term education relationship providing newly qualified (or returning) professionals with clinical, task-orientated teaching and learning. The relationship is primarily

You've no idea what they miss out... If you come in after them, the patient hasn't had anything done for them because the two of them are having such a lovely time; they're such nice girls and they did this and they did that. 'Did they talk about your diabetes 'cause you are a really bad diabetic?' 'No no they didn't talk about that but they did they did give me my medication and they did do my shower'. (*Carol: FG1 p. 36*)

In addition to increasing numbers of inexperienced staff, agency and casual staff were also often employed to support roster requirements. As these staff members were not permanent employees, they were often unfamiliar with the work unit structures and processes. While many of these members were experienced clinicians, they still required orientation and support during each shift: "even agency [staff] are working to capacity, however often you get 50% to 60% strange staff who don't know your ward." (*Louise: FG3 p. 14*)

The strain experienced by EOCNs supporting new staff was exacerbated by the perceived inability of line managers to recognise their increasing workload. This point was lamented by Andrea as "a lack of connection between reviewing the workload and looking at what we actually can manage on the ward" (*Andrea: FG2 p. 13*). This finding is further elaborated in Section 6.3.3.

There are many ways to address the ongoing supervision and support for less experienced staff. One such strategy is a 'Team Nursing' approach where the experienced and less experienced staff are 'teamed' together to enhance the skills and knowledge of the less experienced nurse. This strategy was criticised by many clinical participants, as they perceived they were unable to work autonomously and claim sole responsibility for their patient care.

I hate working with other people where I have to share my patients, because at the end of the day you really are relying on that person's observations skills, work ethic [and] competence. So if you've had a good day yourself and that person's really stuffed up in one of their areas, you go home wearing their problems. I'd much rather get in and be really busy, but do my own work. And I think my patients, from their perspective, I think they benefit much more from a holistic model rather than with team nursing. (*Docie: FG1 p. 3*)

---

concerned with the achievement of pre-determined levels of competence and often finishes with the achievement of set competencies.

<sup>11</sup> Buddying: a system used to meet orientation needs rather than comprehensive transition support. It utilises several experienced nurses from the work unit to act as resource staff for the new employees. Buddies may change daily and have little or no formal education experience.

Moreover, some clinical participants believed the 'Team Nursing' model professionally compromised their judgement, because it conflicted with the accepted facilitation method of the work unit. This difference of perceptions caused tension between the clinical participants and line managers.

She [the Nurse Manager] had a discussion with me that 'you **have**<sup>12</sup> to work as a buddy; you **have** to educate these new grads.' I said, 'look... I'll give them their patients, I'll take mine and when I finish my work I'll go and **help** them because I want them to be responsible for their four and I'll be responsible for my four.' 'No no no... it doesn't work like that.' and I said 'I'm sorry it **works** like that and it **works** like that for me and that's how I'll work.' (*Carol: FG1 p. 36*)

The line managers offered a variety of responses to this workload phenomenon. The majority of the clinical participants considered the workloads unmanageable and their frustration was exacerbated by their lack of power to address this issue. Ironically, this clinical group accepted the workload situation without further negotiation: "everyone rolls over like a good dog and takes it instead of discussing it". (*Andrea: FG3 p. 6*)

The senior leadership group viewed their work differently to the clinical participants and did not contemplate resignation or reduced work hours in response to heavy workloads. Senior leaders recognised the need to work extended hours as an expectation of their senior role, albeit with increased flexibility: "we can choose to work twelve hours one day and eight hours the next day or even have half a day off." (*Emma: FG3 p. 5*). While acknowledging their ability to be flexible with their work allocation, these participants reinforced the personal need to 'do more' as a result of their senior position.

There was **no expectation** that I had to stay behind... There was no boss telling me that you must work till seven each night... It was purely me, so then I had to look at my own rationale and reasons behind why I had to be the super CNC. (*Leonie: IDI p. 2*)

However, while all participants experienced increasing workloads, the individual commitment and attitude to work presented further challenges.

---

<sup>12</sup> Bolding in text indicates the emotional emphasis the participants were demonstrating during interview.

### Increasing workloads necessitates managing additional work hours

Clinical and leadership participants expressed the need to work additional hours to complete their responsibilities. The current practice is not to routinely offer additional salary for the extended work hours, but for EOCNs to be compensated by using the additional hours as 'time off in lieu' (TOIL)<sup>13</sup>. While TOIL appeared an appropriate strategy, in practice, its use generated a number of problems. Participants commented on the difficulty in accessing TOIL, as they were required to negotiate leave in an environment where there were minimal experienced staff to replace them while they took leave.

Participants agreed that consistently heavy workloads were likely to continue. Even with this expectation, each participant demonstrated a strong personal need to complete their work before leaving the shift.

There's simply no point in the work mounting up as you just get nowhere... but I don't like taking work home, with the exception of the roster. I do take the roster home. I quite resent having to do it at home but **that's** because I do so much at work. (*Jenny: IDI p. 7*)

Many clinical participants chose to reduce their work hours as a strategy to avoid continual heavy and extended shifts. Ironically, this strategy of reducing employment hours made little difference to the participants' workload. Participants were still required to complete their work, which often meant that it was necessary to 'unofficially' work at least ten hours a day, rather than the rostered eight-hour shift: "I now fit ten days worth into nine days". (*Janine: FG3 p. 2*)

Changing family commitments posed a further challenge for the EOCNs. All participants spoke of additional commitments external to work, which often generated a conflict between the demands placed on them. Clinical participants perceived that there was an obligation imposed by the leadership team to work additional hours as they were more likely to have older and less dependent children. However, little consideration was given to the participants' additional home responsibilities such as care of elderly parents or adolescent children. This finding is further amplified in Sections 6.2.3 and 6.4.1.

---

<sup>13</sup> Time Off In Lieu (TOIL): time taken back for additional hours worked which replaces overtime payment

## 6.2.2 Risk Factors

The second finding generated from question 1 concerns physical risk factors which include physical and mental hardships of shift work, harassment, violence and burnout.

### *Impact of Shift Work: Particularly Night Duty*

Shift work, with particular reference to night duty, presented a challenge for the clinical participants. The majority of clinical participants working shift work reported that night duty had a detrimental effect on their physical and mental wellbeing. The ability to sustain a 'normal' sleep pattern was problematic when coupled with predisposing health concerns that a number of EOCNs identified as experiencing. Grace explained her strategy to avoid such shifts.

It's a very, very busy area. If you work four days, you have to do four nights a month; and if you work full-time, you do five nights a month. I certainly was doing that and I just wasn't coping very well, so I did everything I could to get out of it. Well, I went to a lot of trouble actually. I had a bout of cancer, and then I went through the Sleep Clinic and got a letter from the hospital. (*Grace: FG1 p. 4*)

Further, sleep deprivation due to working night duty shifts raised safety concerns for the EOCNs. Excessive tiredness inhibited their ability to concentrate and to perform their responsibilities with the necessary care: "you know your practice isn't safe because your concentration is down, and that's when you've got fear on top of lack of sleep." (*Docie: FG1 p. 8*)

The risk to personal safety was likewise identified:

When you think of all the things that we're managing in After Hours [Management]... I used to walk all night and if I sat down I'd go to sleep... so I never sat down. I was like a crazy idiot running around all night, but you couldn't be seen going to sleep and I wouldn't risk it. So, I was exhausted and I was **always** exhausted on night duty. The final step came when I almost ran into a lamp post on the way home in the morning. Fortunately home was about a minute away and I couldn't stop shaking for the rest of the day because I couldn't stop thinking what if there was someone standing there. I was terrified... absolutely terrified. I thought to myself, I'm actually a liability after a night duty. I can't get enough rest to ever feel that I could drive safely home in the morning. (*Jenny: FG3 p. 60–61*)

Some roster practices did fail to provide a sufficient recovery period for staff working shift work.

I came from Tasmania to Queensland and in Tasmania you're not allowed to work nights unless you've had a 6 week break from nights [duty]. So it knocked my body around something terrible working in emergency doing nights. You'd have two days off; one was sleeping and one was for actually having to catch up with the housework and next thing you were back on the morning. (*Helen: FG1 p. 1 and 4*)

Excessive night duty shifts also contributed negatively to the EOCNs' physical wellbeing. This health risk was heightened when participants were exposed to a pre-existing physical condition. However, the leadership team gave little consideration to accommodating EOCNs' requests for a reduction of night duty shifts.

My feet are really bad again, so it's physically so much easier not to do night duty. My feet are just wearing out, so I really struggle after three or four shifts in a row; I'm really in pain the whole shift basically, but I have got used to that... that's just pain. I'm just **so angry** at the moment, because I made it **perfectly** clear I thought, maybe I don't communicate very well, but the **reason** I was reducing my shifts was to reduce my night duty... right? The next roster, the one coming out, I've got six shifts; **four** of them are night duty! (*Janine: IDI p. 4–5*)

Likewise, the reduction of employment hours did not always result in the reduction of allocated night duty shifts.

I am I back on night duty again. I've actually done more [night duty shifts] this year than the full-timers. I cut my shifts back so I do less nights [duty shifts]. I knew in my old ward I had to do at least one, so I changed wards and they do minimum of two regardless of how many shifts you do... so I lost out but I'm thinking now how to work it so I can go casual so I don't do night duty. I go through deep depression... I can't sleep all day and I never get my sleeping pattern back. I find it really hard, but I don't mind doing my share. (*Docie: FG1 p. 18–23*)

In addition to personal risk of working shift work, EOCNs also reported harm from exposure to harassment and burnout.

### *Impact of Harassment, Violence and Burnout*

A disturbing theme identified was the amount of harassment and occasional violence experienced. Participants from all classifications identified experiences of harassment. Participants indicated that there are at least three types of interactions that have the potential to generate harassment, whether the perpetrator was a patient, visitor or colleague. While the hospital endorsed a 'no tolerance to harassment policy', some experiences of harassment appeared to originate from

those in leadership positions. Resignation was considered an option to avoid this unacceptable behaviour.

Abuse from a confused or fearful patient is a common occurrence, however staff acknowledged they received abuse from patients and visitors which they considered unacceptable. With high attrition rates in these clinical areas, the line managers are challenged to support their staff with the appropriate resources.

There a many days that I go home and I think 'if I won the lotto tomorrow I'd be out of here'. I'm talking about people who are supposed to be normal, rational people who swear at you in the most appalling way or threaten you. You know one of the staff was told that they were going to follow her to her car and rape her. It's soul destroying for the staff, and it's not only the patients now a days, it's the visitors who are behaving badly. So to me that has an effect on the morale of all the staff. (*Andrea: FG2 p. 11*)

Participants acknowledged the personal care and thoughtfulness they experienced from their colleagues. This caring culture was identified as the pivotal experience that enticed EOCNs to choose to remain in the organisation. Not surprisingly where such an atmosphere is absent, EOCNs often chose resignation.

I would say that I had a similar period probably with a similar timeframe to Deborah where I was seriously considering and actively looking for other positions as well, and that had a major impact on me and if it wasn't for the collegial support of my colleagues who I worked very closely with at that time, I would have moved on. So I **really think** that the influences are much more about people and the value and the relationships with the people. (*Julie: FG3 p. 3*)

Often the power struggles between nurses and medical officers degenerate into abusive conflict which participants found difficult to manage.

Bullying is massive... this antagonistic environment that I alluded to between nurses and doctors... I'm in the emergency department... as you walk in: 'what are you doing about this'... finger pointing, hands on hips... It's a lot of bullying that goes on there directed to the outside service lines so that's difficult to take; it makes it hard to come to work day after day... makes it hard to confront and I know it's an impossible situation. I know it's very political and I think that 'Who is going to take these people up on their bullying?' I think we are too accepting of behaviour as well. (*Mary: FG3 p. 30*)

As participants transitioned towards retirement, many discussed their inability to work at a pace they had earlier in their career. Some participants considered reducing their work hours or resignation as an alternative option. Janine elaborated on her situation:

Well, you see I thought that I could just continue working full-time and doing everything that was required in that position until I retired, but then the crunch sort



of came and I thought, 'I **can't** keep doing this, I just **can't** keep doing this, I physically can't keep doing it or mentally'. I just felt overwhelmed by it all, and I felt like I was burnt out, and I think probably periods of night duty, that would be the worst time, and I think I just can't keep doing this for another two or three years, I can't. (*Janine: IDI p. 1*)

Ironically, other participants increased the number of hours they worked with predictable deleterious results.

Suddenly the patients were irritating me... My fuse was getting short as I was going around the wards... as I was witnessing inept nursing care a lot whereas prior to that I would sort of make accommodation for the staff and say 'oh well they're new or they're young'. I'm usually easy going... take people at face value, accept the fact that everyone is trying to do their bit, but suddenly they're just irritating me. Especially when you think, well they're looking after our dying patients and when suddenly when they weren't doing it right or with compassion, I was starting to get very irritated with that.

I have set up all of the processes so that someone could just walk in and take over and I realised that I wasn't so indispensable. I had already read books about burnout over the years for other members of the team, you know, deny of course that I showed any signs whatsoever until I re-read it about six months ago and did the questionnaire and thought... 'a bit of an eye-opening moment there.' (*Leonie: IDI p. 1–3*)

I'm so tired, so burnt out. I'm taking twelve months without pay. I'm overworked... There's so much to do and I'm drowning... but I'm tired. I've been building it [the service] up. It's been seven years... I couldn't have left it even a year ago because I felt that I had things to do. (*Leonie: FG3 p. 63*)

Not surprisingly, the negative effects of working extended hours also compromised the balance of work and life for the EOCNs.

### **6.2.3 Competing Work and Life Commitments**

The third finding generated from question 1 concerns competing work and life commitments. Claiming and sustaining an acceptable work–life balance was reported as a challenge for many of the participants. Participants also recognised their sense of obligation to work commitments was often detrimental to their personal life.

As the majority of nurses were female, participants described the social placement of women in the lead role for child care and home management. The EOCNs with reducing young family dependence were left vulnerable to requests for additional work. This situation had the potential to compromise their work–life balance and was often seen as 'normal' and unquestioned.

When the big hand goes to twelve and says five pm, they're out of there because they have kids to pick up or that is what their rostering says. I am there by myself with a very sick person, often working back until seven pm. You stay because there is no one else to stay and I am the only full-timer. The problem being that I am the only one there whose children are no longer dependent on them... I am the only one who gets to work back. (*Sam: FG1 p. 3*)

In contrast, other participants choose to compromise their work–life balance by extending their work hours to complete work to their satisfaction.

I'm tired today 'cause again I came in at 6 this morning to get everything ready so that on the day people can say 'gee that went smoothly, that was fabulous'... and I think yes it was because of all the behind the scenes things, but that's what you do, and to me that's presenting a professional front to these Japanese specialists who think our unit is fabulous and it is, and I'm very proud of that. As a team, there's a couple who arrive on time and a couple who leave on time. That's ok... I can't do anything about that. Now I'm not going to compromise that by not staying to do extra work. I don't have kids to look after anymore; they are grown up. Having said that when they were little and very dependent, I still did whatever was needed at work, so I think it's a personal thing. (*Sam: IDI p. 8–9*)

EOCNs recognised the need to balance their work and life in order to maintain physical and mental wellbeing, however, few managed this balance effectively.

It's a really important issue [work] life balance because without it you just get burnt out and very jaded and I don't think you deliver very good care because you don't want to be there in the end. So what I've tried to work out is how many days do I need to be at work for myself and for financial [reasons] and get some continuity of care and how many days do I need for survival at home. Physical tiredness is a huge decision maker for me 'cause I've got some underlying chronic illness and if I get over-tired I end up being unwell for weeks, and then I'm no use to myself at home and I'm not much [use] at work, so physical time is a really big indicator and trigger. I was **so** tired when it came to my days off, that I did nothing... I did hardly any housework, I could **certainly** hardly do any study. The only time I could do any study was when I was on the late [shift] in the morning... I would try and do two hours [study] in the morning, on an early I would do none of it. (*Sue: IDI p. 1–4*)

For some participants, the recognition of imbalance in work and life commitments was more obvious to family members. Changing home situations where partners had retired challenged the participants to reconsider their priorities as Robin did.

I'm tired when I get home. I mean you can be physically tired, but it can be really mentally draining, and if you've been at a computer and talking to people all day, the last thing that you want to do is get on the computer and work when you get home. You want to do your own work at home and I'm sure I'm not alone in that. My husband at home doesn't help, and he has always been a shift worker as well, so we haven't had a lot of time together, so since he's retired the time we do have, he wants more quality time, and I'm tired, so that's where the balance is not good for me. (*Robin: IDI p. 5*)

The 'old' hospital culture of care generated an expectation that was a moral responsibility to work longer than the contractual hours.

As nurses we have always been trained to have all your work done by the end of your shift, and you can't leave until everything is done and [you] feel guilty if it's not and you're a bad nurse; and that was right throughout our careers and you can't get out of it. (*Leonie: FG2 p. 22*)

Those in leadership positions who demonstrate developed maturity in their skills and challenge this culture are particularly appreciated by the clinical participants and their thoughtfulness offers many a reason to remain.

I suppose my work-life balance has been made easier because of my CNC. She was the one that came up with innovative rostering that gives our unit good coverage. It gave me some time as a clinical nurse to do some hands on clinical stuff but a little bit of time in the office to do all the processes that I have to do. **She** was the one who suggested that if you can't cut down from full-time, which I can't financially, how about three x ten hour shifts and one x eight hour shift and then I get three days off a week... not promising that it will always be long weekend, it would have to be who needs what and unit considered as well, but **I** felt very much that **my** needs were really being considered. Now I didn't **ask** her for that, I didn't approach her about that, she just said we are all getting older, what do you think about doing this, and I said I would **love** it. So the ten-hour shifts make me tired but, um **I'm loving** it, absolutely loving it and I think it's given me more energy now that I can do my job to a greater extent, and I **certainly** feel invigorated to do it. (*Sam: IDI p. 1*)

The workplace environment presented numerous challenges for the EOCNs as they contemplated and planned their future workforce participation. Likewise, leadership issues presented challenges which were also pivotal to the EOCNs' decision making.

### 6.3 Research Question 2

The second research question is: How does leadership influence EOCNs' decisions regarding workforce participation?

The three findings concerning research question 2 are:

1. Credibility of leader
  - Visibility of leader
  - Credible management and clinical skills
2. Interaction, team and social cohesion promoted by leadership
3. Support, flexibility and trusting relationships demonstrated by leadership

Each of these findings are now presented in more detail.

### 6.3.1 Credibility of Leader

#### *Leader visibility*

The clinical participants voiced their expectation of line managers' visibility in the work unit. Lack of visibility caused stress as participants perceived their line managers were unable to appreciate their work difficulties. This point was lamented by Wendy:

Well, my manager wouldn't have a clue 'cause my manager has never been into my area to see what goes on for a day... never, not once to see what an environment, a stressful environment it is. So, therefore, when I go to her with a problem, she can't relate to it, because she doesn't know... She simply **does not realise**. She's out there working but **never once** in the whole time I've been under her umbrella has she been into the work unit to see what it's like; never. So really, I have no CN or NM and I am an **RN**. I'm not even paid as a **CN**, and yet it's me... there's nobody else; so I feel very resentful. (*Wendy: FG1 p. 40*)

#### *Credible Management and Clinical Skills*

Further, clinical participants felt that lack of leadership visibility also aligned to their leaders' credibility and maturity in management and clinical skills. The absence of leadership credibility generated a negative response which often resulted in increased sick leave or resignation.

They have no clinical experience. I've just left my last area three weeks ago in disgust. If she [line manager] decided to coordinate the day, you would be guaranteed that there would be no allocation for the afternoon. She was lucky to do them when she was running out the door at 4 o'clock. There was no sheets printed out, the board is still a mess and it wasn't just on busy days; it was quiet days too, because she was in her little office. She put herself down as clinical coordinator... doesn't come out of the office... That's **really bad**. She got the job permanently the other day and I'm so angry. When I discussed with someone higher, she said we're **so pleased** with her because she's a **fantastic** manager. I felt like saying, she's **never held** a patient's hand; she's **never talked** to me. I can't believe the hierarchy employed her. To me she's a waste of space, but she's obviously talked to the right people in the right areas. I don't give any credit to the powers that be here, because they don't care what the real people [think]. I've had more sickies in the last 6 months than I've ever had in the last thirty years, because I've had enough. (*Carol: FG1 p. 11*)

Similarly, Sam reported a lack of respect in the absence of leadership credibility:

You can respect [a manager] not just for the management skills, but to me in a clinical area, my boss has to be clinically competent... and if they're not, I don't have a whole lot of respect for them. If your role is a manager, please go and sit in your office and manage, but don't pretend that you're a clinician; and they seem to have got rid of that whole clinician's role. The level 3 role doesn't exist

anymore and if you're a level 4 [NO7], you are the manager... who's the next clinician?: the level 2 [NO5] and there is nothing in the middle. (*Sam: FG1 p. 39*)

The leader's skills and ability also had the potential to influence workplace communication.

### **6.3.2 Interactions, Team and Social Cohesion Promoted by Leadership**

#### *Interaction and Team Cohesion*

The second finding generated from question 2 concerns the leadership role in nurturing work unit interactions and team cohesion. All participants spoke positively of a work environment enhanced by friendly interactions supported through collegial networks which was promoted by their leader. When the work unit lacked this cohesion, participants indicated that they would do one of two things:

1. Transfer to another work unit or
2. Resign from the organisation.

Docie elaborated:

Work environment is a big thing... if somebody says 'hello, did you have a nice weekend?' It sort of sets the mood the entire day, and I think if your work environment is really good, you're happy to come to work and I know personally, I've been in the area for thirteen years... if I didn't like it, I tell you, I'd be out. I've left after three weeks if they're really nasty and things like this and I think, I don't need this and go somewhere else. (*Docie: FG1 p. 15*)

An antagonistic environment was reported as symptomatic of high acuity<sup>14</sup> and demanding work areas. Many of the participants from all nursing classifications claimed exposure and often acceptance of aggressive interactions.

I think this antagonistic environment that I alluded to in the emergency department... One day when we were in crisis a couple of months ago, I was dealing with the nurse and we were talking about what the strategies we were using and she was quite happy with the conversation I just had. As I was about to leave, two of the doctors came in and said 'what are you doing about it?' This nurse immediately... the body language changed, stood up and lined herself up with the two doctors... finger pointing, hands on hips. So, I went and got really angry... came back to sort the doctors out and said I really didn't appreciate being spoken to the way you just spoke to me and had the finger out. It's a lot of bullying that goes on there... and that's difficult to take. It makes it hard to come to work day after day... makes it hard to confront. I think we are too accepting of behaviour. (*Mary: FG3 p. 30–32*)

---

<sup>14</sup> Acuity: relates to the turnover time of patients into and out of the work unit setting.

Building and sustaining synergy within the work teams was an aspired goal for EOCNs. However, many participants reported generational differences<sup>15</sup> and authority power often compromised this aspiration.

There's one [medical officer] who is an absent-minded professor, but he's brilliant. Now he can have days where he's a nightmare, and he'll have days where he'll come back and he'll say 'I'm sorry'... and you think that's ok. So I'm used to him now, so I don't mind that. I've got another couple who would walk straight through you if you didn't get out of the way. One's [a] much younger man and he doesn't tolerate the older nurses at all. He likes the young pretty ones... He's not sleezy at all... but he's rude... I just think 'whatever mate'. Some days that just gets on my nerves and I just think, I've had enough, particularly when it's me doing the slog and you're standing there chatting to that one that's younger... and they're having a fabulous time and he turns around and says, 'you better get the next one [patient]'... and I say, 'it's all cleaned up', and I say 'have you done your share of the cleaning up and setting up for the next procedure?' No I've done it... So yes of course we are ready. So that **gets on my nerves** big time.

It's only trivial... who cares... it's I've seen that a lot. Mind you, when things start going down the gurgler, who do they call for?... a couple of us older ones, and I feel a little glow of satisfaction, and I think now it honestly doesn't take much to make me happy at work. But the days when it doesn't happen, I could just walk off and leave them. And that's petty in the overall scheme of things, you have to get your satisfaction from somewhere else and I do, most of the time I'm just tired, I just want to stay home, and I can't, so I come to work and while I'm at work I'll give it everything I can. (*Sam: IDI p. 23–24*)

### *Social Cohesion*

In addition to team cohesion, the ability to develop social cohesion through networks was seen as a valued support mechanism by all participants. These networks were an important and necessary strategy for feeling emotionally safe, particularly when leadership maturity and support was ineffective.

The relationships I now have with people... because they sustain me in the workplace. I always think that if you have sufficiently good working relationships with people, they will get you through the difficult times. Having said that, every so often in your life you can get an absolute rotter that can make your life difficult and you think, 'oh gee is it worth it?' (*Emma: FG3 p. 3*)

However, the development of these networks presented difficulties for the participants. Clinical EOCNs acknowledged that working unsociable shifts or working away from the mainstream workforce generated feelings of social isolation which were difficult to manage.

---

<sup>15</sup> Generational issues are further presented in Section 6.4.4

There was no social network for After Hours nurse managers, which is what I did for so many years, but then... I was ostracised as a part-timer. A bad thing if you went part-time and did it only weekends. (*Jenny: FG3 p. 31*)

Similarly, Leonie reported:

I don't really belong anywhere. I'm under palliative medicine, but we don't really belong so we don't have a home ward or a home. I feel the roving CNCs have dipped out a bit there and we don't have an educator that is assigned to us. It is like hit and miss. (*Leonie: FG3 p. 27*)

The importance of nurturing a safe environment for participants to gather and socially connect emerged as another valuable support strategy. They reported that the opportunity to meet with fellow colleagues has been lost, particularly since the previous opportunities such as the hospital accommodation was no longer available. "That's what I miss; the old dining room where every age level from every part of the hospital [meet] and you'd share your lunch". (*Sam: FG1 p. 61*)

Further, this safe environment provided an opportunity for participants to share work experiences and exercise problem-solving with colleagues.

What would really be good is a forum like this and it needs to be across service lines. I just attended that Executive Director of Nursing Service (EDNS) leadership course and it was such an eye opener talking to two NUMs who work at the other end of the ninth floor from me. Just hearing about the way they do things and networking and finding out that we all pretty much are having the same problems. I think it needs to be something where you can share problems and solutions, and not something where you [are] actually spoken to and actually have a set agenda. Once a month or once every two months, even if you didn't achieve huge amounts, it's a good support group to have. (*Andrea: FG3 p. 30*)

When social interactions were nurtured within the work units, leaders were also reported as being flexible and thus promoted trusting relationships.

### **6.3.3 Support, Flexibility and Trust Demonstrated by Leadership**

#### *Supportive Leadership Building Trusting Relationships*

The third finding generated from question 2 concerns support, flexibility and building trust which were nurtured by the leadership group. Participants acknowledged that when leaders understood and considered their individual needs, trusting relationships were more likely.

Overwhelmingly, participants discussed their willingness to remain or extend their employment as a result of their leader's ability to nurture a caring environment through supportive interactions.

Our nursing leadership is excellent. She is probably one of the best bosses I have worked for. She has people lining up wanting to work there. When people leave they always want to come back. She is very progressive... if you want to do education, she is all for it. If you want some time off, she is very [obliging]... She probably will retire at the end of next year and really I think a lot of people will probably leave then because she's such a good boss. If you have a good environment to work in and you have the crappiest day... she is a **good** boss. Even if you ring up and say look my car has a flat tyre, some people don't understand that but she does. If you say you want to go off to this meeting... yes you know. When my mother was **dying**, and took time off to nurse her in the nursing home, she was **excellent**. It was a bit like... you come back after she passes away, you know. But if you sort of take a sickie... she's **no fool**. (*Docie: FG1 p. 36*)

A disturbing issue raised during interviews was the lack of support from the leadership team. Participants from all classifications reported the deleterious impact of the lack of leadership consistency, maturity of skills and support. Not surprisingly, this unsupportive environment caused EOCNs to consider resignation.

You've got people who are overriding your decisions. There is a well-known person [patient] who comes in who behaves absolutely appallingly. Won't meet his appointments in the dialysis unit; arrives when he wants to and then demands [treatment out of scheduled times] – 'I want this now!' Went through the whole psych process thing... and had a full team management plan for him. All this hours of meetings and management care put in place and the first time he arrives on the wrong day out of time which is very often charted on the diary sheet, they say sorry... you ring through to the Medical Superintendent's office [to confirm the prearranged time]. *Reply*: 'You will be dialysing him now!' How can you make that decision at that level? How can you be so unsupportive of the teams downstairs? There would be hours and hours of professional time put into managing the behaviour problems and you arrive on the one day and everybody gets to do extra work. I tell you that's the day if I won the lotto, like I said I'd be out of here... It's ridiculous. (*Andrea: FG2 p. 37*)

However, novice EOCN leaders acknowledged that they were often left to manage unfamiliar roles without the appropriate support and guidance. In the absence of this guidance, they often turned to their colleagues for support.

After all these years, you can't help but be a good clinician on the ward, but then all of a sudden somebody gives you the key to the office and says, 'there you go, you're the NUM' and at the stage when there was a whole lot of us appointed to various wards, all the NUMs were new, there was a lack of mentors, there was a lack of nurse managers. Our nurse managers were all changing, our divisional director was changing. Essentially it's been stumbling along. I only found out this accreditation, one or two things that I was supposed to be doing for the last few



years, but you only find things out when people come and ask you where they are... fortunately for me it was all the other NUMs too. (*Andrea: FG2 p. 28*)

Similarly, Leonie reported:

We're a small team: three doctors and three nurses. If I need support for the management things as a level 4, sure there is my nursing director [who is] often away or busy doing the bigger things or helping poor me do the PADs [Performance Appraisal and Development] on the CNs so you have to work a lot of it out yourself... There isn't really the mentors there that guide you, sure you can ask them but no one actually says look this is that new form, this is how we are all going to fill it out; it arrives on the email all of these attachments and you think, 'oh my god what do I have to do with this', there's no one there to guide you. So I feel the roving CNCs have dipped out a bit there and we didn't have an educator that was sort of assigned to us; it was like hit and miss sort of. (*Leonie: FG2 p. 25*)

Participants reported that leaders demonstrated varying levels of ability to provide flexible and efficient rosters. Often clinical participants found rostering practices were inflexible due to the difficulties of employing sufficient skilled staff to meet staffing needs. As a result, attempts by EOCNs to avoid night duty shifts were often unsuccessful and caused them to consider resignation as an alternative option.

I don't think there is anything you can do about it. The thing is, it's not even that they need me to be in charge or to work as a NO5... There will be 3 NO5s on nights [duty], I'll guarantee you, because we're just filling in the spaces, we're just working as numbers. They're [leadership] still getting at me. I've thought about how much can you put up with you know, and I don't know. I thought I could keep doing this 'till I'm 60, then the point came when I **can't** and I don't want to either is the other thing, because I just didn't enjoy it, I just don't want to keep doing it. And I think since I've been doing it [working] part-time, that feeling **has been worse**. The less you're there, the more you don't want to go back, and I just enjoy my life so much when I'm at home, doing the things I love doing, then go to work happy and then half an hour and I feel like I want to get out of here, I'm going to punch someone's lights out and I just want to leave. (*Janine: IDI p. 6–8*)

Moreover, while these poorly executed rosters were often perceived by clinical participants as unfair, many accepted the status quo. Over time, many EOCNs decided to reduce their work hours to avoid these arduous shifts.

I found that the rostering was anything but flexible. I've done years of rostering when I was a nurse manager and I would never put somebody on a **late** to finish and **an early** to start because you feel totally ripped off but they're doing it all the time. I found that was very hard to do at this stage in my life. I'm not going to argue... I thought well OK... not overly happy that I would finish most of my working week on a late, which meant I got home to bed at 11.30 pm and I was back at work, two days off at 6.45 am after my days off, which I always felt a bit cheated by. In the end I just sort of stopped asking and accepted it... The only

way I could get a little bit more time off was to say, 'Look I can't do this, I'll go .8.' (Sue: IDI p. 4–7)

While rostering allocations presented challenges for the line managers, participants expressed difficulty in accessing 'time off in lieu' (TOIL) for working extended hours. This inflexibility from the leadership group was often interpreted by the participants as devaluing their work contributions.

You want to have a couple of hours here and there well yes it's ok, but there's always forty questions that go with it, and I would expect that at **my level**, I've answered all of the questions myself before I've actually decided to take the time off. If I've got a really good boss and I want to have a whole day off for whatever reason, I think that should be a consideration without having to get onto the begging mat. It seems there is not enough give and take; and it's not like it's something I ask for every month or even every six months. It might be once a year but I certainly think that it should be a two way street, but it comes down to individual line managers. It has been intimated to staff that people who take a lot of TOIL... that it's failure on your part (to balance workloads). I think that can **really annoy** line managers, and annoy NUMs like myself. I mean you know what your responsibilities are... you know the time and effort that you put in and that just shows ignorance to me, ignorance and stupidity. (Andrea: IDI p. 4)

In contrast, some participants acknowledged the thoughtfulness, flexibility and maturity of skills they experienced from their leaders. This caring culture was identified as the fundamental reason they remained in the organisation.

My CNC is fabulous and she is the only reason I stay. I don't think that nursing is any better or worse [than] any other establishment. It's probably the same and certainly the only reason I stay is my CNC and she has imaginative rostering; she considers that there must be a balance between work and family life. The problem being I'm the only one there whose children are no longer dependent on them, I am the only one who gets to work back. I'm the only one who does long shifts. I don't do short shifts but in my day when the kids were little, we didn't have those options and I'm pleased that we have that option now for people with dependent kids to work six hour shifts; I'm happy for them. (Sam: FG1 p. 2)

Leadership skills and knowledge were a major influence for the EOCNs as they considered their continued participation in the profession. In addition, when leaders considered EOCNs' personal and professional needs, EOCNs reported they felt valued and were more likely to remain.

## 6.4 Research Question 3

The third research question is: How does personal and professional recognition influence EOCNs' decisions regarding workplace participation?

The four findings concerning research question 3 are:

- Feeling valued for personal and professional contribution
  - Respect for personal and professional experience
  - Valuing commitment
  - Age bias
- Recognition through remuneration
  - Fair and comparative pay
  - Financial security
- Opportunity for professional development and advancement
  - Accessing professional development
  - Implied value of professional development
  - Professional advancement
- Dissonance between the generations
  - Sense of loyalty
  - Inequity and different expectations
  - Generational interaction compromising learning

Each of these findings are now amplified.

### 6.4.1 Feeling Valued for Personal and Professional Contribution

#### *Respecting Professional and Personal Experience*

A key finding of question 3 concerns the extent of recognition and value for the EOCNs' professional experience. Advanced clinical skills and organisational knowledge were gained over time and all participants expressed an expectation of professional acknowledgement if they demonstrated these diverse skills.

Clinical participants expressed their disquiet for minimal opportunities to ascend the career ladder in nursing. While promotional opportunities were readily available for those in management and leadership positions, clinical participants perceived a lack of recognition and structural opportunity to demonstrate their professional knowledge.

Devaluing clinical positions was further evidenced by the need for clinical participants to undertake numerous non-nursing roles.

... if you want them to be the clinical leader [NO5] on the day, **why** have they got a full patient load? **Why** are they answering the phone for the receptionist **and** looking after the new grad **and** this that? **That's crazy**. The whole nursing system at the moment is... I think it belittles nursing actually. You're only rewarding people who go into the management stream. Clinicians are not respected or looked after by not just this organisation but by nursing generally. (Sam: FG1 p. 39)

However, all participants acknowledged a desire to share their skills and knowledge with colleagues and as a result, expressed increased commitment and satisfaction.

I think that's most important... being valued, being treated as a resource and having a body of knowledge that somebody else needs to access... I think that it's important. It's job satisfaction at the end of the day. It's going home glowing. (Mary: FG3 p. 45)

Often a perceived power struggle between the participants and leaders was demonstrated by lack of recognition and support. Over time, this form of abuse resulted in EOCNs' resignation.

If she'd wanted me to do that project, I would have been **more** than happy to do it, **more than interested**, but she wouldn't give away the power. What bugged me was she didn't do it [either]. When I did do it, I didn't get any thanks for it, in fact I got derogatory comments. But then it was good enough to be presented at a peer review group. That wasn't a one off situation... that happened in **various forms** throughout the six or seven years that I worked there. It was that and **a lot** of little things like that... I'm just being used and abused here, but I was foolish because I didn't stand up for myself. I was **weak** and when I look back... '**Why** didn't you do this that and the other?' And I don't know why I didn't. I think that and the fact that the people above her knew and still know and nothing was done. I'm over this and my attitude is you either put up or shut up... I was very sad to leave but I did because I thought I can't change this. (Sam: IDI p. 28)

When participants were given the opportunity to work autonomously, they described an increased sense of organisational and professional commitment. Not surprisingly, the lack of 'permission' to perform autonomously often generated a sense of worthlessness and devaluation, and resulted in EOCNs choosing to leave such an environment.

I was an educator in Ballarat and the Director would not let us, even though we were NO7s, put a memo out without her signature. It had to be from her. So that **lack** of recognition, that **lack** of autonomy was something that three of us resigned within a day of each other. All of us went back to the wards, where I hadn't been for twenty-five years [laughter]. That was devaluing. (Mary: FG3 p. 2)

EOCNs acknowledged that when they were given respect for their diverse skills and knowledge, they gained a stronger commitment not only to the leader, but also to the organisation.

### *Valuing Commitment*

All participants acknowledged that they often worked excessive hours to either support less experienced staff or ensure work was completed to a satisfactory level. These excessive hours were a result of their value system or a perceived and subtle message from the leadership team. Of concern to the participants was the lack of recognition and acknowledgement for their demonstrated commitment to the patients and organisation.

Oh I don't consider I'm being **made** to do that [work extended hours], however, I think there is a poor acceptance in this organisation. I've noticed this over many years... it's like the senior level, above nurse managers in particular, don't acknowledge, refuses to acknowledge, chooses not to acknowledge, I'm not sure which it is, the work that is actually required by that level because they simply don't want to know about it. They don't want to provide extra people, because obviously that's more expensive and there's no way of justifying it, whatever their budget structures are, so it's better to just pretend it's not happening. You could count on one hand how many times I go on time, and interestingly, we all apologise when we leave early, and early means earlier than 5 pm. That means you have already done one and a half hours extra. I left the other day at 4.15, and I apologised to someone when I left, and I thought aren't we just so silly, because I seem to expect to stay for a 10-hour day. (*Jenny: IDI p. 4–9*)

Many participants discussed the perceived expectation for the 'older' nurse to work additional hours in order to complete the necessary work. These participants struggled with the need for extended hours in the absence of recognition for their personal needs. The assumption of the participants' availability was perceived as devaluing.

I just feel that us oldies [laugh] are just more prepared to [complete work before leaving the shift]... I just take it as part of my day. I'm supposed to finish at 5 pm, but if I still have a patient in the holding bay, I can't walk out and leave the patient. I still have to stay until such time that the patient is taken through to theatre and I know in the past I've been still sitting there at 5.30 or quarter to 6. Now I never write that down as TOIL or overtime... I just feel that if I can go home a little earlier one night, I'm happy to do that... That's my choice, but it's just expected that you will be there. (*Robin: FG1 p. 3*)

Moreover, many participants struggled with conflict from their spouse as a result of competing work and home commitments.

There was a lot of friction at home because of the long hours that I was putting in and I certainly didn't get the moral support from my husband who's not in the medical field and can't understand why if you work in the public service you not home by 4.30 every afternoon... so yeah that was our constant battle. Never taking work home but hiding it, getting up really early before he would so I could get it finished without copping the criticism from him, working late only when he was going out, so that I didn't get the criticism, so there was a lot of sneaking around really submissive... didn't feel right at all but I just had to get it done. I felt far more satisfied when the work was all done than if I left at 4.30 and it was all there for me the next morning. I couldn't relax with that. I think a lot of it's being a nurse... how we were so indoctrinated that you had all of your work done before you leave... that just seems so endemic... I hear from a lot of nurses too that you just wouldn't leave it half done. (*Leonie: IDI p. 6*)

However, some participants refused to accept the expectation from leadership to work excessive hours and so prioritised their 'essential' work accordingly.

My priorities at work are not necessarily the same as everybody else's... 30 emails from media communication, which I get re-sent four times from my line manager, my nursing director, my safety and quality [officer]... sometimes I'll see the same email four times... I just get sick of it. I haven't got the time to go through sixty to one hundred emails a day, it's just ridiculous, but my line manager will often take home four or five hours worth of readings on weekends, so the feeling I get is that that is the expectation [to do extra work off duty]. When I was complaining about workload a while back, I was just told well that's what you took on when you took on the role, so that's the attitude of that chain of command... not a nasty person... not a uncaring person, but I think they have **totally** not got the balance themselves, so I certainly don't look to them for direction, I set my own. I'm committed to quality outcomes for my patients and my staff and to make sure my ward runs well. All the extra bit of add ons... some you have to prioritise... you know, I'd rather have a confrontation with a line manager than a coroner. (*Andrea: IDI p. 7*)

All participants acknowledged their commitment to delivering effective outcomes, however, many reported concerns for the effects of ageing.

#### *Age concerns*

Participants acknowledged their aspiration to remain healthy in order to continue to work effectively. If physical or mental deterioration, particularly as a result of their ageing, compromised the ability to provide an effective service, resignation was considered.

As long as I'm healthy I'll probably work... So health would be one thing, but if circumstances changed significantly where I didn't feel valued, I would probably go then too. (*Deborah: FG3 p. 51*)

While health and wellbeing were considered essential, many of the participants reflected on ageist biases, which caused them to reflect on their ability for continued contribution.

They say discrimination. 'It's time you moved on... time you moved on, make room for the younger ones'. (*Jenny: IDI p. 32*)

I would hope I will always be effective doing it as well as I could. If I started to feel that I was slipping, making too many mistakes, I would be horrified. I can't walk around and people saying, 'Why are they still here?' I'd hope I'd have the sense to go. It will be when I have actually had enough. I'm just not ready yet. I've got this ongoing thing where I'm too old and I'm not worth it... not worth the investment. (*Jenny: IDI p. 25*)

#### **6.4.2 Recognition through Remuneration**

The second finding generated from question 3 concerns remuneration and recognition of professional skills through comparative pay and financial security. This was particularly important as the participants prepared for retirement.

##### *Fair and Comparative Pay*

Acknowledgement of clinical or leadership experience through remuneration was considered important by all participants. They considered remuneration duly acknowledged their professional experiences and knowledge. However, the current nursing structure and financial constraints posed a challenge for many leaders to recognise EOCNs and their diverse abilities through remuneration.

I think our [nursing] structure in Queensland is very difficult to deal with. You can have an excellent nurse and you can't do anything more than let her or him be an RN because you are limited in how many higher positions you have. I don't think there is enough recognition of our clinicians on the floor and I think that is one of our big deficits and yes... give them a title is one thing... but also give them a little bit more financial incentive as well. (*Jan: FG2 p. 47*)

Further, the lack of penalty rates for senior EOCNs working shift work raised fairness and equity concerns. While this is an industrial issue, EOCNs reported frustration and often chose to resign as a result.

I think there is an equity issue here with money. I am in a NO5 position, but there are no penalty rates [for this position]. It's not so much about the money for me; it's more about the recognition and the equity. I'm paid at a NO5, but I'm working on weekends and evenings so therefore I should be getting penalty rates, but then the other NO5s are all at home doing 9–5pm. It's not a huge factor for me, but now and again I do think about it I have to admit. It's not a massive factor if I had job satisfaction. I wouldn't be going for the position when it comes up... that would stop me going for it. (*Mary: FG3 p. 45*)

In addition to lack of equity between nursing levels, senior EOCNs raised concerns for inequity of remuneration between disciplines and reported a lack of their professional recognition.

I don't know how the healthcare system could afford it... It's a bit like women carers in our society... How do we pay for that? But I think that needs to change. I think that now, not just because we're more scarce, but I think our **value** in the healthcare system should be recognised and I think there should be some **allowance** for some degree of overtime. It just doesn't seem **right** that medical executive directors get numerous loadings because of their director positions and then get overtime. When a meeting is called from 4 to 6pm, they know the medical directors from 5 o'clock are being paid overtime and I just wonder is it not again the system that expects more from **nursing** that they wouldn't expect [from medical staff]. (*Emma: FG3 p. 8–9*)

Moreover, the comparative inequity between academic prepared occupations generated concern and dissatisfaction for all participants.

I thought that our remuneration wasn't too bad; however, I have a friend whose son had just left uni and walked straight into a \$90,000 a year Information Technology job at twenty-two years of age. One of my daughter's friends who had been to TAFE is on \$60,000 a year... and I'm thinking... **what!** When you think that the average unit you're running has thirty-five staff and you're working all these extra hours and you're accountable for all your costs and other things. So then I started to think... There is a whole new group of people that are **way** past us. I'd say I'm not satisfied with remuneration. (*Andrea: FG2 p. 46*)

### *Financial Security*

In addition to receiving fair and comparative pay, the need for financial security, particularly as retirement approached, was an important consideration for EOCNs. However, resignation or reduced work hours were not always possible for those participants who were not financially security.

If I won lotto tomorrow, you wouldn't see me for silver wings and red dust. I used to **love** nursing... but I don't anymore. (*Sam: FG1 p. 42*).

I'm at the stage now where I think I'm past my used by date, um you hear professional sports people say, when did you know it was time to retire, give up the game and they say I just knew. Well I've had that feeling for probably two years and I just **know** that I would like to stop working. I **love** parts of the job, I **absolutely passionately hate** other parts of it, I no longer get a glow coming to work... The reason I stay is money. (*Sam: IDI p. 21*)

Many EOCNs struggled with their decision to remain in the profession when they considered a balance between job dissatisfaction and their need for financial security.



I had a couple of weeks leave and I investigated all sorts of lists... if I did this what sort of impact would that have on my superannuation? If I did this, what would that get rid of... the night duty... the affect on my super [superannuation]. So then that's when I decided I would go part-time. (p. 2)

I've thought about how much can you put up with you know, and I don't know... It's the money. Sixty [years old] is probably the magic number too, because things change a whole lot in relation to your super when you turn 60; you don't pay tax. Sixty has always been our aim... I can keep doing this till I'm 60. Then the point came when I **can't** and I don't want to either is the other thing. I just didn't enjoy it, you know? I think since I've been doing it [working] part-time, that feeling **has been worse**. The less you're there, the more you don't want to go back, and I think, oh well, I'm going to go on holidays, then it will be Christmas, then it'll be new year and then it will only be two years [until I retire]. (*Janine: IDI p. 11*)

While remuneration was an important consideration, recognition of their skills through career advancement was also seen as important.

### 6.4.3 Opportunity for Professional Development and Advancement

The third finding of question three concerns continuing access to professional development, barriers to access and potential for career advancement.

#### *Accessing Professional Development*

As a professional group, all participants acknowledged the expectation to maintain contemporary knowledge and skills in their specialty area. However, many EOCN clinical leaders considered the professional development of younger nurses was a more valuable contribution to the profession.

I think at this time in my career I'm not going to do any more study. I'm happy to go to courses and things like that, but not do more study, but I do **really push** to get my staff off to things... because they're the future. But sometimes it's a bit tough on the floor because we're one down... well stiff biccies... so from my point of view now with professional development, I'm probably sort of more interested in trying to help my staff to get it then I am. (*Maggie: FG2 p. 54*)

More often, many participants considered the maintenance of health and wellbeing more relevant than time taken to access development opportunities.

We have the three days a year and the allowance [Professional Development Allowance (PDA)<sup>16</sup>] but really the interest isn't there anymore, because you're too

---

<sup>16</sup> Professional Development Allowance: refers to the yearly Award allowance paid to permanent Enrolled and Registered Nurses to support ongoing professional and continual development opportunities.

tired... you think, 'do I really want to give up one or two days to do it?' [access professional development] if you can get it. I have grandchildren now and I like to spend a bit of time you know, but I'm too tired. (*Docie: FG1 p. 15*)

In comparison, Sue viewed professional development in her new clinical specialty as an important component of her work life.

I think differently from you ladies. I came back [to nursing] after twenty years and I'm in the process of doing my PhD because I have an enormous hunger for nursing and for nursing knowledge and I really enjoy coming to work each day. (*Sue: FG1 p. 19*)

While EOCNs' access to professional development opportunities varied, the perceived value of such activities was individual.

#### *Implied Value of Professional Development*

The extent of commitment to professional development varied between participants. Janine lamented that "for me, in my everyday work, how is that [professional development] going to improve my performance and often I don't think it does" (*Janine: FG1 p. 15*). Other EOCNs rationalised their decision to access development by considering the financial costs and the accessibility of programs.

This [discussion] is perfect, because I have been thinking about whether I do the nurse practitioner [degree] next year or not... and I think, 'do I really want to spend \$26,000 or \$28,000 doing that?' I've never been overseas and I've worked my backside off all my life... so maybe I should be actually doing something for me you know. But I think that we've had it ground into us that education [is a professional requirement]... (*Robin: FG1 p. 15*).

Leonie explained:

The frustration I've had is with professional development. Our team is so small. So for one key member of that team to be away doing something, it would be like you can't go... I could never get anyone to relieve me, so what's the point. So I've just gotten over it. But it is frustrating. (*Leonie: FG2 p. 55*)

As EOCNs considered the value of professional development, their attitude towards career advancement seemed closely associated.

#### *Professional Advancement*

Those participants in senior leadership roles considered professional development opportunities a means to support their career advancement. While job promotion was not automatic due to years of experience, resignation was often considered when participants were dissatisfied with their aspired development opportunities.

I feel that I'm a big waste of money. I can't spend the rest of my career doing a roster and beds. I went for a position as a Director of Nursing in a two hundred bed hospital. When they started interviewing me... I was absolutely flabbergasted that I couldn't talk the talk... I've come out of there and thought, 'Is this what I've become?' And that was when I thought right I've gotta get out of here, I can't do this. (*Mary: IDI p. 10*)

In contrast, other participants did not consider professional advancement a priority at this end stage of their career. One reason for this lack of interest was a result of having achieved senior nursing appointments throughout their career.

I have been a DON of a country hospital in Western Australia... I did that when I was thirty-six years old. I did that for three years so I feel like I have been there and done that, you know. And I think probably in my case because I've brought up three kids by myself, I have had that position and I have done midwifery and child health. I just think that this time is for **me**. I don't mind being educated and that but I don't want to be tied down. I don't want to be a NO5. (*Docie: FG1 p. 50*)

Likewise, other participants' reduced desire to consider role advancement was caused by the imbalance between working in senior roles and the recognition through remuneration. Consequently, many experienced clinicians did not apply for advanced nursing roles.

I was considering doing the nurse practitioner course for palliative care. I was actually asked by the hospital to do it. The more I looked into it I thought no way... I wasn't going to get any money for my work, I was just working in my own time and I wasn't paid for it, and I would get maybe fifty cents per hour more at the end of it. No way. (*Leonie: FG2 p. 51*)

While the stance concerning professional development varied between EOCNs, so too did the attitudes between the various generations.

#### **6.4.4 Dissonance between the Generations**

The fourth finding of question 3 concerns variations between generations which include commitment levels, inequity and expectations.

##### *Sense of Loyalty and Commitment*

Many participants expressed concern for a perceived lack of commitment and loyalty of the younger generations. This variance was a frustration, particularly for clinical participants as it had the potential to affect workload distribution. Sam lamented her experience with Generation X and Y professionals.

I'm a late baby boomer, I suppose born in fifty-three... means I was born at the tail end of the baby boomers. When we were employed, we were hopeful for a

job, we **thanked** our employer... we are going to work **so hard** for you, you are going to make me so worthy to be working here. Now the Y generation rocks up and says you're going to give me the job... I want it because you need me... I'm going to stay for a couple of years and then I'm moving up, so be very grateful that I'm working for you. I know that for **my** standard, I'm not letting **anybody** pick faults with the work that I do. I was trained under that **regimented** system, it was a cross between the army and a convent, where if you were a good nurse, you got all your work done by the time you knocked off... but if you're in a procedural area, your knock off time is when your patients are gone. (*Sam: IDI p. 35*).

I can't say to a young man who's got a pneumothorax, 'I'm knocking off now mate, sorry keep on breathing if you can. Tomorrow morning something else might happen,' **How can you do that**, legally, morally, ethically... you can't. And yet other people can quite happily... down tools and go and I don't know why; **I know why I stay**; I don't know why they go. (*Sam: IDI p. 6*)

The lack of commitment by Generation X and Y professionals was perceived by EOCNs to potentially compromise patient care. Not surprisingly, this continued frustration led to EOCNs considering leaving this environment.

I don't know if it is because I am getting older, but I'm getting more impatient with attitudes that I'm seeing with the younger nurses, and I'm really trying to be objective and I've been reading up about Generation Y etc. and baby boomers and how you clash and how values are somewhat different etc. and then I tried to look at strategies for perhaps accepting the new way and accepting part responsibility. I am sort of getting a lot more irritated with them. I see it on the ward and I see it as a fall in the professional standards... It's time for me to step back for a while and step out of that. They have full commitment to themselves, but not to the establishment, not to their employer and I don't really feel it's to the patient either. They do the absolute basic that is required of them. Again sweeping generalisations but I'm seeing it more and more. You know they finish their shift at 3.15 and that's it, don't ask them to do anything at 3.16 'cause it's over. It's just very task orientated... 'I've got beds three to six and that's all... don't ask me anything else.' (*Leonie: IDI p. 9–12*)

Moreover, EOCNs described that the lack of commitment and loyalty demonstrated by many of the Generation X and Y group altered the team dynamics within the work unit. These participants felt 'put upon' for younger staffs' choice to ignore their roster responsibilities.

I would say that we [baby boomers] have got much more of a conscience about letting a fellow person down and just wanting to help each other and not calling in sick. I've got a staff member who used to read their pay slip and say: 'I've got eight hours up Mary' [accumulated sick leave]. I would say 'well I've got six hundred hours' and they'd say 'well you need to get a life' and it doesn't even prick their conscience. I don't think it's a lack of respect for older people... it's just they're the one missing out. 'I missed two parties this month, and I'm not missing a third one, so I'm going to be sick... sorry'... but without even having the responsibility of making sure that they change shifts. They'll just ring and say,

'Mary, I can't come on Friday'. As a NUM, I used to panic... all the older nurses were going to be left with all the night duty. I was able to achieve some sort of a balance, but I keep thinking that one day this is going to blow up on me. I'm not going to be able to have so many amiable people on my staff who are happy to do it [work weekend and night duty shifts]. (Mary: IDI p. 22)

Not all participants reported concern for their younger colleagues' ability and work relationships.

It's a bit different for me because I worked with those younger nurses when they **first** brought them into QIT [Technical College] then uni [university], so I have a bit of a bond with them. I know that given time 80% of them end up good nurses. If you honestly go back and look at the people you trained within your hospital system, 80% were good nurses, 20% you think 'oh my god, don't want you looking after me.' From my experience there is no difference.

The difference is that they don't have that sense of loyalty and dedication that we had. They don't have a sense of this is going to be my career forever... this is my stepping stone in my career. It's a job... I'm doing this until I can do the next thing. They don't have that commitment. It's a commitment to their own professional development. **What can I get from this**, not **what can I give to this**. I'll do what I have to do while I'm here and some will do it really well and some will do it pretty averagely, but then I don't think it enters their head, 'what can I give to this place?' (Sue: IDI p. 22)

EOCNs acknowledged concerns for the varying commitment levels between the generations, however, this variance was also recognised in expectations.

### *Inequity and Different Expectations*

Participants acknowledged that leadership teams had different expectations of the various generations, which were often apparent through rostering practices. EOCNs perceived they were often given a larger allocation of unsociable shifts<sup>17</sup>, which understandably resulted in resentment and potential conflict.

You know what she [NUM] does, she **favours** these young ones. If you look at my roster for the past three months, I have the most **appalling** roster. But the young ones, you know, weekend off, weekend off, weekend off. I don't mind **really**, I think the young ones should be out there finding a husband or finding friends, not stuck at work all the time. (Carol: FG1 p. 11)

Moreover, the inequities of rostering practices supported a culture where nurses with dependent family commitments were given their shift preferences. While EOCNs acknowledged the need for increasing shift flexibility for younger nurses, they expressed their umbrage at the lack of consideration for their personal needs.

---

<sup>17</sup> Unsociable shifts include night duty and weekend shifts.

They've got young families, I mean a lot of them come after maternity leave... They just come to work and go home... They don't want to participate, mind you some of the older generation are like that too. I find a lot of the younger ones think that maternity leave is something that they should be entitled to and they **are**, and they don't care who misses out, but they don't appreciate that there is a whole generation there that didn't grow up with maternity leave or all of the perks that they get now. So I think that the old generation doesn't like the fact that it is flaunted and they have these **advantages** that the older ones didn't have. (*Robin: IDI p. 12*)

Work practices also presented a challenge for clinical participants. Many of the EOCNs reported a lack of respect and acknowledgement for the older nurse in preference for younger nurses meeting their own needs.

Well I did say expectations are different, and I think it's a generation gap... They have kids, I've got my dog; they are very much into individual rights. I have my **old** expectations that were engrained in me as part of my training. The one I find extraordinary is that at fifty-five, I'm still expected to do the same amount of physical work as a young women or man has to do... So I'm expected to have more knowledge and more experience and I'm also expected to put that across in the language that they want to hear it in. So if I find it extraordinary that a twenty-five year old can say to me, 'I've done two weeks night duty this year, I'm not doing anymore, I've done my share'... and I think well let the fifty-five year old do it shall we... that will be fine. Would you like the fifty-five year old to do all of the late shifts, so you can go out on a Saturday night, except when you are saving up for your overseas holiday and then you need the higher penalty nights? That really used to bug me. Also, I must have my tea break on time, because I have been at work now and my legs are killing me', and I say 'well you go off and have your tea break now, that's fine and I'll keep standing on a concrete floor, wearing my lead apron and doing a procedure.' And then it comes around to lunch time and you really do need to get them off to lunch on time, they won't come back on time, but the expectation is their rights must be met so, I find that very frustrating. (*Sam: IDI p. 16*)

It is not surprising that the demonstrated differences in commitment levels and expectations were also evident in the manner of communication.

### *Generational Interaction Compromising Learning*

Generational differences in communication styles were acknowledged by participants as having the potential to compromise an effective learning environment. Regardless of their efforts to support the development of these younger nurses, clinical participants raised concerns of poor interaction and work practice by their younger counterparts.

I am really over trying to over-compensate for them and over trying to educate them and trying to instill some set of values that I feel I've gained over the years... They're not interested, a lot of them aren't anyway. I mean I'm making sweeping

generalisations there. They're just not taking it in... They just don't accept the importance of what we are doing. I think that undermines us. Their communication is quite brisk, very clipped and just not very gentle and the family remember everything. They (Generation X and Y) will come in and openly question something that you might do silently, but they are actually saying the words like, 'I thought it was 'Not for resuscitation' (NFR)... oh well we don't have to do that then, we won't have to suction then 'cause he's NFR'. Relatives remember this stuff, and that's what they take with them to their death bed and it's just so distressing. I just think it's futile. The futility gets to me. That's why it's time to step back and do something totally different. (*Leonie: IDI p. 10–12*)

In contrast, other EOCNs reported that the older nurse was not always responsive to the learning needs of the novice nurse.

I do think that most of them are so enthusiastic and I love working with them, but I do see the way they do get treated sometimes. A **brand** new student was giving the hand over. Now it wasn't quite right... you know there were a few gaps, but it was her first time so we all went 'well done, that was great', and I looked over and saw two of the older girls [rolling their eyes]... and I thought you're just bitches, that's just awful, I hope the girl didn't see it. I thought it just wasn't necessary. I don't know if the older girls feel **threatened** by the younger girls... their knowledge is superb, they have a different way of doing things you know... that's fine. I don't think that they are as meticulous as we are in the actual physical care of the patients. I wouldn't dream of looking after a post-natal patient all day without having cleaned her up sometime, changed her pad, cleaned her teeth. You know, it's more important that the notes were all written absolutely superbly... all their obs. [observations] are all absolutely spot on. Some of that emotional support... they are very good at it, mind you the room and everything else could look an absolute pigsty... but that doesn't say that the women hasn't had good care does it. (*Janine: IDI p. 18*)

The ability for participants to have their professional and personal needs met influenced how they interacted at work and how they performed in their role. Ultimately, this influenced their decision about workforce participation.

## 6.5 Research Question 4

The fourth research question is: How does the balance of effort and reward influence EOCNs' decisions regarding workforce participation?

As the balance of effort and reward is an individual phenomenon, presenting the findings using individual case studies is a more appropriate strategy to address this question. A short case study of the eight participants who accepted an invitation for in-depth interview is presented to demonstrate their understanding of this balance.

Participants concluded that if they experienced an imbalance between the amount of effort<sup>18</sup> given and the degree of reward<sup>19</sup> received as a result, they often reconsidered their employment intentions. Not surprisingly, participants reported that if they experienced a balance between effort they gave and the reward received, they would feel motivated to remain in the organisation.

### 6.5.1 Effort–Reward Balance

#### *Participant 1: Mary*

Mary was employed as a senior nurse at Grade 9 level. Her role involved the management of after hours staffing allocations across the facility. Mary had experienced many years of senior leadership roles throughout her career. Achieving job satisfaction through professional development and advancement was a priority for Mary, however, she was challenged by the relationship with her line manager which generated discontentment with her role.

Imagine her frustration and panic when I said, ‘Nicky I’m **so** frustrated with this position. When you advertise it [as a permanent position], I won’t be going for it’. ‘Why, why not... what’s happened?’ (Nicky)... ‘I have no job satisfaction whatsoever’ (Mary). **She is the nicest person in the world**, but she’s **not** a manager’s boot lace... She’s not got one leadership quality. She doesn’t have a strategic bone in her body... She has no time management ‘cause she’s so busy **micro-managing** and not delegating. It’s about finishing my career on a good note. It’s been a really dynamic career up until now and I have had a really good trajectory over the last 6 years and I feel that I owe it to me and my career to end on a good note and for me it can not continue in this vein. This time next year I won’t be sitting in this same position... I know that... whether it’s here, or not, I’ll still be looking. (Mary: IDI p. 11, 27 and 33)

Lacking professional challenges and experiencing increasing frustration, Mary expressed concern about her unfulfilling role.

The position isn’t what I expected it to be. I do a roster and I do beds [allocation of patient beds for the facility]. Initially, it was quite challenging because you were always in bed crisis. There is a lot of antagonism with our area, but I just thought there is no development here for me... and there is no work–life balance because I go home really frustrated and my husband said ‘I’ve never seen you like this’. I like to be dynamic. I like to be a really good resource person. I like to have a challenge and **my** job satisfaction comes from helping others. I mean that’s why we’re nurses ‘cause we want to help others. If you can help your staff then you’re really in effect helping the patients, but I don’t have any of that now. (Mary: IDI p. 3)

---

<sup>18</sup> Effort relates to degree of work demands and obligations of the role.

<sup>19</sup> Reward may be demonstrated by recognition, remuneration, career advancement and security.



Unable to meet professional and personal needs in her current role, Mary sought employment in other facilities. Unsuccessful at interview, Mary reflected on the leadership style of her line manager and the reasons for her demise.

I've actually gone backwards since I've come here. I'm not good at working with people who control you. This management style obviously doesn't suit me (*p. 6*).

I feel guilty... I feel that I'm a big waste of money... I should have had all of the answers [at interview], but [didn't] because I'm so unchallenged. It's a perfect example of if you just sit on somebody for so long... it's the dumbing down... I've just become **so dull** cognitively... I just go through the motions. I've got a head piece on... ring up all of the wards: 'got any beds?'... putting patients in beds there... put out a few little fires here and there... go home feeling like crap... come back the next day... start doing the roster and do it all over again. And that's not what I've aspired to do and I've got eight more years left of my career and I can't see me sitting doing this for eight years of my career. I want to end on a really good note. I've had a really good forty year career up until this point, and I don't want to end it on a very sour, low sort of level. I'd rather go back to night duty on a medical ward or pick up intensive care 'cause at least it gives you some job satisfaction. I've come out of interview and thought 'is this what I've become?' I've gotta get out of here... I can't do this. (*Mary: IDI p. 10*)

Mary experienced a personal conflict with an imbalance between the effort given and the reward received in two recent roles. Regardless of the extensive hours worked, Mary felt great satisfaction in her previous NUM role as she contributed positively to staff and patient outcomes. In comparison, job satisfaction evaded Mary in her current role as a considerably lesser workload caused her to question the value of her contribution.

I think there is inequity within the NO7 role. I was a NO7 as a NUM and was working twelve hour days. I was meeting the night duty some days when they were coming on their 9 o'clock shifts. I was coming to work Saturday morning just because of the massive load of this ward and I was trying to be everything to everybody (*FG3 p. 13*). I felt that if I did the right thing for the staff, I'd do the right thing by the patients. And that was my primary focus and if that meant taking armfuls of work home or staying back till you meet the night staff... that happened so often... then so be it (*IDI p. 14*). I then went to After-Hours [management] at the same level with a **lot more pay** because of the penalty rates. My work-life balance was fantastic. I did my eight hours; I went home **exactly** on time; I came **five minutes** before my shift, not two hours before I was due to go in so I could get some work done. That to me is a **huge** thing and I got a lot more money; I'm talking five or six hundred dollars more a fortnight in the role where we have a **lot more** of responsibility at work but left it at work. (*Mary: FG3 p. 13*)

Mary resigned her position at the study site and took a leadership role in another Australian health facility because she experienced a lack of professional challenge which contributed to inadequate job satisfaction.

### *Participant 2: Sue*

Sue had extensive clinical experience in inpatient and community care. However, at the time of the study, Sue was employed as a NO5 within the mental health specialty, developing new skills. This new clinical specialty presented a welcomed challenge for Sue, however, she was respectful of the potential physical risks this specialty presented: “My husband pleaded with me... ‘don’t do it’”. (*Sue: IDI p. 27*)

Financial security was a necessary consideration for Sue: “financially we’ve never really been well off, so I haven’t got the luxury of saying I just won’t work, because we need to work” (*IDI p. 4*). Of equal importance to Sue was her ability to meet her professional and personal commitments. Sue’s commitment to nursing was evident by her continual effort to advance her clinical and professional standards in this new specialty, however, she struggled with staff not demonstrating the same high level of care and commitment.

Well I observed, this one nurse... she’s quite a brilliant young nurse in many ways, and I thought... well I can just about keep pace with her for everything, but what do I do **differently** that keeps me back there? It’s the **more connection** with my patient. She can disconnect **very readily**. She can get through things like a push feed three times faster than I can, without any doubt, but I couldn’t do that to a patient. (*p. 14*)

I watched people [nurses] just ignore them [patients] like their invisible, and I could never do that and when somebody does ring a bell, I can’t ignore that, I’ll go... I watch and think well if x is going to go and see what his patient wants and if it’s obvious he’s not, I’ll go down and say, ‘You rang the bell. Is there something you need?’ And then I’ll come back to the nurse and say, ‘Your patient needs such and such’. I get annoyed with people who are rude to patients. I always try and lead by example, I tend not to say a **huge** amount but then my face is very much an open book. (*Sue: IDI p. 28–32*)

While it was important for Sue to deliver an advanced level of patient care, she struggled with the balance of work and life commitments. Nursing for Sue was not just a job for monetary return, but rather a way of life. As Sue recognised the necessity of physical wellbeing to remain effective within the workplace, she tried to strategically balance her life and work.

It’s a really important issue, life balance, because without it, you just get burnt out and very jaded and I don’t think you deliver very good care. I’ve tried to work out for myself, how many days I need to be at work for myself financially and get some continuity of care, and how many days do I need for survival at home, and at the moment my focus is to work four days a week and have three days off, preferably together and my theory is one is for me, one is to do some study which

I'm trying to catch up on and one to maintain our home... all very important issues at this point in time (p. 1).

As long as my body will hold up and I can have enough time off, I think that I could continue in a nursing caring role until I'm seventy if I didn't have to work too physically hard. The physical stuff will be the stuff that stops me and I love what I do, I'm so lucky that all my career, I've loved being a nurse. (Sue: IDI p. 30)

One barrier to managing this balance was roster allocations. Roster inflexibility had the potential to minimise her off-duty time for recreation and study.

I was **so** tired when it came to my days off that I did nothing... I did hardly any housework. I could **certainly** hardly do any study. I've done years of rostering when I was a nurse manager in another role and I would never put somebody on a **late** to finish and **an early** to start because you feel totally ripped off. In the end I just sort of stopped asking and accepted it, but I thought you know this was **part** of the decision why I had to go .8; the only way I could get a little bit more time off was to say, 'look I can't do this; I'll go .8'. I accepted it because I thought well I've only got limited time in this area I won't put any more energy into this battle, even my battles I balance out the energy. (Sue: IDI p. 4–5)

Sustaining personal and professional standards was very important to Sue's decision to remain in the workplace. Not surprisingly, if these needs were not met, Sue took action to rectify the situation or withdrew from the workplace.

I'd leave, I'd give it six months at the most like I did at [another] hospital. Working there for six months, I couldn't have gone another shift; it was professionally and personally crippling... it was killing me. It's two things for me: it is the job satisfaction and when I see acute laziness and acute non-caring, it gets my back up. (Sue: IDI p31).

Continuing to realise a balance between work, study and personal life, Sue continues to gain job satisfaction for her nursing role within the mental health speciality.

### *Participant 3: Sam*

As an experienced clinician, Sam worked full-time as a clinical nurse [NO6] in a Day Procedure Unit. This role required specialist skills and knowledge in perioperative nursing, and supportive training to less experienced nurses. Approaching retirement, financial security was important for Sam. Equally, Sam strove to meet her professional and personal needs.

I'm at the stage now where I think I'm past my used by date... I've had that feeling for probably two years and I just **know** that I would like to stop working. I **love** parts of the job; I **absolutely passionately hate** other parts of it. I no longer get a glow coming to work. The reason I stay is money undoubtedly; if I won lotto

tomorrow I would be off, and then I would like to spend – I'd have a nice long break. Then I wouldn't mind somebody hiring me out as an expert. The daily grind I'm sick of that, I'm sick of medical staff who don't talk to you... I'm sick of nursing staff who can't pre-empt... who don't look after each other the way they should ... who are I focused, I centric. (Sam: IDI p. 21)

Supportive leadership assisted Sam's work motivation as she struggled with job dissatisfaction and the ability to maintain a balance between work and life.

Balance it up with a CNC who does so much to keep her staff happy. To work with her... she is just fantastic... I feel a great loyalty to her. I think if my CNC wasn't as supportive... actually, that's probably it in a nutshell... I would have put up with overtime; the on call you get flogged, nursing staff get flogged in our department, but that's the sort of work you do, and I didn't mind that, if my leadership group is supportive and not just in words (p. 21 and 30).

**She** was the one who suggested that if you can't cut down from full-time, which I can't financially, how about three x ten hour shifts and one x eight hour shift. I felt very much that **my** needs were really being considered and that's gonna help me stay longer in that department 'cause I feel loyalty to her. (Sam: IDI p. 1 and 10)

No longer having dependent children, Sam's work-life balance had shifted to focus on her personal priorities. However, even though Sam was an experienced clinician, she objected to leadership requests to work in unfamiliar clinical settings. This concern was due to her perceived lack of clinical support by the regular staff in these areas and her respect for delivering professional standards.

I **did** permanent night duty for many years because it suited the home life. **Now**, I want every second Saturday night off, because my football team plays in town. I would prefer not to work any night duty, but I don't mind being on call for my department... I **don't** want to be on call for the hospital to be placed in **any** work situation wherever my division sees it fit to put me, because I am not up to that anymore. I **can't** do that anymore and I **won't**. So that doesn't make me very popular with my management, but I don't care, I'm not doing it. I'm not **capable**, oh I probably could, I could probably go to the wards and do an eight-hour shift, but ah, I wouldn't get the same amount of work done... I wouldn't get the help that I would need. I'm fifty-five and I'm not doing that anymore, and if it came to it, and they say well you know, push comes to shove, you do it or you are fired, I'm fired... I'm out of there. So it's nice being fifty-five. (Sam: IDI p. 2)

The ability to maintain a balanced work life within the Procedure Unit was difficult, particularly when unscheduled work activities arose. Such situations invite all staff members to share the workload. Sam voiced her concern that the older nurses would often be required to work these longer hours. This concern was a result of varying levels of commitment between the generations.

I'm due off at 5.30 and another colleague is due off at five. So 'we need an ICC (Intercostal Catheter) in this man... can someone ring the bed manager, we need to admit him?' etc. Guess what we haven't started setting up for the conference tomorrow... 'leave that I'm coming in at six tomorrow, leave that, finish up today'. So myself and my fifty-five year old colleague worked back till 7 pm at night. The thirty-five year old went home **on the dot** at five on the dot and I **can't** ... inside of me I'm thinking, you piece of work, I'd love to knock off on time, but what can I say, she's got two young kids at home, hubby's at home I might add but as she points out, I'm employed to work until 5 pm. I knock off at 5 pm. Ok (p.5).

I resent the attitude that no matter what is happening... if the big hand is on the twelve and the little hand is on the five, not even an 'are you going to be ok with that acutely sick person here all by yourself', 'cause I **wouldn't** do it to them, and I think. 'Where is your professionalism?' It is very I focus, and is that a generational thing? I mean nursing is just a reflection of society I think, we're just the same little community, and I think that's part of society. (Sam: *IDI* p. 13)

Not only was Sam concerned about the lack of shared workload, she acknowledged her concern for the younger nurses' perceived lack of commitment to professional practice. Further, Sam's frustration was heightened as she found little confidence in the younger generation's ability to critically manage and deliver patient care.

The bells are ringing, you've got old people who have a basic right to go to the toilet and eliminate instead of lying in their bed and getting wet. **Why wouldn't** you get off your butt and go and help them. I mean, I just find that extraordinary. It's also **very important** that nurses today have access to a computer, and if that means that the bells are ringing and someone has to answer it, and someone has to do the drugs, and someone has to do the drips, and someone has to stop the little old one falling out of bed, then the 55 year old can go and do that 'cause that's what they're trained to do all of those functional things, but the younger one is **more** important and they do the computer stuff. That drives me crazy, 'cause it is a **complete lack of respect** for me as a nurse, it's a complete **putting me in my place** which is obviously lower. They [Generation X and Y] will get things done but I don't believe their heart and soul is in it, and I'm not saying that the younger nurses don't care for their patients, that's ridiculous, we all do, otherwise you wouldn't be there. We don't want nurses to be trodden on, we don't want nurses to work just as a functional unit, but what we do want is people to get out and be with their patients **and pre-empt**... surely that's using your brain, surely you can have holistic nursing without having a nurse sitting at the computer looking all holistically at their blood results and ringing the doctor because their APTT are low and you think yeah but their drip has just run through, so I found that very frustrating. They're not clinically skilled people in general, they're certainly not people who would rather prevent things happening, I don't think they know how, I **don't** think they know how to prevent... it's a knee-jerk reaction to everything because you haven't thought two steps ahead. (Sam: *IDI* p. 17–18)

Regardless of Sam's frustrations with professional practice and generational issues, she continues to work full-time in the same Procedure Unit.

#### *Participant 4: Robin*

As a clinical nurse [NO6] in a perioperative specialty, Robin worked full-time. Although planning for retirement in the near future, Robin demonstrated a strong work ethic and explained the need to gain professional and personal satisfaction for her clinical practice. However, Robin experienced frustration from the disparity of commitment levels of some of her colleagues.

Work does get very stressful. I go home some days and I'm mentally tired, more than physically tired, and my husband will say 'I don't know why you do it, why do you do it if somebody else doesn't?'... and I really can't answer that. I just think that if there is a job to be done... somebody has to do it, and I'm not being a martyr in that I just think that the whole unit functions more effectively if things are **done**. And I suppose I've learnt over the years to delegate some of those things, and I've had a bit more authority... it's easier to delegate and I have learnt to do that over the last few years and for the most part cooperation is good, but there are some people you just can't change and it's very frustrating. Also financially, the next eighteen months it's the big thing. I have to get satisfaction out of what I do or I wouldn't do it... I definitely enjoy what I do. (*Robin: IDI p. 4–6*)

As she is in her transition to retirement, Robin was mindful of her physical and mental tiredness as a result of work. This situation initiated a change in focus to restore her balance in life and work. Earlier in her career, Robin accepted the reality of increasing workloads, however more recently, her attention turned to interests away from work.

I think I reached a point of near burnout a few years ago, where I realised I couldn't do everything and that was a turning point for me... work's got to stay at work and home at home. I was the work move coordinator and there was a lot of pressure. There was a lot of stuff done at home at that time; I realised that I had nothing for me... I couldn't be everything to everybody. At that time I seriously considered giving it away, but I think I realised that the pressure was coming from me not necessarily the job. I learnt boundaries setting and I can organise myself. I don't have any other responsibilities at home anymore... not as far as the children go, so I've found over the last ten years I can concentrate more, enjoy work more and be a bit more committed to it, but I'm finding **now** as I'm getting older... do I really need to be doing this, what else can I be doing? (*Robin: IDI p. 8–11*)

Robin reflected on environment issues which had both a positive and negative influence on her intention to stay in the organisation. Supportive leadership was an incentive for her to remain in the workplace.

The negatives are traveling... like I'm twenty-two kilometres out of town, so the traveling and when you have to pay \$10 for parking... it's a big issue. My CNC will be due to retire any time. I think if management changed and the dynamics of the work area changed significantly – I'd be out of there. If there is conflict in the workplace... I don't want to put up with that. A husband at home doesn't help. He

has always been a shift worker as well, so we haven't had a lot of time together. Since he's retired he wants more quality time and I'm tired, so that's where the balance is not good for me. We have a caravan and we want to travel. I mean money at the moment is very important, but it is not the be all and end all. The next couple of years, if I don't take some time out for myself, I'm not going to travel while we are young enough to do anything. I would like to learn to play bridge and things like that... things completely different from nursing, but I've never had the time or mental energy to do that while I've been nursing, so there are things starting to compete with nursing. (*Robin: IDI p. 5 and 16*)

Finally, health and the ability to continue working were important considerations for Robin. Additional incentives, such as bonus leave for accumulated unused sick leave, were seen as a positive option for her retention.

One of the other major things is health at our age, and I think it's important in the retention side of it, and I think that we should have that extra support much earlier than twenty-five years [of service] or whatever it is and if I had some sort of ill health, an incentive like that would be more likely to keep me here. (*Robin: IDI p. 20*)

Robin continues to work full-time in a perioperative clinical leadership role.

#### *Participant 5: Leonie*

Leonie's clinical experiences included cancer care, medicine and education specialities. Over the past seven years, Leonie was employed as a CNC to develop and manage a new palliative support care service for the study site. The service also aligned to other neighbouring hospitals and the community.

The new service required the development of staff skills to care for the patients accessing the service. Leonie struggled with generational issues and the difficulty in achieving an acceptable professional standard by some of her younger counterparts. With high professional expectations for the service, Leonie was unwilling to accept less than optimal delivery of patient care.

I'm finding as I am getting older I am sort of getting a lot more irritated with them [younger generations]. I see it on the ward and I see it as a fall in the professional standards, so it's time for me to step back for a while and step out of that. (*p. 9*)

I think that undermines us. People only get to die once, so it's got to be done right. They're [Generation X and Y] not interested... It's extremely frustrating and we've had some really unsatisfactory deaths, after hours particularly. The families are just devastated by perceived lack of care in the ward, whether it was real or not, but that's what they will remember and we are seeing that more and more, particularly in the younger nurses. They'll [Generation X and Y] come in and

openly question something that you might do discretely. It's becoming **really** disappointing and we feel **frustrated**: communication, professionalism, **lack of compassion**, lack of following orders, and a lack of follow through... just not thinking... a lot of handing things over. [The younger staff are] just defensive, pass the buck, blame being busy. So then **that's frustrating**, 'cause I don't see that getting **any better** and that was adding to my feelings of burning out and irritability, I can't see much hope for it to improve. (*Leonie: IDI p. 10*)

Further to her concern about questionable professional standards, Leonie was cognisant of a lack of commitment to patient care and the organisation by some of the younger generation of nurses. This concern resulted in feelings of frustration and contributed to Leonie reconsidering her work options.

They have **full** commitment to themselves. They don't extend themselves. 'I don't know anything about him'. Not, 'oh well I'll go and find out' or 'I'll try and help' or 'I'll find the nurse who knows him', just that very task orientated. I think it's futile **trying** to educate this generation... I think that's because I am a bit burnt out. That's why it's time to step back and do something totally different. (*Leonie: IDI p. 9–14*)

In addition to the challenges of providing a competent workforce, Leonie reported minimal support from the leadership team. This situation was difficult as the alignment to the leadership team was not clearly defined. With few professional and social networks and minimal leadership direction, Leonie struggled to gain the support required to develop the new service: '**not a lot of** management support... like things I had to just learn the hard way and there wasn't really anyone there mentoring me about that'. (*Leonie: IDI p. 4*)

The new service required Leonie to work extended hours to complete the necessary work. These additional hours were self-imposed due to her personal standards and value system. Ironically, this praiseworthy decision was the cause of her inability to fulfill her home commitments. Not surprisingly, this generating family conflict. Over time, Leonie realised her physical and mental wellbeing was being compromised. Unable to cope with the work stress, Leonie resigned her position.

I think it was just having to prove myself with the new service and totally new in that role. I hadn't been CNC before, so there was a lot of pressure that I put on myself that I had to perform. I don't think I ever had one sick day in probably the first 6 years because there would be absolutely no one else to take over. I think a lot of it's being a nurse... how we are just so indoctrinated that you **have to have** all of your work done before you leave and that you would never leave **any** loose ends for the next shift. There was a lot of friction at home because of the long hours that I was putting in, and I certainly didn't get the moral support from my husband. There was a lot of sneaking around... I just had to get it done (*p. 6*).



You just can't fix it all. It's very satisfying work, but it's going to get busier and busier and I just don't know if I've got the fortitude to do it anymore. I've already made the decision; I'm so tired, so burned out. (*Leonie: IDI p. 14–17*)

Resignation was a decision not made lightly. Interestingly, Leonie was able to step back from extensive work hours when the service was adequately staffed. At this time, Leonie acknowledged her symptoms of burnout:

I finally got another full-time nurse and then it just sort of started working for itself and I didn't **need** to be there so much. I have set up all of the processes so that someone could just walk in and take over, and I realised that I wasn't so indispensable (*p. 3*).

It's amazing that it took **seven** years to come to that decision. Up until only six months ago, I felt the balance wasn't that bad and then suddenly it just came crushing down on me. I think I was in denial, but that's what you **have to do** to build up services – you've got to put in the big hours and that it was expected that I did that, but mainly expected by myself (*p. 1*).

I'm taking twelve months without pay in October. It's not the grief of the work that's making me leave; I'm overworked... it's so much to do and I'm drowning. I'm going to be a ski instructor, so I'm going from \$40 an hour to \$10 an hour but the money doesn't count, but I'm tired. I've been building it [the service] up and our referral rate is through the roof. I couldn't have left it even a year ago because I felt that I had things to do. So I can walk away from it, but I'm tired (*FG4 p. 63*)

Interestingly enough, now that I've made the decision to go and I have a light at the end of the tunnel, I've been incredibly calm and peaceful. This is the **least** tired I've been in seven years. (*Leonie: IDI p14–17*)

Leonie took leave without pay for twelve months and returned to resign from her CNC position permanently.

#### *Participant 6: Andrea*

Andrea is an experienced clinician and held the position of NUM in a busy medical unit. While Andrea gained considerable satisfaction from her role, financial security was a necessary deliberation.

For me, I need to work, because I need to pay a mortgage, and [am] recently divorced after twenty years of marriage, so that has been a huge lifestyle change for me, and where I may have had some options... you know going part-time, I don't have those options anymore. Financial [security] is a huge issue. If I won the lotto tomorrow, I don't think I'd leave. Job satisfaction is pretty critical for me. I try

and rely a bit on myself for my job satisfaction and change what I can change. Some things you have to accept that you can't change. (*Andrea: IDI p. 16*)

While Andrea enjoyed her role, she was challenged by continual heavy workloads. However, Andrea refused to commit to unnecessary nursing activities by prioritising work unit roles to support a realistic workload. Reduced family commitments contributed to Andrea's flexibility with work commitments.

It really just depends on what my priorities are at home versus what my priorities are at work and I'm sort of a bit older now and my kids are a bit older, so I don't have those pressing issues of running home for after school care and kindy. Professionally I like to get all my tasks done for the day... that's not always possible, but I don't actually take all that on board as my own personal problem. I think workloads are unrealistic and if I have to prioritise and get the most important done and the less important constantly gets put to the bottom of the pile. That's something that the organisation needs to look at. If they want every "i" dotted and "t" crossed, they need to come and cut my workload. I'm more than happy to take direction... they need to come into my job and show me how they can take all those tasks and put them into a eight-and-half-hour day, 'cause I don't know how to do that, as well as keep providing for everybody who puts their hand out with whatever they demand. (*Andrea: IDI p. 2*)

Regardless of prioritising her responsibilities, Andrea often found the need to work extended hours to complete work. However, she expressed her frustrated at the little recognition for this effort and the difficulty in receiving recognition through taking time off in lieu (TOIL).

What annoys me is the perception about TOIL... that TOIL is frowned upon, but I still do it because that's my line manager's problem, not mine. What annoys me is that if I do want to take some time off, it has to be an hour here or an hour there. I can't look at my staff and decide... I can have a whole day off here... I'm owed probably more hours than peoples' long service leave. (*Andrea: IDI p. 3*)

Further, the request to access TOIL generated disparaging remarks from some line managers. Not surprisingly, this caused further frustration and a growing lack of respect for the leadership team.

It has been intimated before in my division... not to me specifically but people who take a lot of TOIL are not coping with their workload. The other thing that was said once... now that some of us have gone down to a nine-day fortnight, we mustn't think that we are going to make up for that day off in TOIL. That was a **stupid** statement... you know the time and effort that you put in and that just shows ignorance to me, ignorance and stupidity. (*Andrea: IDI p. 4-5*)

While the leadership team failed to recognise staff efforts through appropriate access to TOIL, they also gave minimal support for the developing NUMs such as Andrea.

When commencing as a novice NUM, Andrea spoke of her inability to access inspirational and credible mentors to support her development. As a consequence of the lack of mentorship, Andrea often worked in isolation:

Line managers that are out of touch, or line managers who come from the old school that think 'oh yeah what can I do?' or 'we just have to take it on'... well no, I'm sorry we don't, look at the challenges facing nursing and you're the same sort of line manager that we'll end up in some sort of strife if you were making all of the decisions. So it's the lack of mentorship that I have further up the chain, I don't look up to them. I'm not **bagging** my line managers... some have got **really** good heart and if I asked them for help, they'd go and look up stuff and spend a lot of time but I don't find them inspirational at all. There is not one of them that I look up to and think, 'gee, I want to be just like you'. And that's frustrating because I don't have all of the answers. I have my own limitations and my own problems, so who do you go to if you don't admire somebody or aspire to be like somebody further up the chain? (*Andrea: IDI p. 13*)

Further to minimal development opportunities, Andrea expressed her frustration at the lack of acknowledgement or understanding of the nursing role by the leadership team. Understandably, Andrea reconsidered her employment options.

It's when your own line managers and bosses don't acknowledge or actually don't clearly have a clue what you do... **that's** the frustration in the job, when you know nurses are notoriously taking on every other discipline's cast off work and allowing ourselves to be manipulated and molded by other healthcare groups instead of just telling them to get back into their own area and let nurses be nurses. We've sort of become a bit complacent that way... there's a lot of stuff that really needs to be handed back if we're going to tackle the next fifteen to twenty years in nursing and come out looking good and healthy as a profession... It's **very frustrating**... If I had won the lotto, I would have been out of here, and it was not **anything** to do with not loving my job or my ward, it was **pure frustration**. (*Andrea: IDI p. 11*)

Andrea continues to work as a NUM, advocating for clear nursing roles within a busy medical unit.

#### *Participant 7: Jenny*

Jenny worked as one of the NMs responsible for the 'casual pool' staff. A major component of her role was to provide appropriately skilled staff across the facility when staffing numbers were inadequate to provide patient care. While Jenny considered her retirement options, she was keen to remain in the organisation while she continued to gain job satisfaction.

I've given it a lot of thought because I've just turned sixty, and I suppose one starts to think... how many more years do you have in the workforce, and is it realistic, sensible to stay working? I've always said while I enjoy working I will stay... If I

start to not enjoy it for whatever reason, I will probably find a way to not be here. Yes, enjoying coming to work or being at work is, you know, definitely a motivator for me. (*Jenny: IDI p. 1*)

Another strong motivator for Jenny to remain in the workplace was financial security.

Well at the moment it's just the money. The money... I will be a bit more secure if I work a bit longer. My husband says I could leave now... He's **never** put any pressure on me to work. It was a really good thing that I was working when our kids were growing up. Now that's not the case; I could leave... It probably wouldn't make that much difference financially to be honest, but it's nice to have a bit more going into QSuper. (*Jenny: IDI p. 23*)

While motivated to gain financial security, Jenny's job satisfaction was dependent on meeting her professional and personal needs. However, Jenny questioned her continued ability to provide an effective standard of service. This was reinforced by the need to gain recognition from her peers or leadership team.

I would hope I will always be effective. I suppose coming back from leave having people say, 'oh I bet you're popular now you're back', and I thought, well maybe there is some acknowledgement that what I do is good, because there is very little acknowledgement really. I mean, I myself am not very good at applauding people for things and I'm conscious of that. All I could propose is if no one is at me all the time 'cause I've done something wrong, I must be doing something right. I suppose that being valued is definitely part of it, and that's things like asking to go to conference and being allowed to go. There's a lot of inequity where that sort of stuff is concerned. Some people get that a lot more than others. One problem with my role is it's very hard to replace me, so it has to be planned in advanced. I was going to go on a conference at the beginning of this week and then discovered that my replacement had been rostered to cover someone else's annual leave. I've got this ongoing thing where I'm too old and I'm not worth it. I'm nervous that's what they might think. I wonder if it will get to a point where they'll think, 'oh she's too old'. (*Jenny: IDI p. 23–24*)

However, Jenny felt challenged by the lack of professional support and advice she received throughout her career.

I worked part-time for many years... I was frustrated in that role. I felt that as a part-timer, I was very much sidelined, poorly supported. I was very frustrated and thinking there was so much I could do. When I realised I did start to do what I'm doing now. I thought I obviously could have done this a lot sooner if I'd been prepared to. I studied all those years and thought, 'oh here's an opportunity being offered'... I'm not particularly ambitious as a person. I saw it [studying] as just justifying what I already did, so in that sense I probably should have been guided or mentored. I would expect to go and mentor someone in my situation. (*Jenny: IDI p. 1*)

The ability to sustain a work–life balance was a common cause of frustration. However, a strong value system exacerbated an obligation to commit to extended

work hours. These extended work hours caused Jenny considerable frustration as they were often undertaken in her time, thus reducing off duty hours.

Oh I consider that my choice to do that [extra work]... I think for me, there's always that, **that's** my work I should have done that today and I would keep on until it was done. You could count on one hand how many times I go on time, and interestingly we all apologise when we leave early, and early means earlier than 5 pm. That means you have already done 1.5 hours extra. I left the other day at 4.15, and I apologised to someone when I left, and I thought aren't we just so silly, because I seem to expect to stay for a ten-hour day. There's simply no point in the work mounting up and you just getting nowhere, but I don't like taking work home, with the exception of the roster. I quite resent having to do it at home but **that's** because I do so much at work. (*Jenny: IDI p. 4–9*)

Moreover, the lack of recognition of the amount of work required was found to be devaluing. Jenny acknowledged that many leaders had a poor understanding of the role of the NM. However, frustrated with the inequity of the workload, Jenny accepted the status quo.

Nurse managers routinely work exceedingly long hours. It's actually not fair but it's a collective group that are doing it, it's not just me, and it's not because we are inefficient [laughter], it's because the workload is actually unreasonable. It's routine for nurse managers to work ten-hour days and be paid for eight, no one claims TOIL, no one gets paid any overtime. It's just **expected** of nurse managers, and yet we are paid less than most other people. I mean I don't have a problem, I accept all of that. I accept it because I'm here... I've chosen to live with that for whatever the reasons are. I still don't think it is **fair**, there is a part of me that says this is not fair, it ought not to be quite this imbalanced. (*Jenny: IDI p. 4*)

Not surprisingly, a trusting relationship with the leadership team was not forthcoming. Poor interaction and lack of attention to supporting her personal needs added to an unsatisfactory work environment.

My line manager can be very frustrating. She tends not to listen if she doesn't like what she is hearing, but if I said to her, 'look, I've worked ten hours for four days this week'... she'd say 'well that's your choice'... she's not making me stay. I'm choosing to stay and that's **true**, she's just wouldn't know what to say to me. If I were the boss, I would be very aware that maybe it's not a reasonable load for that person. While my line manager is very frustrating, she's a very nice person. She doesn't know how to be a leader and that's frustrating. She's not totally trustworthy. (*Jenny: IDI p. 26 and 28*)

However, despite workplace and leadership concerns, Jenny continues to work full-time as a NM within the casual pool area.

### *Participant 8: Janine*

As an experienced clinical nurse employed in a dynamic Birth Suite, Janine enjoyed her role as a midwife NO(6). Job satisfaction was an important component of her work life, particularly as she planned her retirement. However, physical and mental wellness may influence her earlier retirement.

I thought that I could just continue working full-time until I retired, but I **can't** keep doing this for another two or three years... (*Janine: IDI p. 1*)

The ability to continue to work shift work, and particularly night duty, placed an additional strain on Janine's health. Leadership inflexibility with shift preferences added to her frustration. As a result, Janine reduced her work hours to avoid unsociable shifts.

We were doing five nights [duty shifts] every three weeks. So at the end of that it would take you another week to sort of be back to normal. You would do two weeks of day duty and you'd be back on night duty again, and it was just **knocking the hell out of me**, and I thought no I can't... I just have to accept that. Then I investigated [work options] with QSuper. If I did this, would that get rid of the night duty? He told me, 'Go part-time, you might lose a bit of money but you could be dead too'. So that's when I decided I would go part-time. They would then only give me three night duties which I felt I could do, as the five just knocked me... Physically my feet are really bad again, so it's physically so much easier to not do night duty (*p. 4*).

I also do [teach] MACRARM which is the obstetrics emergencies [program]. Every time I wanted to do a program... 'sorry, I can't release you'. That was what I **really enjoy** and what I really wanted to do, so I **really** felt angry about that. I thought right, stuff you lot, I'll go part time and I'll do my MACRARM [program] as extras. (*Janine: IDI p. 1*)

Financial security was a consideration in Janine's decision to continue to work.

I've thought about how much you can put up with, you know, and I don't know. It's the money. And I just like... I enjoy my life so much when I'm at home doing the things I love doing, then go to work happy and then half an hour later and I feel like I want to get out of here. I'm going to punch someone's lights out and I just want to leave (*p7*).

The money has probably become less important. I thought it would be the most important thing when I went part-time. I thought, 'oh god the money', but it hasn't seemed to change that much. (*Janine: IDI p.22*)

However, the inability for the leadership team to demonstrate the appropriate communication skills was a negative influence. In the absence of leadership support, Janine reported that the team processes and poor interaction devalued her professional contribution:

Some of the people I work with, one in particular... since I've been part-time, I've copped this... 'we never see you now, you're never here, you're just part-time, you're in retirement mode'. I just think, ok other people go all their life part-time, and now I go part-time and I'm no longer any use to them. It's mainly in the way they interact with you... Not my close colleagues... they are all **overjoyed**... they say, 'great that you're part-time, you deserve to be part-time, it's great'. They're fine... it's just that next level up [leadership team] that I'm having issues with. (Janine: IDI p. 8)

While it was common for Janine to work additional hours to complete her work, she willingly accepted this commitment as part of her value system.

I think sometimes what keeps us back is we are trying to do all the clinical stuff because it has to be done, and when your relief comes on you're then catching up on all your level two stuff that you haven't had a chance to do, and looking at your emails because you haven't had a chance the whole shift. It doesn't really annoy me that much. I mean if you had a commitment somewhere else, like a mother or children... that would be different. I think that would put a lot of pressure on you but I don't. I'm just going to be a bit late, so it doesn't really annoy me that much... wouldn't influence me a lot in deciding when I retired... wouldn't be the issue I don't think, it's just a slight annoyance. (Janine: IDI p. 11)

However, Janine questioned her commitment when she reflected on the 'not so committed' practices of the Generation X and Y personnel. These frustrations were exacerbated as Janine recalled her regimented training days.

Yeah, we look at them and go, 'how do they do that?' They are last in the bloody door... they slink in just as the hand over starts whereas everybody else has been there probably ten – fifteen minutes saying good day... they slink in and then they're out the door, and you go, 'how do they do that?' I must be so disorganised. Why do I accept that if I have to stay back to finish something, I feel I have to?... I don't even feel compelled by anybody else; it's just my own expectation. That was engrained in us as students... It's that responsibility thing to finish what you're doing. You remember we used to have to physically line up at the end of a shift and the work book that we got, and 'now has this been done? Has this been done? Has this been done? Ok you can go now', and sometimes she would even go and check and, 'ok you can go now'. (Janine: IDI p. 11)

However, despite some of these negative influences, professional pride was acknowledged as a strong motivator to continue working as a midwife. Janine reflected on her 'midwifery' identity and struggled with professional separation from her role.

I have this thought sometimes... you keep saying you're going to retire at sixty, but when the crunch actually comes, how are you going to feel about that? People ask me what I do and I say I'm a midwife... I'm proud of that, so then I'm going to be a retired midwife am I?... It sort of alters the whole of who you are, doesn't it, and how I often think, so am I going to be ok with that? I don't know. (Janine: IDI p. 18)

Janine considered her physical wellbeing may influence her earlier retirement. While financial security was also important, Janine continued to gain job satisfaction from her midwifery role.

I think in all reality, it would be my feet that I just physically couldn't do it anymore. The option is surgery to my foot and I have had it on one foot and whether that brings me down in the end, I don't know, but the thought of it, just... was pretty rugged. Yes, I think that would be the prime thing, then it would probably come to I can't put up with this crap anymore. And then I think financial might be about third. But I'm looking forward to retirement. It's all I think about not having to go to work. I can't imagine just getting up everyday wandering around the house and going to bed at night, I just can't imagine that. Having said all of that, I really do enjoy my work. (*Janine: IDI p. 24*)

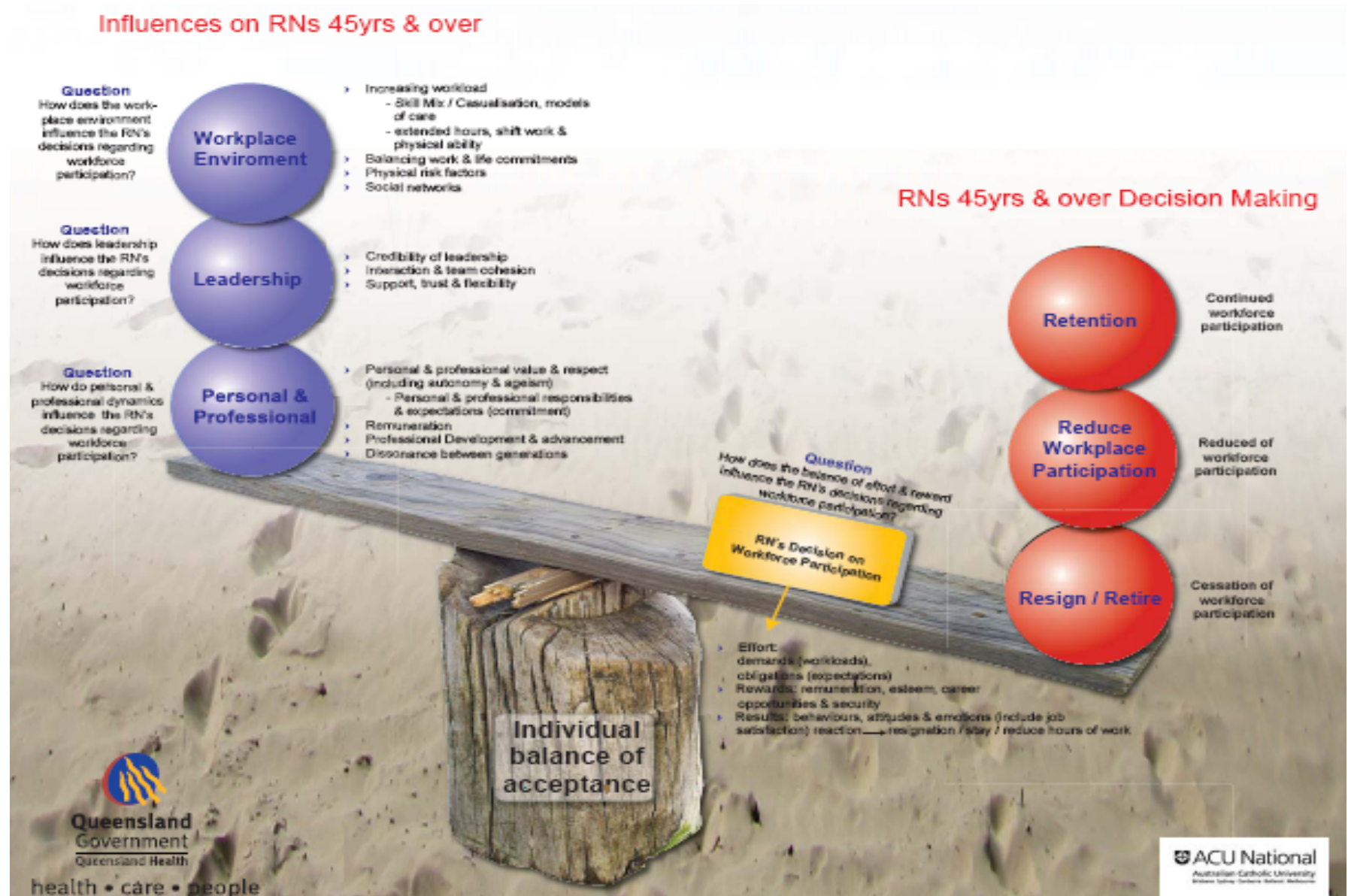
Janine continues to work part-time as a clinical midwife in the Birth Suite.

## 6.6 Conclusion

This chapter identified a number of findings that are conceptually summarised in Figure 6.6:1. The findings that have emerged from the research questions require further synthesis. As a result of the complexity of responses and the duplicity of meanings, it has become difficult to categorise the data into distinct themes. Chapter Seven will use the findings to develop a conceptual framework for this study to further explicate the factors that influence the EOCNs' decision making regarding workforce participation.



Figure 6.6:1 Concept Map of Themes from Data Analysis



# CHAPTER SEVEN: DISCUSSION OF THE FINDINGS

The purpose of this chapter is to discuss the findings presented in the previous chapter (Chapter Six) and synthesise these to develop a conceptual framework which will explicate the factors influencing EOCNs’ decisions regarding their workforce participation.

## 7.1 Introduction

The following table represents an overview of the key issues from Chapter Six and also itemises their sources or points of origin. This considerable number of issues inhibits a focused discussion of the findings and invites further synthesis. Therefore, the findings which have been presented as key issues have been reconceptualised into themes. This Chapter will demonstrate the synthesis of data that developed these key issues into themes. The key issues, their point of origin and reconceptualised themes are presented in Table 7.1:1.

**Table 7.1:1 Origin of Key Issues and Reconceptualising of Issues through Themes**

Key Issues	Origin of Issues in Findings (Chapter Six)	Reconceptualising Issues into Themes
<ul style="list-style-type: none"> <li>Bureaucratic structures suppressing creativity;</li> <li>Lack of skills, maturity and development for leaders;</li> <li>Sustaining an inspired environment.</li> </ul>	<ul style="list-style-type: none"> <li>6.3.1; 6.5.1</li> <li>6.3.1; 6.5.1</li> <li>6.3.3; 6.4.1; 6.4.4</li> </ul>	<b>Leadership Maturity</b>
<ul style="list-style-type: none"> <li>Working additional hours;</li> <li>Commitment to work: <ul style="list-style-type: none"> <li>Self imposed;</li> <li>Commitment imposed by the leadership team;</li> <li>Generational variance in commitments levels.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>6.2.1; 6.2.3; 6.5.1</li> <li>6.2.3; 6.5.1</li> <li>6.3.3; 6.4.1; 6.5.1</li> <li>6.4.4; 6.5.1</li> </ul>	<b>Levels of Commitment to Work</b>
<ul style="list-style-type: none"> <li>Social safety-nets support effective work practices;</li> <li>Collegial networks support health and well-being;</li> <li>Professional and social isolation detrimental to effective work practices.</li> </ul>	<ul style="list-style-type: none"> <li>6.3.2; 6.5.1</li> <li>6.3.3; 6.2.2; 6.5.1</li> <li>6.3.3; 6.5.1.</li> </ul>	<b>Social Capital</b>
<ul style="list-style-type: none"> <li>Willingness to embrace change</li> <li>Barriers to change</li> </ul>	<ul style="list-style-type: none"> <li>6.3.1; 6.3.3</li> <li>6.2.1; 6.2.3; 6.3.2; 6.4.3</li> </ul>	<b>Impact of Change</b>
<ul style="list-style-type: none"> <li>Ageism</li> <li>Physical and mental well being</li> <li>Financial security</li> <li>Professional respect</li> </ul>	<ul style="list-style-type: none"> <li>6.4.3; 6.5.1</li> <li>6.2.2; 6.5.1</li> <li>6.4.1; 6.4.3; 6.5.1</li> <li>6.6.3; 6.5.1</li> </ul>	<b>Considerations of the Older Worker</b>
<ul style="list-style-type: none"> <li>High effort / low reward</li> </ul>	<ul style="list-style-type: none"> <li>6.5.1.</li> </ul>	<b>Balancing Decisions</b>

Each of these themes contributes to a framework to generate the discussion of the findings.

## 7.2 Leadership Maturity

The first theme is Leadership Maturity. In the context of this study, leadership maturity refers to a highly developed level of leadership knowledge, skills and emotional interpretation. The EOCNs' ability to perform their role with leadership maturity has an influence on whether they chose to stay or leave the organisation.

The first aspect which influences their decision is bureaucratic and organisational structures.

### 7.2.1 Bureaucratic structures suppressing creativity

There seems to be a tension between how the EOCNs perceive their role and how their employer perceives it. This tension has a detrimental effect on how nurse leaders do their work. EOCNs reported one reason for this effect is that the facility functioned as a bureaucracy.

I don't know if I'd go for the position when it comes up. I never wanted to be a bed manager. I come to work and it's always crisis and it's antagonistic. You would be fighting with the DEM (Department of Emergency) staff day in and day out... no improvement... no planning. I know it's politically driven and I think, 'Who is going to take these people on?' So that leads to lack of job satisfaction too. (*Maggie: FG3 p. 23*)

Potential EOCN leaders reported low morale and growing cynicism towards accepting leadership roles. Since it was perceived that the organisation functioned in an overt bureaucratic manner, EOCNs suggested this contributed to a decrease in their productivity, enthusiasm and inspiration. The decrease in productivity and inspiration was exacerbated by the need to work through convoluted bureaucratic processes in order to achieve their work outcomes. These convoluted processes were seldom managed through the appropriate leadership and management supports which often resulted in long delays and poor outcomes. "We **fostered** the system. We've always propped it up. If we're required to be at that meeting, we attend that meeting irrespective of anything else that you've got on." (*Julie: FG3 p. 8*).

These convoluted bureaucratic processes not only delayed work activities, but also limited the involvement of EOCN leaders in decision making. With processes such as programs and policies developed at an executive level to address daily problems, there is little opportunity for EOCN leaders to be included in the process. Over time, this lack of inclusion in decision making has had a detrimental effect on how leaders perform in their roles (Sumner & Townsend-Rocchiccioli, 2003). Consequently, this situation is responsible for many EOCNs choosing not to accept leadership roles. If EOCN leaders are active participants in organisational decision making, their involvement may be instrumental in the development of their leadership maturity.

Further, the involvement of EOCN leaders in decision making may generate a sense of increased ownership if their opinions were sought and acted upon.

EOCNs who were not promoted to leadership positions felt their opinions were rarely consulted and likewise felt isolated from decision making deliberations. Not unexpectedly, this resulted in reduced enthusiasm and an inability to demonstrate initiative. Innovation is stifled further by excessive bureaucracy coupled with heavy workloads and insufficient qualified staff (Duffield et al., 2009). One bureaucratic barrier is the allocation of insufficient funding for appropriate resources such as staffing. Too often, National and State budgets are determined without the contributions of the professionals who are required to manage them. Consequently, the budget allocation is incapable of providing the salaries for the number of qualified staff required to do the job (Buchan, 2009b). This situation is the cause of frustration to EOCN leaders and is an area requiring a stronger voice from clinicians.

Since EOCNs reported that when they have inadequate resources to provide the care required, the quality of care may be compromised. As a result of insufficient resources, EOCNs reported feelings of guilt, frustration, dissatisfaction and fear of making medical errors. These issues often entice nurses, and particularly the EOCN, to resign from the profession. Further, hierarchical structures have been identified as the cause of avoidable clinical errors, which may in turn be detrimental to patients' health (Institute of Medicine of the National Academics, 2001). This increase in medical errors is caused by the inability of nurse leaders to provide appropriate skill mix on a shift by shift basis. With limited qualified nurses available to meet patient care needs, unqualified nurses are often employed as an alternative strategy. The result of this strategy has been an increased risk of medical errors which has a deleterious influence on the quality of patient care.

As a consequence, clinical leaders are constantly challenged to support staff in alternative ways so that staff can do what is required with fewer resources.

It's the staffing shortages. If I won the lotto tomorrow, I'd be out of here. People say the words around the hospital, but there is no action. We are coming under increasing pressure... look at patient falls, look at this... Do they know what the workload is? But people keep adding onto it and nobody is reviewing it. I think if our workload could be really reviewed and we don't need administrators looking at our workload. We need peer review of our workload and to get rid of what we

don't need to do with organisational support, I reckon we could sort out the nursing workload issue just like that. (*Andrea: FG2 p. 17*)

Too few nurses to deal with the increasing workload entertains the possibility that the traditional high care given to patients can not always be guaranteed. This problem needs to be addressed, particularly with so many EOCNs retiring in the near future. With insufficient qualified staff engaged in increased workload, there is a concern that the quality of nursing care is decreasing. While nurse leaders are clearly aware of this dilemma, they have been unable to address it. Naturally enough, overwork and the inability of nurses to guarantee quality care has contributed to both a lowering of morale and increased resignations of experienced EOCNs.

As a result of inappropriate skill mixes, there is a need for qualified nurses to work extended hours to meet patient needs. While this is unsatisfactory, it is unlikely that this problem can be addressed, particularly with so many EOCNs retiring in the near future. Organisations are at risk of not supporting the challenge to provide a flexible and progressive approach to healthcare by not reviewing how services can be most effectively delivered. With the relevant supportive structures, increase retention of the experienced EOCN may be generated (Anderson et al., 2010).

However, an excessive bureaucratic culture mutes the contributions of those who may have some solutions to the problems.

*Question:* From a leadership perspective, do you feel that you are listened to as experienced nurses?

*Numerous participants:* No, no.

(*Sam: FG1 p. 31*): I think that they'll use your experience as they need you... You can be in charge 'cause you know what you are doing. But other times it's '**No**'.

(*Carol: FG1 p. 31*): But also if you talk out, you're in trouble.

This is a troubling phenomenon both from a personal and professional perspective. EOCNs have considerable experiences and skills that if utilised would contribute to a resolution to many of these problems. However, their potential for leadership is too often ignored and their initiative stifled, if not destroyed. Such a lack of professional and personal care of EOCNs generates a toxic workplace culture which contributes to unnecessary resignations of dedicated and capable EOCNs. These findings are consistent with the literature (Sumner & Townsend-Rocchiccioli, 2003).

### 7.2.2 Lack of skills development for leaders

The second aspect of leadership maturity that invites explanation is the development of leadership skills. There is a dissonance between EOCNs in formal leadership positions and expectations of other staff and the organisation. “She is the nicest person in the world, but she is not a manager’s boot lace. She’s not got one leadership quality. She doesn’t have a strategic bone in her body... she has no time management ’cause she’s so busy micro-managing and not delegating.” (*Maggie: IDI p. 27*).

However, ECONs (NO 6 and above) reported a constant struggle to perform effectively in their leadership role.

After all these years, you can’t help but be a good clinician on the ward, but then all of a sudden somebody gives you the key to the office and says there you go you’re the NUM. At the stage when there was a whole lot of us appointed to various wards, all the NUMs were new, there was a lack of mentors, there was a lack of nurse managers... essentially it’s been stumbling along. (*Andrea: FG2 p. 28*)

In the past, the promotion of clinicians occurred because they were good ‘hands on’ practitioners. Ironically, there was a downside to this situation. Novice leaders tended to operate too often in isolation since they had not experienced the nurturing of emotional intelligence that an appropriate mentorship program develops. The result is that too many clinicians lack the ability for personal reflectivity or self-awareness (Nielsen & Munir, 2009) and this deficiency contributes to clinicians generating an unnecessary emotionally abrasive workplace atmosphere that neither nurtures patient care nor EOCN satisfaction, a phenomenon identified in the literature (Letvak & Buck, 2008).

Further, EOCNs’ confidence in the leader’s ability had an impact on job satisfaction and their likelihood to remain in the organisation.

I had a great job that I thoroughly enjoyed in this organisation, but I resigned and left for the private sector. I couldn’t cope with the environment created by the boss. (*Sam: FG1 p. 1*).

The clinical EOCNs reported that they had left workunits and sometimes the hospital if they no longer had confidence in their leader's clinical and management skills. To a lesser degree, many EOCNs reported an increase in sick leave applications which has a disruptive effect on the workunits' team dynamics and productivity. "I've had more sickies in the last six months than I've ever had in the last thirty years. She has no clinical experience. I can't believe the hierarchy employed her." (*Carol: FG2 p. 10–11*). Clearly then, the findings of this study and other research indicates that the inadequate development of leadership potential undermines both personal credibility and respect for professional competency (Manion, 2004). This situation generates difficulties for nurse leaders to support clinicians to practice with the appropriate skills and standards.

However, clinical nurse leaders are responsible for the standard of clinical practice of the nursing staff within their workunit. As clinical standards are directly related to the standard of patient care, the role of the nurse leader is pivotal in organisational quality assurance. Recognising the importance of the leadership role, the organisation has provided increased opportunities for novice clinical leaders to attend leadership development programs. However, novice leaders continue to report that they work in unsupportive and professionally isolated environments.

If I need support for the management jobs, sure there is my nursing director who is often away or busy doing the bigger things, so you have to work a lot of it out yourself. There isn't really any mentor there to guide you. Sure you can ask them but no one actually says 'look this is that new form; this is how we are all going to fill it out.' It arrives on the email... all of these attachments and you think 'oh my god, what do I have to do with this?' There's no one there to guide you. It was like hit and miss. (*Leonie: FG2 p. 27*).

Ongoing support for novice EOCN leaders was reported as minimal. EOCNs suggested that they continued to struggle with the role as they received no support to apply the skills and knowledge of leadership into their practice. Unless this issue is addressed adequately, it may continue to affect the competency and confidence of developing clinical leaders (Crethar, Phillips, Stafford, & Duckett, 2009). Such an uninviting environment offers little encouragement for EOCNs to remain in the profession.



However, the delivery of leadership programs is only one strategy in the development of leadership maturity. “My nurse leader is excellent – she is probably one of the best bosses I have worked for. When people leave, they always want to come back. She is very progressive.” (*Docie: FG1 p. 35*). While EOCNs demonstrate their loyalty to a credible and effective leader, the provision of formal leadership programs does not guarantee the practice of effective leadership (Duffield et al. 2009). Moreover, there is ample evidence to suggest that good leadership behaviour is observed in those who have not attended formal professional development experiences. Such leadership behaviour may be attributed to years of experience and attention to critical feedback. However, there has been little attention given to harness these skills in support for the development of novice nurse leaders. This is an area that experienced nurse leaders may consider in the future development of novice nurse leaders.

It was difficult for novice nurse leaders to create an environment of trust. In an environment which lacks leadership consistency and credibility, trusting relationships may be difficult to nurture. EOCNs practising in such an environment may not achieve their full potential. It is also unlikely that their professional needs will be met. This generates dissatisfaction for both leaders and clinicians, and results in the increased likelihood of further resignations (Laschinger, 2005). Since this is the case, trust in the leadership team is becoming increasingly important. This study confirms that leadership maturity is pivotal in creating an environment in which EOCNs can deliver innovative and effective patient care.

### **7.2.3 Sustaining an inspired environment**

The third aspect of leadership maturity in relation to the EOCNs’ ability to perform in their role is sustaining an environment where effective patient care can be delivered. EOCNs report a discrepancy between their ability to perform their role with expertise and permission to perform. “I was an educator and the Director would not even let us send a memo without her signature. Lack of recognition, lack of autonomy was something that caused the three of us to resign within a day of each other. That was devaluing.” (*Mary: FG3 p. 3*). As EOCNs developed clinical expertise during their professional career, they expected to be able to practise relatively autonomously within parameters. If the EOCN was denied this independence, they chose to work in alternative environments where their increased professionalism was respected.

Ironically, this situation is occurring in an environment where employing and retaining qualified nurses is problematic. This study confirmed that when EOCNs are encouraged to practise autonomously, they are more likely to demonstrate loyalty towards their leader and remain in the organisation (Brooks & Anderson, 2005).

In addition, the lack of 'permission' to work autonomously limits the opportunity for the EOCNs' expertise to be shared with less experienced nurses.

When I go for the job, they usually say to me 'you've got vast clinical experience, you've worked in other states and other countries and I've completed my preceptor course twice and you know **not once** have I **ever ever** been asked to be a preceptor. I have seen nurses on the ward for two months be asked. They said at a meeting on the ward 'we need some more preceptors here. You girls better start doing the course'. I thought I'm not opening my mouth. I never get asked, they don't think I'm good enough or what ever, so bugger you. (*Docie: FG1 p. 54*)

When novice nurse leaders do not acknowledge EOCNs' experience by authorising them to fully use their skills and knowledge, EOCNs may withdraw their support for developing less experienced nurses. Recognition and acknowledgement of the efforts of staff are key satisfaction factors and thus retention strategies (Jasper, 2006). This is an issue that needs to be addressed in the pursuit of enhancing leadership behaviour and ultimately retaining the EOCN.

The ability to value nurses' contributions and encourage their involvement in decision making enhances organisational and professional role satisfaction, resulting in lower turnover rates (Nielsen & Munir, 2009). However, this requires leadership maturity. The nurturing of leadership maturity remains a challenge for novice EOCN leaders in the current environment.

### **7.3 Levels of Commitment to Work**

The second theme concerns Commitment Levels at Work. EOCNs believe there is pressure to do more with less. There are a number of reasons that contribute to this belief. The first reason is the perceived need to work additional hours, which influenced the EOCNs' decision about remaining in the workplace.

### 7.3.1 Working Additional Hours

As insufficient numbers of qualified nursing staff may lead to an inappropriate skill mix, experienced nurses commonly work extended hours to complete nursing duties. As EOCNs are usually the most readily available and experienced staff members, they are often called to work these extended hours. “The problem is being the only one there whose children are no longer dependent on them, so I am the only one who gets to work back. I am the only one who does long shifts.” (*Sam: FG1 p. 2*). Moreover, there is a perception that the EOCN is more available to meet emergent staffing needs because they no longer have the responsibility of school children at home and consequently have fewer family responsibilities than their younger colleagues. However, this does not exclude the EOCN from the family responsibilities of caring for adolescents, an elderly partner or relatives. This family situation is given minimal attention when additional or longer shifts are requested of the EOCN.

In addition to working extended hours, the EOCNs were required to manage many non-nursing duties which reduced the time available for patient care.

If you want the clinical nurse (NO Grade 5) to be the clinical leader on the day, **why** have they got a full patient load; **why** are they answering the phone for the receptionist **and** looking after the new grad **and** this and that... **that's crazy**... I think it belittles nursing actually. Clinicians are not respected or looked after, not just by this organisation but by the nursing [community] generally. (*Sam: FG1 p. 39*)

These extraneous duties unnecessarily contribute to an already heavy workload (Duffield & Roche, 2009). As a result, the EOCNs expressed resentment and cynicism in the manner their nursing role had evolved.

EOCNs also experienced a dissonance between the words of recognition and the actions of their clinical leader. An example is appropriate. While EOCNs were willing to accept the need to work additional hours, clinical leaders were often reluctant to reconcile this work with TOIL. Indeed, many EOCNs reported a perception of non-approval from the clinical leader. “What annoys me is the perception about TOIL; that TOIL is frowned upon. It has been intimated before that people who take a lot of TOIL are not coping with their workload, but not from too much work.” (*Andrea: IDI p. 3–4*). EOCNs suggested that working additional hours is often ‘conveniently’ viewed by the clinical leaders as poor time management, rather than a genuine request for

more time to complete necessary duties. This apparent lack of respect for the legitimate needs of EOCNs appears to be systemic and may influence the EOCNs' decisions about extending themselves to complete work.

Indeed, there is a perception of unfairness when the leadership team fails to recognise EOCNs professional ability or respect their personal needs. "Nurse managers routinely work exceedingly long hours. It's actually not fair... the workload is unreasonable. My line manager can be very frustrating and she tends not to listen if she doesn't like what she is hearing, but I told her: 'look I've worked ten hours for four days this week.' She'd say 'well that's your choice'... she's not making me do it." (*Jenny: IDI p. 26–8*). This situation has the potential to generate a loss of trust due to the lack of leadership transparency and consistency (Kane-Urrabazo, 2006). It is also unlikely that EOCNs will continue to accept additional work when they are not appropriately recognised for their contribution.

Another consequence of frequent 'over use' of these experienced workers to provide an appropriate roster allocation is the reduction in time for things other than work causing tension in the necessary balance between the realities of work and the need to 'have a life'. The physical and mental wellbeing of the EOCN is at risk of deterioration as they are frequently rostered on night shifts in addition to working extended hours. Many of these nurses choose a reduction of their employment hours in an effort to gain an acceptable work–life balance. "The best thing that I have done for work balance is dropping down to four days a week." (*Janine: FG1 p. 15*). There is sufficient evidence of nurses reducing their work hours or resigning to suggest that they are not prepared to continue to work in such environments (Storey et al., 2009).

Further, a prolonged heavy workload and a poor work–life balance are negatively associated with burnout where too many demands have a deleterious effect on the health of the EOCN. "I need a break from nursing. I'm over it". (*Sam: FG1 p. 57*). However arduous the workload may be, this study identified that the EOCN was more concerned about the lack of acknowledgement of the additional work they undertook.

Many activities nurses undertake are difficult to quantify<sup>20</sup> which minimises the nurse leader's ability to recognise the diversity of activities undertaken within a shift. This situation may contribute to the lack of recognition of the entirety of nurses' work, thus exacerbating feelings of decreased motivation and exhaustion (Freeney & Tiernan, 2009). Continued heavy demands, particularly in the light of little recognition, contribute to feelings of dejection and EOCNs reported strategies to rectify the situation by reducing work hours, transferring to another workunit or resignation. Leonie acknowledged her symptoms of burnout as a result of continuous heavy workloads. These contributed to her eventual resignation.

It's just that overwhelming feeling and that it's going to get busier and I just didn't have the strength for it. I was thinking, 'Have I got the physical strength to be doing this at 65?' Seeing more and more older nurses still working on the wards, still doing night duty at 60 and I'm thinking 'oh my God, I just can't face the idea'... knowing that I will never do night duty again. I have got to get out while I'm still young enough to do something physical. (*Leonie: IDI p. 20*)

While the workloads were reported as consistently heavy, the EOCNs coped in their own ways. Their individual coping strategies were closely associated with the degree of commitment they had to the organisation and the profession (Gould & Fontenla, 2006).

### **7.3.2 Commitment to work**

The second theme concerning work and commitment relates to the varying degrees of commitment expressed by the participants. This study found that the degree of commitment the EOCNs had to the leader, organisation or profession influenced their decision to remain in the profession.

As the number of qualified nurses declines, attention has focused on increasing the commitment levels of the nurses who remain (Allen & Meyer, 1990). Nurses demonstrating high levels of professional commitment usually stay in their chosen field (DeGroot, Burke, & George, 1998). Similarly, it is perceived that nurses who have high levels of organisational commitment demonstrate loyalty by remaining in the organisation (Allen & Meyer, 1990). However, this is a simplistic statement and

---

<sup>20</sup> Quantifying nursing work: There are difficulties in quantifying due to the lack of a common definition and varying collection methods. Data are not comprehensive due to the 'invisible nature of nursing work' (Duffield et al., 2006).

this study offers a more complex dynamic that has been rarely discussed in the literature and which will be amplified.

### 7.3.2.1 Self-imposed

Many of the EOCNs confirmed their commitment to performing work well past their paid work hours. “I just feel that us ‘oldies’ are just more prepared to work longer. I just take it as part of my day. I can’t walk out and leave a patient.” (*Docie: FG1 p. 3*). Despite the desire to complete additional work prior to leaving each shift, this was often at a cost to the EOCN. Ironically, the personal cost to the EOCN was often outweighed by a sense of satisfaction.

I’m often in the office very late at night and I am always grateful that my husband is out so I can feel relaxed that I don’t have to rush home and I can just sit there and clear the desk and clear the trays ‘cause I don’t have time to do it during the day. A lot of people say ‘don’t do it’, but it’s more satisfying for me to actually get it done. (*Leonie: FG2 p. 20*)

EOCNs regarded their job as a lifetime commitment and this was demonstrated by their strong sense of loyalty. Consequently, many of the EOCNs believed that a reciprocal relationship should exist between them and their employer. Since EOCNs believe nursing is like a vocation which generated a sense of loyalty from them, they considered it reasonable to expect a similar loyalty from their employer (Henry, 2007). However, if this loyalty is repaid with little recognition from the leadership team, it is likely that the EOCN’s commitment will be substantially undermined.

Ironically, the majority of the EOCNs continued to express their devotion to the job. “I think I just had to prove myself. I hadn’t been a CNC before, so there was a lot of pressure that I put on myself. I think a lot of being a nurse... how we are just so indoctrinated that you **have to have** all your work done before you leave.” (*Leonie: IDI p. 14–17*). In the absence of leadership recognition, this study found that the EOCNs directed their attention to a self-fulfilling expectation. However, once this expectation was fulfilled to the EOCN’s satisfaction, there was a risk that the EOCN would no longer feel the need to remain committed to the organisation. “I couldn’t have left even a year ago because I felt that I had things to do. So I can walk away from it now, but I’m tired.” (*Leonie: FG4 p. 63*). The EOCN may choose to reduce their workforce participation or leave the organisation prematurely.

### 7.3.2.2 Commitment imposed by the leadership team

Further to the strong sense of loyalty the EOCNs displayed, this study identified that the leadership team expected more of them. “It’s just expected that you will be there.” (*Leonie: FG1 p. 3*). EOCNs perceived that there was an unspoken expectation from the leadership team to meet the organisational needs whenever necessary. This perception of imposed commitment from EOCNs may be due to leadership immaturity. As leaders struggle to meet patient and organisational needs, they often use the willingness of the EOCN to meet these requirements. This had a deleterious effect on the EOCN as they interpreted these demands as a lack of respect and consideration for their personal needs. Further, this occurrence contravened the reciprocal relationship that the EOCN expected for their commitment. This phenomenon has been amplified in the scholarship (Henry, 2007).

Despite this disparity in expectations, one reason for the EOCNs’ continued loyalty may be attributed to “continuance commitment”, which refers to a conscious decision to remain in the organisation even when the cost of staying outweighs the benefits of the leaving (Allen & Meyer, 1996, p. 2). However, if the EOCN’s needs are repeatedly unmet, it is unlikely that they will demonstrate enthusiasm in their work or gain job satisfaction. This is an issue which leaders need to address to retain EOCNs.

While the clinical EOCNs perceived that the leadership team expected more of them, the EOCN leadership team perceived the same expectation from an executive level.

I think the healthcare system does extremely well out of our nursing directors, because there is no overtime payment and while everybody is saying and I agree, you work twelve hours and then an eight hour – sometimes it’s not as easy to do that, so you do twelve hours, twelve hours, twelve hours. One of my nursing colleagues said where they’re feeling the rub is when a meeting is called for 4 pm to 6 pm, they know the medical directors from 5 o’clock are being paid overtime and I just wonder: “Is it not again the system that expects more from **nursing** than they would expect from medical staff?” (*Emma: FG3 p. 20*)

### 7.3.2.3 Generational variance in commitment

Further, EOCNs reported a disparity of commitment levels between the generations. “We look at them and go ‘how do they do that?’ They are the last in the bloody door... they slink in just as handover starts where everybody else has been there probably ten to fifteen minutes. Why do I accept that when I have to stay back to

finish something?” (*Janine: IDI p. 18*). These shifting patterns of loyalty have the potential to generate conflict between the generations.

Commitment to the patient is essential in providing effective patient care. However, EOCNs also reported differences in the quality of care delivered. “I observed this one nurse. I thought I can just about keep pace with her for everything but what do I do **differently** that keeps me back? It’s the **connection** with my patient. She can disconnect **very readily**. She can get through things like a push feed three times faster than I can, but I couldn’t do that to a patient.” (*Sue: IDI p. 14*). EOCNs see themselves as strongly committed to patient care and the healthcare profession, but are disappointed that nurses belonging to Generations X and Y do not demonstrate similar commitment. “There is a definite shift in the generation, their accountability; their grasp of what we do is different to mine.” (*Emma: FG3 p. 26*). A greater understanding and appreciation of these differences needs to be explored in order to nurture more conducive work relationships between the generations (Henry, 2007). The result of perceived inequity in behaviour between the generations may engender resentment causing nurses to reconsider their employment options, particularly the EOCN as they are already planning their retirement.

This finding has implications for review of workloads and staffing allocations with consideration to the individual needs of EOCNs. There is also little evidence that these work environments support the continued commitment and loyalty of the most experienced nurse: the EOCN. The feasibility of retaining the EOCN should be considered in the context of improvement of the health and wellbeing of these nurses as they are challenged with arduous physical and mental stress (Graham & Duffield, 2010).

## 7.4 Social Capital

The third theme is Social Capital. In the context of this study, social capital refers to the network of relationships which connect people together and embodies three concepts emanating from the findings:

- Social safety nets support effective work practices
- Collegial networks support health and wellbeing
- Professional and social isolation are detrimental to effective work practices.



The participants believed that social capital was of value and importance. The ability to form and nurture work relationships influenced how the EOCN performed in their role. It also had a positive influence on their health and wellbeing.

#### **7.4.1 Social safety nets support effective work practices**

There is a perceived gap between the support networks offered by the employers of EOCNs and those necessary for a productive and sustainable work environment. This network gap has a potential negative effect on how EOCNs work. “Our divisional director was changing... essentially work has been stumbling along.” (*Andrea: FG2 p. 30*). In contrast, EOCNs reported that social networks empowered them to work with increased confidence, particularly when they were given the opportunity to debate and confirm their practice options.

My colleagues in the organisation... our NUM group has fallen into a fairly good supportive group. The relationships we have with some of the nurse managers are very good so there is a lot of support. (*Andrea: IDI p. 17*). Just hearing about the way they do things and networking and finding out that we all pretty much having the same problems... (*Andrea: FG2 p. 30*)

This social network was found by the EOCNs to be helpful, particularly in the absence of leadership support. When EOCNs perceived minimal support from their colleagues or leader, they experienced an increased level of stress. These findings are consistent with the literature (Gess et al., 2008; Laschinger et al., 2001). EOCNs considered social networks within a safe environment to be an important strategy in coping with unfamiliar situations. Moreover, these bonded relationships were built on trust, supporting the EOCNs’ professional or personal needs.

Ironically, while social networks were reported as having a positive influence on the EOCNs’ job satisfaction and their intent to stay within the network, too much social networking generated a toxic response.

She’s so busy micro-managing and not delegating. I’ve actually gone backwards since I’ve come here. I’m not good at working with people who control you. It’s a perfect example of if you sit on somebody for so long... it’s dumbing down... I’ve become so dull cognitively. I’ve gotta get out of here... I can’t do this. (*Mary: IDI p. 10–27*)

Nurse leaders are well placed to empower EOCNs to practise to their potential. However, when too much control is placed on how the EOCN can practise, there is

little opportunity to nurture and value their confidence or development. Evidence of nurse leader's confidence in the EOCNs' skills may potentially minimise stress in the workplace (Gess, 2008). However, due to a lack of empowerment, EOCNs reported increasing dissatisfaction as they perceived their expertise was muted. If the social networks do not foster an empowered and trusting work environment, it is unlikely that the EOCNs will be motivated.

This study also identified reluctance to include the EOCNs in collaborative multidisciplinary networks that had a detrimental effect on how EOCNs felt they performed within the interdisciplinary team. With continuous patient care responsibilities, the EOCN is ideally positioned to develop an informed and therapeutic relationship with the patient.

When I worked in the orthopaedic wards, they used to have discharge meetings. There would be the medical staff, the CNC, the Occupational Therapist and Physiotherapist. We were never invited. The **nurses** who looked after the patients **24 hrs a day** who know them **100% better** – we **know** them... we knew what they were like – walking, eating, **everything** – we weren't asked into the meetings – **never**. And I used to think, that Occupational Therapists had seen this patient **once** in how many weeks? (*Wendy: FG1 p. 45*).

The denial of EOCNs' participation in multidisciplinary team discussions may have a negative influence on the patients' needs as well as the EOCNs' morale. It is not surprising that this cumulative dissatisfaction influences EOCNs to rethink their employment options (Letvak & Buck, 2008).

#### **7.4.2 Collegial networks support health and wellbeing**

The second aspect of social capital concerns the benefits of creating an emotionally safe environment by encouraging relationships between colleagues. Sadly, EOCNs reported that nurturing these relationships was often neglected because too few nurses were available to complete the ever increasing workload in shift activities. "I think this antagonistic environment... finger pointing, hands on hips. 'I really don't appreciate being spoken to the way you just spoke to me.' It's a lot of bullying that goes on there. It makes it difficult to come back day after day." (*Mary: FG3 p. 30*). Support networks with colleagues have the potential to buffer the stress of daily activities and provide the emotional resources to manage anxiety more effectively (Duffield & Roche, 2009). Unfortunately, too often a helping colleague is not available, which has an understandable influence on EOCNs leaving the profession.

Work environment is a big thing. If somebody says 'hello – did you have a nice weekend?' It sorts of sets the mood [for] the entire day. And I think if your work environment is really good, you're happy to come to work and I know personally, I've been in the area for thirteen years, if I didn't like it, I tell you, I'd be out. (*Docie: FG1 p. 15*)

Likewise, collegial networks were considered fundamental to the EOCNs' emotional wellbeing.

I seriously considered and actively looked for other positions as well, and if it wasn't for the collegial support of my colleagues who I worked very closely with at that time, I would have moved on. So I **really think** that the influences are much more about people and the value and the relationships with the people. (*Julie: FG3 p. 3*)

However, with the emotional support of their colleagues, EOCNs often chose to remain in the organisation (Rose & Glass, 2009).

While the benefits of social networking are acknowledged, EOCNs reported little time to socialise with colleagues outside the workunit environment due to the rapid pace of healthcare. Working arduous and often traumatic shifts offers a persuasive rationale for nurses to relax and debrief with colleagues who are best qualified to empathise with their situation. The EOCNs reflected on the absence of an area in which they could regroup and discuss the previous shifts' activities.

Can we come over here and network? That's what I miss; the old dining room where every age level from every part of the hospital (would come) and you'd share your lunch. (*Sam: FG1 p. 61*)

We are so segregated. (*Wendy: FG1 p. 61*)

You miss the companionship. (*Docie: FG1 p. 61*)

I think that it's a great shame. You just need to book the room. If you said to all nurses, 'come on over and have a cuppa', most people would say, 'I'd rather go home actually'. Getting rid of the communal dining area was a great shame. (*Sam: FG1 p. 61*)

... but even if you make an effort – even if it's after work, half an hour, it will make a difference you know. (*Docie: FG1 p. 61*)

The ability for EOCNs to recapture and nurture social networks was reduced as a result of demanding work and home commitments. Certainly, the findings

demonstrated that there is considerable work to occur in order to rekindle a sense of community and wellbeing.

### 7.4.3 Professional and social isolation detrimental to effective work practices

The third aspect of social capital concerns professional and social isolation. EOCNs reported their need to feel connected to a like work group. However, the geographic placement of the workunit may contribute to professional and social isolation. Workunits physically distanced from their service line negatively influenced the EOCNs' sense of belonging and access to structures and supports which assisted the completion of work initiatives. "I don't really belong anywhere. We don't have a home ward. I feel the roving CNCs have dipped out a bit." (*Leonie: FG2 p. 25*). This team was isolated from physical and human resources that other wards accepted as the norm. As a result, there was a sense of seclusion which disconnected them from the other service lines and activities within the facility. The seclusion from other work units and resources has the potential to compromise the delivery of optimum services and the enthusiasm of the EOCN.

The study identified that a sense of belonging was promoted by the structure and design of the job. In the absence of clear professional alignment within the workunit, the EOCNs reported a reduced ability to contribute to unit outcomes.

I have no ownership of **anything**. I don't **own** a body of work. Mine is more crisis management, so there is very little job satisfaction. I don't have that autonomy to **own** something; I can't actually accomplish anything at the end of the day. I don't really have a body of knowledge, or I'm not an expert at anything anymore. (*Maggie: FG3 p. 22–3*)

Unfortunately, EOCNs believed their professional isolation contributed to feelings of being devalued and increasing dissatisfaction. "I could drop out of the organisation... my role, not me and really not have **any** impact, that's how I feel about my position. So I have a very frustrating role." (*Maggie: FG3 p. 22*). There is little evidence that nurse leaders considered the detrimental effect professional isolation has on the EOCN. This presents an opportunity for nurse leaders to ensure all professional roles align to workunit objectives and therefore optimise the contributions of EOCNs (Duckett, 2005).

The theme of Social Capital has implications for the health and wellbeing of the EOCN, and support of professional and social networks in the pursuit of quality achievements. The absence of these networks has the potential to negatively influence the EOCN's job satisfaction by generating feelings of segregation and being devalued. This study confirms the importance of an environment which affords staff the opportunity to gain support from their colleagues, which ultimately has a positive influence on retention of the EOCN (Rose & Glass, 2009).

## **7.5 Impact of Change**

The fourth theme is Impact of Change. The healthcare environment is dynamic by nature and change is a constant phenomenon which requires the nurse to maintain currency in professional knowledge and practice. For this to occur means that there needs to be a focus on how nurses negotiate the invitation to change as a result of professional renewal (Shermont & Krepcio, 2006). How change is managed at the study site influenced how the EOCNs undertook their work and subsequently how they viewed their workplace.

### **7.5.1 Willingness to embrace change**

EOCN leaders were receptive to how the dynamic of the professional context invited change. Indeed, more often than not, EOCN leaders responded enthusiastically to new challenges:

You feel that you can contribute and make [a] difference. When you are able to move through quite a few challenges, you are then able to develop a certain capacity to enjoy it and to develop more through the challenges that the environment offers you. (*Josephine: FG2 p. 2–4*)

This enthusiasm was increased if they experienced the capacity to have an element of control over change initiatives. This was because ownership of work choice contributed to their positive view towards these sometimes disruptive and threatening activities. "We do have more control compared to the NO5s with heavy workload. So I can appreciate they see the world quite differently." (*Deborah: FG3 p. 5*). The EOCN leaders' positive response to change may be a result of their being well informed of the background and intent for change (Henry, 2007). Nevertheless, a positive outlook did not negate the many barriers of change that need addressing.

### 7.5.2 Barriers to change

One of the most contentious findings from this study concerned a disparity between how the leaders understood and managed change compared with the perspective adopted by EOCNs. Because leaders generally confined their change strategy to issuing orders of change, the EOCNs resented their subordinate role unreflectively obeying orders from a superior. This situation generated tension between the EOCNs and the leadership team. The findings identified several barriers to successful change which influenced how EOCNs managed change initiatives. These barriers invite further explanation.

The first barrier to change was a perception of enforced initiatives. EOCNs resented change, an enforced initiative imposed upon them without an invitation to contribute. This situation can be demonstrated through the facility's model of patient allocation. The model, which was practised in the majority of acute clinical areas, aimed to support the development of novice nurses through clinical supervision, preceptorship and mentorship by more experienced nurses. The clinical EOCNs were commonly assigned to support the novice nurses because they had diverse experiences and vast practical knowledge.

Many clinical EOCNs were antagonistic towards this supposed partnership and maintained their practice of patient care independently of the partnership. The EOCNs' rejection of the partnership is a major concern for nurse leaders and the ongoing development of novice nurses.

I cannot stand team nursing. I hate working with other people where I have to share my patients, because at the end of the day you really are relying on that person's observations skills, you're relying on that person's work ethic, you're relying on that person's competence. If that person really stuffed up in one of their areas, you go home wearing their problems. I think my patients benefit much more from a holistic model rather than with team nursing. You really are doing a full assessment of the patient. I could not believe that it's being forced in such a way. (*Sue: FG1 p. 4*)

Likewise, EOCNs reported an absence of consultation and involvement in the planning of this model of patient allocation. In addition, a perceived absence of consultation may be a result of leaders neglecting to inform and explain change comprehensively to their team members, which may generate misperceptions and misinformation. These misperceptions potentially reduce the EOCNs' desire to

comply with such initiatives which may also effect the continued development of the novice nurse.

A further barrier to embracing change initiatives reported by EOCNs concerned the manner in which these initiatives were relayed to them. Some styles of communication had a negative influence on the willingness to change and exacerbated stress levels for the EOCN leading to increasing dissatisfaction.

She had a discussion with me... **a discussion** with me that 'you **have** to work as a buddy; you **have** to educate these new grads.' I said look, I'll give them their patients, I'll take mine and when I finish my work I'll go and **help** them because I want them to be responsible for their four and I'll be responsible for my four... 'No, no, no. It doesn't work like that.' I said 'I'm sorry it **works** like that and it **works** like that for me and that's how I'll work.' (*Carol: FG1 p. 36*)

Open and transparent communication enables change to be appropriately managed and supports the resolution of problems (Balnaves & Caputi, 1993). A shared process of generating change is not only a better way to produce authentic and sustainable changes, but also creates a nurturing work atmosphere for EOCNs by reducing the stress generated by fear of the unknown (Duffield & Roche, 2009). However, in the absence of appropriate interactions, a fracture in the working relationship between the leader and clinical EOCN is more likely to occur.

The reason why EOCNs were reluctant to engage in a partnership relationship with novices may be their fear that such a relationship is likely to generate a changing environment. Loss of control naturally generates professional insecurity (Chapman, 2010), which is a real challenge for those with so many years of experience. Sadly, nurse leaders failed to register this insecurity in the EOCNs. This lack of empathy contributed to an abrasive atmosphere in the workplace. In addition, feelings of insecurity were exacerbated by the inability of leadership to appreciate the experience of EOCNs or value their contributions (Henry, 2007). Not surprisingly, in such a demoralised atmosphere, there is a fear that the high quality of patient care may not always be guaranteed.

A further obstacle to embracing change initiatives may be attributed to denial that anything may be useful. Many EOCNs demonstrated a preference to continue past practice with growing skepticism to proposed changes such as the patient allocation model. This generates a tension between nurse leaders and many clinical EOCNs.

The tension is a lack of acceptance of change and denies that there will be any influence on the EOCN. However, one risk for the EOCN, workunit team and organisation occurs when there is a preference to continue past practices that have been consistently shown to fail or have resulted in an undesirable consequence (Chapman, 2010). A further risk is continuing to practice as they always have by denying that there is any necessity to change. Denying that the status quo can be improved may have a detrimental effect on the culture of a unit and the organisation. The tension generated by denial may foster dissatisfaction and may often lead to withdrawal (Duffield et al., 2009). However, leaders were reported to continue to 'enforce' strategies without collegial conversations with the EOCN often creating a deleterious environment. A better understanding of the needs of custodians of change and EOCNs will inform strategies to improve engagement in change activities.

## **7.6 Considerations of the Older Worker**

The fifth theme concerns the older nurse. Several issues relevant to the older worker influenced the EOCNs' ability to function in the workunit and their intention to continue to work. The first older worker issue which influenced the EOCNs was ageist attitudes.

### **7.6.1 Ageism**

Many EOCNs believed there was an organisational culture that did not readily appreciate the skills and knowledge of the older nurse. EOCNs perceived that negative stereotypes of older nurses were more often demonstrated by subtle actions rather than verbalised.

I did have an occasion to hear comments made by the nursing director, who said... "It's time some people moved over and make room for the younger generation." I was absolutely incensed at the time, I thought... how dare someone actually make that comment, blatantly discriminatory, to a group of people who she obviously thought were holding up positions that should be available to younger people? I just thought it was the most disgraceful remark to people who are a group who are contributing enormously. It was insulting to a group. (*Jenny: FG2 p. 53*)

EOCNs reported concern for these types of ageist stereotypes and prejudices as they demonstrated a lack of professional and personal respect for their commitment and contribution to the profession. These ageist attitudes generated disturbing responses from the EOCNs. Consequently, senior EOCNs were likely to be



perceived as too passive, which in turn led to negativity and conflict in workplace relationships.

In some cases, these derogatory comments may support the EOCNs' concern for their continued value as a result of their increasing age. While Antidiscrimination Legislation exists (Office of the Parliamentary Counsel, 1991), the Act has limited value if it is not applied in conjunction with the education of staff on rights and obligations. Negative attitudes towards ageing could have an influence on any attempt to implement social policies within the facility, particularly when directed towards the EOCN (Laditka, Fischer, Laditka, & Segal, 2004).

However, unlike other group stereotypes based on sex or race which remain static, each individual will grow older and as a consequence be at risk of ageism (Laditka et al., 2004). Ironically, in addition to ageist attitudes from other staff, EOCNs reported a personal concern for ageing and how it may affect their ability to work effectively.

What am I doing at work? Is work where you think you'll spend your last 10 years? I would hope I will be effective doing it. If I started to feel that I was slipping, making too many mistakes, I would be horrified. I can't walk around and people are starting to say: 'Why is she still here? Then I'd hope I'd have the sense to go... if someone pushed you out the door and forces you to leave... (*Jenny: IDI p. 24-25*).

The EOCN's attitude concerning their age may be more disruptive as it demonstrates uncertainty about their own ability, regardless of their extensive experience. This lack of confidence may also be a result of an organisational culture which reinforces devaluing of the EOCNs' contribution.

### **7.6.2 Physical and mental wellbeing**

The second issue related to the older worker is the importance of physical and mental health. EOCNs reported that the current healthcare environment was often detrimental to their health and wellbeing.

Well, I thought that I could just continue working full-time and doing everything that was required until I retired, but then crunch came and I thought, I just **can't** keep doing this, I physically can't keep doing it or mentally. I go home absolutely physically wrung out. (*Janine: IDI p. 1*)

EOCNs experienced exhaustion with heavy workloads and a declining ability to recover from shifts as readily as they had in previous years. The opportunity to relax after work was often not realistic. Domestic duties absorbed possible recovery time for the EOCN, thus increasing their feelings of exhaustion. "You'd have two days off; one was sleeping and one was actually having to catch up with the housework and next thing you were back on the morning shift." (*Helen: FG1 p. 1&4*). The literature supports the notion that continued heavy workloads and unpredictable shift rotations are detrimental to the health of nurses, particularly the older nurse (Winwood, Winwood, & Luchington, 2006). However, this situation is unlikely to improve with work environments characterised by an accelerated pace, increasing patient complexities and staff shortages (Lavoie-Tremblay et al., 2006).

Although the literature identifies research findings on the actions to retain older nurses, there is little known about the adaptability of working conditions or the effectiveness of any implemented strategies (Zeytinoglu, Denton, Davies, Baumann, Blythe, & Boos, 2007). Unfortunately, it is difficult for nurse managers to adapt the workplace for the older nurse as there are few organisational policies or strategies in place to address the physical challenges associated with ageing. Nevertheless, many EOCNs and nurse managers reported that they devised their own strategies to support health and wellbeing.

I used to work a 14-hour day and decided that it was too much for me at that stage because I'd work Monday, Tuesday and have Wednesday off and recover and then work Thursday, Friday and have the weekend off to recover. So I put up a proposition to go down to .8 and have a job sharing situation with my CNs. From my point of view, it's been great. I have all the experience. I've got something to offer but I should be comfortable too with the amount of hours that I am working. I said to the EDNS, 'we shouldn't have to do this [at this] stage in our careers'. (*Maggie: FG2 p. 9*)

The organisation endorses rotational shifts for all nurses in the clinical area regardless of age or health status. However, this is contrary to promoting staff health and well being (Letvak & Buck, 2008). Ironically, the notion of collective participation in these unsociable shifts is to support the principle of equity; however, there was little accompanying consideration for the older worker. "There is no recovery time and my body just wasn't handling it. As soon as I had the opportunity to move, I did." (*Sue: FG1 p. 7*).

To physically be able to manage night duty at our age is a problem because one policy must fit all... that you've all got to do rotational shifts, and some people are providing a doctor's certificate and they're actually been told no, they can't stay under those circumstances and they're being moved out of the area of their expertise on their medical certificate because they can't fit the mould of doing all of those shifts and you're losing all this expertise... and so persecution is not the answer. The hierarchy doesn't do it. (*Desley: FG2 p. 61*)

Although the detrimental health effects of shift work, particularly night duty, for all nurses is undisputed in the literature (Gabrielle et al., 2007), EOCNs continue to be allocated to work these shifts with little consideration of their increasing age. In the absence of flexible options, many EOCNs choose to leave or have been required to transfer out of their clinical area of specialty. "The bottom line is that nurses should be recognised for being older, recognised for having some value and protected from what that means from a... shift work point of view." (*Jenny: FG2 p. 60*).

A further challenge to achieving health and wellbeing was the provision of an acceptable work–life balance for the EOCNs. "I worked all my life, I'm 57. I've been trying to rear kids and now I have grand kids. It's just me and my husband now, so this is now about my life." (*Jan: FG2 p. 18*). At a time when retirement options are being considered, the EOCNs highlighted their preference for quality time away from work. If EOCNs are unable to achieve a balance between work and home, they often chose an organisation that can provide flexibility to meet their needs. The retention of experienced RNs has been suggested as a key factor in solving the RN shortage (Blakeley & Ribeiro, 2008). However, it is unrealistic to assume that EOCNs will delay retirement or early retirement given current working conditions.

### **7.6.3 Financial security**

Finance was identified as a strong predictor of the EOCNs' decision concerning retirement. For many EOCNs, the choice to retire is not an option. "I am only here until I get my super (superannuation) to a level where I can go." (*Karen: FG2 p. 43*). The study identified several reasons for the uncharacteristic extension of some of the EOCNs' work life. Most recently, the global financial crisis has had a detrimental effect on superannuation funds, causing a delay in retirement plans (Eley et al., 2010). Moreover, the long-term effect of juggling family commitments and work has reduced the ability for many EOCNs to generate sufficient superannuation funds to adequately support their retirement. In addition, EOCNs who were sole parents

reported the necessity to continue to work in order to meet mortgage repayments as well as to increase their financial security.

While many EOCNs reported a need to continue to work for financial reasons, they identified a preference for less arduous and time-consuming work. Nurse leaders have an important role in providing work flexibility to meet the EOCNs' financial, professional and work life needs. However, with constant staffing inadequacies and organisational goals to be met, this is not always possible nor was it seen as a priority.

To be a NO6 where I work, you have to give even more of yourself. You have to be doing projects at home... you have a lot of work to do to prove you are worthy to be a clinical facilitator. Quite frankly, my transition is to retirement. I did all of that in my forties and I don't want to have to do that now. (*Grace: FG1 p. 14*)

The Transition to Retirement Program offered in some facilities (Northside Health Service District, 2008) aims to support flexibility at work prior to retirement. This program may support a balanced work life and relevant finances to meet the EOCNs' needs. However, there are currently few organisational strategies to support this initiative at the study site. The prejudice against the older worker may be a barrier to moving seamlessly in and out of flexible work arrangements without actually retiring (Andrews et al., 2005). There is a pressing need for nurse leaders to consider flexible work arrangements as EOCNs are likely to transfer to an organisation where this is available.

EOCNs also raised concerns of inequity of pay for similar work. The responsibilities of delivering safe and effective patient care were reported as understated, particularly as many EOCNs were also responsible for large numbers of staff and substantial budgets.

One of my daughter's friends who hadn't... I think been to TAFE... she's not particularly highly qualified is on \$60,000 a year. And I'm thinking... **what**... you know. When you think the average unit you're running 35 staff... and your working all these extra hours and you're accountable for all your costs." (*Andrea: FG2 p. 46*).

Remuneration and comparative pay has constantly been debated as a recruitment and retention strategy (Department of Medical Sociology, 2008). However, while

healthcare continues to be challenged by multiple problems, it is unlikely that increased wages in isolation will rectify all of these problems.

#### **7.6.4 Professional respect**

There is disparity between the years of accumulated skills and organisational knowledge EOCNs have gained and the value and respect they receive. “I think nurses of our vintage have a lot to offer and people should recognise that the culture of the organisation should actually recognise older peoples’ experience.” (*Jenny: FG2 p. 58*).

One method of recognition of experience is by the invitation for inclusion in relevant decision making. Several examples of minimal opportunities for EOCNs’ inclusion have been discussed in Sections 7.2.1 and 7.5.2 and therefore, while relevant to this theme, shall not be repeated. However, it is important to highlight the EOCNs’ desire for inclusion and the manner in which the organisation encourages EOCNs to share their experiences with colleagues.

What I think important is the way the organisation treats you as you get older – not with an ageist mindset. Not being left out because of your age. Does the organisation value the older nurse’s contribution or just give a pat on the head indicating you’re not smart and young? Also important is the valuing of corporate knowledge. Just because you’re young and eager, it doesn’t mean that you are better. Also, just because you’re old, you shouldn’t sit back and go into ‘noddy land’ – you still have professional responsibilities. (*Julie: FG 3 p. 54*)

Ironically, while nurse leaders acknowledged that older nurses perform at an advanced level, were attentive to patients and loyal to organisational needs (Tremblay, O’Brien-Pallas, Viens, Brabant, & Gelinas, 2006), they did not always reflect this notion in the workplace. EOCNs reported that there was little evidence that the organisation promoted the use of their skills. Devaluing skills may be reflected in a reduced incentive for some EOCNs to continue to develop in the profession. However, EOCNs interested in career development reported many barriers in accessing programs.

The applicability and diversity of the program content was often unsuitable for the EOCNs’ specific professional needs. “I was looking at all the seminars on and I have been to most of them at least twice. You’ve been through the ringer once and you give it a break and next year you will go again.” (*Carol: FG1 p. 53*). Because program

developers generally confined content delivery to broad organisational imperatives, EOCNs took exception to 'wasting time' attending such programs. The absence of relevant programs demonstrates a lack of value in the EOCNs' continued professional development and their particular needs. Ageism may contribute to the perception that there is little value in continuing to train the older worker, thus promoting the perception that 'you can't teach an old dog new tricks' (Hemens, 2008). Moreover, the organisation's attitude about the older nurses' ability and receptivity to training may be influential in the decisions about content delivery (Tourigny & Pulich, 2006).

Indeed, many of the development programs provided by the organisation were designed for the less experienced nurse. As a result, EOCNs often placed their attention on supporting novice nurses attendance to these programs.

I think at this time in my career I'm not going to do any more study, I'm happy to go to courses and things like that, but not do more study, but I do **really push** to get my staff off to things... because they're the future. So from my point of view now with professional development, I'm probably more interested in trying to help my staff to get it than I am. (*Maggie: FG2 p. 54*)

The EOCNs' perceptions concerning their abilities to learn may be responsible for a 'self-fulfilling prophecy' of unworthiness. In a financially driven environment, organisations are required to justify return on investment prior to allocating funds for training purposes. Ageist attitudes may determine that younger nurses are a better investment due to their anticipated remaining years of service (Laditka et al., 2004). Such a viewpoint may reinforce the lack of value in the older nurse. However, with minimal years remaining in the workforce, any reluctance for EOCNs to access professional development opportunities may reaffirm ageist attitudes (Rix, 2005) and ultimately affect the quality of patient care.

The personal cost of accessing development programs was often found to be high. This influenced the EOCNs' attitude towards program attendance. While EOCNs were cognisant of the need for life-long learning, they were also concerned about the high personal cost of education. "I was considering doing the nurse practitioner of palliative care. The more I looked into it I thought no way. I wasn't going to get any money for my work, I was just doing my own time." (*Leonie: FG2 p. 51*). Alternatively, other clinical participants considered that they had completed sufficient study during

their career and work–life balance was a greater priority. “I have been a DON of a country hospital in Western Australia. I did that for three years so I feel like I have been there and done that. I just think that this time is for **me**. I don’t mind being educated but I don’t want to be tied down.” (*Docie: FG1 p. 50*). The literature reaffirmed the study’s findings that many EOCNs on the brink of retirement were less interested in job related training (Rix, 2005).

A reason why many EOCNs were reluctant to access programs was the lack of staff available to replace those attending programs. As a result, many reconsidered the value of continuing to request permission to attend programs.

Being valued is definitely part of it, and that’s things like asking to go to a conference and being allowed to go. There’s a lot of inequity where that sort of stuff is concerned. Some people get that a lot more than others. One problem with my role is it’s very hard to replace me, so it has to be planned in advance. I was going to go on a conference at the beginning of this week and then discovered that my replacement had been rostered to cover someone else’s annual leave. I’ve got this ongoing thing where I’m too old and I’m not worth it. I’m nervous that’s what they might think. I wonder if it will get to a point where they’ll think, oh she’s too old. (*Jenny: IDI p. 23–4*)

Overcoming the ageist perceptions requires consideration by the leadership teams and staff. EOCNs bring a wealth of knowledge and networking connections which can not be replaced by younger nurses in the short term. However, if EOCNs see minimal organisational response to support their needs as older workers, they may drift into retirement or choose to work elsewhere.

## **7.7 Balancing Decisions**

The sixth theme is Balancing Decisions. EOCNs considered their decision for staying in the organisation or the profession as a result of balancing their professional and personal priorities. In the context of this study, the Effort/Reward Imbalance Model is an appropriate heuristic to appreciate the EOCN’s phenomenon (Siegrist, 1996). When EOCNs experience an imbalance of the effort applied to work and the reward for that work, they reported an increase in stress levels. This tension has a detrimental effect on job satisfaction and the personal health and wellbeing of the EOCN. However, it is the balancing of the priorities to work and the ability to sustain work in this stressful environment which influences the EOCN’s decision about continued work life. There are multiple issues that EOCNs consider when determining their decision to remain in or leave the workplace. Because such a

decision is based on a fabric of complex and interrelating dynamics, it is appropriate to discuss this issue using a framework of one particular EOCN's journey motif.

### 7.7.1 High effort / low reward

As the CNC, Leonie was responsible for developing a new palliative care service which spanned two hospitals. Leonie experienced a discord between the high levels of work and minimal reciprocal rewards from the organisation. Over time, this imbalance resulted in high stress levels. "I'm **overworked**... it's **so** much to do and I'm **drowning**." (FG2 p. 20). Extended hours seemed necessary to complete the required work, particularly as the number of staff within the team was small. However, working extended hours generated family conflict.

There was a lot of friction at home because of the long hours that I was putting in and I certainly didn't get the moral support from my husband. That was our **constant** battle, never taking work home but hiding it, getting up really early before he would so I could get it finished without copping the criticism from him, **working late** only when he was going out, so that I didn't get the criticism. So there was a lot of sneaking around... really submissive... didn't feel right at all but I just had to get it done. I felt far more satisfied when the work was all done than if I left at 4.30 and it was all there for me the next morning. I couldn't relax with that. (IDI p. 6)

The need to work until the job was completed outweighed the pending criticism and arguments she expected from her husband. While the balance of work was unreasonably high, Leonie tacitly accepted this workload as part of the new service development. This high motivation to work may be disguised as 'over-commitment'. EOCNs engage in such dysfunctional activities that 'over-commitment' satisfies the need to gain some control over the work life situation. High cost and low gain at work is frequent in people who exhibit a specific motivational pattern of coping with demands and is characterised by excessive work-related commitment (over-commitment) (Department of Medical Sociology, 2008). Further, perceptual distortion prevents the individual from accurately assessing a balance between cost and gain relationships (Schulz, Damkroger, Heins, Wehlitz, Lohr, & Driessen, 2009).

Moreover, the support network available to Leonie was minimal. Geographic isolation from the mainstream services generated difficulties in gaining the necessary professional support to manage this new service.

I don't really belong anywhere. We don't have a home ward. If I need support for the management things, sure there is my nursing director who is often away or



busy doing the bigger things so you have to work a lot of it out yourself. It was like hit and miss. You might be sent an answer to your email like 3 days later. (FG2 p.28-32).

In the absence of leadership support, Leonie justified the need to maintain control over her work life. However without leadership support, feelings of devalue and dissatisfaction resulted. The acceptance of effort without support may be due to the individual's strategic reasoning (Department of Medical Sociology, 2008). As such, Leonie determined that the long hours with or without leadership support were necessary to achieve an effective new service regardless of the stress this generated.

Indeed, in the process of building the new service, other stressors were identified. As a consultation service, the nurses in the workunits were responsible for delivering the patient care as negotiated. A shortage of appropriately skilled nurses to provide the level of care required for these palliative patients was problematic. Moreover, Leonie believed younger nurses needed to demonstrate increased sensitivity in their delivery of patient care.

My fuse was getting short as I was going around the wards and witnessing inept nursing care. They're looking after our dying patients and they weren't doing it right or with compassion. I was starting to get very irritated with that. I am already over trying to over-compensate for them and over trying to educate them and trying to instill some set of values that I feel I've gained over the years, they're not interested. (IDI p.1-9)

Understandably, Leonie experienced frustration at the perceived lack of interest or care demonstrated by less experienced nurses. Indeed, with little ability to control the care given over a 24-hour period across several workunits, Leonie experienced increasing levels of stress about her role.

Over time, the stress of continually supporting the service along with concerns for the delivery of quality patient care had an exhausting effect on Leonie. "The **futility** of just **trying** to educate this generation... I think that's because I am a bit burnt out." (IDI p. 13). In an effort to improve her wellbeing, Leonie considered reducing her work hours, however this would require either relinquishing the CNC position or negotiating a job share arrangement. "I know I can't call those shots, the job is full-time so I know I can't make it any less than that, and I know I would slip back into the old practices of working late." (IDI p. 15)

Leadership immaturity may account for the lack of insight in supporting alternative work options. The probable consequences of this inflexibility may include increasing stress levels, which exacerbated her decline in health and finally led to the resignation of an experienced and committed staff member. The study reaffirms the body of literature that suggests that emotional exhaustion and probable burnout is predicted by effort–reward imbalance and over–commitment with contributing factors such as working with a difficult client population, limited resources and unreciprocated giving (Schulz et al., 2009).

Emotional exhaustion was exacerbated by an imbalance in work–life situation. “I don’t think I ever had one sick day in probably the first 6 years because there would be absolutely no one else to take over. It’s the rod for my own back as no one ever wants to relieve me because they think the hours are so horrendous.” (*FG2 p. 6 & 20*). Challenged by a small and specialised team, the allocation of leave or professional development opportunities was made more difficult. “I could never get anyone to relieve me, so what’s the point. So I’ve just gotten over it but it is frustrating.” (*FG2 p. 52*). Leonie chose to accept this situation without further discussion or negotiations with nurse leaders. This may be a result of being overwhelmed with constant heavy workload and little experience of previous leadership support. The inability to balance work and home commitments is responsible for dissatisfaction, increasing exhaustion and staff turnover (Duffield et al., 2009). However, sharing interactions with palliative patients reinforced the value of a balanced life for Leonie.

They’re all full of regrets for the things they didn’t do, not the things they did do when they were younger. I mean I’m 50 next week. I’ve got to get out while I’m still young enough to do something physical. If I don’t do it now, I probably won’t do it at 65. (*FG2 p. 20 & 64*).

The effort expended at work was high, however, the rewards received were low. This situation was unsustainable in the long term. Rewards can be realised through money, esteem and career opportunities including job security (Schulz et al., 2009). However, remuneration did not rank highly for Leonie’s personal needs. “I don’t want to work this hard. I don’t have to financially.” (*IDI p. 14*). An alternative strategy to recognise staff is to provide access to professional development. “I was considering doing the nurse practitioner of palliative care. I wasn’t going to get any money for my work, I was just doing my own time and I wasn’t paid for it, and I get maybe 50 cents

per hour more at the end of it. No way.” (*FG2 p. 51*). Sadly, the only opportunity for Leonie to access programs or support her career development was in her off-duty time. The lack of available staff is not a new phenomenon, nevertheless it did demonstrate that the ‘system’ displayed little value for such a committed EOCN.

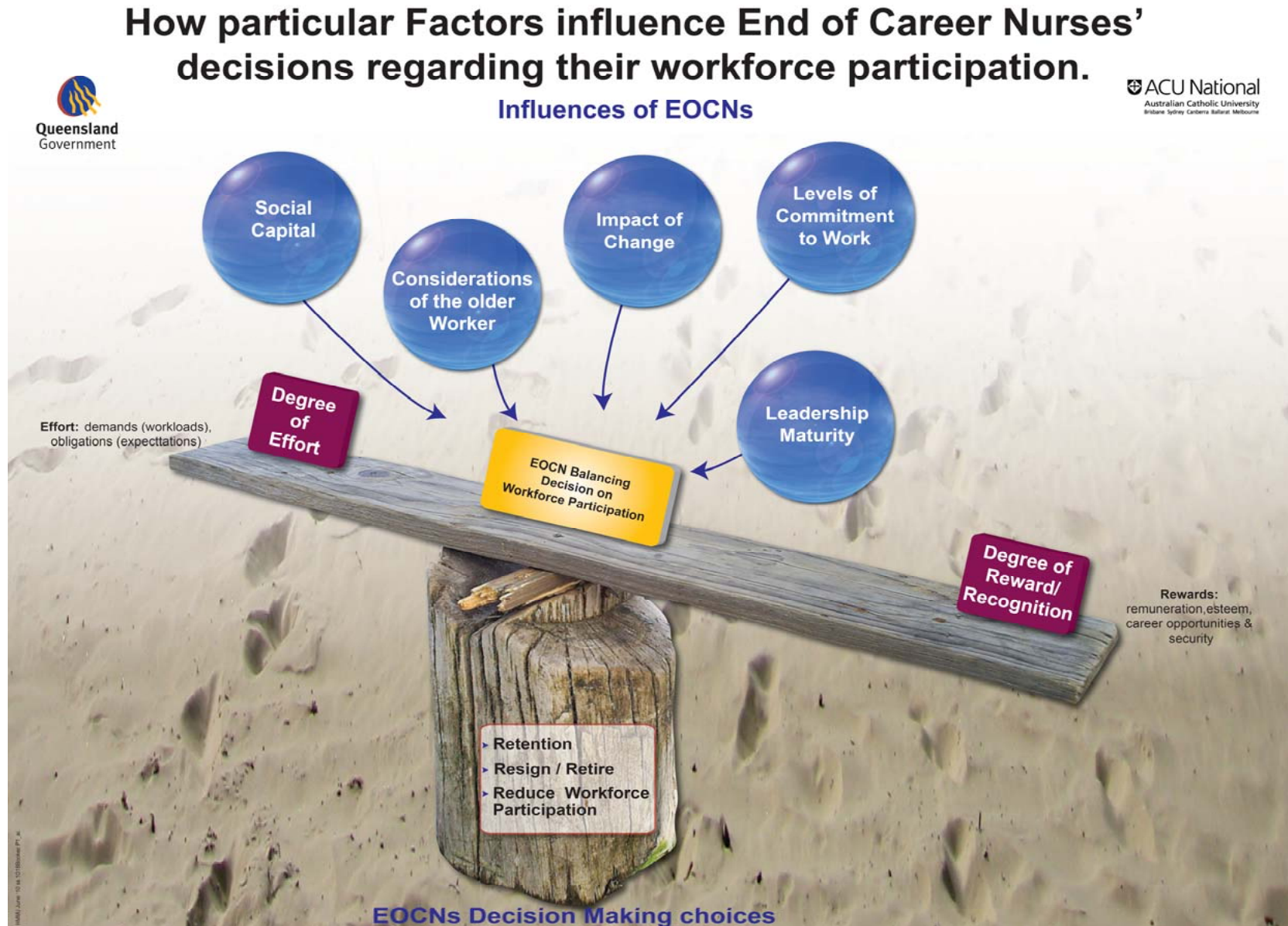
Leonie reported feelings of exhaustion, helplessness and an inability to continue to work in this environment. Considering the balance of effort and rewards, Leonie determined to reduce her continued work life. “I’m so tired, so burned out. I’m taking twelve months without pay. I couldn’t have left it even a year ago because I felt that I had things to do. (*Leonie: FG3 p. 63*). This study reaffirms the wider research that concludes that work related rewards eventually have an influence on a persons’ health and wellbeing (Ostry, Kelly, Demers, Mustard, & Hertzman, 2003).

Relief from emotional exhaustion was realised only when Leonie made the decision to leave the profession. “I don’t feel tired anymore, interestingly enough now that I’ve made the decision to go and I have a light at the end of the tunnel, I’ve been incredibly calm and peaceful.” (*IDI p. 17*). The study confirms the Effort / Reward Model which proposes that jobs characterised by a perceived imbalance between high effort and low rewards are stressful and are strong predictors for burnout, especially emotional exhaustion (Schulz et al., 2009). Understanding the concept of balancing effort with reward may assist EOCNs’ coping behaviours and also support leaders who choose to create a work environment which is conducive to retaining the EOCN and their expertise. Indeed, lower efforts in job demands and stress levels coupled with adequate ‘rewards’ such as social support, respect from colleagues and job control have been shown to contribute to lower burnout, and higher job satisfaction and commitment in nurses (Bakker, Killmer, Siegrist, & Schaufeli, 2000).

Leonie has since resigned her position and is no longer working in the profession.

This chapter discussed the findings presented in the previous chapter (Chapter Six) that were generated from this study of the factors that influence EOCNs’ decisions regarding their workforce participation. Figure 7.7:1 provides a conceptual view to support this discussion.

**Figure 7.7:1 Conceptual View of Findings**



## **CHAPTER EIGHT: CONCLUSIONS AND RECOMMENDATIONS**

The purpose of this chapter is to present the conclusions and recommendations of the study.

### **8.1 The Purpose of the Study**

In response to the phenomenon of EOCNs prematurely retiring from the healthcare workforce, this research explored factors that influence EOCNs' decisions regarding their workforce participation. This study also aimed to appreciate the rationale behind the perceptions of the EOCNs and the implications for practice.

A review of the literature highlighted factors which influence EOCNs' decisions regarding their workforce participation. The research data confirm the relevance of a number of diverse influences on the EOCN and highlight the usefulness of an individual Effort and Reward Imbalance Model (Siegrist, 1996) contributing to the decision making. The research identifies tension generated by EOCNs' unmet professional and personal needs.

### **8.2 Research Design**

This study adds value to the discussion on the work environment and the importance of leadership to meet the professional and personal needs of the EOCN. The EOCNs' decision to remain in or leave the organisation is considered in light of the balance between effort and reward. This research design was focused by the following research questions:

- 1) How do workplace environmental factors influence the EOCNs' decision regarding workforce participation?
- 2) How do leadership factors influence the EOCNs' decision regarding workforce participation?
- 3) How do personal and professional recognition factors influence the EOCNs' decision regarding workforce participation?
- 4) How does the balance between effort and reward influence the EOCNs' decision regarding workforce participation?

An interpretive approach was used. A constructionist epistemology was adopted for this research as it emphasises that meaning is socially constructed and further espouses the influence of culture in shaping the way phenomena are interpreted, providing a definite world view (Crotty, 1998).

The particular focus of this research was an examination of the social interaction between the participants and their context as they make sense of their perceptions. The complexities of social interaction within the acute healthcare setting are challenged by history, culture, internal and external influences and varying interpretations and perceptions of the nurses' experiences. Symbolic interactionism was adopted as the lens to inform the theoretical perspective of this study because it seeks to understand and describe the EOCN's subjective experience from the individual's view.

Given the in-depth exploration of the social interactions between the EOCNs and their context, a case study approach was considered appropriate for this study. The study offers a voice to the experiences of the EOCNs as they interact and respond to multiple influences in and out of their work environment. Case study allowed flexibility to describe, explore and explain both the context and technical characteristics of the phenomena, and is well suited to the dynamic changes within the healthcare system (Yin, 2003). In addition to gaining insight into the beliefs of EOCNs, further insights were illuminated which can influence policy, procedures and future research (Merriam, 1998).

Participant selection was purposeful and guided by the boundaries which established the case of EOCNs who provide direct or indirect care or support services within an acute healthcare setting. The case study boundaries included only those EOCNs with a broad range of nursing classifications [Nursing Officers (NO) Grade 5–12] as it is considered that all nursing levels are exposed to experiences which may influence workforce participation decisions. Timeframes of work experiences were imposed and included a minimum of ten years of practice. This decision was based on the premise that practicing within such timeframes would ensure the EOCNs understood the diverse issues of the nursing profession and the healthcare environment. This purposeful selection provided the opportunity for information rich insights into the issues of the phenomenon under study.

The data gathering strategies were:

- Survey (218 participants)
- Focus group interviews (21 participants) and
- In-depth semi-structured interviews (8 participants).

### **8.3 Limitations of the Research**

This research is situated in a large tertiary acute referral hospital in Queensland and concerns the context and motivations of the EOCNs to remain or leave the workforce. There are concerns that case study provides little basis for scientific generalisation (Yin, 2003). However, some researchers suggest that the capacity to make general conclusions is unnecessary or impossible, arguing in favour of thick description, naturalistic generalisations or transferability (Lincoln & Guba, 2004). The focus of case study is on particularisation, rather than generalisation. There is emphasis on uniqueness of the case which implies in-depth knowledge of the phenomenon and the understanding of the case itself (Stake, 1995). The aim of this case study is to 'give voice' to the EOCNs, representing their case authentically, which is the core to discovering 'symbolic truths'. The notion of authenticity is considered with regard to the legitimacy of researchers speaking on behalf of others, or challenging the idea that collectively people have but one perspective (Hammersley, Gomm, & Foster, 2004). The study outcomes will be suggestive rather than conclusive and will not provide one perspective of the phenomenon (Crotty, 1998). However, if colleagues review the research and believe it to be relevant to their situation, the findings may be transferable. The decision of transferability is the responsibility of the individual considering the findings as opposed to the researcher of the original study (Barbour, 2005).

A second limitation of the research is the personal and professional relationship of the researcher to many of the participants. As the researcher is known to a number of participants and holds a senior position at the study site, there is a risk of whether the participants provided honest, rich data. The researcher is conscious of the possible bias and influence this may have on the research findings. The professional integrity of the researcher together with the choice of multiple data collection techniques minimises the researcher's bias in the collection and analysis stages (Merriam, 1998).

## 8.4 Research Questions Addressed

This section addresses each of the specific research questions which focused the conduct of this research.

### 8.4.1 Research Question One

The first question is:

**How do workplace environmental factors influence the EOCNs' decision regarding workforce participation?**

Three workplace environmental factors had a negative influence on the EOCNs' decision to remain in the workforce. They are:

1. Workload
2. Health and wellbeing
3. Work–life balance.

Each of these influences will be addressed.

The first issue is workload. Currently, the EOCNs have a heavy workload. This included extra supervisory roles, which often meant they were required to work extended hours to complete their work. This generated a negative influence, which often caused them to consider leaving.

The second issue is health and wellbeing. The EOCNs questioned their physical ability to maintain a pace required with the current workloads. Inflexible rosters meant that EOCNs worked the same number and often more unsociable shifts, such as night duty, than their younger colleagues. This caused EOCNs to reflect on their desire to remain in such an environment which may have a negative impact on their health and well being.

The third issue is competing work and life commitments. The work environment gave little latitude for considering the personal needs of the EOCN away from the work environment. As females, there was a social expectation that they will accept a major responsibility for home duties and child care. However, as a result of the EOCNs ageing, it was assumed by leaders that they had less family commitments. These



assumptions led to the belief that EOCNs were readily available to support additional work commitments. This generated a professional and personal conflict for the EOCNs, which caused some to reconsider their workplace options, while others accepted the additional work albeit reluctantly.

#### **8.4.2 Research Question Two**

The second question is:

**How do leadership factors influence the EOCNs' decision regarding workforce participation?**

Two leadership factors had an influence on the EOCNs' decision to remain in the workforce. They are:

1. Leadership credibility and
2. Supportive interactions.

The first issue is leadership credibility. The EOCNs considered that when leaders were not readily available on the workunit, the leaders were unable to appreciate their work difficulties. This lack of visibility caused disrespect for the leaders as the EOCNs questioned their leaders' credibility in management skills. This often resulted in EOCNs taking increased amounts of sick leave or resigning. However, where leaders were involved and demonstrated an interest in workunit activities, the EOCNs felt supported and remained within the unit.

The second issue is supportive interactions. EOCNs valued an environment where their leaders nurtured social networks. However, in many instances, EOCNs worked in an antagonistic and abrasive environment and felt unsupported by their leader. This unsupportive environment caused a lack of trust in the leader and the associated toxic work environment (Sumner & Townsend-Rocchiccioli, 2003), which often resulted in the EOCN transferring to another workunit or resigning.

### 8.4.3 Research Question Three

The third question is:

**How do personal and professional recognition factors influence the EOCNs' decision regarding workforce participation?**

Four personal and professional factors had an influence on the EOCNs' decision to remain in the workforce. They are:

1. Valuing contributions
2. Professional development
3. Remuneration
4. Generational variances.

The first issue is valuing contributions. EOCNs expected recognition for their skills and knowledge by sharing their experiences with colleagues and an opportunity to work autonomously. When given this opportunity, EOCNs responded with increased commitment and job satisfaction. However, the lack of 'permission' to perform autonomously often generated a sense of worthlessness and resulted in EOCNs choosing to leave such an environment.

The second issue is professional development. The maintenance of contemporary knowledge was recognised as important by EOCNs; however, the value of programs was acknowledged by participants with varying degrees of interest. Many EOCNs considered programs were directed towards the novice nurse and that the novice nurse's development was considered a more valuable contribution to the profession than theirs. In contrast, EOCN leaders considered professional development an important means to support career advancement.

The third issue is remuneration. EOCNs considered that remuneration was one method of recognising their professional expertise. However, comparative inequities of remuneration between disciplines generated a perceived lack of value for their professional contribution. The need to ensure financial security, particularly as retirement approached was a strong motivator among EOCNs to remain in the organisation.

The fourth issue is generational variances. EOCNs perceived that their younger colleagues did not share the same degree of professional commitment and loyalty that they demonstrated. This perceived lack of professionalism displayed by younger colleagues had the potential to compromise patient care, leading the EOCN to consider leaving the organisation.

#### **8.4.4 Research Question Four**

The fourth question is:

**How does the balance between effort and reward influence the EOCNs' decision regarding workforce participation?**

Imbalance between effort and reward had an influence on EOCNs' decision to remain in the workforce.

If the EOCNs experienced an imbalance between the amount of effort they gave and the degree of reward received, they reconsidered their employment intentions. EOCNs expected to receive respect and acknowledgement for their expertise by having a voice in workunit and patient decisions. Recognition of their experience generated feelings of worth and appreciation for their professional contributions. By receiving this recognition, EOCNs felt rewarded for their efforts. When EOCNs experienced a balance between effort given and the reward received, they felt motivated to remain in the organisation.

### **8.5 Conclusions of the Study**

#### **8.5.1 Contributions to New Knowledge**

There are a number of conclusions made from this research that contribute new knowledge.

##### *Leadership Maturity*

This thesis concludes that work satisfaction and personal recognition have far more influence on decisions concerning job retention than considerations about increased salary or workload. This conclusion implies that those in leadership positions need to develop their skills in order to cultivate a shared leadership culture in the workplace that recognises individual competency and celebrates personal initiative.

### *Social Capital*

The second conclusion that generates new knowledge concerns social capital. The participants, even in a toxic atmosphere, chose to remain so long as they experience strong personal and professional friendships with colleagues. When formal leadership is lacking, staff generate an alternative leadership model demonstrating power based on personal shared leadership. This has strong implications concerning the shared leadership culture in organisations.

### *Extraneous 'Effort' Concept*

The third conclusion that generates new knowledge concerns an additional category to nurses' work ('demands'). While the Effort–Reward Imbalance Model claims three different kinds of effort (cognitive, physical and emotional 'demands') (Vegchel, Jonge, Meijer, & Hamers, 2001), this study identifies an additional 'effort' concept. Nurses are often required to engage in ancillary roles from other professional groups such as administration and after-hours physiotherapy support, which contributes to the dimensions of their workload. This conclusion implies that leaders need to consider the complexities of the 'effort' of nurses' work in order to optimise a balance between effort and reward.

### *Viewing Effort and Reward Collectively*

The fourth conclusion that generates new knowledge concerns the equal importance of both the 'effort' and 'reward' components in the Effort–Reward Imbalance (ERI) Model. This study contests previous research which places an emphasis on either effort or reward components. Research has identified that high efforts are 'the most crucial factor in the Effort Reward Balance' (Vegchel et al., 2001, p. 135). In contrast, other researchers have placed an emphasis on the reward structure of work (Marmot, Siegrist, Theorell, & Feeney, 1999). Examples of extrinsic reward factors identified in the study included: flexibility in rosters; comparative pay and support for financial preparedness; professional respect; an emotionally safe and supportive environment; and access to relevant professional development with career advancement opportunities. Employees weigh the costs and benefits of continued employment collectively, which acknowledges that different effort constructs in combination with different occupational rewards have an affect on employee wellbeing and job satisfaction. This conclusion implies that leaders need to honour all aspects of the ERI model equally in order to optimise a balance between effort and reward.

### **8.5.2 Contribution to practice**

There are a number of conclusions made from this research that contribute to practice.

#### *Transferring Skills*

This thesis concludes that in spite of increased workloads and an abrasive workplace culture, participants of the organisation appear to maintain a strong commitment to mentoring and supporting colleagues. However, there are barriers to transferring this expertise and organisational knowledge. At a time when nursing shortages are critical, it is important that leaders harness this expertise in support of continued quality patient care and professional respect with consideration to an acceptable workload. This conclusion implies that both leaders and staff need to cultivate a shared learning culture in the workplace that recognises and celebrates exchange of knowledge.

#### *Workplace Design*

The second contribution to practice concerns workplace design. Physical working conditions such as heavy workloads coupled with unsociable shifts were identified as being detrimental to staff health and wellbeing. Participants chose to reduce their work hours or permanently leave the organisation in order to avoid such conditions. This conclusion implies that those in leadership positions need to review work practices and job design to promote an environment that fosters and supports a safe and healthy workplace.

#### *Skill Development and Lifelong Learning*

The thesis concludes that participants of the organisation value the opportunity to maintain their contemporary skills and knowledge through relevant professional development opportunities. However, opportunities were often minimised by an organisational preference to focus such support towards the less experienced nurse. In addition, the relevance of program content for the experienced staff member is particularly important to sustain interest and motivation in accessing programs. The thesis concludes that experienced members of the organisation value opportunities to enhance their knowledge and support their lifelong learning.

### **8.5.3 Contribution to Policy**

There are two conclusions made from this research that contribute to policy.

#### *Age Sensitive Policy*

This thesis concludes that there is a lack of organisational policy and practices which are sensitive to the needs of the mature members of the organisation. By appreciating the relevant concerns and needs of employees identified within this study, nurse leaders and policy developers can more aptly nurture a work environment free of ageism. This conclusion implies that those in leadership and policy development positions need to support an age sensitive culture by honouring the principles of antidiscrimination and supporting a safe and healthy environment.

#### *Supporting Transition to Retirement*

The second conclusion that contributes to policy concerns retirement support. This thesis concludes that the organisation is void of pre-retirement planning support strategies. As life expectancy continues to extend, financial preparedness becomes an important consideration in the timeliness of retirement decisions (Eley et al., 2010). With many unpredictable economic variables, it may be of benefit to staff and organisations to assist employees to explore long-range financial planning (Preston, 2009).

## **8.6 Recommendations**

The conclusions of this research identify a number of issues emanating from workforce decision making. The following recommendations address key issues and support the retention of the EOCN.

Recommendations should be considered and implemented by relevant agencies such as staff development, policy developers and human resource staff.

1. Develop leadership networks through a mentorship model for nurse leaders to provide direction and clarity to their role. Such networks would support leaders' ongoing development and their application of leadership principles into practice, resulting in a shared leadership culture in the workplace.

2. Review the roles and responsibilities of the older worker in light of the disparity in the physical and mental abilities in older and younger workers. Greater recognition of employee health and wellbeing, particularly for the older worker, will support a healthy work environment and enhance longevity of workplace participation.
3. Promote and foster opportunities for the older and more experienced worker to mentor novice nurses. Job redesign will promote the recognition of the older nurses' expertise and enhance the opportunity for transfer of skills and knowledge to the less experienced nurse while addressing the physical hardships of the EOCNs' workload.
4. Provide accessible professional development programs which are relevant to the older worker's learning needs to maintain their contemporary knowledge. A stronger focus on programs specific to the needs of the older nurse will nurture their continued motivation for life long learning.
5. Offer pre-retirement counseling which incorporates the principles of 'transition to retirement' concepts at key career decision points. An increased focus to support the older worker in preparing their retirement plans will provide a balance between their financial situation and flexibility in their continued worklife.
6. Give greater recognition of and application of strategies to enhance the balance of the individual's effort and the reward received to foster their continued satisfaction in the workplace. Such recognition will acknowledge the value of the nurse and enhance their motivation and continued commitment to the profession.
7. Develop and implement policies which are sensitive to the older worker's needs. As a consequence, the older worker's contribution will be recognised and maximised which will support retention in the work place.
8. Promote opportunities for nurses to foster social networks with colleagues to promote an emotionally safe environment and a supportive culture.

Social capital has implications for the health and wellbeing of the nurse, and will also enhance professional and social networks in the pursuit of quality achievements.

9. This research may be the catalyst of further research into this topic.
  - Replicate the study for other professional groups. The health profession is at risk of losing large numbers of 'baby boomers' in the near future. This will affect groups such as Medical, Allied Health and Dentistry. Professions such as education are facing similar workforce issues and may gain value in considering the feasibility of transferring this study to their professional group.
  - Further research to identify if specific 'effort' constructs which are aligned to particular 'reward' constructs have an effect on employee wellbeing.

This research has identified several profound challenges for the older worker and the management of these issues by the leadership teams within healthcare. The need for an urgent review and revitalisation of current thinking and practices against the reality of a rapidly changing and shrinking workforce has been established, and such a review is necessary for the sustainability of healthcare. This research confirms the results of similar research in this area and identifies additional findings for consideration into this topic.



## REFERENCES

- Aiken, L. H., Clarke, S. P., & Sloane, D. M. (2000). Hospital restructuring: Does it adversely affect care and outcomes? *Journal of Nursing Administration*, 30, 457-465.
- Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J., & Silber, J. H. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *Journal of the American Medical Association*, 288, 1987-1993.
- Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J. A., Busse, R., Clarke, H. (2001). Nurses' reports on hospital care in five countries. *Health Affairs (Millwood)*, 20(3), 43-53.
- Al-Hussami, M. (2008). A study of nurses' job satisfaction: The relationship to organizational commitment, perceived organizational support, transactional leadership, transformational leadership, and level of education. *European Journal of Scientific Research*, 22, 286-295.
- Allen, N., & Meyer, J. (1990). The measurement and antecedents of affective, continuance, and normative commitment to the organization. *Journal of Occupational Psychology*, 63(1), 1-18.
- Allen, N., & Meyer, J. (1996). Affective, continuance, and normative commitment to the organization: An examination of construct validity *Journal of Vocational Behavior*, 49, 252-276.
- American Nurses Association. (2001, September 7). Nurses say health and safety concerns play major role in employment decisions, *Nursing World*, p.1.
- American Nurses Credentialing Centre. (2010). Magnet Recognition Program. Retrieved 21.04.2010, 2010, from <http://www.nursecredentialing.org/International/MagnetProgOverview.aspx>
- Amick, B. C., Kawachi, I., Coakley, E. H., Lerner, D., Levine, S., & Colditz, G. A. (1998). Relationship of job strain and iso-strain to health status in a cohort of women in the United States. *Scandinavian Journal of Work Environment and Health*, 24(1), 54-61.
- Amos, M. A., Hu, J., & Herrick, C. A. (2005). The impact of team building on communication and job satisfaction of nursing staff. *Journal of Nurses in Staff Development*, 21(1), 10-16; quiz 17-18.
- Anderson, B., Manno, M., O'Connor, P., & Gallagher, E. (2010). Listening to nursing leaders: Using National database of nursing quality indicators data to study excellence in nursing leadership. *Journal of Nursing Administration*, 40(4), 182-187.
- Anderson, R. A., Corazzini, K. N., & McDaniel, R. R., Jr. (2004). Complexity science and the dynamics of climate and communication: reducing nursing home turnover. *Gerontologist*, 44, 378-388.

- Andrews, J., Manthorpe, J., & Watson, R. (2005). Employment transition for older nurses: A qualitative study. *Nursing and Health Care Management and Policy*, 51(3), 298-306.
- Apker, J., Ford, W. S., & Fox, D. H. (2003). Predicting nurses' organizational and professional identification: the effect of nursing roles, professional autonomy, and supportive communication. *Nursing Economics*, 21(5), 226-232, 207.
- Armstrong-Stassen, M. (2005). Human resource strategies and the retention of older RNs. *Journal of Nursing Leadership*, 18(1), 50-66.
- Auerbach, J., & Welsh, J. (1994). Aging and competition: A policy action agenda. In J. Auerbach & J. Welsh (Eds.), *Aging and competition: Rebuilding the U.S. workforce* (pp. 225-236). Washington, DC: The National Planning Association.
- Australian Bureau of Statistics. (2006). 6238.0 - *Retirement and retirement intentions, Aug 2004 to June 2005*. Retrieved 21.07.06, from <http://www.abs.gov.au/AUSSTATS/abs@.nsf/7d12b0f6763c78caca257061001cc588/d85e2a6345a76bf5ca25710c007481a0!OpenDocument>.
- Australian Government. (2009). The online source for all Australians over 50. Retrieved 14.06.2009, from <http://www.seniors.gov.au/internet/seniors/publishing.nsf/Content/Home+Page>
- Australian Government. (2010). *A national health and hospitals network for Australian's future*. Retrieved 03.03.2010, from [http://www.health.gov.au/internet/main/publishing.nsf/Content/nhhn-report/\\$FILE/NHHN%20-%20Full%20report.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/nhhn-report/$FILE/NHHN%20-%20Full%20report.pdf).
- Australian Health Ministers' Conference. (2004). *National health workforce strategic framework*. Sydney: Australian Government Publishing Service.
- Australian Institute of Health and Welfare. (2009). *Nursing and midwifery labour force 2007*. Canberra: AIHW: National Health Labour Force Series no.43. Cat. no. HWL 44.
- Australian Nursing Federation. (2004). Submission to the Productivity commission research study: Implications of the ageing of Australia's population. Retrieved 05.03.2007, from [http://www.anf.org.au/pdf/submissions/2006/Sub\\_Providing\\_Nsg\\_Workforce\\_Future.pdf](http://www.anf.org.au/pdf/submissions/2006/Sub_Providing_Nsg_Workforce_Future.pdf)
- Australian Nursing Federation. (2006). Providing a nursing workforce for Australians into the future. *2007 - 2008 Australian Government Pre-Budget Submission*. Retrieved 6.03.2010, 2010, from [http://www.anf.org.au/pdf/submissions/2006/Sub\\_Providing\\_Nsg\\_Workforce\\_Future.pdf](http://www.anf.org.au/pdf/submissions/2006/Sub_Providing_Nsg_Workforce_Future.pdf)
- Australian Nursing Federation. (2008). Providing a nursing workforce for Australians into the future. *2008-2009 Australian Government pre-budget submission*. Retrieved 09.04.2010, from [http://www.anf.org.au/pdf/submissions/2009/Sub\\_Budget\\_Submission\\_09-10.pdf](http://www.anf.org.au/pdf/submissions/2009/Sub_Budget_Submission_09-10.pdf)

- Bakker, A. B., Killmer, C., Siegrist, J., & Schaufeli, W. B. (2000). Effort-reward imbalance and burnout among nurses. *Journal of Advanced Nursing* 31, 884-891.
- Bally, J. (2007). The role of nursing leadership in creating a mentoring culture: Successful mentoring: The essential dimensions. *Nursing Economics*, 25(3), 143-148.
- Balnaves, M., & Caputi, P. (1993). Corporate constructs: To what extent are personal constructs personal? *International Journal of Personal Construct Psychology*, 6(2), 119-138.
- Baltimore, J. (2006). Nurse collegiality: Fact or fiction? *Nursing Management*, 37(5), 28-36.
- Barbour, R. (2005). Making sense of focus groups. *Medical Education*, 39, 742-750.
- Barclay, L. (2006). Retaining older nurses in hospital practice: A newsmaker interview with Barbara J. Hatcher, PhD, RN, MPH. *Medscape*. Retrieved 12.07.2006, from [http://www.medscape.com/viewarticle/537115\\_print](http://www.medscape.com/viewarticle/537115_print)
- Barkway, P. (2001). Michael Crotty and nursing phenomenology: Criticism or critique? *Nursing Inquiry*, 8(3), 191-195.
- Bassey, M. (1999). *Case study research in educational settings*. Birmingham, England: Open Press University.
- Batch, M., Barnard, A., & Windsor, C. (2009). Who's talking? Communication and the casual/part-time nurse: A literature review. *Contemporary Nurse*, 33(1), 20-29.
- Batcheller, J., Burkman, K., Armstrong, D., Chappell, C., & Carelock, J. L. (2004). A practice model for patient safety: The value of the experienced registered nurse. *Journal Nursing Administration*, 34(4), 200-205.
- Benner, P. (1985). Quality of life: A phenomenological perspective on explanation, prediction, and understanding in nursing science. *Advances in Nursing Science*, 8(1), 1-14.
- Bennett, J., Davey, B., & Harris, R. (2009). Commitment expressions of nurses aged 45 and over: Organisational, professional and personal factors. *Journal of Research in Nursing*, 14, 391-400.
- Berg, B. L. (2004). Ethical issues. In *Qualitative research methods* (5<sup>th</sup>. ed., pp. 43-74). Boston: Pearson Education.
- Bjork, I. T., Samdal, G. B., Hansen, B. S., Torstad, S., & Hamilton, G. A. (2007). Job satisfaction in a Norwegian population of nurses: A questionnaire survey. *International Journal of Nursing Studies*, 44, 747-757.
- Blakeley, J., & Ribeiro, V. (2008). Early retirement among registered nurses: Contributing factors. *Journal of Nursing Management*, 16, 29-37.
- Blumer, H. (1998). *Symbolic Interactionism: Perspective and method*. Berkley: University of California Press.

- Boeije, H. (2002). A purposeful approach to the constant comparative method in the analysis of qualitative interviews. *Quality and Quantity*, 36, 391-409.
- Bogdan, R., & Biklen, S. (1998). *Qualitative research for education: An introduction to theory and methods*. Boston: Allyn and Bacon.
- Brooks, B. A., & Anderson, M. A. (2005). Defining quality of nursing work life. *Nursing Economics*, 23, 319-326, 279.
- Buchan, J. (2002). Nursing shortages and evidence-based interventions: A case study from Scotland. *International Nursing Review*, 49, 209-218.
- Buchan, J. (2009a). Achieving workforce growth in UK nursing: Policy options and implications. *Collegian*, 16, 3-9.
- Buchan, J. (2009b). The nursing workforce and global economic recession. *Collegian*, 16, 1-2.
- Buchan, J., & Aitken, L. M. (2008). Solving nursing shortages: A common priority, *Journal of Clinical Nursing*, 17, 3262 - 3268.
- Buchanan, J., & Considine, G. (2002). *'Stop telling us to cope!' NSW nurses explain why they are leaving the profession*. Sydney: Australian Centre for Industrial Relations Research and Training (ACIRRT) and University of Sydney.
- Buerhaus, P., Donelan, K., Ulich, B., Norman, L., & Dittus, R. (2006). State of the registered nurse workforce in United States. *Nursing Economics*, 24(1), 6-12.
- Buerhaus, P. I., Donelan, K., Ulrich, B. T., Norman, L., & Dittus, R. (2005). Is the shortage of hospital registered nurses getting better or worse? Findings from two recent national surveys of RNs. *Nursing Economics*, 23(2), 61-71, 96, 55.
- Calo, T.J. (2008). Talent Management in the era of the aging workforce: The critical role of the knowledge transfer. *Public Personnel Management*, 37(4), 403-416.
- Camerino, D., Conway, P., Heijden, B., Estry-Behar, M., Costa, G., & Hasselhorn, H. M. (2008). Age-dependent relationships between work ability, thinking of quitting the job, and actual leaving among Italian nurses: A longitudinal study. *International Journal of Nursing Studies*, 45, 1645-1659.
- Cappelli, P. (2000). A market-driven approach to retaining talent. *Harvard Business Review*, January-February, 103-111.
- Capuano, T., Bokovoy, J., Hitchings, K., & Houser, J. (2005). Use of a validated model to evaluate the impact of the work environment on outcomes at a magnet hospital *Health Care Management Review*, 30, 229-236.
- Chang, E., Daly, J., Hancock, C., Bidewell, J., Johnson, A., Lambert, V. (2006). The relationships among workplace stressors, coping methods, demographic characteristics, and health in Australian nurses. *Journal of Professional Nursing*, 22(1), 30-38.

- Chapman, A. (2010). Change management. *John P Kotter's 'eight steps to successful change'* Retrieved 27.05.2010, from <http://www.businessballs.com/changemanagement.htm>
- Charmaz, K. (2005). Grounded theory in the 21st century: Applications for advancing social justice studies. In N. Denzin & Y. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., Vol. 20, pp. 507-536). Thousand Oaks, CA. Sage.
- Charon, J. (2001). *Symbolic interactionism: An introduction, an interpretation, an integration* (7<sup>th</sup>. ed.). New Jersey: Prentice-Hall.
- Christmas, K. (2009). The year of positive leadership. *Nursing Economics*, 27(2), 128-133.
- Clarke, S. P., Rockett, J. L., Sloane, D. M., & Aiken, L. H. (2002). Organizational climate, staffing, and safety equipment as predictors of needlestick injuries and near-misses in hospital nurses. *American Journal of Infection Control*, 30, 207-216.
- Coakes, S., & Steed, L. (2001). *SPPS: Analysis without anguish*. Brisbane: John Wiley & Sons.
- Commonwealth Government. (1987). Equal employment opportunity (Commonwealth Authorities) Act (Act No. 32 of 2003 ed.). Canberra: Attorney-General's Department.
- Consumers Union. (2009). *Consumer report: To err is human - to delay is deadly*. Consumers Union Safe Patient Project. Washington: Consumer Reports Health.
- Coombes, I., Heel, A., Stowasser, A., Reid, C., Henderson, A., & Mitchell, C. (2005). Identification of medication errors by nurses during novel, simulated ward, medication safety orientation program. *Journal of Pharmacy Practice and Research*, 35(3), 190-194.
- Cooper, S. J. (2003). An evaluation of the Leading an Empowered Organisation programme. *Nursing Standard*, 17(24), 33-39.
- Corley, M. C., Farley, B., Geddes, N., Goodloe, L., & Green, P. (1994). The clinical ladder. Impact on nurse satisfaction and turnover. *Journal of Nursing Administration*, 24(2), 42-48.
- Cowin, L. (2002). The effects of nurses' job satisfaction on retention: An Australian perspective. *Journal of Nursing Administration*, 32(5), 283-291.
- Cowin, L., Johnson, M., Craven, R., & Marsh, H. (2008). Causal modeling of self-concept, job satisfaction, and retention of nurses. *International Journal of Nursing Studies*, 45, 1449-1459.
- Cox, K. S., Teasley, S. L., Zeller, R. A., Lacey, S. R., Parsons, L., Carroll, C. A. (2006). Know staff's "intent to stay". *Nursing Management*, 37(1), 13-15.

- Creswell, J. (2002). A framework for design. In *Research design: Qualitative, quantitative, and mixed methods approaches* (2nd. ed.). Thousand Oaks, CA: Sage.
- Creswell, J., & Plano Clark, V. (2007). *Designing and conducting mixed methods research*. Thousand Oaks, CA: Sage.
- Crethar, M., Phillips, J., Stafford, P., & Duckett, S. J. (2009). Leadership transformation in Queensland Health. *Australian Health Review*, 33, 357-355.
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Sydney: Allen & Unwin.
- Cyr, J. P. (2005). Retaining older hospital nurses and delaying their retirement. *Journal of Nursing Administration*, 35(12), 563-567.
- Daly, J., Speedy, S., & Jackson, D. (2005). *Nursing Leadership*. Sydney: Churchill Livingstone.
- Day, G. (2007). Nursing morale: Predictive variables among a sample of registered nurses in Australia. *Journal of Nursing Management*, 15, 274-284.
- DeGroot, H., Burke, L., & George, V. (1998). Implementing the differential pay structure. *Journal of Nursing Administration*, 28, 28-38.
- Demerouti, E., Bakker, A. B., Nachreiner, F., & Schaufeli, W. B. (2000). A model of burnout and life satisfaction amongst nurses. *Journal of Advanced Nursing*, 32, 454-464.
- Denscombe, M. (2003). *The good research guide for small-scale social research projects* (2nd ed.). Philadelphia, PA: Open University Press.
- Dent, G. (2006). *Violence in nursing and the law*. Paper presented at the kNOw Conference, Melbourne.
- Denzin, N. (1989). *Interpretive biography*. Thousand Oaks, CA: Sage.
- Department of Communities. (2008). *Ageing: Myth and reality*. Retrieved 07.06.2009, from <http://www.communities.qld.gov.au/seniors/publications/documents/ageing-myth-reality.pdf>.
- Department of Education Science and Training. (2002). *National review of nursing education 2002: Our duty of care* (Report). Canberra.: Department of Education Science and Training.
- Department of Employment and Industrial Relations. (2009). *Experience pays awareness strategy*. Retrieved 07.06.2009, from <http://www.deir.qld.gov.au/employment/initiatives/epas/index.htm>.
- Department of Industrial Relations. (2005). *Valuing older workers*. Retrieved 19.04.2010, from [http://www.justice.qld.gov.au/data/assets/pdf\\_file/0003/12279/ir-olderworkers-booklet.pdf](http://www.justice.qld.gov.au/data/assets/pdf_file/0003/12279/ir-olderworkers-booklet.pdf).



- Department of Medical Sociology. (2008). Effort-reward imbalance at work. Retrieved 7.11.2008, from [http://www.uni-duesseldorf.de/MedicalSociology/fileadmin/Bilder/Dateien/download/ERI\\_Texte\\_und\\_Grafiken/Effort\\_reward\\_imbalance\\_at\\_work.pdf](http://www.uni-duesseldorf.de/MedicalSociology/fileadmin/Bilder/Dateien/download/ERI_Texte_und_Grafiken/Effort_reward_imbalance_at_work.pdf)
- DeVries, M., & Wilkerson, B. (2003). Stress, work and mental health: A global perspective. *Acta Neuropsychiatrica*, 15(1), 44-53.
- Dey, I. (1993). *Qualitative data analysis: A user-friendly guide for social scientists*. London: Routledge.
- Donelan, K., Buerhaus, P., DesRoches, C., Dittus, R., & Dutwin, D. (2008). Public perceptions of nursing careers: The influence of the media and nursing shortages. *Nursing Economics*, 26(3), 143-165.
- Donley, R. (2005). Challenges for nursing in the 21st century. *Nursing Economics*, 23(6), 312-318, 279.
- Donmoyer, R. (2004). Generalizability and the single-case study. In M. Hammersley, R. Gomm & P. Foster (Eds.), *Case study method: Key issues, key texts* (Vol. 3, pp. 45-68). Thousand Oaks, CA: Sage.
- Drury, V., France, K., & Chapman, Y. (2008). Where have all the young ones gone: Implications for the nursing workforce. *The Online Journal of Issues in Nursing*, 14(1), 1-6.
- Duckett, S. J. (2005). Health workforce design for the 21st century. *Australian Health Review*, 29(2), 201-210.
- Duffield, C., Forbes, J., Fallon, A., Roche, M., Wise, W., & Merrick, E. T. (2005). Nursing skill mix and nursing time: The roles of registered nurses and clinical nurse specialists. *Australian Journal of Advanced Nursing*, 23(2), 14-21.
- Duffield, C., Gardner, G., & Catling-Paull, C. (2008). Nursing work and the use of nursing time. *Journal of Clinical Nursing*, 17, 3269-3274.
- Duffield, C., Kearin, M., Johnston, J., & Leonard, J. (2007a). The impact of hospital structure and restructure on the nursing workforce. *Australian Journal of Advanced Nursing*, 24(3), 42-46.
- Duffield, C., & Roche, M. (2009). The implications of staff 'churn' for nurse managers, staff, and patients. *Nursing Economics*, 27(2), 103-110.
- Duffield, C., Roche, M., & Merrick, E. T. (2006). Methods of measuring nursing workload in Australia. *Collegian*, 13(1), 16-22.
- Duffield, C., Roche, M., O'Brien-Pallas, L., Catling-Paull, C., & King, M. (2009). Staff satisfaction and retention and the role of the nursing unit manager. *Collegian*, 16, 11-17.

- Duffield, C., Roche, M., O'Brien-Pallas, L., Diers, D., Aisbett, C., King, M. (2007b). *Glueing it together: Nurses, their work environment and patient safety*. Retrieved 06.09.2008. from [http://www.health.nsw.gov.au/pubs/2007/pdf/nwr\\_report.pdf](http://www.health.nsw.gov.au/pubs/2007/pdf/nwr_report.pdf).
- Dunton, N., & Duncan, J. (2010). *New developments from national database of nursing quality indicators*. Paper presented at the 4th Annual NDNQI Conference, New Orleans, LA.
- Edens, P. (2005). Workplace reengineering, reorganisation, and redesign from nursing management: Principles and practice. *Medscape Critical Care*, 6(2), 1-9.
- Eley, R., Parker, D., Tuckett, A., & Hegney, D. (2010). Career breaks and intentions for retirement by Queensland's nurses - A sign of the times. *Collegian*, 17, 38-42.
- Elloy, D. (2005). The influence of super-leader behaviors on organizational commitment, job satisfaction and organizational self-esteem in a self managed work team. *Leadership and Organizational Development Journal*, 26(2), 120-127.
- Elovainio, M., Forma, P., Kivimaki, M., Sinervo, T., Sutinen, R., & Laine, M. (2005). Job demands and job control as correlates of early retirement: Thoughts in Finnish social and health care employees. *Work and Stress*, 19(1), 84-92.
- Engstrom, M., Ljunggren, B., Lindqvist, R., & Carlsson, M. (2006). Staff satisfaction with work, perceived quality of care and stress in elderly care: psychometric assessments and associations. *Journal of Nursing Management*, 14, 318-328.
- Erbin-Roesemann, M. A., & Simms, L. M. (1997). Work locus of control: the intrinsic factor behind empowerment and work excitement. *Nursing Economics*, 15(4), 183-190.
- Erickson, R., & Grove, W. (2007). Why emotions matter: Age, agitation and burnout among registered nurses. *Online Journal of Issues in Nursing*, 13(1).
- Everson-Bates, S. (1992). First-line nurse managers in the expanded role. An ethnographic analysis. *Journal of Nursing Administration*, 22(3), 32-37.
- Farrell, M. (2003). Health care leadership in an age of change. *Australian Health Review*, 26(1), 153-164.
- Flyvbjerg, B. (2004). Five misunderstandings about case-study research. In C. Searle, G. Gobo, J. Gubrium & D. Silverman (Eds.), *Qualitative research practice* (pp. 420-434). London and Thousand Oaks, CA: Sage.
- Fochsen, G., Sjogren, K., Josephson, M., & Lagerstrom, M. (2005). Factors contribution to the decision to leave nursing care: A study among Swedish nursing personnel. *Journal of Nursing Management*, 13, 338-344.
- Forster, J. (2006). *Violence and aggression in healthcare*. Paper presented at the kNOw Violence Conference, Melbourne.



- Forster, P., & Queensland Health. (2005). *Queensland health systems review: Final report*. Queensland Government Printing Office.
- Freeney, Y., & Tiernan, J. (2009). Exploration of the facilitators of and barriers to work engagement in nursing. *International Journal of Nursing Studies*, 46, 1557-1565.
- Frijters, P., Shields, M., & Price, S. (2003). *Investigating the quitting decision of nurses: Panel data evidence from the British National Health Service* (No. IZA DP No. 794). Bonn, Germany: Institute for the Study of Labor.
- Gabrielle, S., Jackson, D., & Mannix, J. (2007). Older women nurses: Health, ageing concerns and self-care strategies. *Journal of Advanced Nursing* 61, 316-325.
- Garling, P. (2008). *Final report of special commission of inquiry: Acute care in NSW public hospitals*. Retrieved 25.6.09, from [http://www.lawlink.nsw.gov.au/lawlink/SpecialProjects/ll\\_splprojects.nsf/pages/acsi\\_finalreport](http://www.lawlink.nsw.gov.au/lawlink/SpecialProjects/ll_splprojects.nsf/pages/acsi_finalreport).
- Geertz, C. (1973). *The interpretation of cultures*. New York: Basic Books.
- Geiger-Brown, J., & Trinkoff, A. M. (2010). Is it time to pull the plug on 12-hour shifts? *Journal of Nursing Administration*, 40(3), 1-3.
- Gelsema, T. I., van der Doef, M., Maes, S., Janssen, M., Akerboom, S., & Verhoeven, C. (2006). A longitudinal study of job stress in the nursing profession: causes and consequences. *Journal of Nursing Management*, 14(4), 289-299.
- Gess, E., Manojlovich, M., & Warner, S. (2008). An evidence-based protocol for nurse retention. *Journal of Nursing Administration*, 38(10), 441-447.
- Gillham, B. (2004). *Case study research methods*. London: Continuum.
- Giorgianni, S. (2005). Global summit on the aging workforce. *Pfizer Journal*, 9(3), 4-16.
- Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine.
- Glazer, G., & Alexandre, C. (2008). Legislative: The nursing shortage: A public health issue for all. *The Online Journal of Issues in Nursing*, 14(1), 1-3.
- Glesne, C. (2006). But is it ethical? Learning to do it right. In *Becoming qualitative researchers: An introduction* (3rd ed., pp. 129-146). Boston: Pearson.
- Gordon, S. (2005). *Nursing against the odds: How health care cost cutting, media stereotypes, and medical hubris undermine nurses and patient care*. Ithica, NY: Cornell University Press.
- Gould, D., & Fontenla, M. (2006). Commitment to nursing: Results of a qualitative interview study. *Journal of Nursing Management*, 14(3), 213-221.
- Graham, B. (1973). Career identity crisis. *Optimum*, 4(1), 32-41.

- Graham, E. M., & Duffield, C. M. (2010). An ageing nursing workforce. *Australian Health Review*, 34(1), 44-45.
- Greene, M. T., & Puetzer, M. (2002). The value of mentoring: A strategic approach to retention and recruitment. *Journal of Nursing Care Quality*, 17(1), 63-70.
- Guba, E., & Lincoln, Y. (1994). Competing paradigms in qualitative research. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (Vol. 6, pp. 105-117). Thousand Oaks, CA: Sage.
- Gugerty, B., Maranda, M., Beachley, M., Navarro, V., Newbold, S., Hawk, W. (2007). *Challenges and opportunities in documentation of nursing care of patients*. Baltimore, MD: Maryland Nursing Workforce Commission Documentation Work Group.
- Hallin, K., & Danielson, E. (2007). Registered nurses' experiences of daily work, a balance between strain and stimulation: A qualitative study. *International Journal of Nursing Studies*. 44(7), 1221-1230.  
doi:10.1016/j.ijnurstu.2006.05.011.
- Hammersley, M., & Gomm, R. (2004). Introduction. In R. Gomm, M. Hammersley & P. Foster (Eds.), *Case study method: Key issues, key texts* (Vol. Introduction, pp. 1-16). Thousand Oaks, CA: Sage.
- Hammersley, M., Gomm, R., & Foster, P. (2004). Case study and theory. In R. Gomm, M. Hammersley & P. Foster (Eds.), *Case study method: Key issues, key texts* (Vol. 12, pp. 234-258). Thousand Oaks, CA: Sage.
- Hancock, D., & Algozzine, B. (2006). *Doing case study research: A practical guide for beginning researchers*. New York: Teachers College Press.
- Hart, S. M. (2006). Generational diversity: Impact on recruitment and retention of registered nurses. *Journal of Nursing Administration*, 36(1), 10-12.
- Hasselhorn, H. M., Tackenberg, P., & Peter, R. (2004). Effort-reward imbalance among nurses in stable countries and in countries in transition. *International Journal of Occupational and Environmental Health*, 10(4), 401-408.
- Hatcher, B., Bleich, M. R., Connolly, C., Davis, K., O'Neill Hwelett, P., & Stokley Hill, K. (2006). *Wisdom at work: The importance of the older and experienced nurse in the workplace*. Princeton, NJ: Robert Wood Johnson Foundation.
- Hayes, L., O'Brien-Pallas, L., Duffield, C., Shamian, J., Buchan, J., Hughes, F. (2006). Nurse turnover: A literature review. *International Journal of Nursing Studies*, 43(2), 237-263.
- Heartfield, M. (2006). *Specialisation and advanced practice discussion paper*. Melbourne.
- Hegney, D., Eley, R., Plank, A., & Buikstra, P. (2006a). Workplace violence in Queensland, Australia: The results of a comparative study. *International Journal of Nursing Practice*, 612(4), 220-231.

- Hegney, D., Plank, A., Builstra, E., Parker, V., & Eley, R. (2005). *Nurses: Worth listening to*. Brisbane: Queensland Nurses' Union; Centre for Rural and Remote Area Health; University of Southern Queensland.
- Hegney, D., Plank, A., & Parker, V. (2003). Nursing workloads: The results of a study of Queensland Nurses. *Journal of Nursing Management*, 11(5), 307-314.
- Hegney, D., Plank, A., & Parker, V. (2006b). Extrinsic and intrinsic work values: Their impact on job satisfaction in nursing. *Journal of Nursing Management*, 14(4), 271-281.
- Hegney, D., Tuckett, A., Parker, D., & Elay, R. (2008). *Your work, your time, your life: A summary report to conference delegates*. Paper presented at the Queensland Nurses' Union Annual Conference (July), Brisbane. Retrieved 25.05.2009, from [http://www.gnu.org.au/data/assets/pdf\\_file/0005/118157/Your-work-your-time-your-life-summary-repor-to-2008-conference-FINAL-secure.pdf](http://www.gnu.org.au/data/assets/pdf_file/0005/118157/Your-work-your-time-your-life-summary-repor-to-2008-conference-FINAL-secure.pdf).
- Hemens, J. (2008). The business impact of an ageing workforce. *Management*, 60(7), 435-436.
- Henry, A. (2007). *Inspiring tomorrow's leaders today: Breaking down the barriers at work*. Macquarie Centre: N.S.W.: Messenger.
- Huberman, M., & Miles, M. (1994 ). Data management and analysis methods. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (Vol. 27, pp. 428-444). Thousand Oaks, CA: Sage.
- Hughes, K. K., & Marcantonio, R. J. (1991). Compensation of home health, public health, and hospital nurses. Extrinsic and intrinsic rewards. *Journal of Nursing Administration*, 21(11), 23-29.
- Human Resources. (2005). Australia lags in human resource capital management. *Chatswood, N.S.W.: THC Press, March*, 11-23.
- Institute of Medicine of the National Academics. (2001). *Keeping patients safe: Transforming the work environment of nurses*. Washington: National Academy of Sciences.
- International Council of Nurses. (2006). *The global nursing shortage: Priority areas for intervention*. Geneva, Switzerland: International Council of Nurses.
- International Council of Nurses. (2007). Position statement: Nurse retention and migration. Retrieved 9.04.2010, 2010, from <http://www.icn.ch/psretention.htm>
- Jasper, M. (2006). Editorial. Recruitment and retenting nurses: The perennial challenge. *Journal of Nursing Management*, 14(4), 253-254.
- Johnston, M. (2007). Nurse recruitment and retention: Imperatives of imagining the future and taking proactive stance. *Content Management*, 24(2), iii-v.
- Joseph Rowntree Foundation. (2002). *Public policy initiatives for older workers*. Retrieved 05.03.2007, from <http://www.jrf.org.uk/knowledge/findings/socialpolicy/pdf/d62.pdf>.

- Kane-Urrabazo, C. (2006). Management's role in shaping organizational culture. *Journal of Nursing Management*, 14(3), 188-194.
- Kerfoot, K. (2000). Leading from the inside out. *Pediatric Nursing*, 26, 639-640.
- Kilpatrick, K., & Lavoie-Tremblay, M. (2006). Shiftwork: What health care managers need to know. *Health Science and Health Care Management (Frederick)*, 25(2), 160-166.
- Kluska, K., Laschinger, H., & Kerr, M. (2004). Staff nurse empowerment and effort-reward imbalance. *Canadian Journal of Nursing Leadership*, 17(1), 112-128.
- Kronos and The Australian Health Workforce Institute. (2008). *Australian nursing workforce research*. Sydney: The Australian Health Workforce Institute.
- Krueger, R. (1994). *Focus groups: A practical guide for applied research* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Kuper, H., Singh-Manoux, A., Siegrist, J., & Marmot, M. (2002). When reciprocity fails: Effort-reward imbalance in relation to coronary heart disease and health functioning within the Whitehall II study. *Occupational and Environmental Medicine*, 59, 777-784.
- Kupperschmidt, B. (2006). Addressing multigenerational conflict: Mutual respect and carefronting as strategy. *Online Journal of Issues in Nursing*, 11(2), 1-9.
- Laditka, S., Fischer, M., Laditka, J., & Segal, D. (2004). Attitudes about aging and gender among young, middle age, and older college-based students. *Educational Gerontology*, 30, 403-421.
- Lafer, G. (2005). Hospital speedups and the friction of a nurse shortage. *Labor Studies Journal*, 30(1), 27-46.
- Lanza, M. L., Zeiss, R., & Rierdan, J. (2006). Violence against psychiatric nurses: Sensitive research as science and intervention. *Contemporary Nurse*, 21(1), 71-84.
- Laschinger, H., Finegan, J., Shamian, J., & Wilk, P. (2001). Impact of structural and psychological empowerment on job strain in nursing work settings: Expanding Kanter's model. *Journal of Nursing Administration*, 31, 260-272.
- Laschinger, H., & Leiter, M. P. (2006). The impact of nursing work environments on patient safety outcomes: The mediating role of burnout/engagement. *Journal of Nursing Administration*, 36(5), 259-267.
- Laschinger, H. K., & Finegan, J. (2005). Empowering nurses for work engagement and health in hospital settings. *Journal of Nursing Administration*, 35, 439-449.
- Laurence, J. (2003, June 16). Employers who ignore stress face legal action. *The Independent*, p. 1.
- Lavoie-Tremblay, M., O'Brien-Pallas, L., Viens, C., Brabant, L. H., & Gelinas, C. (2006). Towards an integrated approach for the management of ageing nurses. *Journal of Nursing Management*, 14, 207-212.

- Leach, L. S. (2005). Nurse executive transformational leadership and organizational commitment. *Journal of Nursing Administration*, 35, 228-237.
- Leavitt, T. (1996). Labor Force Characteristics of Older Workers. In W. Crown (Ed.), *Handbook On Employment and the Elderly* (2<sup>nd</sup>. ed., pp. 15 - 56). London: Greenwood Press.
- Lee, H., & Cummings, G. (2008). Factors influencing job satisfaction of front line nurse managers: A systematic review. *Journal of Nursing Management*, 16, 768-783.
- Lee, R. J., & Mills, M. E. (2005). International nursing recruitment experience. *Journal of Nursing Administration*, 35, 478-481.
- Leiter, M. P., Harvie, P., & Frizzell, C. (1998). The correspondence of patient satisfaction and nurse burnout. *Social Science in Medicine*, 47, 1611-1617.
- Leners, D., Wilson, V., Connor, P., & Fenton, J. (2006). Mentorship: Increasing retention probabilities. *Journal of Nursing Management*, 14, 652-654.
- Letvak, S. (2005). Health and safety of older nurses. *Nursing Outlook*, 53(2), 66-72.
- Letvak, S., & Buck, R. (2008). Factors influencing work productivity and intent to stay in nursing. *Nursing Economics*, 26(3), 159-165.
- Levtak, S. (2005). Health and safety of older nurses. *Nursing Outlook*, 53(2), 66-72.
- Lickman, P., Simms, L., & Greene, C. (1993). Learning environment: The catalyst for work excitement. *Journal of Continuing Education in Nursing*, 24(5), 211-216.
- Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.
- Lincoln, Y., & Guba, E. (2004). The only generalization is: There is no generalization. In R. Gomm, M. Hammersley & P. Foster (Eds.), *Case study method: Key issues, key texts* (Vol. 2, pp. 27-44). Thousand Oaks, CA: Sage.
- Lindholm, M. (2006). Working conditions, psychosocial resources and work stress in nurses and physicians in chief managers' positions. *Journal of Nursing Management*, 14, 300-309.
- Luthans, K. W., & Jensen, S. M. (2005). The linkage between psychological capital and commitment to organizational mission: A study of nurses. *Journal of Nursing Administration*, 35, 304-310.
- Ma, C. C., Samuels, M. E., & Alexander, J. W. (2003). Factors that influence nurses' job satisfaction. *Journal of Nursing Administration*, 33, 293-299.
- Manion, J. (2004). Nurture a culture of retention. Frontline nurse leaders share perceptions regarding what makes--or breaks--a flourishing nursing environment. *Nursing Management*, 35(4), 29-39.
- Manojlovich, M. (2005). The effect of nursing leadership on hospital nurses' professional practice behaviours. *Journal of Nursing Administration*, 35(7/8), 366-374.

- Marmot, M., Siegrist, J., Theorell, T., & Feeney, A. (1999). Health and the psychosocial environment at work. In M. Marmot & R. Wilkinson (Eds.), *Social determinants of health* (pp. 105-132). Oxford: Oxford University Press.
- Marquie, J. C., & Foret, J. (1999). Sleep, age, and shiftwork experience. *Journal of Sleep Research*, 8, 297-304.
- Maslach, C. (1976). Burned-out. *Human Behavior*, 5(9), 16-22.
- Mather, J. (2006, August). Bullying culture exposed. *Nursing Review*, 1.
- Mayhew, C., & Chappell, D. (2001). *Occupational violence : Types, reporting patterns, and variations between health sectors*. Sydney: School of Industrial Relations and Organisational Behaviour and Industrial Relations Research Centre University of New South Wales.
- Maykut, P., & Morehouse, R. (1994). *Beginning qualitative research: A philosophical and practical guide*. London: The Farmer Press.
- McGillis-Hall, L., & Doran, D. (2007). Nurses' perceptions of hospital work environments. *Journal of Nurse Management*, 15, 264-273.
- McNeese-Smith, D. (2000). Job strategies of entry, mastery, and disengagement among nurses. *Journal of Nursing Administration*, 30(3), 140-147.
- McNeese-Smith, D. K. (2001). A nursing shortage: building organizational commitment among nurses. *Journal of Healthcare Management*, 46(3), 173-186.
- Medical Interest Based Bargaining. (2005 ). Details of doctors' EB agreement. Retrieved 5 December 2005, from <http://qheps.health.qld.gov.au/eb6/ibb/medical/ ME01652.pdf>
- Merriam, S. (1998). *Qualitative research and case study applications in education*. San Francisco: Jossey-Bass.
- Meyer, J., & Allen, N. (1991). A three-component conceptualization of organizational commitment. *Human Resource Management Review*, 1, 61-89.
- Minnick, A. F. (2000). Retirement, the nursing workforce, and the year 2005. *Nursing Outlook*, 48(5), 211-217.
- Mion, L. C., Hazel, C., Cap, M., Fusilero, J., Podmore, M. L., & Szweda, C. (2006). Retaining and recruiting mature experienced nurses: a multicomponent organizational strategy. *Journal of Nursing Administration*, 36(3), 148-154.
- Morinaga, K., Ohtsubo, Y., Yamauchi, K., & Shimada, Y. (2008). Doctors' traits perceived by Japanese nurses as communication barriers: A questionnaire survey. *International Journal of Nursing Studies*, 45, 740-749.
- Morrow, P., & McElroy, J. (1987). Work commitment and job satisfaction over three career stages. *Journal of Vocational Behavior*, 30, 330-346.

- Morton-Cooper, A., & Palmer, A. (1993). *Mentoring and preceptorship: Guide to support roles in clinical practice*. Malden, USA.: Blackwell.
- Moss, S. (2009). *Queensland Health nursing and midwifery state-wide nursing sensitive indicator*. Brisbane: Queensland Health.
- Moye, J., & Swan, B. (2009). Growing ambulatory care nurse leaders in a multigenerational workforce. *Nursing Economics*, 27, 408-415.
- National Health Workforce Taskforce. (2009, April). *Health workforce in Australia and factors for current shortages*. Retrieved 28.06.09, from <http://www.nhwt.gov.au/documents/NHWT/The%20health%20workforce%20in%20Australia%20and%20factors%20influencing%20current%20shortages.pdf>.
- Nedd, N. (2006). Perceptions of empowerment and intent to stay. *Nursing Economics*, 24, 13-18.
- Needleman, J., Buerhaus, P., Mattke, S., Stewart, M., & Zelevinsky, K. (2002). Nurse-staffing levels and the quality of care in hospitals. *New England Journal of Medicine*, 346(22), 1715-1722.
- Nelson, D., Godfrey, L., & Purdy, J. (2004). Using a mentorship program to recruit and retain student nurses. *Journal of Nursing Administration*, 34(12), 551-553.
- Nielsen, K., & Munir, F. (2009). How do transformational leaders influence followers' affective well-being? Exploring the mediating role of self-efficacy. *Work and Stress*, 23(4), 313-329.
- Nogueras, D. J. (2006). Occupational commitment, education, and experience as a predictor of intent to leave the nursing profession. *Nursing Economics*, 24(2), 86-93, 55.
- Norman, D., Donelan, K., Buerhaus, P., Willis, G., Williams, M., Ulrich, B. (2005). The older nurse in the workplace: Does age matter? *Nursing Economics*, 23(6), 282-299.
- North Queensland Workforce Unit. (2005). *Report on retention of mature-aged nurses (50 years and over) in the northern zone*. Brisbane. Queensland Health.
- Northside Health Service District. (2008). Transition to retirement program for nurses policy (Vol. POLNHD080003v1, pp. 4): Queensland Health.
- O'Brien-Pallas, L., Duffield, C., & Hayes, L. (2006). Do we really understand how to retain nurses? *Journal of Nursing Management*, 14, 262-270.
- O'Donoghue, T. (2007). *Planning your qualitative research project: An introduction to interpretivist research in education*. New York: Cromwell Press.
- Office of the Parliamentary Counsel. (1991 ). Anti-discrimination act (reprinted No. 4<sup>th</sup> ed., pp. 1-154): Queensland Government.



- Office of the Public Service Commissioner. (2008). *Attraction and retention series: A focus on people and business. A guide for the Queensland public service: Managing and ageing workforce*. Retrieved 27.05.2009, from [http://www.opsc.qld.gov.au/library/docs/resources/publications/Retention/Ageing\\_AGuide\\_All.pdf](http://www.opsc.qld.gov.au/library/docs/resources/publications/Retention/Ageing_AGuide_All.pdf).
- Ostry, A., Kelly, S., Demers, P., Mustard, C., & Hertzman, C. (2003). A comparison between effort-reward imbalance and demand control models. *Public Health*, 3(10), 1-27.
- Parfitt, B. (2009). Health reform: The human resource challenges for Central Asian Commonwealth of independent states (CIS) countries. *Collegian*, 16, 35-40.
- Parish, C. (2007). Delayed retirement will take toll on nurses' health, study warns. *Nursing Standards*, 21(35), 11.
- Patton, M. (1990). *Qualitative evaluation and research methods* (2nd. ed.). Thousand Oaks, CA: Sage.
- Pines, A., & Maslach, C. (1978). Characteristics of staff burnout in mental health settings. *Hospital and Community Psychiatry*, 29(4), 233-237.
- Pines, A. M., & Kanner, A. D. (1982). Nurses' burnout: lack of positive conditions and presence of negative conditions as two independent sources of stress. *Journal of Psychosocial Nursing and Mental Health Services*, 20(8), 30-35.
- Polit, D., & Beck, C. (2004). *Nursing research: Principles and methods* (7<sup>th</sup> ed.). Philadelphia: Lippincott Williams & Wilkins.
- Polit, D., & Beck, C. (2008). *Nursing research: Generating and assessing evidence for nursing practice* (8 ed.). Philadelphia: Lippincott, Williams & Wilkins.
- Porter, L., Steers, R., Mowday, R., & Boulian, P. (1974). Organizational commitment, job satisfaction, and turnover among psychiatric technicians. *Journal of Applied Psychology*, 59, 603-609.
- Prescott, P. A. (1989). Shortage of professional nursing practice: a reframing of the shortage problem. *Heart Lung*, 18(5), 436-443.
- Preston, B. (2009). The Australian nurse and midwifery workforce: Issues, developments and the future. *Collegian*, 16, 25-34.
- Pryce, J., Albertsen, K., & Nielsen, K. (2006). Evaluation of an open-rota system in a Danish psychiatric hospital: A mechanism for improving job satisfaction and work-life balance. *Journal of Nursing Management*, 14, 282-288.
- Queensland Government. (2009). *Transition to retirement: Earlier access to your super*, Retrieved 17.08.09, from <http://qsuper.qld.gov.au/>
- Queensland Health. (2003). *Rostering framework: Best practice for rostering nursing personnel*. Retrieved 20.07.2006, from <http://www.health.nsw.gov.au/health-public-affairs/violence/DiscussionPaper1.pdf>.



- Queensland Health. (2008). *Business planning framework: A tool for nursing workload management*. Retrieved 09.04.2009, from <http://www.health.qld.gov.au/ocno/documents/BPF.pdf>.
- Queensland Health. (2010). *The Queensland Health preceptor program 2010*. Retrieved 19.05.2010, from <http://www.health.qld.gov.au/ocno/publications.asp>.
- Queensland Health Integrated Resource Manual. (2006). *Registered nurses' continuing education accelerated advancement (qualifications) entitlement* (No. IRM 2.1-29): Queensland Health.
- Queensland Nurses' Union. (2009a). Federal Budget Submission 2009 - 2010. Retrieved 10.04.2010, from [http://www.qnu.org.au/data/assets/pdf\\_file/0014/2732/2009-2010-Federal-budget-submission.pdf](http://www.qnu.org.au/data/assets/pdf_file/0014/2732/2009-2010-Federal-budget-submission.pdf)
- Queensland Nurses' Union. (2009b). Review of public and private hospitals. *Submission to the productivity commission*. Retrieved 09.04.10, from [http://www.qnu.org.au/data/assets/pdf\\_file/0007/136681/Public-and-Private-hospitals-draft-submission-final.pdf](http://www.qnu.org.au/data/assets/pdf_file/0007/136681/Public-and-Private-hospitals-draft-submission-final.pdf)
- Queensland Nurses' Union. (2009c). Submission to Economic Development Committee: Legislative Assembly of Queensland. Retrieved 14.04.2010, from [http://www.qnu.org.au/data/assets/pdf\\_file/0020/118127/Employment-creation-policy-final.pdf](http://www.qnu.org.au/data/assets/pdf_file/0020/118127/Employment-creation-policy-final.pdf)
- Queensland Nurses' Union. (2010a). 2010-2011 QNU state budget submission. Retrieved 09.04.2010, from <http://www.qnu.org.au/news/publications/reports/current-releases/2010-2011-qnu-state-budget-submission>
- Queensland Nurses' Union. (2010b). Action plan. *The Queensland Nurse*, 29, 20-21.
- Queensland Nurses' Union. (2010c). Nurses and midwives focusing on the bigger picture. *The Queensland Nurse*, 29, 19.
- Queensland Nursing Council. (2005). *Policy on the regulation of nurse practitioners in Queensland*. Retrieved 20.07.2006, from [http://www.qnc.qld.gov.au/upload/pdfs/qnc\\_policies/Policy\\_on\\_the\\_regulation\\_of\\_nurse\\_practitioners\\_in\\_Queensland\\_2005.pdf](http://www.qnc.qld.gov.au/upload/pdfs/qnc_policies/Policy_on_the_regulation_of_nurse_practitioners_in_Queensland_2005.pdf).
- Rambur, B., McIntosh, B., Val Plumbo, M., & Reinier, K. (2005). Education as a determinant of career retention and job satisfaction among registered nurses. *Journal of Nursing Scholarship*, 37(2), 185-192.
- Reid Ponte, P., Gross, A., Galante, A., & Glazer, G. (2006). Using an executive coach to increase leadership effectiveness. *Journal of Nursing Administration*, 36(6), 319-324.
- Riley, J., Rolband, D., James, D., & Norton, H. (2009). Clinical ladder: Nurses' perception and satisfiers. *Journal of Nursing Administration*, 39(4), 182-188.

- Ritter-Teitel, J. (2003). Nursing administrative research: the underpinning of decisive leadership. *Journal of Nursing Administration*, 33(5), 257-259.
- Rix, S. (1996). Investing in the future: What role for older worker training? In W. Crown (Ed.), *Handbook on employment and the elderly* (pp. 304-323). Westport, CT: Greenwood Press.
- Rix, S. (2005). Rethinking the role of older workers: promoting older worker employment in Europe and Japan. Retrieved 29.07.2006, from [http://catalogue.iugm.qc.ca/GEIDFile/ib77\\_workers.PDF?Archive=197027991520&File=ib77\\_workers\\_PDF](http://catalogue.iugm.qc.ca/GEIDFile/ib77_workers.PDF?Archive=197027991520&File=ib77_workers_PDF)
- Rogers, A., Hwang, W., Scott, L., Aiken, L., & Dinges, D. (2004). The working hours of hospital staff nurses and patient safety. *Health Affairs (Millwood)*, 23(4), 202-212.
- Rose, J., & Glass, N. (2009). An investigation of emotional wellbeing and its relationship to contemporary nursing practice. *Collegian*, 16, 185-192.
- Rukholm, E., Stamler, L., Bednash, G., Potempa, K., Macleod, D., & Parfitt, B. (2009). Scaling up the global nursing health workforce: Contributions of an international organization. *Collegian*, 16, 41-45.
- Sadovich, J. M. (2005). Work excitement in nursing: An examination of the relationship between work excitement and burnout. *Nursing Economics*, 23(2), 91-96, 55.
- Sarantakos, S. (1998). *Social Research*. South Yarra, VIC: MacMillian Education Australia.
- Schmitt, N., White, J., Coyle, B., & Rauschenberger, J. (1979). Retirement and life satisfaction. *Academy of Management Journal*, 22(2), 282-291.
- Schofield, D. J. (2007). Replacing the projected retiring baby boomer nursing cohort. *BioMed Central Health Services Research*, 7, 87.
- Scholz, R., & Tietje, O. (2002). *Embedded case study methods: Integrating quantitative and qualitative knowledge*. Thousand Oaks, CA: Sage.
- Schulz, M., Damkroger, A., Heins, C., Wehlitz, L., Lohr, M., Driessen, M. (2009). Effort-reward imbalance and burnout among German nurses in medical compared with psychiatric hospital settings. *Journal of Psychiatric and Mental Health Nursing*, 16, 225-233.
- Schwandt, T. (1994). Constructivist, interpretivist approaches to human inquiry. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (Vol. 7, pp. 118 - 138). Thousand Oaks, CA: Sage.
- Shermont, H., & Krepcio, D. (2006). The impact of culture change on nurse retention. *Journal of Nursing Administration*, 36(9), 407-415.
- Shirey, M. R. (2006). Authentic leaders creating healthy work environments for nursing practice. *American Journal of Critical Care*, 15, 256-267.

- Shirey, M. R. (2009). Authentic leadership, organisational culture, and healthy work environments. *Critical Care Nursing Quarterly*, 32(3), 189-198.
- Siegrist, J. (1996). Adverse health effects of high-effort/low-reward conditions. *Journal of Occupational Health Psychology*, 1(1), 27-41.
- Sikma, S. K. (2006). Staff perceptions of caring: The importance of a supportive environment. *Journal of Gerontological Nursing*, 32(6), 22-29.
- Silvestro, R., & Silvestro, C. (2000). An evaluation of nurse rostering practices in the National Health Service. *Journal of Advanced Nursing*, 32, 525-535.
- Simms, L. M., Erbin-Roesemann, M., Darga, A., & Coeling, H. (1990). Breaking the burnout barrier: resurrecting work excitement in nursing. *Nursing Economics*, 8(3), 177-187.
- Sjoberg, A., & Sverke, M. (2000). The interactive effect of job involvement and organizational commitment on job turnover revisited: a note on the mediating role of turnover intention. *Scandinavian Journal of Psychology*, 41, 247-252.
- Smith, A., Oczkowski, E., & Smith, C. (2008). *To have and to hold: Retaining and utilising skilled people*. Retrieved 04.04.2010, from <http://www.ncver.edu.au/research/proj/nr06004.pdf>.
- Somers, M. J. (1995). Organizational commitment, turnover and absenteeism: an examination of direct and interaction effects. *Journal of Organizational Behavior*, 16(1), 49-56.
- Spence, K., Tarnow-Mordi, W., Duncan, G., Jayasuryia, N., Elliott, J., King, J. (2006). Measuring nursing workload in neonatal intensive care. *Journal of Nursing Management*, 14(3), 227-234.
- Stake, R. (1994). Case studies. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (Vol. 14, pp. 236-248). Thousand Oaks, CA: Sage.
- Stake, R. (1995). *The art of case study research*. Thousand Oaks, CA: Sage.
- Stake, R. (2004). The case study method of social inquiry. In R. Gomm, M. Hammersley & P. Foster (Eds.), *Case study method* (Vol. 1, pp. 19-26). Thousand Oaks, CA: Sage.
- Stein, M., & Deese, D. (2004). Addressing the next decade of nursing challenges. *Nursing Economics*, 22, 273-279.
- Steinberg, M., Najman, J., Donald, K., McChesney-Clarke, G., & Mahon, C. (1994). *Attitudes and practices of employers and employees towards older workers in a climate of discrimination*. Brisbane: Department of Social and Preventive Medicine, University of Queensland.
- Storey, C., Cheater, F., Ford, J., & Lesse, B. (2009). Retaining older nurses in primary care and the community. *Journal of Advanced Nursing*, 65(7), 1400-1411.

- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research. Grounded theory procedures and techniques*. Newbury Park, CA: Sage.
- Stuenkel, D. L., Cohen, J., & de la Cuesta, K. (2005). The multigenerational nursing work force: essential differences in perception of work environment. *Journal of Nursing Administration*, 35, 283-285.
- Sumner, J., & Townsend-Rocchiccioli, J. (2003). Why are nurses leaving nursing? *Nursing Administration Quarterly*, 27(2), 164-171.
- Swan, B. (2008). Making nursing-sensitive quality indicators real in ambulatory care. *Perspectives in Ambulatory Care*, 26(3), 195-205.
- Sweet, M. (2005). Beating bullying. *Australian Nursing Journal*, 12(9), 16-19.
- Takase, M., Maude, P., & Manias, E. (2005). Nurses' job dissatisfaction and turnover intention: Methodological myths and an alternative approach. *Nursing and Health Science*, 7(3), 209-217.
- Tesch, R. (1990). *Qualitative research: Analysis types and software tools* London: The Falmer Press.
- The Lewin Group (2009a). *Evaluation of the Robert Wood Johnson wisdom at work* (No. Final). Virginia: The Lewin Group.
- The Lewin Group. (2009b). *Wisdom at work: Retaining experienced RNs and their knowledge. Case studies of top performing organisations*. Virginia: The Lewin Group.
- Thorgrimson, D. H., & Robinson, N. C. (2005). Building and sustaining an adequate RN workforce. *Journal of Nursing Administration*, 35(11), 474-477.
- Tourangeau, A., & Cranley, L. (2005). Nurse intention to remain employed: Understanding and strengthening determinants. *Journal of Advanced Nursing Administration*, 55(4), 497-509.
- Tourangeau, A., Cummings, G., Cranley, L., Ferron, E., & Harvey, S. (2009). Determinants of hospital nurse intent to remain employed: Broadening our understanding. *Journal of Advanced Nursing* 66(1), 22-32.
- Tourangeau, A., Doran, D., Pringle, D., O'Brien-Pallas, L., McGillis-Hall, L., Tu, J. (2006). *Nurse staffing and work environments: Relationships with hospital level outcomes*. Toronto: Canadian Health Services Research Foundation.
- Tourigny, L., & Pulich, M. (2005). A critical examination of formal and informal mentoring among nurses. *The Health Care Manager*, 24(1), 68-76.
- Tourigny, L., & Pulich, M. (2006a). Improving retention of older employees through training and development. *Health Science and Health Care Management (Frederick)*, 25(1), 43-52.
- Treasurer of the Commonwealth of Australia. (2010). *Australia to 2050: Future challenges*. Retrieved 3.02.2010, from [http://www.treasury.gov.au/igr/igr2010/report/pdf/IGR\\_2010.pdf](http://www.treasury.gov.au/igr/igr2010/report/pdf/IGR_2010.pdf).

- Tremblay, M., O'Brien-Pallas, L., Viens, C., Brabant, L. H., & Gelinas, C. (2006). Towards an integrated approach for the management of ageing nurses. *Journal of Nursing Management*, 14, 207-212.
- Tsutsumi, A., Kayaba, K., Nagami, M., Miki, A., Kawano, Y., Ohya, Y. (2002). The effort-reward imbalance model: Experience in Japanese working population. *Journal of Occupational Health*, 44, 398-407.
- Tuschke, H. (2006). *Aggression prevention and management safety development fund project*. Paper presented at the kNOw Conference, Melbourne.
- Tveiten, S., & Severinsson, E. (2006). Communication: A core concept in client supervision by public health nurses. *Journal of Nursing Management*, 14, 235-243.
- Twigg, D., & Duffield, C. (2009). A review of workload measures: A context for a new staffing methodology in Western Australia. *International Journal of Nursing Studies*, 46, 137-140.
- U.S. Department of Health and Human Services. (2008). *National healthcare quality report*. Rockville, MD: Agency for Healthcare Research and Quality.
- Ulrich, B. T., Buerhaus, P. I., Donelan, K., Norman, L., & Dittus, R. (2005). How RNs view the work environment: results of a national survey of registered nurses. *Journal of Nursing Administration*, 35(9), 389-396.
- Vegchel, N., Jonge, J., Meijer, T., & Hamers, J. (2001). Different effort constructs and effort-reward imbalance: Effects on employee well-being in ancillary health care workers. *Journal of Advanced Nursing*, 34(1), 128-136.
- Webb, B. (2002). Using focus groups as a research method: A personal experience. *Journal of Nursing Management*, 10, 27-35.
- Webb, C., & Kevern, J. (2001). Focus groups as a research method: a critique of some aspects of their use in nursing research. *Journal of Advanced Nursing*, 33(6), 798-805.
- Webster, J., Flint, A., & Courtney, M. (2009). A new practice environment measure based on the reality and environment of nurses' working lives. *Journal of Nursing Management*, 17(1), 38-48.
- Weston, M. (2006). Integrating generational perspectives in nursing. *Online Journal of Issues in Nursing*, 11(2), 1-7.
- White, R. (2004). Discourse analysis and social constructionism. *Nurse Researcher*, 12(2), 7-16.
- Winwood, P., Winefield, A., & Luchington, K. (2006). Work-related fatigue and recovery: The contribution of age, domestic responsibilities and shiftwork. *Journal of Advanced Nursing*, 56, 438-449.
- Wolf, G., Bradle, J., & Nelson, G. (2005). Bridging the strategic leadership gap: A model program for transformational change. *Journal of Nursing Administration*, 35(2), 54-60.

- Wolf, G. A., Bradle, J., & Greenhouse, P. (2006). Investment in the future: A 3-level approach for developing the healthcare leaders of tomorrow. *Journal of Nursing Administration*, 36, 331-336.
- World Health Organisation. (2006). *World health report: Working together for health*. Geneva: World Health Organisation.
- World Health Organisation. (2008). Primary health care: Now more than ever. Retrieved 2.05.2010, from [http://www.who.int/whr/2008/whr08\\_en.pdf](http://www.who.int/whr/2008/whr08_en.pdf)
- Wright, S. (2005). *Nursing: Burnout a spiritual crisis*. Middlesex, England: Nursing Standard.
- Yin, R. (1994). *Case study research: Design and methods* (2<sup>nd</sup>. ed.). London: Sage Publications.
- Yin, R. (1999). Enhancing the quality of case studies in health services research. *Health Services Research*, 34(5 Pt2), 1209-1224.
- Yin, R. (2003). *Case study research: Design and methods* (3<sup>rd</sup>. ed.). Thousand Oaks, CA: Sage.
- Zaloshnja, E., Miller, T. R., & Waehrer, G. (2006). The impact of occupational injury reduction on the U.S. economy. *American Journal of Industrial Medicine*, 49, 719-727.
- Zavodsky, A., & Simms, L. M. (1996). Work excitement among nurse executives and managers. *Nursing Economics*, 14(3), 151-155, 161.
- Zeytinoglu, I., Denton, M., Davies, S., Baumann, A., Blythe, J., & Boos, L. (2006). Retaining nurses in their employing hospitals and in the profession: Effects of job preference, unpaid overtime, importance of earnings and stress. *Health Policy*, 79, 57-72.
- Zeytinoglu, I., Denton, M., Davies, S., Baumann, A., Blythe, J., & Boos, L. (2007). Detriorated external work environment, heavy workload and nurses' job satisfaction and turnover intention. *Canadian Public Policy*, XXX111(Special), 31-47.

## **APPENDICES**

### **Appendix A: Registered Nurses Workforce Decisions Survey**

## SURVEY

# REGISTERED NURSES WORKFORCE DECISIONS

---

The purpose of this survey is to gather information about how Registered Nurses aged 45 years and over make decisions concerning their work situation.

There are no right or wrong answers.

.

Your answers are confidential.

When you have completed the survey, please place it in the self addressed envelope provided and return the survey through the internal post by 31<sup>st</sup> March 2008.

*Do not write your name on the survey.*

---

*Thank you for taking the time to complete this survey*



## CONSENT FORM – CONTACT FOR FOCUS GROUP

### COPY FOR PARTICIPANT TO SUBMIT

TITLE OF PROJECT: Registered Nurses Decision Making regarding their Workforce Participation:  
A Case Study of Registered Nurses aged 45 years and over.

STAFF SUPERVISOR: Dr Karen Flowers

STUDENT RESEARCHER: Catriona Booker

COURSE: Doctor of Education

#### Participants section

I ..... (*the participant*) have read and understood the information in the information letter inviting participation in the research, and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, which involves an invitation to participate in audiotaped focus group taking about one hour. Realising that I can withdraw from the study at any time, I understand that withdrawal will in no way affect my employment at Royal Brisbane and Women's Hospital.

I agree that research data collected for the study may be published or provided to other researchers in a form that does not identify me in any way. I agree to be contacted by telephone if needed to arrange a mutually convenient time to attend the focus group. I also agree to maintain confidentiality of the focus group discussions. I am over 18 years of age.

Name of participant: ..... Telephone number: .....  
(block letters)

Signature: ..... Date: .....

Research Student: Catriona Booker

Signature: .....

Date: .....

Staff Supervisor: Dr Karen Flowers

Signature: .....

Date: .....

## Section 1.

### DEMOGRAPHICS

Instructions: **Please tick the box** and or complete the statement.

1. Gender:              Female |              Male |
2. Age Range:  
45-50 |    51-55 | 56-60 |              61-65 | 65+ |
3. I have been working as a Registered Nurse (in any facility) for \_\_\_\_ years
4. I have been employed as a Registered Nurse at the RBWH for the last:  
1 – 4 years              |              5 – 10 years |              10 – 15 years |              15 – 20 years |  
20 – 25 years |    25 – 30 years |              30 + years |
5. I am currently employed at RBWH:  
Full time | Part time | \_\_\_\_\_ hr/week              Casual | \_\_\_\_\_ hr/week
6. I work shift work:              Yes |              No |
7. a) I have recently changed my hours of employment              Yes |              No |  
b) I have recently reduced my hours of employment              Yes |              No |

If yes, please indicate the nature and timing of the reduction and or change in hours

---

---

- c) I have recently changed my employment status    Yes |              No |

If yes, please indicate the most appropriate type of change/s in status below:

Full time to Part time		Part time to Full time	
Full time to Casual		Casual to Full time	
Part time to Casual		Casual to Part time	

Please comment on the reason for the change

---

---

8. I hold or have held the following classifications at RBWH:

Nursing Officer Level	Year Range	Work Area
NO 1		
NO 2		
NO 4		
NO 5		
NO 6		
NO 7		
NO 8		
NO 9		

9. My current area of work is mostly:

Medical_____	Surgical_____
Critical Care_____	Perioperative_____
Cancer Care_____	Mental Health_____
Women's Health_____	Neonatology_____
Casual Pool_____	
Other _____	Please describe:

---



---

10. I hold the following post-registration qualifications:

Qualification	Year Achieved

11. I am intending to retire from nursing within the next \_\_\_\_\_ years.

12. I am intending to leave RBWH within the next \_\_\_\_\_ years.

## Section 2.

### QUESTIONS

1. To what extent do you agree with the following statements about your work environment in relation to your decision to remain in nursing.

<i>Please circle your response</i>	<i>Strongly disagree</i>			<i>Strongly agree</i>	
a) I feel satisfied with the workload allocation in my work unit	1	2	3	4	5
b) I am able to complete the necessary work to meet my patients' needs	1	2	3	4	5
c) Experienced nurses have a heavier workload because of their supervisory workload	1	2	3	4	5
d) I have considered reducing my employment status to avoid a heavy workload	1	2	3	4	5
e) There is workplace harassment (by patients or staff or visitors) within my work area	1	2	3	4	5
f) There are effective processes within my workplace to address workplace harassment	1	2	3	4	5
g) The organisation provides safety equipment eg lifting equipment, retractable syringes	1	2	3	4	5

*Please add any additional comments:*

---



---

2. To what extent do you agree with the following statements about leadership in relation to your decision to remain in nursing.

<i>Please circle your response</i>	<i>Strongly disagree</i>			<i>Strongly agree</i>	
a) I feel that the leadership team within my work unit listens to my concerns	1	2	3	4	5
b) I am supported by those who have leadership responsibilities in my work area	1	2	3	4	5
c) The work unit leadership team responds appropriately when I voice opinions concerning work practices	1	2	3	4	5
d) Team processes have priority in my work area	1	2	3	4	5
e) I am trusted by the leadership team in my work unit to do my job	1	2	3	4	5
f) The leadership team provides flexible rostering opportunities to meet my personal needs	1	2	3	4	5
g) The leadership team provides flexible rostering opportunities to meet my professional needs	1	2	3	4	5
h) Consistent with my skills ability, I feel able to practise autonomously	1	2	3	4	5

*Please add any additional comments:*

---

---

---

---

**3. To what extent do you agree with the following statements about your personal and professional needs in relation to your decision to stay in nursing.**

<b><i>Please circle your response</i></b>	<b><i>Strongly disagree</i></b>			<b><i>Strongly agree</i></b>	
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>a)</b> I experience a high level of job satisfaction in my work unit					
<b>b)</b> Financial remuneration is the key motivator for my work					
<b>c)</b> Professional development opportunities are afforded equally to all staff in my work unit regardless of age					
<b>d)</b> Younger or less experienced nurses are provided with more professional development opportunities than older nurses in my work unit					
<b>e)</b> I relate well with the different generations at work					

*Please add any additional comments:*

---

---

---

**4. To what extent do you agree with the following statements about your effort and recognition received in relation to your decision to remain in nursing.**

<b><i>Please circle your response</i></b>	<b><i>Strongly disagree</i></b>			<b><i>Strongly agree</i></b>	
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>a)</b> There is a balance between my effort at work and the recognition I receive for my effort within the work area					
<b>b)</b> I am recognised for the efforts I make at work					
<b>c)</b> I am rewarded for the efforts I make at work					
<b>d)</b> The leadership team recognises staff efforts within my work areas					

If you agreed with the above statements, please describe the recognition and or rewards you receive.

---

---

---

*Please add any additional comments:*

---

---

---

---

**5. Open-ended responses**

- a) What are the most important influences on your intent to remain in nursing?

---

---

---

- b) What aspects of the workplace environment not addressed in this survey do you consider important to retaining nurses like yourself?

---

---

---

- c) What aspects of professional relationships not addressed in this survey do you consider important to retaining nurses like yourself?

---

---

---

- d) Please add any additional comments on issues which may be influencing your employment in nursing.

---

---

---

On completion, please place the survey in the self-addressed envelope provided and return the survey through the internal post by 31<sup>st</sup> March 2008.

*Thank you for completing this survey.*

## **Appendix B: Human Research Ethics Committee Approval Form**



Human Research Ethics Committee

Committee Approval Form

**Principal Investigator/Supervisor:** Dr Karen Flowers Brisbane Campus  
**Co-Investigators:** Associate Professor Denis McLaughlin Brisbane Campus  
**Student Researcher:** Ms Catriona Booker Brisbane Campus

**Ethics approval has been granted for the following project:**

An exploration of End of Career Nurses' (EOCN) decision making regarding their workforce participation

**for the period:** 7 February 2008 to 30 June 2009


**Human Research Ethics Committee (HREC) Register Number:** Q200708 15

The following standard conditions as stipulated in the *National Statement on Ethical Conduct in Research Involving Humans (2007)* apply:

- (i) that Principal Investigators / Supervisors provide, on the form supplied by the Human Research Ethics Committee, annual reports on matters such as:
  - security of records
  - compliance with approved consent procedures and documentation
  - compliance with special conditions, and
- (ii) that researchers report to the HREC immediately any matter that might affect the ethical acceptability of the protocol, such as:
  - proposed changes to the protocol
  - unforeseen circumstances or events
  - adverse effects on participants
  - The HREC will conduct an audit each year of all projects deemed to be of more than low risk. There will also be random audits of a sample of projects considered to be of negligible risk and low risk on all campuses each year.

Within one month of the conclusion of the project, researchers are required to complete a *Final Report Form* and submit it to the local Research Services Officer.

If the project continues for more than one year, researchers are required to complete an *Annual Progress Report Form* and submit it to the local Research Services Officer within one month of the anniversary date of the ethics approval.



Signed:

Date: 7 February 2008  
(Research Services Officer, McAuley Campus)

## **Appendix C: RBWH HSD Ethical Approval Letter**



**Queensland  
Government**

**Royal Brisbane & Women's Hospital & Health Service District  
Office of the Human Research Ethics Committees**

1 February 2008

Ms Catriona Booker  
Centre for Clinical Nursing  
RBWH

Dear Ms Booker,

Enquiries to: **Queensland Health**  
Coordinator  
Phone: 07 3636 5490  
Fax: 07 3636 7800  
Our Ref: 2007/184  
E-mail: RBWH-Ethics@health.qld.gov.au

**PROTOCOL 2007/184 : AN EXPLORATION OF END OF CAREER NURSES' (EOCN)  
DECISION MAKING REGARDING THEIR WORKFORCE PARTICIPATION**

At a meeting of the Royal Brisbane & Women's Hospital Human Research Ethics Committee held on 10 December 2007, the Committee reviewed the above Protocol. The Royal Brisbane & Women's Hospital Human Research Ethics Committee is duly constituted, and operates and complies with the National Health and Medical Research Council's 'National Statement on Ethical Conduct in Research Involving Humans and Supplementary Notes, 2007'. The Chair of the HREC reviewed your further correspondence on 16 January 2008.

It is advised that on the recommendation of the Human Research Ethics Committee, the Clinical Chief Executive Officer, Royal Brisbane & Women's Hospital has approved your request for ethical approval of the following:

- *Protocol Version submitted 14 November 2007*
- *NEAF dated 14 November 2007*
- *Registered Nurses Workforce Decisions Survey*
- *Information Letter: Survey and Further Contact for Focus Group Version 2 dated 8 January 2008*
- *Consent Form- Contact for Focus Group Version2 dated 8 January 2008(for participant and Investigator)*
- *Participant Information Letter: Focus Group Version 2 dated 8 January 2008*
- *Consent Form – For Focus Group and Contact for Individual Interview Version2 dated 8 January 2008(for participant and Investigator)*
- *Participant Information Letter: Individual Interview Version 2 dated 8 January 2008*
- *Consent Form – for Individual Interview Version2 dated 8 January 2008(for participant and Investigator)*

**Other documents submitted**

- *Confirmation from ACU National for research proposal*
- *CV for Catriona Booker*

**Condition of Approval**

***A condition of this approval is for the open ended questions to be submitted to the Human Research Committee at a later date.***

During the conduct of the study you are required to adhere to the following conditions:

- If recruitment has not commenced within 12 months, please advise the Coordinator, HREC.

Office	Postal	Phone	Fax
Herston Rd Herston Q 4029	Post Office Herston Queensland 4029 Australia	07 3636 5490 ISD + 61 7 3636 5490	07 3636 7800

- All forms required when submitting reports to the HREC are accessible on the Herston Intranet. In the first instance please access the Commencement Form and return to this office when the study commences. Please contact the Coordinator if you do not have access to this site.
- In accordance with RBWH Policy 72005: Clinical Trial Documentation, all medical records of research participants must contain documentation regarding the patient's involvement in the trial.
- All investigations must be carried out according to the "Declaration of Helsinki 2000" as subsequently modified and the latest statement by the National Health and Medical Research Council on Human Experiments and on Scientific Practice. Should a copy of the 'Declaration of Helsinki 2000' as subsequently modified be required, please request a copy from the Coordinator, Human Research Ethics Committee.
- Attachment I is a letter listing some matters specified by the National Health and Medical Research Council to which you as the research worker must adhere.
- Attachment II gives the Committee composition with specialty and affiliation with the Royal Brisbane & Women's Hospital.
- You are required to provide a report on any pilot study and the outcome of the study at the completion of the trial or **annually** if the trial continues for more than 12 months.
- If any subsequent change/amendment is made to the protocol it will be necessary for you to obtain approval from the Human Research Ethics Committee. In addition a summary of the amendments and a comment is required from the Principal Investigator. All amended documents must contain revised version numbers, version dates and page numbers. Changes must be highlighted using Microsoft Word "Track Changes" or similar. Please contact the HREC Coordinator if assistance is required.
- Serious Adverse Events must be notified to the Committee as soon as possible. In addition the Investigator must provide a summary of the adverse events, in the specified format, including a comment as to suspected causality and whether changes are required to the Patient Information and Consent Form.
- If the results of your protocol are to be published, an appropriate acknowledgment of the Hospital should be contained in the article. Copies of all publications resulting from the study should be submitted to the Human Research Ethics Committee.
- Please ensure that a copy of any publication that results from this protocol is also forwarded to the Herston Medical Library for future reference.
- The Hospital administration and the Human Research Ethics Committee may inquire into the conduct of any research or purported research, whether approved or not and regardless of the source of funding, being conducted on hospital premises or claiming any association with the Hospital; or which the Committee has approved if conducted outside the Royal Brisbane & Women's Hospital Health Service District. This may include consultation with the Principal Investigator and/or a visit to the research site by a member of the HREC and/or Coordinator of the HREC.

Should you have any problems, please liaise directly with the Administration staff of the Human Research Ethics Committee early in your program.

We wish you every success in undertaking this research.

Yours faithfully



**Dr Conor Brophy**  
**Chair of Human Research Ethics**  
**Royal Brisbane and Women's Hospital**

Office	Postal	Phone	Fax
Herston Rd Herston Q 4029	Post Office Herston Queensland 4029 Australia	07 3636 5490 ISD + 61 7 3636 5490	07 3636 7800

## **Appendix D: Participant Information Letter Focus Group**

## PARTICIPANT INFORMATION LETTER: FOCUS GROUP

TITLE OF PROJECT: Registered Nurses / Midwives Decision Making regarding their Workforce  
Participation: A Case Study of Registered Nurses / Midwives aged 45 years and over.

NAME OF STAFF SUPERVISOR: Dr Karen Flowers

NAME OF STUDENT RESEARCHER: Catriona Booker

COURSE: Doctor of Education

Dear Participant,

As part of my doctoral studies at Australian Catholic University, I am conducting a study on how Registered Nurses / Midwives 45 aged years and over make decisions regarding their workforce participation. It is anticipated that better understanding of how experienced nurses / midwives make these decisions will inform future retention strategies.

Recently, you completed a survey about your work history, workplace and plans for retirement. At that time, you indicated your interest in participating in a focus group to further explore the research topic. At this time you are also invited to express interest in being invited to participate in an individual interview following the focus group. A cross section of nurses / midwives have been selected to participate in the focus group. As your participation would be a valuable addition to the study, an invitation is extended to you to participate in *Focus Group 1 on the 1st Floor, Centre for Clinical Nursing at xx pm on dd/mm/2008*.

The audio-taped focus group will take about an hour. Participants have been selected and allocated to one of the three (3) groups of similar nursing levels ie NO 1- 2; NO 4; and NO 5-9, in order to provide a comfortable environment within the group. A sample of the proposed questions will be provided two (2) weeks prior to the scheduled focus group to allow time for you to consider your views.

Your participation in the focus group and or consent for further contact for an individual interview is voluntary and you can withdraw at any stage without any affect on your employment at Royal Brisbane and Women's Hospital. While it is not expected that you will experience any distress from your involvement in the study, provision through Employee Assistant Scheme is available to support you, if required at anytime. If you are interested in participating in the focus group and agree to being contacted for the individual interview, please complete the attached consent form and return one copy using the preaddressed envelope provided and keep the other copy for your records.



All information resulting from this study will not identify you in any way, ensuring the confidentiality of your responses. Additionally, participants involved in the focus group are asked to maintain confidentiality of the group discussions. A summarised report of the outcomes of the study will be made available at completion of the study.

If you have any questions, concerns or require further information regarding the study please contact either the Student Researcher Catriona Booker: phone (07) 36368264 e-mail [Catriona.Booker@health.qld.gov.au](mailto:Catriona.Booker@health.qld.gov.au) or the Principal Supervisor: phone (07) 36237292 e-mail [karen.flowers@acu.edu.au](mailto:karen.flowers@acu.edu.au).

This study has been approved by the Human Research Ethics Committees at the Australian Catholic University and Queensland Health. In the event that you have any complaint or concern about the way you have been treated during the study, or you have a query that the Student Researcher and Principal Supervisor have not been able to satisfy, you may write to:

Chair, Human Research Ethics Committee

C/- Research Services

Australian Catholic University

Brisbane Campus

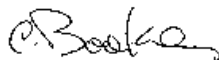
PO Box 456

VIRGINIA QLD 4101

Tel: 07 3623 7429

Fax: 07 3623 7328

Any complaint will be treated in confidence and will be fully investigated. The participant will be informed of the outcome.



.....  
Catriona Booker  
Student Researcher  
2<sup>nd</sup> Floor Centre for Clinical Nursing  
Royal Brisbane and Women's Hospital  
Herston Rd  
Herston 4029



.....  
Dr Karen Flowers  
Principal Supervisor  
Faculty of Health Sciences  
Australian Catholic University  
1100 Nudgee Rd  
Banyo 4014

## CONSENT FORM –FOR FOCUS GROUP AND CONTACT FOR INDIVIDUAL INTERVIEW

### Copy for Participant to Keep

**TITLE OF PROJECT:** Registered Nurses / Midwives Decision Making regarding their Workforce Participation: A Case Study of Registered Nurses / Midwives aged 45 years and over.

**STAFF SUPERVISOR:** Dr Karen Flowers

**STUDENT RESEARCHER:** Catriona Booker

**COURSE:** Doctor of Education

### Participants section

I ..... (*the participant*) have read and understood the information in the information letter inviting participation in the research, and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, which involves an invitation to participate in audiotaped focus group taking about one hour. Realising that I can withdraw from the study at any time, I understand that withdrawal will in no way affect my employment at Royal Brisbane and Women's Hospital.

I agree that research data collected for the study may be published or provided to other researchers in a form that does not identify me in any way. I agree to be contacted by telephone if needed to arrange a mutually convenient time to attend the focus group and discuss the invitation for individual interview. I also agree to maintain confidentiality of the focus group discussions. I am over 18 years of age.

Name of participant: ..... Telephone number: .....  
(block letters)

Signature: ..... Date: .....

Research Student: Catriona Booker

Signature: ..... Date: .....

Staff Supervisor: Dr Karen Flowers

Signature: ..... Date: .....



**CONSENT FORM –FOR FOCUS GROUP  
AND CONTACT FOR INDIVIDUAL INTERVIEW**

**Copy for Participant to Submit**

**TITLE OF PROJECT:** Registered Nurses / Midwives Decision Making regarding their Workforce  
Participation: A Case Study of Registered Nurses / Midwives aged 45 years  
and over.

**STAFF SUPERVISOR:** Dr Karen Flowers

**STUDENT RESEARCHER:** Catriona Booker

**COURSE:** Doctor of Education

**Participants section**

I ..... (*the participant*) have read and understood the information in the information letter inviting participation in the research, and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, which involves an invitation to participate in audiotaped focus group taking about one hour. Realising that I can withdraw from the study at any time, I understand that withdrawal will in no way affect my employment at Royal Brisbane and Women's Hospital.

I agree that research data collected for the study may be published or provided to other researchers in a form that does not identify me in any way. I agree to be contacted by telephone if needed to arrange a mutually convenient time to attend the focus group and discuss the invitation for individual interview. I also agree to maintain confidentiality of the focus group discussions. I am over 18 years of age.

Name of participant: ..... Telephone number: .....  
(block letters)

Signature: ..... Date: .....

Research Student: Catriona Booker

Signature: ..... Date: .....

Staff Supervisor: Dr Karen Flowers

Signature: ..... Date: .....

## **Appendix E: Participant Information Letter Individual Interview**

## PARTICIPANT INFORMATION LETTER: INDIVIDUAL INTERVIEW

TITLE OF PROJECT: Registered Nurses / Midwives Decision Making regarding their Workforce  
Participation: A Case Study of Registered Nurses / Midwives aged 45 years  
and over.

NAME OF STAFF SUPERVISOR: Dr Karen Flowers

NAME OF STUDENT RESEARCHER: Catriona Booker

COURSE: Doctor of Education

Dear Participant,

As part of my doctoral studies at Australian Catholic University, I am conducting a study on how Registered Nurses / Midwives aged 45 years and over make decisions regarding their workforce participation. It is anticipated that better understanding of how experienced nurses / midwives make these decisions will inform future retention strategies.

Recently, you attended a focus group about your work history, workplace and plans for retirement. You have previously indicated your interest in participating in an individual interview to further explore the research topic. A cross section of nurses has been selected to participate in the interview. As your participation would be a valuable addition to the study, an invitation is extended to you to participate in *an interview on the 2nd floor, Centre for Clinical Nursing at xx hrs on dd/08/2008*.

The audio-taped interview will take about an hour. A sample of the proposed questions will be provided two (2) weeks prior to the scheduled interview to allow time for you to consider your views.

Your participation in the interview is voluntary and you can withdraw at any stage without any affect on your employment at Royal Brisbane and Women's Hospital. While it is not expected that you will experience any distress from your involvement in the study, provision through Employee Assistant Scheme is available to support you if required at anytime. If you are interested in participating in the interview, please complete the attached consent form and return one copy using the preaddressed envelope provided and keep the other copy for your records.

All information resulting from this study will not identify you in any way, ensuring the confidentiality of your responses. A summarised report of the outcomes of the study will be made available at completion of the study.

If you have any questions, concerns or require further information regarding the study please contact either the Student Researcher Catriona Booker: phone (07) 36368264 e-mail [Catriona\\_Booker@health.qld.gov.au](mailto:Catriona_Booker@health.qld.gov.au) or the Principal Supervisor: phone (07) 36237292 e-mail [karen.flowers@acu.edu.au](mailto:karen.flowers@acu.edu.au).

This study has been approved by the Human Research Ethics Committees at the Australian Catholic University and Queensland Health. In the event that you have any complaint or concern about the way you have been treated during the study, or you have a query that the Student Researcher and Principal Supervisor have not been able to satisfy, you may write to:

Chair, Human Research Ethics Committee

C/- Research Services

Australian Catholic University

Brisbane Campus

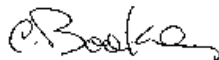
PO Box 456

VIRGINIA QLD 4101

Tel: 07 3623 7429

Fax: 07 3623 7328

Any complaint will be treated in confidence and will be fully investigated. The participant will be informed of the outcome.



.....  
Catriona Booker  
Student Researcher  
2<sup>nd</sup> Floor Centre for Clinical Nursing  
Royal Brisbane and Women's Hospital  
Herston Rd  
Herston 4029



.....  
Dr Karen Flowers  
Principal Supervisor  
Faculty of Health Sciences  
Australian Catholic University  
1100 Nudgee Rd  
Banyo 4014

## CONSENT FORM – INDIVIDUAL INTERVIEW

### Copy for Participant to Keep

**TITLE OF PROJECT:** Registered Nurses / Midwives Decision Making regarding their Workforce Participation: A Case Study of Registered Nurses / Midwives aged 45 years and over.

**STAFF SUPERVISOR:** Dr Karen Flowers

**STUDENT RESEARCHER:** Catriona Booker

**COURSE:** Doctor of Education

#### Participants section

I ..... (*the participant*) have read and understood the information in the information letter inviting participation in the research, and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, which involves an invitation to participate in audiotaped individual interview taking about one hour. Realising that I can withdraw from the study at any time, I understand that withdrawal will in no way affect my employment at Royal Brisbane and Women's Hospital.

I agree that research data collected for the study may be published or provided to other researchers in a form that does not identify me in any way. I agree to be contacted by telephone if needed to arrange a mutually convenient time to attend the individual interview. I am over 18 years of age.

Name of participant: ..... Telephone number: .....  
(block letters)

Signature: ..... Date: .....

Research Student: Catriona Booker

Signature: ..... Date: .....

Staff Supervisor: Dr Karen Flowers

Signature: ..... Date: .....

## CONSENT FORM - INDIVIDUAL INTERVIEW

### Copy for Participant to Submit

TITLE OF PROJECT: Registered Nurses / Midwives Decision Making regarding their Workforce Participation: A Case Study of Registered Nurses /Midwives aged 45 years and over.

STAFF SUPERVISOR: Dr Karen Flowers

STUDENT RESEARCHER: Catriona Booker

COURSE: Doctor of Education

#### Participants section

I ..... (*the participant*) have read and understood the information in the information letter inviting participation in the research, and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, which involves an invitation to participate in audiotaped individual interview taking about one hour. Realising that I can withdraw from the study at any time, I understand that withdrawal will in no way affect my employment at Royal Brisbane and Women's Hospital.

I agree that research data collected for the study may be published or provided to other researchers in a form that does not identify me in any way. I agree to be contacted by telephone if needed to arrange a mutually convenient time to attend the individual interview. I am over 18 years of age.

Name of participant: ..... Telephone number: .....  
(block letters)

Signature: ..... Date: .....

Research Student: Catriona Booker

Signature: ..... Date: .....

Staff Supervisor: Dr Karen Flowers

Signature: ..... Date: .....