

**Opinions of Registered Nurses about
Quality of Working Life
in
Victoria's Public Hospitals**

Submitted by

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ABSTRACT

High quality of working life is vital for maintaining an adequate workforce, and given the current global nursing workforce shortage, the quality of nurses' working lives is of particular importance. The literature suggests that ensuring working conditions are attractive enough to retain nurses in the workforce is the most cost-effective and sustainable strategy for addressing the nursing shortage.

Drawing upon the Theory of Work Adjustment as a theoretical framework, this cross-sectional, mixed-method study sought to explore the opinions about quality of working life held by nurses working in public hospitals in Victoria. Differences in opinion about key aspects of working life between nurses who planned to continue a career in nursing and those who planned to make a career change were also sought. Data were collected using a Likert-style survey and semi-structured interviews and were analysed by means of the SPSS computer program and qualitative content analysis.

The results of this study add to the relatively small body of knowledge about the quality of working life of nurses in Australia. The main findings were that factors such as interactions with patients and friendly, supportive work colleagues made the greatest contribution to the participants' quality of working life, but that they felt a sense of injustice about being underpaid and undervalued in relation to their demanding work responsibilities.

Overall the findings were compatible with those of previous research related to nurses' quality of working life, but in addition, this study identified the main factors in the workplace that drive nurses to plan a career change. This information may be useful in prioritising the interventions needed to improve the problematic aspects of nurses' working conditions. The findings may therefore help improve the retention rates of nurses in the workforce.

DECLARATION OF AUTHENTICITY

I, Rita Funnell, declare that the PhD thesis entitled 'Opinions of Registered Nurses about quality of working life in Victoria's public hospitals' is no more than 100,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work.

Signature:

Date:

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CONTENTS

ABSTRACT	2
DECLARATION OF AUTHENTICITY	4
ACKNOWLEDGEMENTS	5
CONTENTS	6
LIST OF TABLES	14
LIST OF FIGURES	16
CHAPTER 1 – INTRODUCTION	17
1.1 Overview of the chapter.....	17
1.2 Background to the study	17
1.2.1 Reasons for the nursing shortage	19
1.2.1.1 The ageing nursing workforce	19
1.2.1.2 Increased career options for women	21
1.2.1.3 The inability to prepare sufficient new nurses.....	22
1.2.1.4 Nurses’ working conditions	22
1.2.2 The impact of the nursing shortage.....	24
1.2.3 Proposed strategies to combat the nursing shortage in Australia	26
1.2.3.1 Expanding the number of graduates	26
1.2.3.2 Increasing the intake of overseas qualified nurses.....	27
1.2.3.3 Adjusting the skill mix.....	28

1.2.3.4	Reducing attrition	29
1.3	The need for further investigation	32
1.4	Aims of the study	33
1.5	The theoretical framework and research methods	33
1.6	Significance of the study.....	34
1.7	Operational definitions	35
1.7.1	Quality of working life	35
1.7.2	Nurses in Australia.....	36
1.7.3	Nurse turnover	37
1.7.4	Peri-operative nursing.....	38
1.7.5	Intrinsic and extrinsic rewards.....	38
1.7.6	Work/family fit and work/family conflict	38
1.7.7	Burnout	39
1.7.8	Emotional intelligence	39
1.7.9	Emotional labour.....	39
1.8	Organisation and structure of the thesis.....	40
1.9	Chapter summary	42
 CHAPTER 2 – LITERATURE REVIEW		43
2.1	Introduction.....	43
2.2	The theoretical constructs of QWL and job satisfaction.....	43
2.2.1	The dimensions of QWL.....	44
2.2.2	The dimensions of job satisfaction	45

2.3	The nature of nursing work.....	47
2.4	Nurses' working conditions	50
2.4.1	Working hours	51
2.4.2	Work demands	54
2.4.3	Leadership and management	57
2.4.4	Interpersonal relationships at work.....	59
2.4.5	Financial reward	65
2.5	Nurses' health and wellbeing.....	68
2.5.1	The stresses and strains of nursing work	71
2.6	Intentions to stay or leave the nursing profession.....	74
2.7	Moderators of nurse attrition	78
2.8	Chapter summary	81

CHAPTER 3 – THE THEORETICAL AND METHODOLOGICAL

	APPROACH.....	83
3.1	Introduction.....	83
3.2	The theoretical approach.....	83
3.3	The Theory of Work Adjustment.....	85
3.3.1	The six value dimensions.....	87
3.4	The methodological approach.....	89
3.4.1	The pragmatist paradigm	90
3.5	Chapter summary	91

CHAPTER 4 – RESEARCH DESIGN AND METHOD	93
4.1 Introduction.....	93
4.2 The mixed method research design	93
4.3 The quantitative component of the study.....	97
4.3.1 The setting and the survey sample.....	97
4.3.2 The sample size.....	99
4.3.3 Data collection procedures.....	100
4.4 The research instrument for data collection.....	100
4.4.1 Modification of the IES Quality of Working Life survey	102
4.4.2 Validity and reliability of the modified survey.....	103
4.4.2.1 Content validity.....	103
4.4.2.2 Face validity.....	104
4.4.2.3 Reliability.....	106
4.5 Quantitative data analysis	107
4.5.1 Data transformation	107
4.5.2 Configuring the participants into groups	108
4.5.3 Statistical tests	109
4.6 The qualitative component of the study.....	110
4.6.1 The interviewees	110
4.6.2 The qualitative procedures.....	112
4.6.3 Data management	114
4.7 Qualitative data analysis	115
4.7.1 The process of qualitative content analysis	116
4.7.1.1 Making coding decisions	117

4.7.1.2	Inductive category formulation.....	118
4.7.1.3	Establishing translation (coding) rules	120
4.7.1.4	Reviewing the remaining un-coded text	122
4.8	Rigour in the design and implementation of the study	122
4.9	Ethical considerations	124
4.10	Chapter summary	125
 CHAPTER 5 – RESULTS.....		127
5.1	Introduction.....	127
5.2	Results from the quantitative component of the study	128
5.2.1	The demographic profile of survey participants	128
5.2.2	Participants’ opinions about the quality of their working life	131
5.2.3	Demographic profile comparison of participants according	
	to their career intentions	132
5.2.4	Differences in opinions between participants planning to	
	stay and those planning to leave nursing	134
5.2.5	Relationships between selected key elements of QWL	136
5.3	Results from the qualitative component of the study	137
5.3.1	Main reasons for planning to stay in nursing.....	137
5.3.2	Main reasons for planning to leave nursing.....	138
5.3.3	Extended exploration of the open question data.....	139
5.3.3.1	A rewarding career with adverse conditions.....	140
5.3.3.2	Feelings of grievance	141
5.4	Brief summary of results from the open question data.....	143

5.5	The interviews.....	144
5.5.1	The interviewees	144
5.6	Results from the interview data	145
5.6.1	An intrinsically rewarding but arduous profession.....	145
5.6.2	The importance of supportive work colleagues	147
5.6.3	The importance of the unit manager	149
5.6.3.1	The unit manager and general wellbeing.....	149
5.6.3.2	The unit manager and work/life fit	150
5.6.3.3	The unit manager and feeling valued as a good nurse.....	152
5.6.4	A sense of injustice	153
5.6.4.1	Grievance related to work pressure	154
5.6.4.2	Grievance related to reward/effort imbalance	156
5.6.4.3	Grievance related to workplace safety.....	157
5.6.4.4	Grievance related to feeling undervalued as a health professional.....	159
5.7	Further exploration prompted by qualitative results.....	161
5.7.1	Further exploration related to work/family fit	161
5.7.2	Further exploration related to views about resources	163
5.7.3	Further exploration related to negative behaviours	164
5.7.4	Further exploration related to doctor/nurse relationships.....	165
5.7.5	Further exploration related to autonomy in nursing practice.....	165
5.8	Chapter summary	166

CHAPTER 6 – DISCUSSION	168
6.1 Introduction.....	168
6.2 The demographic profile of the study participants	168
6.3 The participants’ quality of working life	171
6.4 An intrinsically rewarding but arduous profession.....	174
6.4.1 The links between quality of care, intrinsic rewards and	
work values	180
6.5 The imbalance between extrinsic rewards and work effort	182
6.5.1 Opinions about financial rewards	182
6.5.2 Opinions about professional advancement opportunities	184
6.5.3 The links between extrinsic rewards and work values	185
6.6 Relationships in the work environment	187
6.6.1 Relationships with work colleagues	188
6.6.2 Doctor/nurse relationships	190
6.6.3 Relationships with unit managers	192
6.6.4 Bullying and harassment.....	192
6.6.5 The links between interpersonal relationships and work values.....	196
6.7 The importance of effective management	197
6.7.1 The links between effective management and work values	201
6.8 The need for an acceptable work/family fit	201
6.8.1 The links between work/family fit and work values.....	204
6.9 A sense of injustice	205
6.10 Future career decisions	207
6.11 Chapter summary	208

CHAPTER 7 – CONCLUSIONS AND RECOMMENDATIONS 210

7.1 Introduction..... 210

7.2 Implications of the study..... 210

7.3. The culture of the work environment 211

7.4 Pressure of work 212

7.5 Nurses’ health and safety 213

7.6 Unit managers 214

7.7 Financial and other rewards for nurses 215

7.8 Policies and practices to support work/family fit 217

7.9 Limitations of the study 218

7.10 Recommendations for further research..... 220

REFERENCES..... 226

APPENDICES 272

Appendix A: Survey participant information letter 272

Appendix B: Nurses Quality of Working Life Survey 275

Appendix C: The expert review panel 284

Appendix D: Interviewee information letter..... 286

Appendix E: Consent form 289

LIST OF TABLES

4.1	Modifications to the survey instrument following Stage 2 pilot testing	105
4.2	Cronbach's Alpha reliability coefficients	107
4.3	Examples of fragmentation of data and application of sub category codes.....	119
4.4	Examples of sub categories subsumed into minor and major categories.....	120
4.5	Coding rules applied to the major category 'the importance of supportive work colleagues'	121
4.6	Segments of data positioned within coding rules for the major category 'the importance of supportive work colleagues'	122
5.1	Age of participants	129
5.2	Family background of participants	129
5.3	Educational level of participants'	129
5.4	Participants' years of experience as an RN.....	130
5.5	Participants' years of tenure with current employer	130
5.6	Participants' main area of work	130
5.7	Participants' opinions about quality of working life.....	131
5.8	Demographic profile comparison of participants by their career intentions.....	133

5.9	Differences in opinions between participants planning to stay and leave nursing	135
5.10	Main reasons for planning to stay in nursing.....	138
5.11	Main reasons for planning to leave nursing.....	139
5.12	Participants' opinions about the quality and availability of resources.....	163
5.13	Between-group differences in opinion about resources	164

LIST OF FIGURES

4.1	Flowchart of the research design	95
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CHAPTER 1 – INTRODUCTION

1.1 Overview of the chapter

This study was concerned with the working lives of nurses employed in public hospitals in the State of Victoria, Australia. It sought their opinions about multiple aspects of their employment conditions that impacted upon their quality of working life. It also sought to identify if there were differences in opinion about multiple key aspects of working life between those who were planning to stay in nursing and those who were planning to make a career change. This chapter commences with a brief account of the background for the study. Next, the research aims are defined. The chapter then offers a discussion about the significance of the study and its contribution to the body of knowledge about nurses' quality of working life. It concludes with an outline of the organisation and structure of the thesis.

1.2 Background to the study

The world has entered a time of scarcity of economic and human resources that is impacting upon the health of global populations. The lack of qualified health professionals, particularly nurses, is now one of the major barriers to achieving the United Nations' Millennium Development Goals for improving population health (Anand & Barnighausen, 2004). In 2004, The World Health Organisation (WHO) launched a ten-year action plan aimed at solving this problem, and two years later, also with a specific focus on the nursing shortage, the International Council of Nurses (ICN) launched the Global Nursing Workforce Project (International Council of Nurses, 2006; World Health Organisation, 2006).

Although there are an estimated 12 million nurses worldwide (Buchan & Calman, 2005), this number is far less than sufficient to meet labour force requirements (International Council of Nurses, 2006; World Health Organisation, 2006). Developing countries are those most severely affected. There are less than 10 nurses per 100,000 people in the Central African Republic, Liberia and Uganda, compared to more than approximately 1,000 per 100,000 in countries such as Norway, Finland and Australia (Australian Health Workforce Institute, 2008; Buchan & Calman, 2005; World Health Organization, 2004). In sub-Saharan Africa, the HIV/AIDS epidemic has created a huge increase in the demand for care and simultaneously, through the associated illness and death of healthcare workers, seriously undermined the capacity of the medical and nursing workforce, resulting in a total collapse of health care systems in this area (Dovlo, 2005; World Health Organisation, 2006). Most developed countries, including the United States of America (USA), Canada, and those throughout Europe are experiencing less critical, but still serious, nursing shortfalls (Auerbach, Buerhaus, & Staiger, 2007; Buchan & Calman, 2004; Royal College of Nursing UK, 2005). Auerbach et al. (2007) indicated that by 2020 there would be a deficit of 340,000 nurses in the USA and the Canadian Nurses' Association (2008) predicted that Canada would experience a deficit of 78,000 nurses by 2011, rising to 113,000 by 2016.

Similarly to most other developed countries, the shortage of nurses in Australia is serious. The Australian Health Workforce Advisory Committee (AHWAC) (2004a, 2004b) predicted a nursing workforce shortfall of 60,799 nurses over a ten year period, with the gap estimated at 5,504 in 2006 and 8,329 in 2012. According to a

2002 National Review of Nursing Education, if effective measures are not implemented to address the nursing shortage, Australia will experience a shortfall of 31,000 by the year 2062 (Armstrong, 2003). The shortage is particularly severe in the acute in-patient hospital setting (Australian Health Workforce Advisory Committee, 2004b; Hogan, Moxham, & Dwyer, 2007). As advised by the Australian Health Workers' Institute (2008), there now needs to be a strong focus on implementing strategies to address the shortage problem because "the scope of the challenge is quite clear" (p. 3).

1.2.1 Reasons for the nursing shortage

The world is moving into its twelfth consecutive year of nursing shortage, which is the longest lasting shortage in half a century (Auerbach, et al., 2007). This is due to a range of converging socio-demographic and socio-economic factors including ageing populations; increased career opportunities for women; the inability to prepare sufficient numbers of new nurses; and nurses' inadequate working conditions.

1.2.1.1 The ageing nursing workforce

Globally the nursing workforce is ageing and large numbers of nurses are approaching retirement age (Buchan & Calman, 2005). At the same time that the nursing workforce is ageing, a large proportion of the general population is also ageing. This is seriously exacerbating the existing burden of chronic illness and causing a burgeoning demand for health care (International Council of Nurses, 2006). Thus, there is an expanding need for more nurses when, concurrently, large numbers of nurses are preparing to retire from the profession. The problem of the

ageing nursing workforce is very serious. For example, in the USA the average age of registered nurses was 47 years in 2004, compared to 45 years in 2000 (Federal Division of Nurses, 2004). In 1991, one in four (26%) nurses on the UK Nursing and Midwifery Council (NMC) register were aged under 30 years; by 2007 fewer than one in ten (<10%) were aged under 30 and approximately 200,000 (30%) on the register were aged 50 years or older (Buchan & Secombe, 2008). According to these authors, the ageing nursing workforce in the UK presents “a critical challenge in the next 10 years” (p. 3).

Similarly to the situation in many other countries, the ageing population in Australia is increasing the demand for nursing care, while at the same time large numbers of nurses are planning to retire from working life (Australian Health Workforce Advisory Committee, 2005). According to Schofield (2007), the average age of Registered Nurses (RNs)¹ in Australia increased to 43 years in 2004, compared to 41 years in 1999. Australian Institute of Health and Welfare (2009) statistics revealed that by 2007 the average age of RNs had increased to 44 years. Schofield’s calculations suggested that just as a result of the loss of older nurses, Australia would need to replace an average of 14% of the total nursing workforce every five years between the years of 2006-2026. This is between 20,000 – 25,000 nurses every five years, and a total of about 90,000 nurses over the entire period (Schofield, 2007). As in other countries, the ability to replenish the nursing workforce is dependent on the ability to recruit sufficient new nurses. Schofield (2007) expressed the concern that the ageing of the general population in Australia, as elsewhere, was diminishing the

¹ A definition of an RN in Australia is provided under operational definitions in Chapter 1.

labour pool of young adults, when this was the age group that supplied the majority of new nursing students. She identified that during 2006 and 2026, the general population would grow by 24%, and the population aged 65 years or older would grow by 79%, whereas those under the age of 30 years would grow by only 8%. According to Schofield (2007), in Australia, an average of 5000 students per annum are expected to graduate with a nursing degree between 2006 and 2026. Schofield concluded that while this will be roughly enough new recruits to replace older nurses retiring from the profession, it will not be enough to compensate for the future nursing care needs of the Australian population. It will not be sufficient to provide for the increasing care demands that will be created by the ageing general population, nor to compensate for the attrition from nursing that will occur unrelated to age-related retirement from the workforce (Schofield, 2007).

1.2.1.2 Increased career options for women

Another factor contributing to the gravity of the current nursing shortage is the expansion of career opportunities for women (Hallam, 2002; Muldoon & Reilly, 2003). Increasingly, more women are entering formerly male-dominated professions such as medicine, law and business. As Buerhaus, Staiger and Auerbach (2000) pointed out, only half as many women are selecting nursing as a career than was the case 25 years ago. In addition, because the nursing profession has provided women with attributes and skills that are valued in other areas of employment, qualified nurses are being actively recruited to other industries (Duffield, Aiken, O'Brien-Pallas, & Wise, 2004).

1.2.1.3 The inability to prepare sufficient new nurses

The third factor exacerbating the nursing deficit is that the number of nurses being educated to provide care is now being outstripped by the increasing demand for nurses to provide that care (Buchan & Calman, 2005). Currently, the number of students able to enter nursing programs is restricted by inadequate educational resources (Australia & New Zealand Council of Deans of Nursing & Midwifery, 2008; Canadian Nurses' Association, 2008; Fang & Htut, 2009). According to the American Association of Colleges of Nursing (2008), insufficient numbers of clinical sites, classrooms, clinical preceptors, and budget constraints meant that in 2008 nursing schools in the USA were forced to turn away almost 28,000 applicants eligible to undertake baccalaureate nursing programs. In order to meet projected demand for new graduates, these USA nursing schools were required to increase their intake of student nurses by 90% in 2008, but the lack of educational resources limited the increase to only 2.2% (American Association of Colleges of Nursing, 2008). In addition, nursing schools in the USA are confronted with a severe lack of suitably qualified faculty staff. Fang and Htut (2009) describe recruiting sufficient numbers of nurse academics to replace those retiring from the workforce as a major challenge.

1.2.1.4 Nurses' working conditions

Healthcare systems worldwide have, in recent years, been subject to reform and restructuring as countries have attempted to contain rapidly escalating costs of healthcare (Duffield, Kearin, Johnston, & Leonard, 2007). Nursing services constitute the highest proportion of operational expenses in hospitals, therefore these

services have been a primary target for restructuring (Ritter-Teitel, 2002). In order to decrease running-costs and to address the shortage of RNs, some healthcare agencies, including hospitals, have changed the skill mix of staff who provide patient care (Australian Commission on Safety and Quality in Healthcare (ACSQH), 2008).

Adjusting the skill mix is a method used in human resource management to achieve the most flexible and cost effective use of staff (Lookinland, Tiedman, & Crosson, 2005). Skill mix models in nursing commonly include a combination of RNs (some of whom might be Clinical Nurse Specialists and Clinical Nurse Educators), ENs,² and unlicensed personnel such as Patient Service Assistants and Personal Care Attendants. In some instances, the numbers of RNs were reduced and some Nurse Unit Manager positions were replaced with more business-oriented administrators who were not nurses (Sherson, 2005; Stone et al., 2003).

Compared to previous decades, the overall complexity of nursing work has intensified in all areas where nurses are employed. Nurses are required to adapt to rapid advances in high care technology (Hallin & Danielson, 2007). Further, inpatients are more unwell on arrival, length of hospital stay is shorter, and as a consequence hospitalised patients require more nursing care (Duffield, Kearin, et al., 2007). Concurrently, the number of RNs available to provide patients with the care they require has decreased (Australian Commission on Safety and Quality in Healthcare (ACSQH), 2008; Duffield et al., 2007; Wise, 2007). In particular, the reduced ratio of RNs to ENs has caused increased stress and strain on the RNs who

² A definition of an EN in Australia is provided under operational definitions in Chapter 1.

remain in the workforce (Burke, 2005). The shorter average length of hospital stay for patients is an effect of the cost-saving approach and in many hospitals the turnover (discharges and new admissions) of patients has become more rapid.

This has increased the workload of nurses and has contributed to their dissatisfaction with working life (Duffield, Kearin, et al., 2007). According to the International Council of Nurses (2006) high work demand and poor working conditions are factors hindering recruitment and according to several other studies they are factors influencing nurses' decisions to leave the profession (Cheung, 2004; Gordon, 2005; Kingma, 2006; Lavoie-Tremblay et al., 2008; Stone, et al., 2003).

1.2.2 The impact of the nursing shortage

Representing 40-50% of the global health care workforce, nurses comprise the largest single group of healthcare providers in virtually every country (Productivity Commission, 2006). As nurses constitute such a major share of the healthcare workforce, the shortage of nurses impacts negatively on the health and wellbeing of global populations (Buchan & Calman, 2005). Hospital-based nurses, for example, provide 24 hour care which facilitates continuous observation of patients. This means they provide the means of early detection and prompt action when a patient's condition deteriorates (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002). Lower numbers of nurses in hospitals, in particular reduced numbers of RNs, are associated with a reduced quality of patient care (Buerhaus, DesRoches, Donelan, & Hess, 2009; Gurses, Carayon, & Wall, 2009; Leurer, Donnelly, & Domm, 2007), and a higher incidence of negative health-related events. These include a higher incidence of in-hospital patient mortality, a higher number of hospital-acquired complications

such as pneumonia, and a longer time spent in hospital (Aiken, et al., 2002; Dall, Chen, Seifert, Maddox, & Hogan, 2009; Duffield, Roche, et al., 2007; Kane, Shamiliyan, Mueller, Duval, & Wilt, 2007).

Consistent with most other countries, nurses comprise almost half (40.5%) of the total number of health workers employed in Australia's health care system (Australian Institute of Health and Welfare, 2006a). Of the entire nursing workforce, more than 85% are RNs (Australian Institute of Health and Welfare, 2006b).

Reflecting the global situation, the lack of nurses in Australia is having a negative impact on health care services in almost every area that nurses work (Australian Health Ministers' Conference, 2004). The greatest impact is in the public hospital sector where the shortage is associated with bed closures, lengthening waiting lists for hospital treatment and ambulance diversions from emergency departments (Preston, 2006; Wise, 2007). More importantly, the prolonged shortage is having a detrimental impact on quality of working life for those nurses who remain in the staff-depleted healthcare system (Gordon, 2005). Their workload demands are intensified and many nurses are feeling pressured to work longer hours than they wish and not to take the leave to which they are entitled (Schofield & Earnest, 2006).

1.2.3 Proposed strategies to combat the nursing shortage in Australia

The Australian Health Workforce Advisory Committee (2004a) identified four strategies as being of particular importance in narrowing the gap between the supply and demand of nurses in Australia: expanding the number of graduates; increasing the intake of overseas nurses; adjusting the skill mix; and reducing attrition. The key issues related to these four areas are outlined below.

1.2.3.1 Expanding the number of graduates

While there is no doubt that it is necessary to expand the number of new nurse graduates, the ability to do so is seriously limited by a shortage of faculty resources and appropriate clinical experiences for student nurses (Australia & New Zealand Council of Deans of Nursing & Midwifery, 2008). It is estimated that Australia needs 10,000 new graduate nurses (RNs) per year from 2006 onwards to meet workforce requirements (Australian Health Workforce Advisory Committee, 2004a). Although Preston (2006) indicated training rates would increase from 3.3% in 2006 to 4.6% in 2010, the Australian Health Workforce Advisory Committee (2004) predicted a shortfall of 4,000 new graduates per year from 2006 onwards, which is 40% higher than the numbers of graduates expected to complete their courses (Gaynor et al., 2008). While there are plans to expand the number of graduates by increasing university places over the next four years, the Australia and New Zealand Council of Deans of Nursing and Midwifery (2008) indicated these plans will be hampered by limited educational resources. The Council reported that the infrastructure was already stretched to capacity in many schools of nursing, that there was a critical lack

of clinical placement opportunities for students, and that there was a serious deficit of suitably qualified and experienced clinical educators.

1.2.3.2 Increasing the intake of overseas qualified nurses

Increasing the intake of overseas nurses is a short-term, expensive and impractical solution to the nurse shortage problem, and can be severely detrimental to third world nations (Buchan & Calman, 2005; Gordon, 2005; Lookinland, et al., 2005). In spite of this, Australia, concurrently with many other countries, has actively recruited qualified nurses from overseas to fill the void of nurses in the workforce. As a result, nurse migration to Australia has been rising in recent years. Between 2004 and 2009 there was a 10% increase in the number of overseas-qualified nurses registering to work in Australia (Nurses' Board of Victoria, 2009). However, recruitment activities and orientation programs needed by overseas qualified nurses are costly and as Gordon (2005) has commented "Hospitals are paying thousands of dollars in fees and expenses for every foreign nurse they recruit" (p. 375). Further, the ICN strongly condemns recruiting qualified nurses from developing countries as unethical because it depletes the essential nursing workforce in areas where population health is particularly poor and health care services are severely sub-standard (Buchan & Calman, 2005; International Council of Nurses, 2006). According to the ICN (2007) increasing the intake of overseas qualified nurses is not proving effective enough to prevent the continuation of a lack of nurses either in Australia, or in other countries (International Council of Nurses, 2007), suggesting that recruiting nurses from international sources is neither an effective nor a sustainable strategy.

1.2.3.3 Adjusting the skill mix

Adjusting the skill mix of staff responsible for the provision of patient care is an unsafe strategy. International research shows that administrators in some overseas hospitals have adjusted the skill mix by reducing the ratio of RNs to ENs, and this research provides abundant evidence that reducing the ratio in this way jeopardises the quality of patient care (Aiken, et al., 2002; Dall, et al., 2009; Estabrooks, Mididzi, Cummings, Ricker, & Giovannetti, 2005; Lankshear, Sheldon, & Maynard, 2005; Needleman, Buerhaus, Mattke, & Stewart, 2002; Shields & Watson, 2008). For example, in a controlled study of over 27,000 hospital admissions in Pennsylvania, the odds of 30-day mortality and failure to rescue (death following a medical complication) were 19% lower in hospitals where 60% of the nurses held bachelor or higher degrees than in hospitals where only 20% of nurses held this level of qualification (Aiken, Clarke, Cheung, Sloane, & Silber, 2003).

In 2000, a staffing model for Australia was outlined that involved reducing the number of RNs and increasing the number of ENs (Duckett, 2000). The scope of practice of ENs has been extended in recent years so that many are now trained to undertake a range of nursing care responsibilities that were once the exclusive domain of RNs. Thus it has become increasingly more compelling for healthcare administrators to decrease the ratio of RNs to ENs (Australian Nursing and Midwifery Council, 2006; Victorian Government Department of Human Services, 2008). A report from the Australian Health Workforce Institute indicated that the shortage of RNs and issues of cost containment were forcing healthcare administrators to increase the numbers of less skilled staff to provide patient care

(Australian Health Workforce Institute, 2008). However, little information is available about the extent to which skill mix in Australian hospitals has been adjusted over time (Duffield et al., 2005). One New South Wales study, involving 286 wards across 27 hospitals, revealed there had been a 2.3% reduction in the proportion of RNs to other care staff on medical-surgical wards within a five year period (2001-2006) (Duffield, Roche, et al., 2007). The same study also demonstrated that when the proportion of RNs was higher, patients were less likely to fall and experience injuries, or to suffer hospital-acquired pneumonia. Moreover, there were statistically significant relationships between a higher amount of hours RNs were present on the ward and decreased incidences of deep vein thrombosis/pulmonary embolism and physiological/ metabolic derangement (Duffield, Roche, et al., 2007). The research has demonstrated that down-grading the skills mix jeopardises patient wellbeing and safety and is therefore not a safe or desirable way to address the nursing shortage (Shields & Watson, 2008).

1.2.3.4 Reducing attrition

Reducing attrition of qualified nurses is the most practical and cost-effective way of addressing the nursing shortage (Cavanagh & Coffin, 1992; Hogan, et al., 2007; Shields & Ward, 2001). While the current attrition rate of nurses in Australia is difficult to determine, Witham (2000) reported that “In Victoria there are 70,000 nurses with 56,000 working in the system and about 2000 dropping out every year” (p. 9). Preston (2006) suggested that the number of nurses in Australia who leave nursing permanently was alarmingly large and identified that many left during the first five years after first gaining registration to practice. Further, The Australian

Institute of Health and Welfare (2009) reported that in 2007 there were over 22,000 RNs who were not working as nurses in the Australian health care system. Of these, almost half (49.2%) were not employed and were not looking for work, but over 42% (n=9,342) were employed in areas of work that did not involve nursing. The remainder, almost 9% (n=1,926), were employed as nurses, but not in Australia.

Studies show that working conditions are directly related to nurse attrition rates (Aiken, Havens, & Sloan, 2000; Armstrong, 2005; Buchan, Ball, & Rafferty, 2003). In particular, there is evidence of reduction in nurse attrition in hospitals implementing the Magnet model of business management (Aiken, et al., 2000; Buchan & Calman, 2004; Kramer & Schmalenberg, 1991). The concept of 'the magnet hospital' emerged in the United States of America (USA) in 1980 and, according to Chen and Johanatgen (2010), there are currently approximately 344 hospitals in the USA operating under this model. Hospitals functioning under this 'magnet' model offer working conditions designed to successfully attract, retain and motivate nurses by providing a quality of working life above that provided in other hospitals (Buchan, et al., 2003). Magnet working conditions normally include more flexible working schedules and clinical career opportunities and the presence of well-prepared and qualified nurse executives (Armstrong, 2005; Buchan, et al., 2003). As hospitals in Australia have grappled with difficulties in retaining nursing staff, they have employed some magnet strategies to improve the quality of nurses' working life. However, as Armstrong (2005) pointed out, few Australian hospitals have embraced the formal Magnet model. The Princess Alexander Hospital in Queensland has done so, gaining formal accreditation as a Magnet hospital from the American

Nurses' Association in 2000. A study conducted at the Princess Alexander Hospital further demonstrated the connection between working conditions and attrition rates and reported a reduction in nurse attrition from 25% in 1999 to about 10% in 2001 (Armstrong, 2005).

A variety of strategies to improve nurses' working conditions and reduce attrition rates were recommended following a succession of reports on the Australian nursing workforce. These included: increasing support for new graduates; implementing fixed national nurse/patient ratios; improving flexibility in rostering systems; establishing career pathways that retain nurses at the bedside; implementing a system to reward those nurses who study to gain advanced levels of clinical expertise; implementing paid leave for post-graduate study; and improving nurses' rates of pay (Australian Department of Employment Science and Training, 2002; Australian Health Ministers' Conference, 2004; Australian Health Workforce Advisory Committee, 2004a; Bennett, 2001; Heath, 2002; Jones & Cheek, 2003; Preston, 2002, 2006). However, there has been little exploration as to how effectively these strategies have been implemented, or of how the various characteristics of the hospital work environment are perceived by RNs currently employed in Australia's public hospitals.

While all of the strategies discussed above may have some degree of positive impact on the nursing shortage, it is indisputable that it is reducing attrition rates that is the most cost-effective and sustainable solution. Increasing the number of new graduates is a time consuming and expensive strategy. It takes at least three years to

educationally prepare a new graduate RN. Recruiting more nurses from overseas is not only costly, but also ineffective in managing the global shortage. More importantly, it is an unsustainable and in some cases an unethical strategy (Buchan & Calman, 2005; Duffield, et al., 2005; Gordon, 2005). The third suggested approach, adjusting the skill mix, is not a desirable strategy because it can jeopardise the quality of patient care (Aiken, et al., 2002; Dall, et al., 2009; Estabrooks, et al., 2005; Lankshear, et al., 2005; Needleman, et al., 2002; Shields & Watson, 2008). Therefore, reducing attrition of RNs is obviously the most financially practical approach to addressing the nursing shortage and maintaining an appropriately skilled nursing workforce.

1.3 The need for further investigation

The most critical issue for responding effectively to the nursing shortage is reducing the attrition of RNs (Sochalski, 2002). Reducing attrition necessitates understanding the organisational factors in the work environment that affect nurses' quality of working life. As indicated previously, over recent years the Australian healthcare system has been subject to a process of restructuring that has impacted upon nurses' working conditions. However, in Australia "Little evaluation has been undertaken to determine the impact of hospital structure and organisational change on the RN nursing workforce" (Duffield, Kearin, et al., 2007, p. 42). Although there are a number of studies that have focused on RNs, each of these has considered nursing work from one specific aspect. For example, Duffield, Roche et al. (2007) explored the components of nurses' workload, while Buchanan and Considine (2002) investigated the reasons why nurses leave the profession, and Wise (2007) examined

management practices that undermined nurse/patient ratios. Other recent Australian studies investigated: the impact of shift work on nurses' lifestyle and health (Pisarski, Lawrence, Bohle, & Brook, 2008); the effect of organisational factors on nurses' morale (de Boer & Day, 2007); and the influence of work environment factors on the psychological health of new-generation nurses (Lavoie-Tremblay, et al., 2008). However, a review of the literature indicated that no prior research conducted in Victoria has comprehensively explored nurses' opinions about the multiple factors that impact upon RNs quality of working life in a single study. Further, little is known about whether or not RNs who plan to stay in the nursing profession hold views about their quality of working life that are different to the views of those who plan to leave. Improved retention of RNs may only be achieved by ensuring their working conditions are attractive. It is therefore important that the opinions RNs hold about the various dimensions of work that impact upon their quality of working life are examined.

1.4 Aims of the study

The overall purpose of this study was to explore RNs' opinions about multiple factors that impacted upon the quality of their working lives. In addition, this study aimed to explore if there were differences in opinion about these factors between RNs who planned to stay in the nursing profession and those who planned to leave.

1.5 The theoretical framework and research methods

One theoretical framework appropriate to exploration of nurses' quality of working life is the Theory of Work Adjustment. This theory was selected as the scaffolding to

underpin the study because it is directly related to how employees experience work and the work environment, and to factors that affect continuance/discontinuance in a particular type of employment (Dawis, 2000; Dawis & Lofquist, 1984). The factors that impact upon the experience of working as a nurse, and on decisions to stay or leave the profession, are complex and as such they are difficult to evaluate effectively using a single method of inquiry. Therefore the study involved a mixed method approach which incorporated quantitative and qualitative methods of data collection and analysis.

1.6 Significance of the study

A better understanding of nurses' quality of working life may offer the opportunity for the development of targeted interventions in the workplace that will have the potential to improve nurses' working conditions. It is possible that findings from this study may be useful to healthcare managers in planning and restructuring hospital environments in ways that will better support nurses in their work, and therefore help retain them in the profession. While reducing attrition of RNs is not the only factor that impacts on service provision, it has the potential to improve the quality of patient care, and to limit the need for bed closures and so shorten waiting lists for surgery and other medical procedures. In addition, nurses who are satisfied with the quality of their working lives are more likely to promote positive attitudes to others in the community. This may improve the public image of nursing as a profession and can therefore be beneficial in recruitment efforts. While the public tends to hold nurses in high esteem, nursing work is generally not perceived as attractive (Brodie et al. 2004; Darbyshire, 2010; Hallam 2000, 2002; Janiszewski-Goodin, 2003). This study will

add to the body of knowledge necessary to improve recruitment and retention rates so that health care services can be expanded to meet the growing needs of the Australian population.

1.7 Operational definitions

This section provides operational definitions for the following terms applied in the thesis: quality of working life (QWL); nurses in Australia; nurse turnover; peri-operative nursing; intrinsic and extrinsic rewards; work/family fit and work/family conflict; burnout; emotional intelligence; and emotional labour.

1.7.1 Quality of working life

In this study, in close alignment with the key concepts of the Theory of Work Adjustment (Dawis, 2000; Dawis & Lofquist, 1984) nurses' quality of working life is conceived as the extent to which nurses are able to fulfil their personal work-related needs and values in the nursing work environment, while concurrently satisfying the requirements of the employing healthcare organisation.

The term quality of working life (QWL) was coined by the Australian born psychologist, Elton Mayo in 1930 and it was he who first applied the concept to workplace research (Hsu & Kernohan, 2006). When using the term throughout this thesis, the abbreviated form, QWL, is applied when discussion relates to the theoretical construct of quality of working life and when statistics are presented or discussed. In the interests of the flow of text the full term, 'quality of working life', is generally applied in all other situations.

QWL as a theoretical construct has evolved through the merging of the structural, systems perspective of organisational behaviour with the interpersonal, human relations, supervisory-style perspective (Cherns, 1978). As a result of the influences on the way the concept of quality of working life has developed, it has been viewed in a variety of ways. These include being considered as a movement, as a set of organisational interventions and as the nature of working life experienced by employees (Carlson, 1980; Wyatt & Wah, 2001). This thesis is framed in accordance with the latter perspective.

1.7.2 Nurses in Australia

There are two levels of nurse in Australia, Enrolled Nurses (ENs) and Registered Nurses (RNs). The RN is a tertiary educated, first-level nurse, whereas the EN, who has completed a shorter (12-18 months) course of nurse education, is the second (lower) level nurse. In order to be eligible to practice, both levels of nurse are required to meet national competency standards. At the time this study was conducted practice standards were stipulated by the Australian Nursing and Midwifery Council (ANMC). However, in July 2010 a move from state to national registration was implemented for nurses in Australia, and the administration body became the Australian Health Practitioner Regulation Agency (AHPRA). RNs include university graduates who have completed a Bachelor of Nursing or higher degree. They also include some nurses who hold a hospital training certificate gained before nursing education moved from hospital based training to the tertiary sector. In the state of Victoria hospital based training for RNs ceased in 1993 (Sherson, 2005).

Depending on the degree of experience and career path chosen, the status of an RN may extend to positions that include clinical nurse consultant (CNC), clinical nurse specialist (CNS), nurse manager, nurse educator, nurse practitioner and nurse researcher (Daly, Speedy, & Jackson, 2010). Prior to the change to national registration in July 2010, RNs and ENs in Victoria were registered by the Nurses' Board of Victoria as Division 1 or Division 2 nurses respectively. As a result, nurses registered to practice in Victoria are commonly referred to as Division 1 or Division 2 nurses. However, throughout this thesis, when it is necessary to differentiate between the levels of nurse, the nationally recognised terms RN and EN are applied. Where appropriate, the generic term 'nurse' is used to enhance ease of description and flow of the thesis composition.

1.7.3 Nurse turnover

Nurse turnover refers to the work-related movements of nurses. It involves movement on several levels: the movement of nurses between jobs within the same organisation (internal moves); the movement of nurses to positions in alternative organisations (external moves); and the total withdrawal (attrition) of nurses from the nursing profession (Krausz, Koslowsky, Shalom, & Elyakim, 1995). In most instances throughout this thesis, nurse turnover is mentioned in the context of attrition from the profession.

1.7.4 Peri-operative nursing

Peri-operative nursing refers to all nursing care provided to patients at the time of them having surgery. In the context of this study, it refers to primarily to nurses working in operating theatres, recovery rooms and day surgery units.

1.7.5 Intrinsic and extrinsic rewards

Congruent with the classifications of rewards in nursing established by De Gieter et al. (2006) intrinsic rewards are interpreted as those that stem from good and fulfilling contacts with patients, gratitude, recognition from others and positive feelings about the social usefulness of nursing work. They are rewards promoting feelings of satisfaction with work that are internally generated, for example feelings of achievement and pleasure from knowing one has provided a patient with the best possible care. Intrinsic rewards are different, less tangible, and less easily measured than rewards that are extrinsic, meaning those that are externally generated. Extrinsic rewards include financial and non-financial benefits such as salary, prizes for achievement, social functions organised by hospitals, and time release for continuing education (De Gieter, et al., 2006).

1.7.6 Work/family fit and work/family conflict

The terms work/family fit and work/family conflict are defined as situations where the demands and responsibilities from work and family roles are either mutually compatible or are in some way incompatible (Greenhaus, Parasuraman, & Collins, 2001; Grzywacz, Frone, Brewer, & Kovner, 2006).

1.7.7 Burnout

Burnout in the context of this study relates to an advanced form of work-related stress. This is associated with a group of symptoms that involve physical, emotional and behavioural categories. These include a depletion of physical energy, emotional exhaustion, draining of personal coping resources, depersonalisation, cognitive dysfunction and a sense of helplessness and negativism in the face of normal everyday events (Dolan, 1987; Ekstedt & Fagerberg, 2005; Maslach, Jackson, & Leiter, 1996).

1.7.8 Emotional intelligence

Emotional intelligence is a concept with multiple components that encompass perception, assimilation, understanding and management of emotions. The underlying principle is that individuals with high emotional intelligence work to maintain relationships (Jordan & Troth, 2002). In the context of this study, the term is applied on the basis that high emotional intelligence results in superior conflict resolution skills and the use of constructive methods of conflict management.

1.7.9 Emotional labour

Emotional labour is a concept first introduced by Hochschild (1983). It relates to the effort needed to portray appropriate emotions and simultaneously suppress one's true emotions when engaged in employment involving direct contact with the public. It is defined by Morris and Feldman (1996) as the "effort, planning, and control required to display organisationally desired emotions during interpersonal transactions" (p. 987)

1.8 Organisation and structure of the thesis

With the aim of demonstrating the sequential links and continuity between each chapter in the study, this final section of chapter one provides a brief synopsis of each subsequent chapter in the thesis.

Chapter 2 begins with the identification of the dimensions contained within the two theoretical constructs commonly used in research that explores experiences of working life: quality of working life (QWL) and job satisfaction (JB). In order that the study findings may be contextualized in a sound understanding of what it is that nurses do, the literature that reveals the realities of nursing work is then summarised. Drawing on the body of research that explores nurses' experiences of work, the chapter next highlights what is known about nurses' current working conditions and their health and wellbeing. This chapter concludes with an account of the literature concerned with nurses' reasons for staying or leaving their profession and the factors that moderate attrition.

Chapter 3 describes the theoretical framework that underpins this thesis and provides an explanation as to how the philosophical stance of pragmatist supports the choice of using mixed quantitative and qualitative research methods.

Chapter 4 provides a detailed account of the research design and methodology selected for the study. Part A of the chapter provides a justification for the mixed method approach and the choice of a sequential design (Creswell, 2003). This is followed by a description of the sampling, data collection and analysis processes

employed for the quantitative component of the study. Part B describes the sampling, data collection and analysis processes for the qualitative component. The chapter concludes with an account of the ethical considerations relevant to the research.

Chapter 5 presents the results of the study. The quantitative findings are presented in Part A of the chapter and include an account of the demographic characteristics of survey participants and the results stemming from the Likert-scale survey data. The qualitative results are offered in Part B of the chapter. This includes findings from two data sources; the open survey questions and the transcribed interviews.

Chapter 6 presents a discussion of the study findings. The results of the two methodological approaches are integrated and interpreted in terms of the study participants' opinions about their quality of working life. The discussion is framed predominantly within six themes; a rewarding but arduous profession; relationships in the work environment; health and safety at work; the importance of effective management; the need for an acceptable work/family fit; and a sense of injustice. As the results from the quantitative and qualitative data are assimilated they are also contextualized within the related literature.

Chapter 7 presents the conclusions and recommendations for action suggested by the study findings. It also provides a reflection on the research methods employed and outlines the limitations of the study. This chapter concludes with suggestions for the direction of future research in the area of nurses' quality of working life.

1.9 Chapter summary

This introductory chapter provided information about the enormity of the shortage of nurses that is central to the evolution of this thesis. Reasons for the nursing shortage, the impact of the lack of nurses, and the strategies aimed at addressing this problem were explained. The necessity for further investigation involving exploration of nurses' quality of working life was justified as important in the attempt to limit nurse attrition from Australia's healthcare sector. This chapter also included operational definitions and the format for the presentation of this thesis. The next chapter offers a review of the literature concerned with nursing and nurses' quality of working life and other related topics.

CHAPTER 2 – LITERATURE REVIEW

2.1 Introduction

Two main theoretical constructs were employed to research nurses' experience of working life: quality of working life (QWL) and job satisfaction. As they provide the foundation for much of what is included in this chapter, an explanation of the different dimensions encompassed within these two inter-related concepts is provided first. Also in order to contextualize the issues relevant to the quality of nurses' working lives, it is important to comprehend what it is that nursing work entails, therefore the nature of nursing work is the next topic addressed. The chapter then reviews the literature related to key aspects of nurses' working conditions. This is followed by a synopsis of the literature concerned with nurses' health and wellbeing and an overview of the research specifically connected with nurses' decisions to stay or leave the nursing profession. The latter incorporates an account of the literature identifying factors known to moderate nurse attrition.

2.2 The theoretical constructs of QWL and job satisfaction

As Denvir, Hillage Cox, Sinclair and Pearmain (2008) explain, the differences and relationships between the theoretical constructs of QWL and job satisfaction are complex, but they do share similarities. The seminal work of Cherns (1978) makes it clear that the theoretical concept of QWL "owes its origins to the marriage of the structural systems perspective of organisational behavior with the interpersonal, human relations, supervisory-style perspective" (p. 39) and the key elements of this

perspective are consistent with themes central to theoretical understandings of job satisfaction.

2.2.1 The dimensions of QWL

Similarly to the way nurses' quality of working life is conceived in this study, Brooks and Anderson (2005) explain this notion as "the degree to which nurses are able to satisfy important personal needs through work experiences, while simultaneously achieving the goals of the employing organisation" (p. 324). According to Brooks and Anderson, one of the first major works to have comprehensively delineated empirical referents for measuring QWL from the perspective of employees was a paper presented by Richard Walton at one of the earliest annual International Quality of working Life conferences held in the USA. Walton (1975) outlined eight conceptual categories: adequate fair compensation; safe, healthy working conditions; growth; security; social integration; constitutionalism; work life; and the social relevance of work. Since then, several researchers have been instrumental in adding to and refining the conceptual categories used to measure employees' quality of working life (Denvir, et al., 2008; Hsu & Kernohan, 2006; James, 1992; Levine, 1983; Levine, Taylor, & Davis, 1984; J. Taylor, 1978; Wyatt & Wah, 2001). Venkatachalam and Velayudhan (1997) reviewed the conceptual categories (dimensions) applied in research into quality of working life conducted between 1973 and 1996. They identified seven that were applied consistently. These were: security; economic rewards; autonomy; organisation and interpersonal relations; worker involvement and commitment; working conditions and work complexity; personal growth opportunities and quality

of working life feelings. More recently, Denvir et al. (2008), on behalf of the Institute of Employment Studies in the UK, which has an extensive history in the development of survey tools to measure employees quality of working life, recently designed and piloted a new survey. They recommended future approaches conceptualize quality of working life within eight broad dimensions of leadership; management; working conditions; rewards; skills and prospects; relations at work; the nature of work; and the organisation of work.

2.2.2 The dimensions of job satisfaction

Traditionally, job satisfaction has been the construct used to explore nurses' experience of work, and by comparison, the extent of nursing-related research employing the QWL construct is limited. Job satisfaction is a multi-dimensional, complex phenomenon (Golbasi, Kelleci, & Dogan, 2008; Hong Lu, While, & Barriball, 2005). In a review of related nursing research, Curtis (2007) identified that it has essentially been conceived in three ways: as an outcome of a particular type of nursing work; as an outcome of organisational factors; and as related to the personal characteristics, personality types and biographical factors of nurses themselves. A central theme runs through the conceptualizations of job satisfaction: being that it has an affective component (feelings of personal fulfillment) and a perceptual component, which is an assessment of whether or not one's work meets one's needs (Price, 2001; Tovey & Adams, 1999).

Spector (1997), after reviewing commonly used job satisfaction measures, formulated a list of 14 aspects of work that had been most frequently linked to job

satisfaction. These were: appreciation; communication; co-workers; fringe benefits; job conditions; nature of the work itself; the nature of the organisation itself; organisation's policies and procedures; pay; personal growth; promotion opportunities; recognition; security and supervision. Tovey and Adams (1999) employed a qualitative approach to compare the major sources of satisfaction and dissatisfaction experienced by a random sample of 130 nurses working in the acute care wards in the English National Health Service (NHS) during the 1990s. They identified the emergence of job satisfaction variables not previously included in quantitative measures. These included role conflict, lack of job security, inadequate resources, using new technology, a perceived lowering of patient care standards, coping with increasing amounts of documentation and the experience of working in a rapidly and constantly changing environment. More recently, Coomber and Barriball (2007) summarized the dimensions of work most frequently evaluated in job satisfaction studies as pay, co-workers, supervisors, organisational factors and the work environment.

Although it has been used extensively in nursing studies, some researchers have directed criticism at the concept of job satisfaction as a means of exploring opinions about working life. For example, Denvir et al. (2008) imply that job satisfaction may be a less useful construct than QWL because it is a more psychological and therefore more subjective notion. They point out that survey data generally shows "that ratings of subjective factors are not always consistent with objective measures" (Denvir, et al., 2008, p. 8). In accordance with this view, Brooks and Anderson (2004) suggest that because information from quality of working life measures is more objective

than that from job satisfaction measures it has greater potential to affect change in workplace practices that will benefit nurses, patients and their employers. They consider that: “job satisfaction is an unsatisfactory construct to assess either the work itself or employees’ feelings about work and the work environment” (p. 269). This opinion is based on their understanding that 30% of the variance explained in job satisfaction studies is a function of personality, the nurse’s personal disposition that an employer can do little to change.

2.3 The nature of nursing work

As Parker (2010) explained, the literature presents extensive debate about the nature of nursing work that involves ideas of nursing as both an art and a science. Within the nature of nursing debate, caring is proclaimed as a fundamental feature that Jackson and Borbasi (2010) suggested is “understood as the basis of modern nursing” (p. 90). and Jasmin (2009) suggested is ‘the moral centre of the nursing profession’ (p. 415).

Jones and Cheek (2003) identified that in encompassing art and science, nursing requires unique professional skills and special personal attributes. They suggested these include strong theoretical knowledge, high level communication skills, assessment and clinical judgement skills, plus the ability to solve problems. Nay and Pearson (2001) agreed, they emphasised that in order to provide high quality care, contemporary nurses need to keep abreast of scientific advances, including new technologies, drugs, procedures and equipment. They further suggested that nurses need to be prepared to undertake many responsibilities formerly undertaken by

medical staff. Jasmine (2009) is of the same opinion, she stated that nursing involves multiple diverse functions, many being tasks that are performed while applying scientific concepts. These include assessment of patients, implementation and evaluation of care and the education of patients to address their health-related knowledge deficits. Jasmine stated that, concurrently with applying scientific concepts, nurses also need to practice the art of caring which she describes as establishing harmonious connections with patients by skilfully applying the more intangible communication skills such as empathy, kindness and compassion in a way that is culturally sensitive. With a similar frame of reference, Parker (2010) related the art of caring to aesthetic integrity. She described this as being characterised by aesthetic sensibility, which is responsiveness in nursing that encompasses recognising and meeting the individual and unique needs of particular patients. She reflects on the complexities of nursing as a profession whose members must employ their knowledge of science and expertly combine it with the skilled art of caring. Parker also acknowledged the challenges facing nurses in applying aesthetic sensibility in the current market-driven work climate with its dominating economic rationalist approach to healthcare.

As evidenced by the many nurse theorists who all made efforts to explain the nature of nursing and caring, nursing entails multiple facets and has a high degree of complexity. Among these are Hildegard Peplau, who developed a theory of interpersonal relationships in nursing (Peplau, 1952, 1991), Jean Watson who developed a transpersonal theory of caring (Watson, 1979, 1985) and Madeleine Leininger who considered nursing work from a transcultural perspective (Leininger,

2002). Patricia Benner also enhanced understanding of professional nursing practice through the analysis of stories that nurses told about their everyday experiences of nursing work (Benner, 1984). Additionally, Jocalyn Lawler's (1991) research provided unprecedented enlightenment about the highly invisible side of nursing work, the intimate 'behind the screens' contact nurses have with patients when caring for their private, personal bodily needs and functions.

While these and many other nurse academics contributed greatly to capturing and portraying the complex realities of what nursing actually entails, there are multiple historical and media-generated images of nursing that perpetuate persistent, and often inaccurate, public perceptions of nurses and nursing work (Darbyshire, 2010; Hallam, 2000, 2002; Janiszewski-Goodin, 2003). There is a wide range of images held by those who choose nursing as a career and these often do not reflect reality (Kiger, 1993; Spouse, 2000). For example, Brodie et al. (2004) found that students were entering nursing courses with misconceptions and stereotypical images of nursing as a subordinate occupation, requiring only basic common sense and little intelligence. Additionally, Spouse (2000) found that nursing students' experience of clinical practice was far removed from their initial perceptions of what being a nurse would be like. However, while expectations of nursing may differ, according to Mimura, Griffiths, and Norman (2009) most people who choose to become a nurse tend to share at least one perception in common; they perceive nursing as the type of work that will fulfil the work value of Altruism, the desire to help others. These authors stated that meeting the Altruism value, the desire to do work that benefits others in the community and to meet personal and emotional needs was "the most

frequently motivating influence reported by people who choose nursing as a career” (p. 603). Similarly, De Cooman (2008) found that among young graduate nurses, the traditional attractions of nursing were still important and that altruism continued to rate highly as an important value at work. The danger, as Mimura et al. (2009) pointed out, is that nurses who are motivated by altruism needs, and therefore are attracted strongly by the role of helping others through the caring nature of nursing work, may be more vulnerable to dissatisfaction with work in the face of the realities caused by fiscal constraints. This appears to be borne out by the body of evidence indicating incompatibility between the caring role nurses desire and expect to take and the roles they actually perform. This incongruity, which is often referred to as role discrepancy, role tension, or role ambiguity, has consistently been associated with low job satisfaction (Chang & Hancock, 2003; Kalleberg, 1977; McGillis-Hall & Doran, 2007; Scarpello & Vandenberg, 1992; Takase, Phillip, & Manias, 2006; Yung, 1996). By logical extension, low job satisfaction can be linked to low quality of working life.

2.4 Nurses’ working conditions

In response to concerns about attrition and the nursing shortage, research has focused on nurses’ working conditions in a range of areas. These include the impact on nursing practice of ward design/characteristics (Gurses, et al., 2009; Hurst, 2008; Rechel, Buchan, & McKee, 2009) and organisational factors within the hospital work environment (Hasselhorn et al., 2005; Milisen, Abraham, Siebens, Darras, & Dierckx de Casterle, 2006; NHS Institute for Innovation and Improvement, 2010; Van Bogaert, Clarke, Vermeyen, Meulemans, & Van de Heyning, 2009). Further, there is

a growing body of literature concerned with workplace discrimination (Allan, Cowie, & Smith, 2009; Larsen, 2007; Seago & Spetz, 2008) and other negative workplace behaviours, including bullying and physical violence (Burnes & Pope, 2007; Lindy & Schaefer, 2010; Morrison & Nolan, 2007; Roche, Diers, Duffield, & Catling-Paul, 2010; Tabak & Koprak, 2007). In addition, nurses have been included in several studies concerned with work-family conflict (Blanchard, Tremblay, Mask, & Perras, 2009; Lindsay, Maher, & Bardoel, 2009; Thanacoody, Bartram, & Casimir, 2009; Yildirim & Aycan, 2008). However, little research was identified in the literature that comprehensively, in a single study, considered the multiple aspects of nurses' working conditions in relation to their opinions about the quality of their working life.

Given the breadth of the literature, key issues are encompassed within the following topics: working hours; work demands; leadership and management; interpersonal relationships; and financial rewards, each of which will be discussed in turn.

2.4.1 Working hours

Because hospitalised patients need continual attention, nursing is characterized by 24-hour work schedules and therefore must incorporate various combinations of morning, evening and night shifts, as well as weekend work. As Wilson, Polzer-Debruyne, Chen and Fernandes (2007) indicate, this type of regime can result in "dynamic discontinuities between workers and the rest of their lives" (p. 163). This has been shown to occur in shift-workers employed in a variety of occupations. Wilson et al. (2007) found this was the case among factory employees, and Day and

Chamberlain (2006) found it was a problem for police officers. Problems in balancing shift work with other life activities have also been revealed as a difficulty for firefighters (Halbesleben, 2009), flight attendants (Chung & Chung, 2009) and doctors (Bamford & Bamford, 2008). However, shift work has been shown to have some advantages for the predominantly female nursing workforce. For example, Brooks and McDonald (2000) found that the option of night shifts accommodated the desire of women with young children to return to nursing work. Nevertheless, as in other types of work, shift work is a cause of work-family conflict in nursing. Barnett, Gareis and Brennan's (2008) study of nurses in the USA compared the experience of nurses working day shifts (7am-3pm) and evening shifts (3pm-11pm). They reported that those working evening shifts experienced higher levels of work-family conflict. Similarly, Grzywacz et al. (2006) found evidence of widespread work-family conflict among 2,000 nurses in the US; 92% of whom reported work interference with family in the six months prior to participating in the study. A phenomenological Australian study exploring the experience of mid-life nurses conducted by West, Boughton and Byrnes (2009) revealed that nurses between 45 and 60 years of age, who had shift work experience of greater than 15 years, had juggled work and family needs at a high personal cost. In efforts to manage shift work around the needs of family, they had prioritized the needs of others to the "almost total sublimation" of their own needs (p. 114). The problem is not confined to the western world: Yildirim and Aycan's (2008) study of nurses in Turkey found that work overload and irregular work schedules had the strongest relationship with, and were therefore the strongest predictors of, nurses' work-to-family conflict and that this conflict was associated with lower job and life satisfaction.

The combination of non-standard work hours and high work demands in nursing creates a risk of work-family conflict which is a common source of stress and burnout³ (Grunfield et al., 2005; Hang-yue & Loi, 2005) that can be detrimental to family relationships, mental health and job performance (Tammy, Allen, Herst, Bruck, & Sutton, 2000; Yildirim & Aycan, 2008). However, while Admi, Tzischinsky, Epstein, Herer and Lavie (2008) found that almost 30% (n=688) of hospital nurses in Israel were sleep deprived because of poor adaptation to shift work, this did not impact negatively on the quality of their work performance when compared with their peers who were not working rotating shifts. This outcome appears counter-intuitive, but may be explained by the use only of reported clinical errors and occupational incidents to measure work performance.

Based on survey data from 530 nurses in Australia, Pisarski et al. (2008) identified a range of interventions likely to improve work-life conflict and subjective health among shift-workers. They suggest a combination of actions is needed: increasing support from supervisors and colleagues; strengthening team identity; creating a positive team environment; and increasing individuals' control over the work environment. However, they do not advise on the specifics of how these suggested interventions might be implemented. Pryce, Albertson and Nielsen (2005) evaluated an open-rota system within which nurses in Denmark designed their own work-rest schedules. They demonstrated that this system resulted in improved work-life balance and job satisfaction for participating nurses. This corroborated the findings of Darvas and Hawkins (2002), that the ability to self-roster was very important to

³ A definition of burnout is provided under operational definitions in Chapter 1.

nurses and contributed strongly to making a NSW intensive care unit a satisfying working environment. The authors believed this self-rostering system contributed to the stability of staff in the unit which, in contrast to other NSW intensive care units, had few or no vacancies during the five years prior to the study.

Conflict between the two domains of home and work is more likely to occur when increased demands in one domain make it more difficult to meet the demands of the other domain (Thanacoody, et al., 2009; Yildirim & Aycan, 2008). Therefore, the potential for nurses to suffer work-family conflict has increased over the last two decades during which time major reforms and restructures within hospitals have radically raised their work demands (Duffield, Kearin, et al., 2007; Hallin & Danielson, 2007). As Duddle and Boughton (2007) state “widespread drastic restructuring of the healthcare system in recent times has profoundly impacted on the way health care is delivered” and this has led to nurses in Australia having “absorbed a disproportionate amount of the burden from cost-cutting measures” (p. 35).

2.4.2 Work demands

The nursing literature consistently evidences that nurses are working under pressure. The results of an International Council of Nurses’ (2009) survey suggest that work pressure is a multi-national problem: nurses from eleven countries rated workload as the most unfavourable aspect of their work. Compatibly, Buerhaus et al.’s (2009) study indicated that nurses employed in hospitals in the USA were working under a great deal of pressure. Nearly nine out of ten (89%) of the 468 study participants perceived that the supply of nurses was less than required for getting daily work

completed and 51% perceived the supply was “much less” than required (p. 291). Similarly, Brooks and Anderson (2004) in their study of acute care hospital nurses in America found that 67% (n= 227) of participants felt their workload was too heavy, 59% (n=199) indicated there were not enough nurses employed in their work units, and less than half (47%, n=181) felt they had enough time to do their job well. Considine and Jakubauskas (2008) found that nurses and doctors employed in public hospitals in NSW, Australia, were working extremely long hours, and reporting levels of exhaustion that were extremely high compared to the general population. Over half of more than 1,500 public hospital doctors and nurses in the study reported that they were ‘always’ or ‘usually’ exhausted and full-time nurses were working an average of three hours of mostly unpaid overtime per week in order to manage their workloads. Wise (2007), reporting on nurses’ working conditions in the public health system in Victoria, Australia, stated that the nurse-to-patient ratios introduced by the government in 2001 are “no longer keeping pace with nurses’ workload” (p. 1) and “the 2006 survey finds nurses working under pressure in a destabilised environment” (p. 1). This fits with the results of Aiken et al.’s (2002) earlier USA study. This involved a cross-section of hospital nurses (n=10,184) and found that those working with the highest nurse-to-patient ratios were experiencing burnout and dissatisfaction at more than twice the extent of those with lower ratios. Compatibly, Sheward, Hunt, Hagen, MacLeod and Ball (2005) concluded, from a study of nurses in Scotland and England, that increasing numbers of patients to nurses was associated with an increasing risk of emotional exhaustion and job dissatisfaction among the nursing staff.

A number of factors have been shown to have a buffering effect on high work demand. These include: intellectual stimulation, charismatic leadership and recognition and reward for effort (Alton, 2002; Stordeur, D'hoore, & Vandenberghe, 2001); feelings of empowerment, control and autonomy over work (Aiken, et al., 2002; Joiner & Bartram, 2004; Larrabee et al., 2003; Laschinger, Finegan, & Shamian, 2001); and social support from colleagues and managers (Apker & Zabava-Ford, 2003; Joiner & Bartram, 2004; van der Heijden et al., 2010). In addition, an initiative called 'The Productive Ward Program: Releasing Time to Care', introduced in the UK (NHS Institute for Innovation and Improvement, 2010), has been evaluated as successful in helping nurses increase the time they spend with patients. This program empowers nurses to identify and implement changes to organisational processes, at the ward level, that they consider most beneficial to them in effectively managing their work.

As mentioned earlier, as a result of concerns about both the need to improve retention of nurses in the profession and patient safety, some studies have considered the impact of ward design/characteristics and organisational factors on nursing practice. For example, McGillis-Hall and Doran (2007) explored the impact of unit staffing models, patient complexity, nursing care delivery models and mechanisms used for coordinating care on outcomes for nurses. Their findings concluded that nursing care delivery which did not involve a total patient care (holistic care) model, increased nurses' work pressure and that the lower nurses' perceptions of the quality of the care provided, the higher their perceived level of work pressure. Gurses et al. (2009) reported that nurses working in Intensive Care Units faced performance

obstacles that frustrated efforts to get their work done, increased their workloads and negatively affected their quality of working life and perceived quality of patient care. These obstacles included poor workspace design, disorganized patient rooms and supply areas, delays in getting essential supplies and the unavailability and poor condition of equipment.

Buerhaus et al. (2009), reporting on national surveys of hospital-based nurses in America, suggest that efforts to improve nurses' working conditions, and therefore the quality of their working life, may be having a positive effect. RNs perceived that between 2006 and 2008 improvements had occurred in several areas, including the time they were able to spend with patients and the quality of nursing care they were able to provide. Robinson and Perryman (2004) also reported improvement. They indicated that between 2000 and 2002 staff employed within the UK National Health Service (NHS) perceived an improvement in their levels of stress and work pressure and that according to most key indicators the NHS was progressively becoming a better place to work in terms of employee quality of working life. However, while the evidence suggests that hospitals may be improving in terms of how they are perceived as places to work, Seago and Spetz (2008) state that they still "tend to be the places of the highest degree of job dissatisfaction among nurses" (p. 22).

2.4.3 Leadership and management

The importance of skilled leadership to the future of the nursing profession and of skilled and supportive management to individual nurses' quality of working life and retention has been clearly established (Cummings et al., 2010; Cummings et al.,

2008; Davidson, 2010; Gunnarsdottir, Clarke, Rafferty, & Nutbeam, 2009; Kovner, Brewer, Wu, Cheng, & Suzuki, 2006; McGillis-Hall & Doran, 2007; Sellgren, Ekvall, & Tomson, 2007; Tomey, 2009; van der Heijden, van Dam, & Hasselhorn, 2009; Wade et al., 2008). Jasper (2007) for example, suggests that the nurse manager is the person ultimately responsible for the quality and culture of the work environment. Demerouti, Bakker, Nachreiner and Schaufeli (2000) state that the unit manager can play a key role in creating a supportive and collegiate atmosphere in which employees feel valued. According to Cummings et al. (2010), unit managers who respond to the emotional needs of staff and “support and invest in them and their abilities” (p. 378) enhance the likelihood of the nursing unit meeting the goal of excellence in patient care. According to Robinson and Perryman (2004) it is particularly the qualities of the immediate, front-line manager that has a profound influence on employees’ quality of working life. They reported that when staff experienced good relationships with their immediate line managers they expressed greater happiness with a wide range of other features of working life and displayed a greater intention to continue working with their current employer.

A number of other studies indicate that support from managers is important to nurses’ wellbeing at work. For example, Wade et al. (2008) found that nurse manager ability, leadership and support of nurses was a statistically significant predictor of nurses’ job enjoyment. Sellgren et al. (2007) reported that Swedish nurses who had managers with strong leadership skills perceived a more creative work climate and experienced higher job satisfaction than did nurses whose managers had an ‘invisible’ leadership profile. Gunnarsdóttir et al. (2009) found that

Icelandic nurses generally felt supported by their unit-level managers and that managerial support was both a predictor of job satisfaction and quality of patient care. Tomey (2009), who reported on an analysis of research (1982-2002) related to nursing management practices, identified correlations between transformational leadership and participative management styles and nurse satisfaction and retention. She identified a range of positive management practices that were shown to have fostered a healthy, staff-focused work environment and to have enhanced nurses' job satisfaction. These included expanded career development opportunities, reward schemes, staff health and well-being programs, and strategies to promote nurse autonomy and empowerment. On the other hand, Tomey (2009) identified that impatient, defensive, and unsupportive leadership, lack of supervision and guidance, and lack of recognition of contributions were major stressors for nurses. Similarly, Cummings et al.'s (2010) analysis of quantitative research which focused on nurse management (1985-2009) identified 24 studies that evidenced how leadership styles focused on people and relationships were associated with higher nurse job satisfaction. They located ten studies reporting that leadership styles focused mainly on tasks were associated with negative outcomes and lower nurse job satisfaction.

2.4.4 Interpersonal relationships at work

Supportive colleagues and a friendly work atmosphere have been shown to improve nurses' quality of working life. For example, Cummings et al. (2008) found that positive relationships among nurses, managers and physicians played an important role in the quality of oncology nursing environments and the job satisfaction of nurses' working within them. Freney and Tiernan (2009) reported that supportive

colleagues had a positive influence on how nurses coped with the strain of their work. However, numerous studies indicate that difficult and unsupportive relationships at work reduce nurses' quality of working life. Many studies show that such relationships are linked to nurses' job dissatisfaction, stress, and attrition from the profession (Agervold & Milkelsen, 2004; Almost, 2005; Farrell, 1997; Farrell, Bobrowski, & Bobrowski, 2006; Peter, Macfarlane, & O'Brien-Pallas, 2004).

Poor working relationships sometimes involve nurses being confronted with negative behaviour directed towards them from peers, managers and other health care professionals, but perpetrators also include patients and their relatives (Camerino, Estry-Behar, Conway, van Der Heijden, & Hasselhorn, 2008; de Boer & Day, 2007; Diaz & McMillan, 1991; Farrell, et al., 2006; Lindy & Schaefer, 2010; Sofield & Salmond, 2003).

Types of negative behaviour towards nurses include racial discrimination and racial bullying (Allan, et al., 2009; Hunt, 2007; Larsen, 2007; Seago & Spetz, 2008), verbal incivility and shouting, emotional abuse, physical assaults, intimidation, and threatening, as well as obscene behaviours (Burns & Pope, 2007; Farrell, et al., 2006; McKenna, Smith, Poole, & Coverdale, 2003; Morand, 2005; Roche, et al., 2010). According to Rowe and Sherlock (2005), nurse-to-nurse aggression most frequently occurs in the form of anger, judging, criticizing and condescension.

Gacki-Smith et al. (2009), who reported on a survey of 3,465 members of the USA Emergency Nurses Association, stated that more than 50% had experienced physical

violence (spat on, hit, pushed or shoved, scratched or kicked) and 70% had experienced verbal abuse and being yelled or cursed at, intimidated, or harassed with sexual language or innuendo. Farrell et al. (2006) reported that of almost 2,500 nurses surveyed in Australia, the majority 63% had experienced some form of verbal or physical abuse in the four working weeks prior to completing the survey. The main types of verbal abuse included rudeness, shouting, sarcasm, swearing and unjustified criticism. The main types of physical abuse included being struck with a hand, fist or elbow, being pushed, or shoved, or being scratched. Farrell et al. (2006) found that abuse was most commonly directed toward nurses from patients and their relatives or visitors. On the other hand, Rowe and Sherlock (2005) reported that other nurses were the major source of verbal aggression towards nurses and Sofield and Salmond (2003) reported that, for nurses working within a USA multi-organisation hospital, doctors were the most frequent source of such abuse.

Smooth working relationships between doctors and nurses are essential to patient wellbeing (Ogbimi & Adebamowo, 2006). Harmony between these professional groups is also important to the quality of nurses' working life, yet as Gordon (2005) suggests, "A broad social failure to understand what nurses do, which is embedded in the medical system, often produces oppressive and dysfunctional nurse-physician relationships" (p. 11). While this appears to be borne out in studies indentifying doctors' failure to recognize nurses' professional worth and the associated difficulties with communication between them (Morinaga, Ohtsubo, Yamauchi, & Shimado, 2008; Mulcahy & Betts, 2005; Rosenstein, 2002; Snelgrove & Hughes,

2000), others suggest nurse/doctor relationships are not problematic (Aiken et al., 2001; Budge, Carryer, & Wood, 2003; Gunnarsdottir, et al., 2009).

Farrell (1997) suggests that nurse-to-nurse hostility might be the most stressful form of interpersonal workplace conflict, reporting that nurses found aggression from nurse colleagues more challenging and stressful to deal with than that directed toward them from patients, doctors or co-workers in other disciplines. While not specifically relating the comment to nurses, Robinson and Perryman (2004) note that “harassment of any form from co-workers has a bigger impact on staff perceptions of their wellbeing” than that from any other source (p. 91).

In spite of the likely impact of negative workplace behaviours on the quality of nurses’ working life, Roche et al. (2010) explain that it is difficult to accurately determine the prevalence of violence towards nurses. This is because of the multiple definitions of ‘violence’ and the many ways of collecting data, which extend from self-reports to secondary analysis of workers’ compensation claims. However, the results of their study suggest emotional abuse, threat and actual violence towards nurses working in medical/surgical settings within Australian hospitals may be fairly common. About one third of almost over 2,500 nurses participating in their study perceived emotional abuse during the last five shifts worked. Reports of threats (14%) and actual violence (20%) were lower, but there was great variation in the extent of all of these problems among different nursing units. Roche et al. suggest this was related to working conditions in each particular work environment. For example, lack of staff and work pressure in one unit led to late administration of

medications that caused patients to become aggressive. This is compatible with Landau and Bendalak's (2008) finding that higher workloads led to increased exposure to violence for nurses working in hospital emergency wards. It also agrees with Ogbimi and Adebamowo's (2006) finding that the stress created by staff shortages was an important determinant of poor nurse-doctor relationships. Further it is reflective of how participants in Peter et al.'s (2004) study blamed the extent of staff anger and frustration on heavy workloads and difficult work conditions. Commensurate with these findings, Holmes (2006) having reviewed a range of strategies including zero-tolerance, strongly advocates that the most appropriate and effective response to deal with the problem of violence in healthcare settings is to "provide better trained staff and more of them, better facilities, and better operating systems" (p. 222).

Buerhaus et al. (2009) found that hospital work environments had improved in some areas between 2006 and 2008, but had worsened in terms of how safe nurses felt at work and their experiences of sexual harassment, hostility and physical violence. This suggests that nurses may be at increasing risk of damage to their health and wellbeing from negative behaviour in the workplace. Verbal aggression can lead to emotional dissonance and exhaustion in employees (Karatepe, Yorganci, & Haktanir, 2009). People who are the recipients of harassment, discrimination, aggression and/or violence may suffer psychological distress resulting in symptoms of anxiety, irritability and depression (Agervold & Milkkelsen, 2004; Almost, 2005; McKenna, et al., 2003), and outcomes can also include post-traumatic stress disorder (Rippon, 2000a). Jordan and Troth (2002) suggest that nurses with high emotional

intelligence⁴ tend to use more effective methods of dealing with conflict and are therefore less likely to suffer negative health effects than those with lower emotional intelligence. They conclude that their study results indicate: “that nurses who are taught emotional management and discussion skills within their organisations may be better equipped to deal with and resolve conflict situations in their day to day work” (p. 99).

There are indications that policies and practices implemented over the last decade, designed to protect nurses in Australia from negative behaviours, may not be having the desired effect. For example, Hegney, Eley, Plan, Buikstra and Parker, (2006) surveyed nurses working in aged care and acute care in Queensland in 2001 and 2004 and comparison between surveys revealed increasing levels of workplace violence. Even though nurses were aware of workplace policies designed to deal with violent incidents, they considered them to be inadequate. Later, De Boer and Day (2007), also reporting on a study of nurses working in Queensland, found that participants perceived little was being done to alleviate the workplace abuse and violence being experienced. Continuing concerns with workplace violence have led to investigations being undertaken in several different geographical areas of Australia to determine what needs to be done to address the problem. In Victoria, a taskforce investigation resulted in 29 recommendations (Nurse Policy Branch Department of Human Services, 2005). One major outcome was the development of a policy framework and resource kit. This provided a plan for action to prevent occupational violence within health care settings (Victorian Government Department

⁴ Emotional intelligence is defined under operational definitions in Chapter 1.

of Human Services, 2007). The Victorian Taskforce on Violence in Nursing Reference Group has been monitoring, and reporting on the implementation of all recommendations since 2005 (Victorian Taskforce on Violence in Nursing Reference Group, 2010). However, the reports do not include evaluation of the effectiveness of the implemented recommendations. Further, the researcher located little evidence, from the perspective of nurses currently working in the front line of patient care, as to the efficacy of protective policies and practices operating in Victoria's hospitals.

What is certain, is that while friendly and supportive interpersonal relationships may enhance employee quality of working life, difficult, particularly aggressive, interactions undermine the mental wellbeing, and therefore the quality of working life, of those who are at the receiving end of such behaviour (Agervold & Milkelsen, 2004; Almost, 2005; McKenna, et al., 2003; Rippon, 2000a, 2000b). There is a considerable body of evidence that indicates coping with aggression is difficult and stressful, and often leads to emotional exhaustion and nurses' attrition from their profession (Farrell, 1997; Farrell, et al., 2006; Karatepe, et al., 2009; Robinson & Perryman, 2004; Roche, et al., 2010; Sofield & Salmond, 2003).

2.4.5 Financial reward

Some, but not all, job satisfaction and quality of working life studies incorporate exploration of nurses' opinions about their pay. Some suggest that pay is one of the predominant aspects of work to concern nurses. For example, Shields and Ward's (2001) survey of almost 10,000 nurses working in the British National Health

Service revealed that of 13 aspects of work, pay was one of four strongly associated with low job satisfaction, the others being poor career advancement opportunities, increased workload, and workplace relations. Robinson and Perryman's (2004) UK study indicated that pay was the only aspect of working life that received a negative score on an attitudinal quality of working life survey conducted at London's National Health Service. However, from the report on this study, the opinions of nurses could not be distinguished separately to those of other health service employees. Lu, While and Barriball (2007) reporting on a survey of nurses conducted in Mainland China, indicated that almost three quarters (73%, n=373) of the sample were dissatisfied or very dissatisfied with their rates of pay. Similarly, Yin and Yang (2002), from the findings of a meta-analytic study, reported that salary and fringe benefits were the strongest factors related to nursing turnover⁵ in Taiwanese hospitals. However, they pointed out that the salaries of Taiwanese nurses did not compare favourably to those of their counterparts in some other countries.

In contrast, other studies suggest that pay is not a major issue for nurses in relation to other aspects of work. For example, Bozell's (2001) survey of 300 nurses in the USA revealed that pay level was one of the least significant factors associated with job dissatisfaction and reasons for leaving a nursing position. Similarly, Kover, Brewer, Wu, Cheng and Suzuki (2006) found no association between pay and job satisfaction in nurses working in the USA. However, they did find that distributive justice, which pertains to the fairness of pay, was related to nurses' satisfaction. Brooks and Anderson (2004) also reported nurses' in the USA perceived unfairness in relation to

⁵ Nurse turnover is defined under operational definitions in Chapter 1.

pay. While slightly more than half (57%, n=194) of the 341 nurses in their study viewed their pay as adequate, many wrote comments about their salaries not being competitive with other industries. Correspondingly, Freeney and Tiernan's (2009) focus group study of nurses in Ireland identified that participants felt their salaries compared poorly to those of other members of the multidisciplinary team, such as physiotherapists and occupational therapists. This led them to feel their hard work was not recognised and that they were devalued as members of the health care team. Participants in Freeney and Tiernan's study also felt unfairly treated in relation to staff facilities for nurses compared to those of other professional groups.

Curtis (2007), also researching in Ireland, revealed apparently conflicting results. Of six components of work, nurse participants indicated pay was the factor of second most importance to job satisfaction, whereas it contributed least to their current level of job satisfaction. Curtis (2007) emphasised that pay was the component of work with the largest dissonance between importance to, and current level of, job satisfaction and strongly suggested this reflected a need for improvement in nurses' financial rewards.

According to the Department of Education, Training and Youth Affairs (DEETYA) (2001), pay rates do not appear to be a primary factor underpinning low job satisfaction in nurses working in Australia. However, Buchanan and Considine (2002) reported that improvements in pay appeared to be necessary in drawing ex-nurses (and potentially more new nurses) back to public hospitals in Australia, but that attractive rates of pay would not serve to retain them in the workforce because

“nurses, have historically not been solely or even primarily attracted to the money of nursing” (p. 45). Buchanan and Considine stated that improvements in management systems, to make them less focused on cost containment, were much more important than pay rates in maintaining a stable and workable staffing level in Australian public hospitals. However, more recently, and in direct contrast, Considine and Jakubauskas (2008) found that from a list of factors that would encourage nurses to stay in the public hospital system, “the number one motivation for nurses is improved pay” (p. 9). Similarly, Wise (2007) reported that two-thirds of approximately 2,500 nurses in Victoria indicated that an increase in salary was an initiative that would keep them in the profession. Approximately one half of the survey participants rated improved shift penalty rates as an incentive to remain. However, as this study involved only members of the Australian Nurses Federation, it is not known if the same would apply to non-union members of the nursing profession. The findings of another study conducted in Victoria by Takase, Maude and Manias (2005) suggested that a lack of opportunity to gain a higher income was an occupational characteristic that was incongruent with nurses’ professional needs.

2.5 Nurses’ health and wellbeing

As Daly, Speedy and Jackson (2010) make clear, unlike any other job, nursing offers the privilege of being able to work with people in the most highly intimate moments of their lives, from sharing in the joy of a birth to the sorrow of a death and almost anything else in between. During such times, interactions with patients and their relatives provide opportunities for nurses to make a difference to people’s lives. This promotes intrinsic, pleasurable feelings of achievement and satisfaction that enhance

quality of working life, sustains a sense of wellbeing at work and drives motivation to continue a career in nursing (Buchanan & Considine, 2002; Cortese, 2007; Curtis, 2007). These rewarding relationships, together with the support and friendliness of professional colleagues, are two factors commonly linked to nurses' enthusiasm and motivation for their work (Buchanan & Considine, 2002; Duffin, 2009; Gordon, 2005). However, research findings over the past decade reflect differing degrees of enthusiasm among nursing populations. In a study of five countries, Aiken, et al. (2001) found that with the exception of Germany, a high proportion of registered nurses were dissatisfied with their jobs. Curtis (2007) reported low to moderate levels of job satisfaction among nurses in Ireland. Gordon (2005), drawing on interviews with practicing nurses and nurse academics, combined with an extensive review of research studies, concluded that nurses were working "against the odds" (p. 8) and that, as a result, low morale, and by logical extension, a poor sense of wellbeing, prevailed among nurses in many countries. On evaluating the evidence, she concluded that low morale, and the resulting exodus of nurses from the profession throughout the industrialised world, was not to do with a lack of enthusiasm or passion for nursing, but to poor working conditions. She projected that "future nurses, like those today, would probably want to leave the bedside as soon as they experience the odds of hospital working conditions" (Gordon, 2005, p. 7).

Conversely, Brooks and Anderson (2004) reported that nurses in USA were moderately happy with their quality of working life, as reflected by a mean of 3.9 on a 1-6 rating scale on which 1 reflected very poor and 6 reflected very good quality of working life. They advised caution, however, in interpreting this finding given the

limited use and evaluation of their new survey instrument. Also, Daehlen (2008) reported beginning nurses in Norway were fairly satisfied with their present jobs and Golbasi et al. (2008) found nurses in Turkey were moderately satisfied. Lu, While and Barriball (2007) reported more than half of nurses (53.7% , n= 275) surveyed in Mainland China were also satisfied, but that 15% (n=77) were experiencing moderate to extreme occupational stress. A recent key message from the International Council of Nurses (ICN) Global Health Survey (2009) is more positive, reporting that most nurses still find great enjoyment in their work, even though they are experiencing problems with their working conditions, and workloads in particular. Similarly, Duffin (2009), reporting on a study of 160 UK emergency department nurses, reveals that many love working in their area of specialty and, even though 86% felt they were under pressure at work, 92% said they would recommend emergency room nursing to their colleagues. They reported enjoying patient contact and being able to make a difference, great camaraderie with work colleagues, their autonomy of practice, and the challenges and variety of emergency care work. These studies appear to suggest that efforts to improve nurses' working conditions, and therefore their sense of wellbeing and quality of working life, over the past decade may have been effective, and that currently nurses may not be as dissatisfied and demoralised as seriously as Gordon (2005) predicted they might be. Nevertheless, Poghosyan, Aiken and Sloane (2009), reporting on an analysis of data from a large scale cross-sectional survey of nurses from eight countries, indicate that nurses are experiencing stress and burnout to the extent that it has become a global workforce challenge for the profession.

2.5.1 The stresses and strains of nursing work

As Freeney and Tiernan (2009) point out, nursing as a career is inherently stressful. It is physically demanding and, because nurses are constantly confronted with the suffering and grief of others, it is emotionally draining (Lin, St. John, & McVeigh, 2009; McGrath, Reid, & Boore, 2003). It also involves emotional labour⁶ (Huyhn, Aldeson, & Thompson, 2008). Indeed, as Kinman (2009) explains, any work that involves high levels of direct interpersonal interaction with clients tends to involve emotional labour, and is therefore potentially a stressful form of employment. This applies to many areas of human service work including social work (Antle et al., 2006; Coffey, Dugdill, & Tattersall, 2009), police work (Dowler & Arai, 2008; Regehr, LeBlanc, Jelley, & Barath, 2008) and school teaching (Chaplain, 2008; Stoeber & Rennert, 2008). However, Khan (1993) suggests that nurses experience higher than average levels of work-related stress. Demerouti et al. (2000) point out that nurses are considered to be particularly susceptible to chronic stress and burnout. To some extent, this is borne out by a study of nurses' working lives conducted by the UK Royal College of Nursing which found that their levels of psychological wellbeing were lower than that of the general population (Ball & Pike, 2006). Conversely, however, Johnson et al. (2006), reporting on a study of stress across 26 different occupations, found that while nurses were scoring lower than average levels of job satisfaction, they were not reporting higher than average scores on stress factors.

⁶ Emotional labour is defined under operational definitions in Chapter 1.

As indicated previously, non-standard work hours, high work demands and negative behaviour in the work environment all have the potential to exacerbate the inherent causes of stress in nursing. High work pressure can be particularly stressful if it makes it difficult for nurses to perform patient care to a standard that is personally satisfying.

There is a substantial body of evidence that suggests excessive work demands are preventing nurses from providing a desired quality of patient care (Aiken, et al., 2002; Buerhaus, et al., 2009; Dall, et al., 2009; Duffield, Roche, et al., 2007; Gurses, et al., 2009; Kane, et al., 2007; Leurer, et al., 2007). Leurer et al. (2007) found that nurses in Canada who were struggling to provide a high standard of care within their current work environments experienced a sense of frustration and fatigue. Similarly, Clare and van Loon (2003) and Mangone, King, Croft and Church (2005) found that when nurses could not provide patient care in accordance with their professional and personal standards they experienced severe job stress. Further, Buerhaus et al. (2009) found that 45% of RNs employed in the USA believed that the shortage of nurses in their hospitals exacerbated their workloads and consequently interfered with them being able to provide the desired type of holistic care that was “respectful of and responsive to individual patient preferences, needs and values” (p. 295).

Kelly (1998) and Goethals, Gastmans, Dierckx de Casterlé (2010) suggest that when nurses cannot sufficiently integrate their own values and norms into their daily practice, they experience internal moral distress. This is commensurate with the work of Peter and Liaschenko (2004) who suggest that nurses define a major portion of

their moral identity as nurses in terms of the quality of the nurse-patient relationship, and may experience distress and a desire to leave nursing when they encounter need in their patients but lack the adequate means to provide for those needs. Jameton (1984) defined moral distress as arising when “one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (p. 6). Kelly (1998) described it as an acute form of psychological disorientation in which novice nurses, in her grounded theory study, were questioning their professional knowledge, what kind of nurses they were, and what kind of nurses they were becoming. Francis (2010), having undertaken an investigation into care provision at the Mid-Staffordshire National Health Service Trust in the UK, found that some nurses were experiencing psychological disconnection, feelings of total detachment from their work, which presents an even more serious problem than psychological disorientation. Francis (2010) suggests that psychological disconnection may be a coping mechanism used when nurses are not working under acceptable conditions, and the quality of their working life therefore at a low level. He commented:

I am concerned that the staff in the hospital in general, and the nursing staff in particular, are thoroughly demoralized as a result of the events of the last few years. I believe that many have adopted a survival strategy of going through the motions of doing their job as opposed to pursuing a much valued and necessary vocation (Francis, 2010, p. 400).

2.6 Intentions to stay or leave the nursing profession

Many studies have examined predictors of nurses' intention to leave their jobs (nurse turnover), and intention to leave has been shown to be a good predictor of actually leaving (Brewer, Kovner, Green, & Cheng, 2009; Liou, 2009). Studies concerned with the attrition of nurses are frequently undertaken from the perspective of employers and therefore reflect their loss from particular healthcare organisations, but not necessarily the profession (Brewer, et al., 2009). However, according to Krausz et al.'s (1995) findings from a longitudinal study, turnover in nursing is generally an incremental process, with nurses first deciding to leave the ward, then the hospital, and finally the profession.

It is a consistent theme in the research that a nurse's job satisfaction/dissatisfaction is a predictor of intention to stay or leave (Larrabee, et al., 2003; McCarthy & Tyrell, 2007; Park & Kim, 2009; Shields & Ward, 2001; van der Heijden, et al., 2010; van der Heijden, et al., 2009). However, from a review of the job satisfaction literature, Crow, Smith and Hartman (2005) concluded that there was a long list of 'dissatisfiers' associated with nursing work, but that there was no agreement on which 'dissatisfiers' had the greatest impact on nurses' decisions to leave.

Nevertheless, the research reveals parallels between nurses' reasons for leaving a current position or organisation and reasons for leaving the profession. For example, Gardulf et al. (2005) found that 54% (n=449) of nurses surveyed in Sweden planned to leave their current positions. The two most commonly cited reasons for this decision were dissatisfaction with salary and psychologically strenuous and stressful

work. Similarly, Flinkman et al. (2008) found that two of the main reasons for Finnish nurses leaving the profession were discontent with pay and the demands of the work. According to Webster, Flint and Courtney (2009) the main reasons nurses employed in a large city hospital in Australia were leaving either a work unit or the organisation included: feeling unsafe; feeling undervalued; difficulties getting their work done; lack of opportunity for professional development; and inflexible work schedules. With a reasonably high degree of similarity, Cheung, Bessell and Ellis (2004) identified the main reasons for nurses in Australia having actually left the profession were: the inability to perform effectively as a nurse; the inability to uphold professional standards of care; the conflict between the needs of families and the demands of the work; an inability to advance professionally within a nursing career. They suggest that when tensions have accumulated, one 'shock' event can be "the straw that breaks the camel's back" (p. 17). They suggest this single 'shock' incident or event acts as a trigger for the departure of nurses. Cheung et al.'s findings are compatible with several other studies indicating that the availability of opportunities for professional growth and/or career advancement are associated with decisions to stay or leave nursing (Gardulf, et al., 2005; McCabe & Garavan, 2008; Robinson, Perryman, & Hayday, 2004; Secombe & Smith, 1997; Yin & Yang, 2002). In a study investigating nurse turnover in New Zealand's public hospitals, North et al. (2006) found that the main attractions of an alternative career included better career prospects and better rates of pay.

Robinson and Perryman (2004) suggest that the experience of workplace abuse is an important factor in turnover intentions because staff who suffer this type of

mistreatment “feel less able to cope with work pressures and became disillusioned” (p. 91). Farrell et al. (2006) reporting on a study of over 2,400 nurses in Australia found that 24% had considered resigning from a position because of verbal mistreatment and 11% had left a nursing position during their careers because of verbal or physical abuse. Similarly, in their study, also based on nurses in Australia, Roche et al. (2010) found that emotional abuse correlated positively with the intention of nurses to leave their current position. Spence-Laschinger, Leiter, Day and Gilin (2009) reported that, among nurses in Canadian hospitals, incivility in the work environment, a form of verbal abuse, was related to health professionals’ experience of burnout, and “Supervisor incivility and burnout were particularly important determinants of turnover intentions” (p. 309). Sofield and Salmond (2003) reported that of just over 450 nurses in the USA, over a third indicated they would consider resigning as a result of the verbal ill-treatment they had experienced. From their qualitative data, Sofield and Salmond found that USA nurses had not only left positions as a result of verbal abuse, but also that nurses changed their work status from full-time to part-time in order to decrease their exposure to this behaviour. The latter was enacted as an alternative to leaving a position to avoid the abuse.

Leiter and Maslach (2009) tested whether a mediation model of nurse burnout could predict nurses’ turnover intentions. They found a strong link between nurses’ feelings of cynicism, burnout and intention to leave. Three aspects of work led to cynicism in the participants. These were exhaustion from unmanageable workloads, value conflicts and unfairness in work settings that did not support a nursing model of care, and inadequate reward systems. The researchers stressed that “cynicism

plays a pivotal role in translating nurses' experience of working life into action plans" (p. 337). They suggest that cynicism reflects psychological withdrawal from work which "predicts intentions to withdraw completely" (p. 337).

2.7 Moderators of nurse attrition

As mentioned in the previous chapter, the concept of ‘Magnet’ status hospitals was introduced in the USA in an effort to moderate nurse attrition. Magnet status hospitals are those recognized by The Magnet Recognition Program, a program of the American Nurse Credentialing Centre (ANCC), as highly effective nursing care environments with characteristics likely to attract and retain nurses (Cook & Hyrkas, 2010).

While The Magnet Recognition Program is based on 14 magnet attractions, Kramer and Schmalenberg (2008) formulated “eight essentials of magnetism” (p. 57). These are the attractions of most importance as determined from the perspective of nurses working in the acute care areas of US Magnet status hospitals. They are: “Work with other nurses who are clinically competent; Collegial/collaborative nurse-physician and interdisciplinary relationships; Autonomy in clinical decision making; Supportive nurse managers; Control of nursing practice; Support for education; Perception that staffing is adequate;” and “Culture in which concern for patients is paramount” (p. 57). As Ulrich, Buerhaus, Donelan, Norman and Dittus (2007) point out, identification of these essential Magnet attributes allows organisations that may not have the resources to pursue formal Magnet recognition to make improvements in areas of most importance to nurses.

The introduction of identified magnet characteristics into hospitals has proven effective in enhancing nurses’ working conditions and improving retention in the workforce (Aiken, et al., 2000; Armstrong, 2005; Chen & Johanatgen, 2010; Kramer

& Schmalenberg, 1991; Schmalenberg & Kramer, 2008; Stone et al., 2007; Ulrich, et al., 2007). This implies there is merit in a claim by Grant, Colello, Riehle and Dende (2010) that the Magnet Model provides an “exceptional framework for building an agile and dynamic workforce” (p. 326).

The “essentials of magnetism” identified by Kramer and Schmalenberg (2008, p. 57) resonate with the literature that links feeling respected and valued by work colleagues to nurses’ engagement with, and commitment to, their work (Finlayson, 2002; Leurer, et al., 2007; Robinson, et al., 2004; Snape & Spencer, 2003; Webster, Flint, & Courtney, 2009); perceptions of empowerment to intent to stay or leave nursing (Zurmehly, Martin, & Fitzpatrick, 2009); and feeling supported by managers to nurse morale, job satisfaction and retention (Garrett & McDaniel, 2001; Leurer, et al., 2007; MacPhee & Scott, 2002; van der Heijden, et al., 2010). Further, Kramer and Schmalenberg’s “essentials of magnetism” resonate with the literature that associates support for further education with decisions to stay or leave nursing (Gardulf, et al., 2005; McCabe & Garavan, 2008; Robinson, et al., 2004; Secombe & Smith, 1997; Yin & Yang, 2002); inadequate staffing and high workload to stress and burnout (Aiken, et al., 2002; Considine & Jakubauskas, 2008) and concerns about quality of patient care with nurses’ frustration and fatigue (Leurer, et al., 2007) and moral distress (Clare & van Loon, 2003; Goethals, et al., 2010; Jameton, 1984; Kelly, 1998; Mangone, et al., 2005; Peter, et al., 2004).

While gaining Magnet recognition has been the focus of nurse administrators in the USA for over 20 years, and the success of the model has seen the concept gaining

momentum internationally (Flynn & McCarthy, 2008; Grant, et al., 2010), according to Chen and Johanatgen (2010), there are currently only two hospitals in Australia with formal Magnet status. It can only be assumed that this is because there is insufficient awareness of the magnet model or that there are is a lack of resources to enable organisations to pursue magnet status. However, some of the recommendations to help moderate nurse attrition that are contained in reports on the Australian nursing workforce are compatible with magnet characteristics. For example, those that suggest implementing fixed national nurse/patient ratios, more flexible self-rostering systems, paid study leave and career pathways that better reward for study efforts (Australian Department of Employment Science and Training, 2002; Australian Health Ministers' Conference, 2004; Australian Health Workforce Advisory Committee, 2004a; Bennett, 2001; Heath, 2002; Jones & Cheek, 2003; Preston, 2002, 2006).

Reports by Forster (2005) and Francis (2010) advise on strategies to improve workplace culture within hospitals. In his report on care within a National Health Service Trust in the UK, Francis (2010) stresses the importance of a culture that fosters supportive relationships and good management to the efficient functioning of work units and quality patient care. By logical extension, such a culture is likely to impact positively on the quality of working life experienced by staff, and their retention in their employing hospital. Francis notes that:

Staff in the difficult environment of a hospital deserve and are entitled to support, respect and recognition for good standards.

They should not have to contend with a culture of fear and bullying. Dedication, compassion and effective teamwork contribute to the welfare of patients and should be valued. Pride in achievement needs to be fostered. Above all, staff, both nursing and medical, are entitled to effective leadership at every level (Francis, 2010, p. 400).

In a report on The Queensland Health Systems Review, Forster (2005) suggests the culture of an organisation is strongly influenced by its leadership model. Forster recommended that systemic organisational improvements for Queensland Health needed to include “the appointment and development of leaders who can, by example, inspire staff and develop the attitudes, culture and beliefs desired” (Forster, 2005, p. 4).

Compatible with these reports, Hofmeyer (2003) also emphasised the importance of social connectedness, cooperation, respect and trust (social capital) among employers and employees. She provided a convincing argument for the need to foster positive and harmonious relationships through building “inclusive social capital capacity” (p. 9) within health care environments. She suggested this was a vital approach to improving nurses’ quality of working life and moderating their attrition from the profession.

2.8 Chapter summary

This chapter has provided an account of the dimensions contained within two theoretical constructs commonly applied in nursing research on nurses’ quality of

working life. Drawing on the work of nurse academics and theorists, it has also portrayed the nature of nursing work. The literature concerned with nurses' job satisfaction, and nurse stress and burnout, has provided an account of nurses' working conditions and the effect of these conditions on their health and wellbeing.

This chapter has also demonstrated how the research relating to nurses' quality of working life has generally focused on particular facets of nursing work or specific variables. This current research takes a more inclusive approach to comprehensively examine, in a single study, a broad range of factors that impact on nurses' quality of working life.

The final two segments of the chapter were dedicated to providing a synopsis of the literature that outlined the reasons why nurses stay or leave the profession and the factors that moderate attrition. The latter segment revealed that multiple reports have recommended strategies to improve nurses' quality of working life and to enhance their retention in the nursing workforce. However, the researcher identified relatively little in the literature that evaluated the implementation of these strategies and their effectiveness on the quality of working life of nurses employed in Australian hospitals, particularly those in the State of Victoria. The following chapter provides an explanation of the theoretical and methodological approaches underpinning this thesis.

CHAPTER 3 – THE THEORETICAL AND METHODOLOGICAL APPROACH

3.1 Introduction

This chapter explains the rationale for the selection of Dawis and Lofquist's (1984) Theory of Work Adjustment as the theoretical underpinning for the thesis. It also describes the pragmatist orientation that was the philosophical viewpoint on which the choice of the mixed method research approach was based.

3.2 The theoretical approach

This thesis, being concerned with nurses' experience of working life and their decisions to stay or leave their profession, could reasonably have been embedded within a variety of theoretical frameworks, for example, Ajzen and Fishbein's Theory of Reasoned Action (Ajzen & Fishbein, 1980) or LeRoy Beach's Image Theory of Decision Making in Organisational Contexts (Beach, 1990). Both of these theories are focused on decision-making processes that can be applied to decisions about staying or leaving particular jobs or types of employment. However, the theoretical model selected for use was the Theory of Work Adjustment (Dawis & Lofquist, 1984). This theory was the preferred choice because it is highly specific to employees' experience of the work environment yet more wide-ranging in focus than theories focused predominantly on decision-making processes. It takes account of multiple dimensions of work that serve to fulfil employees' needs, interests and personal values about what they need and desire from their work. Further, the importance of mutually satisfying interaction between employee and employer is a

major concept within the theory, and the quality of nurses' working lives is directly influenced by their interactions with hospital managers and management systems.

While Dawis and Lofquist (1984) originally designed the Theory of Work Adjustment for application to vocational rehabilitation clients, it has been shown to be appropriate for use with all adults who are in the process of making career choices or who are experiencing work adjustment difficulties at any stage of working life (Dawis, 2000). This study was focused on nurses who, as a group of employees, are frequently reported to be considering new career choices as a result of the difficulties they face at work (Aiken, et al., 2002; Buchanan & Considine, 2002; Coomber & Barriball, 2007; Gordon, 2005; Hayes et al., 2006). Therefore this was an additional factor leading to the decision to use the Theory of Work Adjustment as the theoretical underpinning for this study.

Drawing extensively on their original Theory of Work Adjustment, Dawis and Lofquist developed a more generalised Person-Environment-Correspondence (PEC) theory of counselling (Dawis, 2002; Lofquist & Dawis, 1991). However, because it relates specifically to the area of work, it was the well-developed Theory of Work Adjustment that was favoured as the theoretical underpinning for this thesis. Further, the concepts within the Theory of Work Adjustment have been systematically and reliably tested, and refined, throughout a period of more than 35 years (Sharf, 2002).

3.3 The Theory of Work Adjustment

Within Dawis and Lofquist's (1984) Theory of Work Adjustment, quality of working life is conceptualised as "the quality of the relationship between employees and the total working environment" (Davis, 1983, p. 80). The work environment requires that certain activities be performed, and the individual brings expertise and knowledge to perform the required activities. Central to the theory is the notion that the interaction between employer and employee involves reciprocity, a process where the employee receives compensation for work performance and the employer provides certain preferred conditions, such as a safe and comfortable place to work. In order for the interaction between the individual employee and the work environment to be maintained, the two parties must continue to meet each other's requirements. Within the theory, the degree to which the requirements of both are satisfied is referred to as 'correspondence' (Dawis & Lofquist, 1984, p. 9). Success, or a lack of success, in fulfilling needs, interests and values results in satisfaction or dissatisfaction for either the individual employee or the work environment (employer), or for both parties. Dissatisfaction results in efforts to make adjustments to improve satisfaction (Hesketh & Dawis, 1991).

According to the theory, adjustment involves four components: flexibility, activeness, reactivity and perseverance (Dawis & Lofquist, 1984; Hesketh & Dawis, 1991). Flexibility is the degree of tolerance that both employees and employers have for mismatches between abilities and ability requirements, or between needs, interests and values. Activeness refers to a mode of adjustment that involves seeking to change the other party. For example, this could relate to an

employee requesting more staff in a work environment. It could also relate to the employer asking an employee to change behaviour, for example to stop being late for work. Reactiveness refers to a reactive mode of adjustment that involves the individual, or the organisation, voluntarily making a change to facilitate an improvement in degree of correspondence and satisfaction. For example, this could relate to a nurse reorganising her own work tasks, or the hospital management improving the lighting in a work environment. Perseverance, the final of the four components of adjustment, refers to the length of time that the employee or the employer continues trying to make adjustments to improve levels of satisfaction (Hesketh & Dawis, 1991).

According to the theory, successful work adjustment is indicated by mutual satisfaction: satisfaction of the employee with work, and the satisfaction of the employing organisation with the employee. Mutual satisfaction results in tenure, defined as the state in which an employee remains in the job, and tenure is the principal indicator of successful work adjustment (Dawis & Lofquist, 1984). In regard to the employee, a sense of personal wellbeing, including mental wellbeing, and satisfaction with work are the key components that contribute to continuing tenure (Hesketh & Dawis, 1991).

This study was conceptualised in accordance with the essence of the Theory of Work Adjustment, which is that continued interaction between an individual employee and a particular work environment is dependent upon the employee being in an environment that is compatible with his or her interests, values, needs, temperament

and goals (Hesketh & Dawis, 1991). The two key concepts of particular relevance to this study are that employee satisfaction and tenure are directly related to the extent to which an individual's needs and requirements are filled by the work they do, and the extent to which an individual's abilities and personal values are compatible with those of the workplace (Dawis & Lofquist, 1984; Sharf, 2002).

3.3.1 The six value dimensions

Human values are explained as a set of stable, general beliefs about what is desirable that emerge from society's norms and the individual's core psychological needs and sense of self (Feather, 1988, 1992). Work values have to do with what people consider good or bad at work. They are motivating factors because they govern what people seek, or seek to avoid, in their work in order to gain an acceptable quality of working life. According to Johns and Saks (2005), many values are established early in life and people tend to be attracted to certain occupations because they match their personal values. For example, individuals may be attracted to police work or nursing work for altruistic reasons, because they desire to do work that is of benefit to others. Others may be more attracted to an occupation that offers high status or large financial reward. Meeting altruistic values by fulfilling a need to help others is a common reason for individuals, males and females, choosing a career in nursing (Beck, 2000; Miers, Rickaby, & Pollard, 2006; Thorpe & Loo, 2003), and can be a more compelling value than large financial reward (Bozell, 2001; Buchanan & Considine, 2002).

Within the Theory of Work Adjustment, personal values are linked to the aspects of work that people experience as appealing and rewarding, and they are presented as a cluster of six value dimensions, one of which is altruism. The other five are achievement, comfort, status, safety and autonomy. Each value dimension is linked with a group of work related needs. The value of *altruism* is linked to helping others, working within one's own moral beliefs and ethical code, and harmony with co-workers. The value of *achievement* is linked to the need for feedback from others, opportunities for professional growth and advancement, and the importance of using one's abilities and feeling a sense of accomplishment. The value of *comfort* is linked to diverse aspects of work that minimise stress and include variety, adequate pay, job security, and physical aspects of the work environment. The value of *status* is linked to the need for recognition of effort and expertise, respect from others and opportunities for advancement. The value of *safety* is linked to the need for non-hazardous conditions, orderliness and predictability, competent co-workers and protective workplace policies and practices. The value of *autonomy* is linked with the need for freedom to express creativity, control and responsibility (Dawis, 2002; Dawis & Lofquist, 1984; Hesketh & Dawis, 1991; Hesketh & Westbrook, 1991; Sharf, 2002).

In accordance with the Theory of Work Adjustment, active and reactive modes of adjustment are important in helping individual employees ensure their personal needs and work values are fulfilled at least to a minimum acceptable level of satisfaction. In effect, these modes of adjustment are a form of problem solving. If, after efforts at adjustment, a problem or multiple problems continue, satisfaction, and therefore

quality of working life, may drop below a threshold of minimum acceptability (Hesketh & Dawis, 1991). This increases the potential for employees to terminate their tenure with the employing organisation, and possibly with their chosen profession.

In summary, the Theory of Work Adjustment was selected as the theoretical framework to underpin this study because the wide-ranging ‘needs and values’ perspective allowed for a broad, encompassing approach to investigate the complex phenomena that can impact upon the quality of nurses’ working life. The theory provided a broad framework that allowed exploration of the phenomena through quantitative and qualitative research methods. It was therefore compatible with the pragmatist viewpoint, which was the philosophical stance on which the choice of a mixed method approach to this study was based.

3.4 The methodological approach

The methodological approach was based on the pragmatist viewpoint which is that in exploring complex issues “neither quantitative or qualitative methods alone are sufficient to develop a complete analysis” (McEvoy & Richards, 2006, p. 68). Pragmatism is a philosophical stance that emphasises the pragmatic nature and value of knowledge. Pragmatism contends that meaning (or truth) is best established through scientific inquiry that may be “both objective and subjective in epistemological orientation” (Tashakkori & Teddlie, 1998, p. 25). It is a standpoint that allows researchers the freedom of choice to select methods that are the most

appropriate for their studies, rather than relying on one paradigm or method exclusively (Tashakkori & Teddlie, 1998).

3.4.1 The pragmatist paradigm

Historically, two distinct and opposing paradigms have been common to research in the social and behavioural sciences: the positivist and the naturalistic paradigms. These opposing paradigms have tended to govern choice of research methodology towards either quantitative (positivist) or qualitative (naturalistic) studies. Proponents of these differing paradigms have stridently debated the value of their own methodological positions in what has been described as an increasingly unproductive paradigm war that extended through the 1980s into the 1990s (Tashakkori & Teddlie, 1998). There is a significant cultural divide between supporters of the two paradigms, those who believe in a positivist paradigm; the superiority of hard, objective, generalisable, quantitative data, and those who favour the constructionist paradigm; constructionists being those who profess the superiority of deeper, rich qualitative data (Burke-Johnson & Onwuegbuzie, 2004; Gilbert, 2006; Lincoln & Guba, 1985; McEvoy & Richards, 2006; Tashakkori & Teddlie, 1998). However, many researchers acknowledge the pragmatist paradigm, specifically the importance and usefulness of both quantitative and qualitative approaches (Borkan, 2004; Burke-Johnson & Onwuegbuzie, 2004; McEvoy & Richards, 2006; Patton, 1990; Tashakkori & Teddlie, 1998) and researchers have increasingly turned to mixed qualitative/quantitative techniques to expand the scope and improve the analytical power of their studies (Sandelowski, 2000).

A number of similarities have been identified between the fundamental beliefs of the qualitative and quantitative paradigms. According to Tashakkori and Teddlie (1998) these shared beliefs include that research is influenced by the investigator's personal values, and the theory, hypothesis or framework that he or she uses. Tashakkori and Teddlie also suggest there is a shared belief that reality is multiple and constructed, and a shared belief in the fallibility of knowledge, the view that theories or causal links cannot be proven with certainty. Further, they suggest that both paradigms accept that any given set of data can be explained by a variety of theories. These fundamental similarities are strong and justify the evolution of the pragmatist paradigm, and the increasing use of mixed qualitative/quantitative methods in social and behavioural research (Tashakkori & Teddlie, 1998).

The decision to combine quantitative and qualitative approaches to data collection and analysis in this study was based on the fundamental logic behind the pragmatist paradigm. This is that when the research involves complex issues, a single method approach is not adequate and may result in an incomplete analysis (McEvoy & Richards, 2006).

3.5 Chapter summary

The choice of the Theory of Work Adjustment as a theoretical underpinning for this thesis has been explained. In addition, this chapter has provided an account of the pragmatist orientation, the philosophical viewpoint that informed the decision to use a mixed method approach to data collection and analysis. The following chapter

offers an account of the overall research design and the sequential, complementary, quantitative and qualitative methods employed for this thesis.

CHAPTER 4 – RESEARCH DESIGN AND METHOD

4.1 Introduction

This chapter first describes the research design and methods employed in this study and offers justification for the choices. The body of the chapter is divided into two parts. Part A details the characteristics of participants, sampling procedures, the instrument used for data collection and the process of data analysis employed in the quantitative component of the study. Part B details the sampling procedures, the processes for collection and management of interview data and the data analysis method employed for the qualitative component of the study. The chapter then concludes with an account of how the ethical considerations encountered were managed.

4.2 The mixed method research design

The design for this mixed-method research comprised two phases. Phase 1 was a quantitative study that used a self-administered survey to explore nurses' opinions about their quality of working life. Phase 2 deepened this exploration through face-to-face, semi-structured interviews with individual nurses. Patton (1999) indicates that combining research methods in a single study strengthens overall rigour because it allows the researcher to test for consistency between the different sources of data. Patton suggests that this strengthens the validity of study findings because “different types of inquiry are sensitive to different real world nuances” and “...understanding of inconsistencies can be illuminative” (p. 1193). Multiple commentators agree that mixing quantitative and qualitative method maximises internal validity and overall

rigor in the research process (Creswell, Fetters, & Ivankova, 2004; Denzin & Lincoln, 1994; Knafl & Breitmayer, 1991; Patton, 1999; Roberts & Taylor, 2002; Schneider, Whitehead, & Elliott, 2007; B. Taylor, Kermode, & Roberts, 2006; Teddlie & Tashakkori, 2003). Using mixed methods in this study was necessary because the world of nursing work is extremely complex, and the quality of nurses' working life not therefore evaluated effectively within one method of inquiry alone.

Mixed method research offers a variety of design options, which include sequential and concurrent models (Creswell, 2003; Creswell & Plano-Clark, 2007; DePoy & Gitlin, 1994; Johnstone, 2004; McEvoy & Richards, 2006; Tashakkori & Teddlie, 2003). The design selected for this study is based on a sequential model that involves three stages. As described by Creswell (2003), stage one is the collection and analysis of quantitative data, stage two is the collection and analysis of qualitative data and stage three involves integration of these two separate data sets in a final interpretation stage of analysis. The thematic diagram in Figure 4.1 illustrates the overall study design.

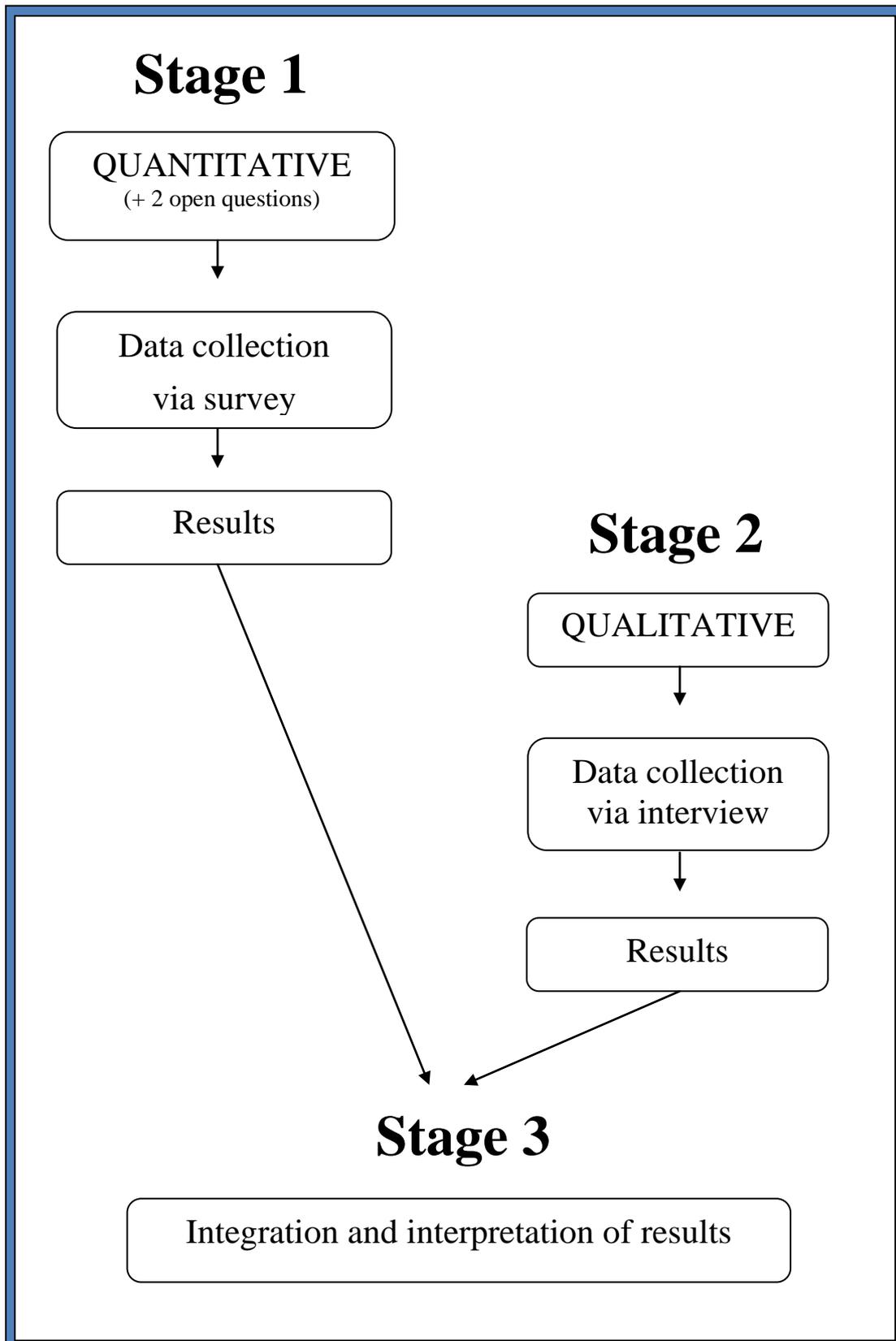


Figure 4.1: Flow chart of the research design

The use of a survey as the first method of data collection enabled the researcher to collect an initial broad base of information from a large number of participants. Gathering a breadth of quantitative data was important because, as it is associated with a higher degree of objectivity than qualitative data, it tends to have a higher level of credibility with people in management (Borbasi, Jackson, & Langford, 2008; Burke-Johnson & Onwuegbuzie, 2004; Guba & Lincoln, 1994; Krauss, 2005; Polit & Beck, 2006). It was anticipated that the findings of this study concerned with nurses' opinions about the quality of their working lives, and their retention in the nursing workforce, would be of interest to hospital administrators and managers.

The main reason for employing qualitative, in-depth interviews as the secondary data source was to gather rich and detailed information that could elaborate on, enhance and therefore strengthen the quantitative findings (Rossman & Wilson, 1985). As Coyle and Williams (2000) point out, qualitative methods can complement quantitative methods because they help to ensure that broad quantitative findings are contextualised appropriately within the relevant social context. Further, it was important to include a qualitative method because this reduced the risk of overlooking any unique, emic personal perspectives that might have existed for nurses currently engaged in nursing work. As Patton (2004) explains, qualitative data has the potential to enhance the quality of quantitative data because it arises from an emic perspective, the insider's personal intimate view of events.

PART A

4.3 The quantitative component of the study

The quantitative phase of the research was a cross-sectional, exploratory study. A structured attitudinal survey was used to collect data from a random sample of nurses in order to assess their opinions about multiple aspects of nursing work that impact upon their overall quality of working life. It was also used to explore whether or not there were differences of opinion about these aspects of work between the nurses who planned to stay and the nurses who planned to leave their profession.

4.3.1 The setting and the survey sample

The settings were two public hospitals; one outer-metropolitan and one regional hospital in the state of Victoria. Public hospitals in Victoria are those operated by the state government. They provide a free service to those who do not have private health insurance. Support for conducting the research was initially sought from the Director of Nursing and the Research Coordinator at each of the respective hospitals. Later, support was sought from individual unit managers. Subsequently, formal approval to commence the research was gained from the Human Research Ethics Committees governing the two participating hospitals between January and June 2006. Approval was also gained from the Human Research Ethics Committee at Victoria University (Victoria University ethics approval reference HRETH 15/104).

RNs were chosen as the target population for this study because they form the majority of nurses employed in the state of Victoria and nationally (Nursing Labour Force Survey, 2003).

Only RNs who were employed within medical and surgical, critical care and coronary care units, accident and emergency departments and peri-operative⁷ areas were eligible to participate. RNs working in these areas were specifically targeted because, as mentioned previously, the shortage of nurses is particularly severe in the acute in-patient hospital setting (Australian Health Workforce Advisory Committee, 2004b; Hogan, et al., 2007).

All ENs were excluded from the study. RNs based in the community, those working in the fields of midwifery and mental health, plus those working as administrators and managers (including nurse unit managers, NUMs) were also excluded. While it is equally important to increase understanding of how both levels of nurse, and RNs in all fields of nursing, experience their quality of working life, they were excluded, in part, because it was necessary to limit the focus of this study to manageable proportions for a single researcher. Further it was considered that work experiences unique to nurses in specialist fields, administrative and management roles had the potential to skew the data.

⁷ Peri-operative nursing is defined under operational definitions in Chapter 1.

4.3.2 The sample size

Key staff in the human resources departments of each hospital identified a total of approximately 2,500 RNs who met the selection criteria. In an effort to ensure the data collected was representative of the larger population, a Sample Size Determination Table developed by Bartlett, Kotrlik and Higgins (2001) was used as a guide to determine the sample size for this study. According to the table, the minimum sample size for a population of 2,000 should be about 112 for continuous data, and 323 for categorical data. This is closely compatible with the minimal sample size of 333 that Krejcie and Morgan (1970), cited in Cohen, Manion and Morrison (2000), indicated was appropriate for a population of 2500. Therefore this study aimed to recruit a minimum of 333 participants.

Information about response rates for mail surveys varies considerably. Bogan (1996) reports that for large mail surveys (between five and six pages), response rates range from 21% - 38%. De Vaus (1995) suggests that when mail surveys are of particular relevance to participants, the response rate may be as high as 60 -70%. In assessing the likely response rate for this survey three factors were considered: the size (five pages); the relevance (to nurses); and the potential effectiveness of recruitment activities. A relatively conservative response rate of 40% was decided upon. In order to ensure sufficient numbers of surveys were returned, the following formula was applied: minimum number of surveys required (333) divided by estimated response rate (40%). As a result, a total of 840 surveys were distributed.

4.3.3 Data collection procedures

Two weeks prior to distribution of the survey, the researcher informed RNs working in the participating wards/units about the study. This face-to-face communication occurred during their change of shift (staff hand-over) meetings.

Distribution of the survey was achieved with the help of Research Coordinators and pay office employees at each hospital. An envelope, containing a participant information letter explaining the study (Appendix A) and a copy of the survey (Appendix B) was attached to the pay slips of a probability sample of RNs who met the selection criteria. A systematic random sampling method was used (Polit & Beck, 2010; Taylor, Kermode & Roberts, 2002). The envelope was attached to the first and every following third pay slip in each ward bundle. Data collection occurred between May and August 2006.

A small prize incentive was offered. Those who completed the survey were invited to participate in a draw to win a \$100 gift voucher that entitled the winner to attend any event, concert or show of their own choice in Melbourne, Victoria. The ethical implications of this incentive are discussed later in this chapter.

4.4 The research instrument for data collection

The instrument used in this study is a modified version of a Quality of Working Life (QWL) Survey developed by the Institute for Employment Studies (IES) at the University of Sussex in the UK (Robinson & Perryman, 2004). A study using this survey was first conducted by the Robinson and Perryman, on behalf of the IES in

1998. Robinson and Perryman's study explored the quality of working life of over 10,000 employees in 14 organisations across the UK National Health Service (NHS). In order to make comparisons about the quality of working life of NHS employees over time, the study since has been repeated annually. In addition the IES survey, where necessary with modifications, has been widely used across various UK government departments and agencies and across a range of other organisations. These include the educational sector, the Royal College of Veterinary Surgeons, the Bank of Scotland and the UK retail industry (Denvir, et al., 2008; Robinson, et al., 2004). While not specific to nurses, the content of the IES survey aligns closely with the work-related issues that are identified in the literature as of major concern to nurses in Australia (Buchanan & Considine, 2002; Duffield, Roche, et al., 2007; Wise, 2007) and internationally (Aiken, et al., 2002; Gordon, 2005; Stone, et al., 2003; Tourangeau & Cranley, 2006). Permission to adapt the survey for use with nurses in Australia was sought and subsequently granted by Ms Dilys Robinson, an IES principal research fellow.

The modified instrument used in this study consists of three parts. The first relates to the participants' socio-demographic details (9 items), the second contains closed questions (69 items) seeking opinions about aspects of work that impact on quality of working life (communication, performance appraisal, pay and benefits, management, work colleagues, equal opportunities, professional development opportunities, stress and work pressure, health and safety measures and job satisfaction). The third part contains the two open questions seeking information about the participants' future career plans.

In part 2, five-point Likert scales were used. All scales ranged from 1 (*strongly disagree*) to 5 (*strongly agree*,) with the exception of one that ranged from 1 (*very dissatisfied*) to 5 (*very satisfied*). With the single exception of the latter, but consistent with the way the Likert scale scores were interpreted in the quality of working life studies conducted by the UK Institute of Employment Studies (IES) (Robinson & Perryman, 2004; Robinson, et al., 2004), the Likert scale data scores were interpreted as follows:

1 - < 2 = strongly disagree (strongly negative view)

2 - < 3 = disagree (negative view)

3 = neither agree nor disagree (neutral view)

> 3 - 4 = agree (positive view)

> 4 - 5 = strongly agree (strongly positive view).

4.4.1 Modification of the IES Quality of Working Life survey

Modifications to the IES Quality of Working Life survey were necessary in order to ensure all items were specific to nurses working in Australian hospitals, and to ensure they sought only information relevant to the scope of this study. Forty-two items were removed on the basis that they were UK specific, or sought personal or other information not required within the scope of this thesis. In addition, some words and terms were replaced with others more suitable for application to nurses working in Australian hospitals. For example, the word '*hospital*' replaced '*Trust*' (referring to the UK NHS); '*unit manager*' replaced '*immediate*' and '*line manager*'; '*nurses*' replaced '*people*' and '*career development*' replaced the word '*training*'. In

addition, items in part 3 of the survey, concerned with intention to stay or leave the NHS, were modified to reflect intention to stay or leave the nursing profession.

4.4.2 Validity and reliability of the modified survey

Researchers at the Institute for Employment Studies at the University of Sussex in the UK used stringent measures to establish the validity and reliability of their Quality of Working Life survey. These included factor analysis, test-re-test, and Cronbach's alpha computations to determine internal consistency (Robinson & Perryman, 2004; Robinson, et al., 2004). Steps were undertaken to determine that validity and reliability remained strong in the modified version of the survey prepared for use in this study. The methods used to evaluate the modified Quality of Working Life survey were content validity, face validity and internal consistency reliability tests (Cronbach's alpha).

4.4.2.1 Content validity

As explained by Parsian and Dunning (2009), content validity involves determining whether the content of a survey is appropriate and relevant to the study purpose. They point out that this process is usually undertaken by a panel of seven or more experts. An expert review panel (Appendix C) evaluated content validity of the modified version of the IES Quality of Working Life survey. The panel, selected on the basis of their expertise in nursing, nursing research, survey development, and statistical analysis comprised seven nurse academics. It is commonly the role of an expert review panel to reduce the number of items in a survey (DeVon et al., 2007). However, in this case the panel suggested that all existing items were relevant and

should be retained, but that seven items should be added to the survey to ensure that all matters of specific concern to nurses in Australia were adequately covered in the content. Items 23, 24, 25, 31, 74, 75, and 77 were added in response to the recommendations of the expert review panel.

4.4.2.2 Face validity

Eleven experienced RNs, colleagues of the researcher, who were actively employed in clinical nursing, assisted in assessing face validity of the modified Quality of Working Life survey. Parsian and Dunning (2009) describe face validity as indicating that the survey “appears to be appropriate to the study purpose and content area” (p. 3). Similarly to Parsian and Dunning’s approach to assessing the face validity of a newly designed questionnaire to measure spirituality, the nurses were asked to complete an evaluation form to: assess clarity of wording and meaning in all survey items; ascertain the appropriateness of the content to the target audience; and assess the layout and style of the survey. The assessment undertaken by the RNs resulted in slight modifications to the wording of survey items number 12, 26, 42, 45, 52, and 78. These modifications, with rationales for implementing the changes, as provided by the RNs, are detailed in Table 4.1.

Table 4.1
Modifications to the survey recommended by RNs

Original item - IES Survey	Recommended change with rationale
The 'grapevine' is the most effective communication channel around here	The informal communication network is the most effective communication channel around here Rationale: The term ' <i>grapevine</i> ' could cause misunderstanding in participants whose first language is not English
I am treated with respect by the staff I work with	I am treated with respect by the doctors I work with Rationale: too general, lack of respect from doctors is the main issue
I feel I have a fair chance to apply for internal vacancies here	I feel I have a fair chance of success when applying for internal vacancies here Rationale: Anyone can apply, but chance of success is a different issue
This hospital is good at supporting disabled employees	This hospital is good at supporting employees with disabilities Rationale: original terminology politically incorrect
Access to career progression is not equal for all groups	People from different racial/ethnic backgrounds have equal access to career progression in this hospital Rationale: Lack of clarity/specificity
How satisfied are you with security in your workplace?	How satisfied are you with staff protection measures in your workplace? Rationale: too general, nurses are concerned about personal protection even when general security is good

In summary, the recommendations and advice of the expert review panel, and the group of hospital-based RNs who assessed the face validity of the survey, resulted in some additional survey items and in changes to the wording of some content. According to Gorard (2003), confidence in the reliability of a modified, but previously validated survey, can be appreciably strengthened when the content of the

modified version is both reviewed by experts and evaluated by people working in the relevant area of study.

4.4.2.3 Reliability

Internal consistency of the modified version of the IES survey used in this study was assessed using Cronbach's Alpha analysis. This is the most commonly used test for establishing internal consistency reliability in surveys using a Likert-scale format (Schneider, et al., 2007). Tests for examining internal consistency provide an estimate of how well a set of survey items fit together conceptually (DeVon, et al., 2007; Schneider, et al., 2007). Results indicate the average correlation among all the items in a scale, this being the degree to which the items that make up the scale are all measuring the same underlying attribute (Pallant, 2005). Results of the Cronbach's Alpha tests (Table 4.2) showed that the reliability coefficient for the QWL survey was 0.93. With the exception of the Communication scale, which contained only four items, the reliability coefficients for all of the individual scales were higher than 0.70. Generally in the social sciences, a Cronbach's Alpha reliability coefficient of 0.70 or higher is considered to indicate internal consistency in a set of items, however, because Cronbach's Alpha values are sensitive to the number of items in a scale, it is common to find quite low values (e.g. 0.5) when scales have fewer than 10 items (Pallant, 2005).

Table 4.2
Cronbach's Alpha reliability coefficients

Scale	No. of items	Reliability coefficient
Communication	4	0.52
Pay and Benefits	3	0.72
Performance appraisal	2	0.79
Management	7	0.92
Colleagues	6	0.72
Equal Opportunities	21	0.91
Professional Development	6	0.90
Stress and work pressure	9	0.90
Health and safety	11	0.87
Job satisfaction	7	0.90
Overall QWL	76	0.93

4.5 Quantitative data analysis

The quantitative survey data was analysed using the Statistical Package for the Social Sciences (SPSS) Version 17. In order to minimise the risk of error, there were always two people present to check for accuracy during data entry. A code book was used to avoid any confusion during data analysis. This facilitated recording of the codes allocated to each of the questions, statements and variables involved in the survey, plus documentation of all other pertinent information, including how each of the responses were coded. The data was screened, cleaned and checked for outliers before analysis was commenced.

4.5.1 Data transformation

Part 2 of the survey contains Likert-style scales that range from 1 (*strongly agree*) to 5 (*strongly disagree*) with 3 (*neither agree nor disagree*) being the neutral point.

These scales explore various aspects of work that contribute to overall quality of working life. These are communication, performance appraisal, pay and benefits, management, work colleagues, equal opportunities, professional development opportunities, stress and work pressure, health and safety measures and job satisfaction. Before analysis was commenced, all negatively worded items were reversed in order that higher scores for the Likert scale items consistently reflected a more positive view. In order to ascertain the participants' general opinion about the various aspects of working life represented in these interval scales, a total scale score was calculated for each aspect. In addition, in order to gain an appreciation of how the participants generally viewed their overall quality of working life, all items comprising the individual scales were combined to create a single 'overall QWL' scale. A total scale score was then calculated for the overall QWL scale. The total scale scores were created by summing up the scores for all items in each respective scale. In order to make interpretation of these scores clearer, the total scale score in each instance was divided by the number of items in the respective scale, thus placing it back into the original 1-5 range.

4.5.2 Configuring the participants into groups

From responses to the questions that ask participants about their future career plans, two groups were identified: participants planning to stay in nursing and those planning to leave the profession. Based on the view that leaving nursing to retire from the workforce related more to a time of life than to the quality of working life, participants identified as planning to leave because of retirement were removed from this study.

4.5.3 Statistical tests

Frequencies and percentages were used for exploration of the demographic data. The Chi-Square tests for independence were used to compare the demographic features of participants planning to stay and planning to leave the nursing profession. In analysing the Likert scale data, the first step was to ascertain the mean, standard deviation and range of scores in relation to opinions about the various aspects of work and overall QWL for the entire sample.

Before further analysis, the assumptions for applying parametric tests were checked. The data were assessed for normal distribution and homogeneity using the Shapiro-Wilk and the Levene's tests respectively. As the assumptions for using these tests were not fulfilled, non-parametric Mann-Whitney U tests were used to explore whether there were differences in opinion about the quality of working life between the group of participants planning to stay and the group planning to leave nursing.

Finally, non-parametric Spearman's rank order correlation analysis (Pallant, 2005) was used to explore possible relationships between selected core constituents of QWL. The level of statistical significance was defined as $p < 0.05$ and all tests were two-tailed.

PART B

4.6 The qualitative component of the study

Semi-structured, in-depth interviews were used in an effort to capture rich, detailed descriptions of factors in the work environment that impact upon nurses' quality of working life and on their decisions to stay or leave their chosen profession. The qualitative data comprised the transcribed tape-recorded interviews, and responses to two open survey questions that asked for participants to provide reasons for either planning to continue, or discontinue, a career in nursing. While the two sets of data were analysed separately, they were both analysed using the process of qualitative content analysis (Palmquist, 2004).

4.6.1 The interviewees

In order to obtain personal stories about the factors that impact the quality of working life, face-to-face interviews were conducted with a purposeful sample of ten hospital-based RNs working in the designated hospital settings, and an extreme sample of five RNs who had left the nursing profession to follow a new career path. Patton (1990) describes an extreme case sample as one whose experiences or outcomes have been extreme, and who therefore have the potential to provide a researcher with especially enlightening information. Choosing to leave one's profession is an extreme outcome (Cheung, 2004). The inclusion of this extreme case sample offered the opportunity to gain rich information about why nurses make the extreme decision to leave a career for which they are qualified and have worked hard to enter. Indirectly, the inclusion of this extreme case sample also provided the

opportunity to gain understanding of what adjustments needed to occur in the workplace in order for them to have continued working in the profession.

The inclusion and exclusion criteria was identical to that for the quantitative component of the research, other than that the RNs who had abandoned the profession were required to have left nursing within twelve months prior to their interviews. It was considered that events and feelings experienced in the prior 12 months were more likely to be recalled with accuracy than after a more extended period of time.

Participants working as RNs were recruited via promotional brochures that thanked those who completed the survey and invited them to participate further through an interview with the researcher. Brochures and information packages were left in the main lunch rooms of the participating hospitals. The packages included a participant information letter (Appendix D) and a consent form (Appendix E). Participants willing to be interviewed were asked to place a completed consent form in a sealed box that was left in each lunch room. The researcher collected the sealed boxes one week after placing them. The first ten employed RNs who agreed to participate were interviewed. The concept of theoretical saturation was used to determine the sample size for this cohort (Strauss & Corbin, 1998). A preliminary data analysis revealed that no new information was gained after the 8th interview.

Snowball (chain) sampling was used to recruit the five participants who formed the extreme sample of nurses who had left the profession. The interviewees who were

working as RNs were asked to give information packages to any colleagues they knew who had left the nursing profession within the previous twelve months. They were requested to ask those colleagues to contact the researcher if willing to be interviewed. This resulted in interviews with two RNs who had left the profession. They were then asked to follow the same process, giving information packages to any of their prior work colleagues who met the criteria for this cohort. This resulted in another three interviews. This extreme case sample was self limiting in size due to the effect of this sampling process. However, “there are no rules for sample size in qualitative inquiry” and “in-depth information from a small number of people can be very valuable, especially if the cases are information-rich” (Patton, 1990, p. 184).

4.6.2 The qualitative procedures

The interviews, which were approximately 60-90 minutes in length, took place at times and locations convenient to the participants and in an atmosphere that ensured privacy and confidentiality. An aide-memoire style interview guide was used as a discreet prompt (David & Sutton, 2004). An informal, conversational mode of interviewing was used because, as May (1997) explains, it is a mode that encourages disclosure and provides a forum within which participants are most likely to reveal deeply held values, opinions and feelings. This was important because nurses are often reluctant to speak out about difficult and sometimes hidden aspects of their work (Buresh & Gordon, 2006; Gordon, 2005; Sherson, 2005). The interviews focussed on gathering information to complement the quantitative data and also to indirectly elicit information, not necessarily in the participants’ conscious awareness, about what they valued and needed from their work in order to experience an

acceptable quality of working life. While the aide-memoire style interview guide was used to ensure no planned areas of exploration were neglected, additional points of concern or interest that were raised, and appeared to be of particular importance to the participants, were also pursued. A range of recommended interview techniques, including verbal and non-verbal cues and focussed and probing questions (Stein-Parbury, 2005) were employed to ensure the topics relevant to nurses' quality of working life were fully explored, while also ensuring that every participant had the opportunity to reveal any uniquely personal experiences (Britten, 1995; Patton, 1990; Smith & Osborn, 2003).

While personal work values were central to the way this study was conceptualised, information about what the interviewees valued and needed from their work was not sought through a direct approach. Rather, the aim was for this information to emerge indirectly through questions focused on the experience of being a nurse, opinions about various aspects of the work environment, and reasons for staying or leaving the nursing profession. This indirect approach to eliciting information about personal work values was taken because, according to Sharf (2002), it is unusual for individuals to have consciously formulated their work values or to have considered them in relation to their workplace and the organisational practices inherent in their particular work environment. In an effort to ascertain what it was that the participants most valued and needed from their work the researcher asked a range of questions. These included, but were not limited to the following:

What were the things that attracted you towards a career in nursing?

Tell me about what happens during an average day at work for you.

What are the best things about your job?

What are the most difficult things you have to deal with at work?

What helps you to cope when life at work gets difficult?

If you could change anything about your job what would you change?

What are the good things about the management in your hospital?

What improvements would you like to see in the way your unit is run?

Tell me about your relationships with the people you work with.

In order to elicit information about decisions to stay or leave nursing, the interviews concluded with the questions: "How do you feel now about nursing as your career choice?" and "Where do you see yourself in two years time?"

4.6.3 Data management

The tape-recorded interview data was transcribed verbatim. The transcripts were divided into two sets, reflecting the two cohorts of participants; employed RNs (cohort 1) and RNs who had left the profession (cohort 2). For ease of tracking, a different coloured font was used for transcribing the data from each cohort. To ensure confidentiality of participants, each was allocated a pseudonym. The transcripts were coded with the cohort number and the allocated pseudonym; for example **C1: Julie**. To provide an audit trail, every page of each transcript was numbered, and each line of every page was also numbered. Use of these tracking mechanisms is illustrated in the following segment of text:

Things were all over the place, messy, you couldn't find anything you wanted. If it's a pleasing environment you want to stay there, if not you don't. **C1: Julie: Pg6:Ln291-293**

Polit and Beck (2006) suggest that when combined, these strategies create a system of identification and tracking that provide an effective audit trail. In this study they make it possible to locate the page and quote from any transcript, therefore providing others with a means to verify the evidence upon which the researcher's assertions and findings are based.

4.7 Qualitative data analysis

Responses to the open questions on the survey and the transcribed interview data were analysed using qualitative content analysis, a method commonly used in nursing and educational research (Graneheim & Lundman, 2004). It is a research method that allows for "sophisticated analysis of both explicit and implicit content of communication texts" (Sproule, 2006, p. 128) and is suitable for analysis of any written material where the content involves communication that describes experiences (Baxter, 1991; Krippendorff, 2004). Sofaer (1999) explains qualitative content analysis as a method that "typically involves the identification of assumptions, values, and priorities" (p. 1111). It is therefore a suitable method to use for the qualitative phase of this study which explores participants' experiences of being a nurse, their work values and their opinions about the various aspects of nursing work that impact upon the quality of their working life.

4.7.1 The process of qualitative content analysis

Elo and Kyngas (2007) explain that there are a diversity of approaches to qualitative content analysis, but that there is no established simple right way of doing it. They advise that each researcher must select the variation of the method that it most suitable for their study. The variation selected for this study is based on Hsieh and Shannon's (2005) conventional qualitative content analysis approach within which knowledge generated is based on the participants' unique perspectives and is "grounded in the actual data" (p. 1280). This approach involves the production of major categories, through what Miles and Huberman (1994) refer to as a systematic process of data reduction and analysis. The procedure undertaken was one of review, reflection and repeated modification of emerging categories. While the method used was based essentially on Hsieh and Shannon's conventional approach, the researcher drew on the works of several advocates of qualitative content analysis, including Palmquist (2004), Busch et al. (2005), Graneheim and Lundman, (2004) and Mayring (2000, 2004) to precisely explain the steps employed when implementing the method in this study. As with all types of thematic analysis, the first steps were the researcher becoming familiar with the data through listening to the audio-taped interviews and noting first impressions. This was followed by the researcher transcribing the data and reading the transcribed texts several times to get a feel for the thematic categories that would emerge. The following steps were:

- Making coding decisions
- Inductive category formulation
- Establishing translation (coding) rules

- Re-viewing un-coded text

These steps, with examples of how they were implemented, are described below. The examples stem from analysis of the interview data. However, the process was the same as that applied to analysis of the responses to the open survey questions.

4.7.1.1 Making coding decisions

This step in the process involved the researcher needing to decide on whether to focus on manifest or latent content in the data. Manifest content refers to the explicit, visible, obvious components of the text, whereas the latent content refers to the implicit, less obvious, underlying meanings of the text (Graneheim & Lundman, 2004; Hsieh & Shannon, 2005; Mayring, 2004). Sproule (2006) explains that implicit coding at the latent level is far more subjective than explicit coding at the manifest level, but that latent level coding allows for a deeper analysis of meaning. Many of the responses to the open survey questions were explicit, simply listing reasons for staying or leaving nursing, therefore analysis of these responses was applied at the manifest level. More lengthy and informative responses to the open survey questions, and the richly informative data, in which implicit meanings were embedded, were analysed at both the manifest and latent level.

According to Taylor, Kermode, and Roberts (2006), it is not uncommon for the frequency with which particular points, ideas or expressions occur in qualitative data to be counted. In an effort to gain increased insight as to the main reasons nurses stay

or leave the profession, analysis of the two open questions in the survey includes a numerical description.

Researchers must decide whether to code manually or to use computer assisted analysis (Palmquist, 2004). A decision to code manually for all of the qualitative was based on the following:

- coding by hand has been identified as allowing more flexibility in the coding process, and making spotting errors easier (Sproule, 2006)
- recognition that although coder reliability is strong in computerised analysis because coding rules are built into the program, there is a risk that such standardisation may detract from contextual meaning (Priest, Roberts, & Woods, 2002)
- computer coding has been linked to a higher risk of analytical error, particularly when coding at the latent level (Palmquist, 2000).

4.7.1.2 Inductive category formulation

Lacey and Luff (2001) suggest that colour-coding and cut and paste systems of data organisation are the methods favoured by researchers undertaking manual data analysis. These were the methods applied to facilitate data organisation during the process of inductive category formulation. The inductive process of painstakingly working through the data several times meant that initially a large number of sub

categories were identified. The combination of colour coding and cut and paste methods facilitated clear visualisation of the data, thus easing the challenge of organising it into a reduced number of categories. The inductive analysis process resulted in the subsumption of old categories, and the formulation of some new ones, as the data was repeatedly reviewed. Through a process of increasingly more abstract thinking, sub categories were grouped together and subsumed within a lesser number of minor categories. Eventually, the minor categories were further subsumed within a small number of major categories. Table 4.3 provides an example of how interview data was first fragmented and allocated a sub category code. Table 4.4 provides an example of how related sub categories were subsumed into minor categories and then further subsumed within one major category.

Table 4.3

Examples of fragmentation of data and application of sub category codes

Data fragmentation	Sub-category code
<p><i>If it hadn't been for my friends in the team, you know, so reassuring saying "We can all make mistakes, you are a good nurse"...that sort of thing...well I think I would have gone and never come back. (C1:Adriana:Pg2:Ln19-25)</i></p>	<p>Reassurance</p>
<p><i><u>I always knew I could call the clinical educator</u> if the nurses on my unit were too busy to help me.. just knowing there was someone on the other end of the phone really helped with the anxiety. (C1:Jenny:Pg7:Ln13-15)</i></p>	<p>Availability of help</p>

Table 4.4
Examples of sub categories subsumed into minor and major categories

Sub Category Codes	Minor Category Codes	Major Category Code
Feeling part of the team Friendly camaraderie	Sense of belonging	The importance of supportive work colleagues
Sharing knowledge Availability of help Getting the work done	Practical help	
Reality shocks Getting it wrong Reassurance Recognition of stress	Emotional support	
Acknowledgement of effort Receiving feedback Respect from others	Feeling appreciated	

4.7.1.3 Establishing translation (coding) rules

Creating translation (coding) rules extends Hsieh and Shannon (2005)’s conventional qualitative content analysis approach in which categories are derived from the inductive data analysis process described above. It is an additional step that “helps the researcher ensure that he/she is coding things consistently throughout the text, in the same way every time” (Busch, et al., 2005, p. 2). Coding rules were established for each major category after inductive analysis had been completed. The data was then re-examined against the coding rules to assess the consistency with which data segments had been placed in categories. This is akin to deductive category formulation in that it involves using the explicit coding rules to test out conceptualisation of the categories by bringing them close to the text for examination (Mayring, 2000).

Coding rules were particularly helpful in distinguishing between segments of data where both negative and positive experiences disclosed by participants related to the same concept and therefore needed to be included within the same major category. For example, several participants described experiences of strong positive collegiate support, whereas others expressed perceptions of a serious lack of collegiate support at work. Table 4.5 provides an example of how coding rules were applied to the major category of ‘The importance of supportive work colleagues’. Table 4.6 provides example segments of data positioned within the coding rules for that category.

Table 4.5
Coding rules applied to the major category of
‘The importance of supportive work colleagues’

Major Category <i>The importance of supportive work colleagues</i>	CODING RULES Statement must meet one or more of the criteria below
POSITIVE	<input type="checkbox"/> Statement must clearly relate to a felt need or desire for support from colleagues in the workplace <input type="checkbox"/> Statement must clearly relate to situations in the workplace that were made easier because of actual experiences or perceptions of support from colleagues <input type="checkbox"/> Statement must indicate that support from colleagues is appreciated and valued as important in the workplace
NEGATIVE	<input type="checkbox"/> Statement must clearly relate to feelings of being stressed, disappointed, upset, or angry as a result of feeling unsupported by colleagues while at work.

Table 4.6
Segments of data positioned within coding rules for the major category
‘The importance of supportive work colleagues’

Major Category <i>The importance of supportive work colleagues</i>	PARTICIPANT RESPONSES
POSITIVE	<p><i>“...If it hadn’t been for my friends in the team, you know saying ‘We can all make mistakes, you are a good nurse’...that sort of thing...well I think I would have gone and never come back.</i></p> <p>C1: Adriana:Pg2:Ln19-21.</p>
NEGATIVE	<p><i>“... I’ve never gone home with such unsettledness as when I left nursing shifts. You know that feeling of lack of confidence and being overwhelmed... unprepared and not supported by anyone”.</i></p> <p>C2:Michelle:Pg:9:Ln32-45</p>

4.7.1.4 Reviewing the remaining un-coded text

Palmquist (2004) explains that it is sometimes necessary to alter coding rules after re-examination of ‘left-over’ text. This examination involves a deductive process of working systematically through any remaining un-coded text, looking for examples of data that might belong in each of the main categories already formulated. This process was followed in this study, but no alterations to the coding rules were necessary at this stage.

4.8 Rigour in the design and implementation of the study

Issues of rigour in the quantitative component of the study have been addressed earlier in this chapter. The actions taken to assess content validity and face validity were explained and Cronbach’s Alpha test results established the internal consistency of the modified survey tool.

Reliability of the qualitative data was enhanced through prolonged engagement with interviewees, which according to both Lincoln and Guba (1985) and Polit and Beck (2006), is important to the credibility of interview data. The interviews were not time constrained and continued until the nurses felt they had expressed all their views. Further the researcher's background in nursing helped to establish comfortable relationships with interviewees. This, together with well-developed interview skills gained through employment in the areas of mental health and bereavement counselling, facilitated the gathering of rich data. Further, qualitative data collection continued until there were no new themes emerging from the analysis, thus data saturation was achieved (MacNee, 2004).

Rigour in the interpretation of the qualitative data, and avoidance of researcher bias, were maximised through close consultation with supervisors and the use of careful data tracking techniques and diligent coding and category formulation (Roberts & Taylor, 2002). Every page of each interview transcript was numbered, and each line on the page was also numbered, therefore it is possible to locate the exact site of particular quotes. This provides an effective audit trail which enables others to be informed about the evidence upon which assertions and research findings are based (Roberts & Taylor, 2002). The use of coding rules ensured consistency in data interpretation (Busch, et al., 2005). The support of an academic nurse colleague, who helped establish the coding rules, and independently coded and categorised the content of interview transcripts, provided a degree of inter-coder reliability (Lincoln & Guba, 1985; Melynk & Fineout-Overholt, 2004; Onwuegbuzie, Jiao, & Bostick, 2004).

The methodological triangulation that occurred through combining qualitative and quantitative data collection and analysis methods facilitated cross-checking of data. Exploration of the quantitative and the qualitative data led to similar findings, which indicates increased credibility of research findings (MacNee, 2004).

4.9 Ethical considerations

Permission to conduct this research was gained from the Human Research Ethics Committees governing the two participating hospitals and Victoria University between January and June 2006 (Victoria University ethics approval reference HRETH 15/104). All of the participants received an information letter explaining the relevant study component and outlining precautions to maintain anonymity and protect confidentiality (Appendices A and D). For example, data storage, access and disposal arrangements were fully explained. Formal written consent was obtained from all participants in the qualitative component of the study and they were invited to select an interview venue that best suited their practical and privacy needs. They were informed the interview would be tape-recorded, that participation was entirely voluntary and that withdrawal from the study was an option at any stage. In the quantitative component formal consent was implied by completion and return of the survey. Those who did so were invited to participate in a draw to win a \$100 gift voucher that entitled the winner to attend any event, concert or show of their own choice in Melbourne, Victoria. Because this was a lengthy survey to complete, the Human Research Ethics Committees viewed this prize as a token of appreciation to nurses who gave their time to contribute to the study. To participate in the draw, participants were required to complete and return a tear-off slip at the end of the

survey (Appendix B: end page). Of necessity, this entailed stating personal contact details, so in order to maintain anonymity participants were advised to return it separately from the survey. In order to ensure the process of picking a winner and posting out the voucher prize was followed in an ethical manner, the draw was made by an independent person in the presence of two senior staff members at Victoria University. The voucher was posted to the winner via the mail system at Victoria University. While the risk was considered minimal, participants in both components of this study were advised that if they felt disturbed by any aspect of the research they could access staff support services, including counselling services, available to every staff member in the participating hospitals. In addition participants in the qualitative component were advised that a counsellor, independent of the hospital management system, was available to assist them, without fee, with any emotional upset resulting through participation in an interview. The availability of a free of charge consultation with a qualified private counsellor is evidenced in Appendix F.

4.10 Chapter summary

The mixed method research design selected for this study, based on Creswell's (2003) sequential explanatory model, has been explained and all methodological decisions have been justified with reference to renowned researchers in the social and behavioural sciences, including Patton (1990, 1999) and Denzin and Lincoln (1994), as well as that of more contemporary commentators on mixed research methods, such as Tashakkori and Teddlie (2003), Burke-Johnson & Onwuegbuzie (2004), Creswell (2003) and Creswell & Plano-Clark (2007). Part A of the chapter offered a comprehensive account of the quantitative component of this study,

explaining the setting, sampling procedures, preparation of the data collection instrument, the two-stage piloting process and the data analysis techniques employed. Part B explained the qualitative component, offering detailed description of the sampling and data collection processes. It included a full account of how the interview data was managed, with particular reference to data tracking techniques. It also explained every step undertaken during qualitative content analysis of the data. Key aspects of the study design that enhanced reliability and validity of findings were summarised. This chapter concluded with discussion of the ethical considerations related to both components of this mixed method research. These thorough accounts of all aspects of the research evidence the effort made to apply intellectual rigour in the implementation of the study and to provide information on which inferences about the credibility of the findings in this thesis can be based.

The following chapter presents the results from exploration of both the quantitative and the qualitative data, while discussion of the findings and their association with the relevant literature occurs in Chapter 6.

CHAPTER 5 – RESULTS

5.1 Introduction

The primary aim of this study was to explore nurses' opinions about multiple factors that impacted upon the quality of their working lives. In addition it aimed to explore if there were differences in opinion about these factors between nurses who planned to stay in the nursing profession and those who planned to leave. Both quantitative and qualitative research methods were used in this exploration. The findings generated from each of these methods are presented in Part A and Part B respectively. Results from further exploration of opinions about particular aspects of employment, prompted by the qualitative findings, are presented in Part C of the chapter. Analytical comment and discussion relating to the findings follows in Chapter 6.

The quantitative data was gathered via a survey of Registered Nurses (RNs), while the qualitative data was generated from the open survey questions and the semi-structured interviews. To strengthen clarity of findings, the qualitative results are frequently provided in conjunction with numerical data.

PART A

5.2 Results from the quantitative component of the study

Part A of this chapter first presents the demographic profile of the study participants and their opinions about the quality of their working life. Then, a demographic profile comparison of participants, according to their career intentions, is provided. The next section presents the results that reveal differences in opinion about quality of working life between participants planning to stay and those planning to leave nursing. The final section in Part A of this chapter presents the results of exploration of the relationships between selected key factors that impact upon quality of working life. When presenting quantitative findings the abbreviation M is used when referring to the mean score.

5.2.1 The demographic profile of survey participants

Of a sample of 840 RNs, 348 returned completed surveys, yielding a response rate of 41%. The participants' demographic information is summarized in Tables 5.1 to 5.6. Results revealed that the majority of participants (93.1%) were female and most (68.4%) worked part-time. The average age was approximately 40 years ($M=39.7 \pm 10.1$ SD), ranging from 21 to 65 years. More than half of the participants were aged 40 years or older (Table 5.1) and more than half worked in medical/surgical wards (Table 5.6).

Table 5.1
Age of participants

Age	N	%
20 - 29 years	72	20.9
30– 39 years	92	26.7
40 – 49 years	114	33.2
50 or more years	66	19.2

The majority (78.4%) had an Australian family background (Table 5.2).

Table 5.2
Family background of participants

Family background	N	%
Australian	273	78.4
Oceanic	2	0.6
UK and Eire	26	7.5
European	38	10.9
North/South America	3	0.9
Asian	4	1.1
Missing data	2	0.6

The results also demonstrated that approximately a third (37.7%) of the participants held post graduate qualifications (Table 5.3).

Table 5.3
Educational level of participants

Educational level	N	%
Hospital Certificate	77	22.1
Bachelor Degree	140	40.2
Post-graduate qualifications	131	37.7

The majority (67.5%) had been working as RNs for 10 or more years (Table 5.4).

Table 5.4
Participants' years of experience as an RN

RN Experience	N	%
2 years or less	26	7.5
2 - < 5 years	29	8.3
5 - < 10 years	58	16.7
10 or more years	233	67.5

Almost a third (29.3%) had been with their current employer for 10 years or more (Table 5.5).

Table 5.5
Participants' years of tenure with current employer

Tenure	N	%
< 2 years	61	17.5
2 - < 5 years	83	23.9
5 - < 10 years	99	28.4
10 years or more	102	29.3
Missing data	3	0.9

Approximately half of the participants (53.2%) worked predominantly in medical or surgical units (Table 5.6).

Table 5.6
Participants' main area of work

Area of work	N	%
Medical/Surgical	185	53.2
Peri-operative [†]	51	14.7
Accident & Emergency	45	12.9
Critical care	41	11.7
Coronary care	26	7.5

[†] Peri-operative nursing is defined in chapter 1.

5.2.2 Participants' opinions about the quality of their working life

Participants were asked for their opinions about multiple aspects of their employment that affect quality of working life. As shown in Table 5.7, the participants felt positive about most aspects of their work but held a negative view of their 'pay and benefits' and 'stress and work pressure'. They felt generally positive about their overall quality of working life.

Table 5.7
Participants' opinions about the quality of their working life

Variable	N[†]	Mean	SD	Min.	Max.
Pay & benefits	348	2.7	0.81	1.0	5.0
Stress & work pressure	348	2.9	0.78	1.0	4.9
Performance & appraisal	347	3.2	0.97	1.0	5.0
Communication	347	3.2	0.67	1.0	4.7
Professional development	347	3.3	0.79	1.0	5.0
Health & safety	348	3.4	0.63	1.5	4.8
Management	347	3.5	0.81	1.0	5.0
Equal opportunities	346	3.5	0.49	1.9	4.9
Job satisfaction	348	3.8	0.64	1.1	5.0
Colleagues	347	3.9	0.52	1.7	5.0
OVERALL QWL	345	3.4	0.40	2.1	4.4

Measured on a scale from 1 'strongly negative view' to 5 'strongly positive view' with 3 being the neutral point. A mean between 2 - < 3 represents a negative view.

A mean between > 3 - 4 represents a positive view.

[†]Variation in number of participants is due to missing data.

'Pay and benefits' (M=2.7) and 'stress and work pressure' (M=2.9) were the two aspects of work rated least favourably, while 'job satisfaction' (M=3.8) and 'colleagues' (M=3.9) were the two elements rated most positively.

5.2.3 Demographic profile comparison of participants according to their career intentions

According to their future career plans, two groups of nurses were identified, those planning to stay in nursing (n=302) and those planning to leave their profession (n=46). Non-parametric Chi-square tests were conducted to determine if the demographic profiles of the two groups differed. No statistically significant differences between the two groups were detected in relation to any of the demographic variables: gender; age; family background; qualifications; years of experience as an RN; mode of employment; years of tenure at current hospital; or area of work (Table 5.8).

Table 5.8
Demographic profile comparison of participants by their career intentions

Variable	Total N[†]	Plan to stay N (%)	Plan to leave N (%)	χ^2	p	df
Gender	348			0.69	0.41	1
Female		283 (93.7)	41 (89.1)			
Male		19 (6.3)	5 (10.9)			
Age (range 21-65 yrs)	344			2.10	0.15	1
< 40 yrs		137 (46.0)	27 (58.7)			
40 yrs or older		161 (54.0)	19 (41.3)			
Family background	346			0.49	0.49	1
Australian		239 (79.7)	34 (73.9)			
Non-Australian		61 (20.3)	12 (26.1)			
Qualifications	348			1.45	0.48	2
Hospital cert.		68 (22.5)	9 (19.6)			
Bachelor degree		124 (41.1)	16 (34.8)			
Post Grad Cert. or higher		110 (36.4)	21 (45.6)			
Years RN experience (range 1-42 yrs)	346			0.03	0.99	2
< 5 yrs		48 (16.0)	7 (15.2)			
5 - < 10 yrs		50 (16.7)	8 (17.4)			
10 or more yrs		202 (67.3)	31 (67.4)			
Employment mode	346			0.00	0.96	1
Full time		93 (31.0)	15 (32.6)			
Part time		207 (69.0)	31 (67.4)			
Tenure (range 6 months - 33 yrs)	345			0.31	0.86	2
< 5 yrs		124 (41.5)	20 (43.5)			
5 - < 10 yrs		85 (28.4)	14 (30.4)			
10 or more years		90 (30.1)	12 (26.1)			
Area of work	348			0.09	0.76	1
Med/surg units		162 (53.6)	23 (50.0)			
^{††} High intensity care		140 (46.4)	23 (50.0)			

[†]Variation in number of participants is due to missing data.

^{††}High intensity care = critical/coronary care, peri-operative and accident and emergency departments.

5.2.4 Differences in opinions between participants planning to stay and those planning to leave nursing

After confirming that the demographic characteristics of the groups of participants planning to stay and planning to leave nursing were comparable, Mann-Whitney U tests were undertaken to explore whether or not there were statistically significant differences between these two groups in relation to their opinions about the quality of their working lives.

As shown in Table 5.9, with the exception of opinions about ‘communication’, there were statistically significant differences between the two groups in relation to their views about all aspects of employment affecting their quality of working life. There was also a statistically significant difference between groups in opinions about overall quality of working life. In each case other than communication, the group planning to stay recorded a statistically significantly higher median score than the group planning to leave (Median =182.79 vs Median 109.38, $p=0.000$).

Table 5.9
Differences in opinions between participants planning to stay and leave nursing

Core Constituent	Stay M (SD)	Stay Median	Leave M (SD)	Leave Median	p value
Pay & benefits	2.8 (0.77)	180.9	2.3 (0.97)	128.7	*0.00
Stress/pressure	2.9 (0.79)	181.2	2.6 (0.69)	130.3	*0.00
Perf. & appraisal	3.2 (0.97)	179.1	2.8 (0.94)	140.7	*0.01
Health & safety	3.4 (0.60)	184.1	2.9 (0.66)	111.7	*0.00
Communication	3.2 (0.66)	177.0	3.0 (0.71)	154.1	0.14
Management	3.6 (0.80)	183.7	3.0 (0.70)	110.4	*0.00
Prof. development	3.4 (0.78)	178.6	3.0 (0.85)	143.8	*0.03
Equal opportunities	3.7 (0.49)	178.1	3.4 (0.52)	143.7	*0.03
Job satisfaction	3.9 (0.58)	182.2	3.4 (0.89)	124.0	*0.00
Colleagues	3.9 (0.51)	180.8	3.6 (0.52)	129.7	*0.00
OVERALL QWL	3.4 (0.39)	182.8	3.0 (0.42)	109.4	*0.00

Measured on a scale from 1 'strongly negative view' to 5 'strongly positive view' with 3 being the neutral point. A mean between 2 - < 3 represents a negative view. A mean between > 3 - 4 represents a positive view.

The group planning to stay viewed all individual aspects of work more favourably than did the group planning to leave, but the group planning to leave rated only three aspects of their work positively, whereas the group planning to stay held a positive view of eight aspects of their work. Of the ten core constituents of work life, 'pay and benefits' and 'stress and work pressure' were the two consistently rated lowest, reflecting that these were the two areas of work commonly viewed least favourably by both groups. 'Colleagues', 'job satisfaction' and 'equal opportunities' were the three aspects of work rated highest by both groups, and therefore consistently perceived most positively. 'Management' was the aspect of work where difference in opinion between the two groups was greatest (difference between means = 0.6).

The group planning to continue a career in nursing held a positive view of the overall quality of their working life, whereas the group planning to leave felt neutral about the overall quality of their working life.

5.2.5 Relationships between selected key elements of QWL

Using Spearman's rank correlation (Spearman's rho), possible relationships between selected core constituents of quality of working life were explored. Results revealed that the perception of 'management' was positively associated with participants' views on 'health and safety' ($r=0.50, p=0.00$), 'professional development' ($r=0.52, p=0.00$) and 'performance and appraisal' ($r=0.62, p=0.00$). A positive relationship was also exhibited between 'health and safety' and 'communication' ($r=0.54, p=0.00$), while a similar level of association was noticed between opinions about 'equal opportunities' and 'professional development' ($r=0.54, p=0.00$).

The following section, Part B of the chapter, provides results from the qualitative data.

PART B

5.3 Results from the qualitative component of the study

As explained previously, there were two sources of qualitative data, the open survey questions and the transcribed interviews. First, the results from the open question data are presented. These sought to determine the participants' main reasons for either planning to stay or planning to leave nursing. This is followed by presentation of the findings from the interview data.

The responses to the open survey questions were placed into thematic categories according to the explicit, obvious meanings in the text. Then responses within each of the categories were counted numerically. The results that indicate the reasons for participants either planning to stay or planning to leave nursing are provided in table format, with a single quotation from the transcribed interviews being provided to illustrate each thematic category.

5.3.1 Main reasons for planning to stay in nursing

Almost all (99%) of the participants who planned to stay in nursing answered the question: "If planning to continue a career in nursing what are your main reasons for choosing to stay?" On average, each participant provided two or three reasons for this choice. As shown in Table 5.10, intrinsic rewards gained from the nature of nursing work was the most commonly cited reason for staying. The second most commonly cited reason related to having supportive work colleagues. This was followed, in decreasing order of prevalence, by the other three categories: an

effective unit manager; work/family fit; and too hard to change career. Perceptions of having no choice but to stay in nursing were generally associated with comments about it being too difficult to make a career change due either to family circumstances, or the cost and effort involved in gaining the necessary qualifications to change career.

Table 5.10 Main reasons for planning to stay in nursing
(n=302, average of 2-3 reasons per participant)

Reasons for planning to stay in nursing	Frequency	Examples from the text
Intrinsic rewards	272 (91%)	<i>“I enjoy it, I get great satisfaction from making a difference in someone’s recovery to good health.” (ID:338)</i>
Supportive colleagues	105 (35%)	<i>“The staff I work with are not just colleagues but friends and we are a well-oiled team.” (ID:110)</i>
An effective unit manager	97 (32%)	<i>“We cope because we all help each other and that comes from the NUM, she fosters the good team spirit.” (ID:174)</i>
Work/family fit	83 (27%)	<i>“The flexibility nursing provides is great when you have a young family.” (ID:331)</i>
Too hard to change career	51 (17%)	<i>“I am disappointed with nursing, I would like to try something else but I have spent so much money on my degree I have to stick with it.” (ID:102)</i>

5.3.2 Main reasons for planning to leave nursing

All of the participants planning to leave responded to the question: “If planning a career change, what are your main reasons for leaving the nursing profession?” On average, each of the participants provided between three and four reasons for their decision to embark on a career change. Stress and work pressure was the most commonly cited reason, followed by work/family conflict, dissatisfaction with pay,

having an ineffective unit manager, lack of a career pathway and bullying and harassment (Table 5.11).

Table 5.11 Main reasons for planning to leave nursing
(n=46, average of 2-3 reasons per participant)

Reasons for planning to leave nursing	Frequency	Examples from the text
Stress & work pressure	43 (93%)	<i>“A once great and satisfying job has become unrewarding and too demanding.” (ID:92)</i>
Dissatisfaction with pay	39 (85%)	<i>“We don’t get paid enough for the stress and work we do.” (ID:346)</i>
Work/family conflict	36 (78%)	<i>“I have burnt out due to shift work especially enforced night shift ...too tough on me and my family.” (ID:342)</i>
An ineffective unit manager	24 (52%)	<i>... “the final straw a unit manager with less experience than me telling me how to do my job and not even making sure we have the equipment and resources to do it”. (ID:211)</i>
Lack of a Career Pathway	9 (20%)	<i>“...more responsibility comes with post grad specialties, but virtually no chance of moving up the career ladder goes with that.” (ID:284)</i>
Bullying and harassment	5 (11%)	<i>“there is serious horizontal violence and cattiness in nursing, lateral bullying that goes on and I’m completely sick of dealing with it.” (ID:208)</i>

5.3.3 Extended exploration of the open question data

There was a great variation in the length of responses to the open questions. Some participants commented briefly and simply, but most wrote extensively. This resulted in an unpredicted large volume of textual data. Both sets of responses included a mixture of negative and positive comments about nursing work, regardless of future career plans. For example, in addition to stating why they planned to stay, many participants also wrote comments to express their feelings about factors that troubled

them about nursing. Similarly, while those planning to leave wrote extensively on worrying factors, many also included comments which expressed their enjoyment of nursing. While the volume of data was not anticipated, it provided an unexpected level of information about nurses' quality of working life. This prompted the researcher, in an effort to ensure completeness, to explore the open question data in its entirety, as a unified data set. This resulted in the identification of two additional thematic categories:

- A rewarding career with adverse conditions
- feelings of grievance

5.3.3.1 A rewarding career with adverse conditions

The majority (90%) of the participants found nursing work inherently rewarding, as suggested by words and phrases such as passion for nursing, enjoyment/love of nursing, and satisfaction. But contradicting these positive views, over three-quarters (77%) expressed concerns about working conditions as suggested by words such as hard, heavy, draining, demanding, constant pressure, exhausting and debilitating. The following responses describe how the participants felt about nursing as a rewarding and satisfying career, but how also, the pressure of the work had a negative impact:

I stay because I love nursing and I know that no other job will give me the rewards that nursing does but it has a very high toll on the mind and body. (ID:154)

I like nursing it is very satisfying work but I am terribly unhappy with how hard nursing is now and have to get out for my own mental health. (ID:175)

Fifteen per cent of the participants indicated that they were concerned about having the stamina to stay in nursing as they grew older. For example, “*The pressure and the shift work is not something I could sustain in later working life, it is too physically detrimental (ID:327) and “Nursing is very rewarding, but it is for the young, I am only 42 but I am already exhausted by it” (ID:39)*. A small number of participants (5%) indicated they felt they only had enough energy to stay in nursing because they were employed in a part-time capacity. For example: “*I can be energetic and enthusiastic in my part time role but I don’t have the stamina for full-time” (ID:44)*. Almost three quarters (68%) of the participants worked part-time and a small number of these (5%) indicated work pressure was a reason for choosing to do so.

5.3.3.2 Feelings of grievance

Almost a third (30%) of the participants used words such as unfair, frustrated, dispirited, angry, resentful and bitter when they referred to their working conditions. As depicted in the following two comments, the impact of work pressure on personal wellbeing was a primary source of the grievance:

It makes me b----y [expletive]angry that nurses are constantly expected to work above and beyond what is [sic] reasonable limits

with less and less resources.... it's because nurses are shattered that they are leaving and management doesn't seem to get that!

(ID:160)

I feel mentally and physically drained most of the time ... I feel resentful that I have trained for something I like but can no longer do because I do not want to live my life feeling like this. (ID:340)

Feelings of grievance also stemmed from participants' concerns about the ability to provide the type and quality of patient care consistent with professional standards. The following statements illustrate the extent of unease about this situation:

It is frustrating that you are so b----y [expletive] busy you cannot give the quality of care you are trained to give... patients are suffering nurses are upset and no-one seems to care. (ID:121)

It is unfair that nurses are put in a position where they cannot give the level of care they should be able to give and feel guilty about leaving because that makes it even worse for patients. (ID:92)

Participants also appeared to feel aggrieved about an imbalance between the extrinsic rewards they received for their work compared to the extent of their efforts. For example: “Nurses are like slaves in the hospital system, overworked underpaid, undervalued” (ID:98), and “Overwork for poor income, lack of opportunities for

career advancement, all take and not enough returns for what nurses are worth.”

(ID:294)

Notably, while almost a third (30%) of the participants appeared to feel aggrieved that they were being treated unjustly, particularly in relation to pay and work demands, only 13% indicated they were planning to leave the profession.

5.4 Brief summary of results from the open question data

In summary, results from the open question data indicate that the main reasons the participants chose to continue working as a nurse were the intrinsic rewards that provided feelings of satisfaction, working alongside supportive colleagues, having an effective unit manager, having an acceptable work/life fit, and perceiving they had no alternative. The main reasons given for planning to leave the profession were stress and work pressure, work/life conflict, being dissatisfied with pay, an ineffective unit manager and lack of a career pathway. Nearly all (90%) of the participants reported enjoying rewards inherent in nursing work. However, over three quarters (77%) of all participants were concerned about the impact of demanding workloads, almost a third (30%) reported feelings of grievance about being treated unjustly, and almost a third reported they either planned to leave within the next two years (13%) or were only staying in nursing because it was too hard to do anything else (17%).

5.5 The interviews

Fifteen semi-structured interviews were conducted to deepen understanding, gained from the survey data, about how nurses viewed the quality of their working lives and also to deepen understanding about what they valued and needed from their work, and the factors in the workplace that impacted upon their plans to stay or leave nursing.

5.5.1 The interviewees

All of the 15 interviewees were female and aged between 23 and 39 years. Twelve were from an Australian family background, two were from a European, and one was from a Middle Eastern family background. They had between one and eleven years of nursing experience and an average tenure of four years. Four had commenced their nurse education as school-leavers, eleven had entered as mature age students. Fourteen held a Bachelor of Nursing degree, one held a Master of Nursing degree. Five had left nursing within twelve months prior to the interview in order to undertake a career change. Their new career paths included podiatry, law, accountancy, local government and work as a sales representative. All of the interviewees worked mainly in a general medical/surgical unit (11), a peri-operative area (2), or an accident and emergency department (2). Of the ten who were currently employed as nurses, six planned to stay in nursing for at least the next two years and four planned a career change within the next two years.

5.6 Results from the interview data

Examination of the interview data involved exploration of both the explicit, and the less obvious implicit, meanings embedded within the transcribed texts. This resulted in the identification of four thematic categories: an intrinsically rewarding but arduous profession; the importance of supportive collegiality; the importance of the unit manager; and a sense of injustice. These are discussed in turn and illustrated with quotations from the transcribed interview data.

5.6.1 An intrinsically rewarding but arduous profession

In parallel with the findings from the open question survey data, results from the interview data illustrated that all of the interviewees experienced tension between job satisfaction associated with intrinsic rewards and a degree of work pressure they considered beyond reasonable. Their stories provided a vivid picture of how the job satisfaction they gained from the nature of the work fostered a desire to stay in the profession but also how the toll of heavy workloads exerted pressure to leave. The following comment by one of the interviewees clearly depicts the extent of tension between a positive view of nursing as a profession and a negative view of working conditions:

Nursing is a great profession but do you know why I would leave tomorrow if I could? Shifts like last night that's why...could not get a replacement for a sick staff member could not get a nurse to special the acutely confused patient new patients kept rolling

through the door when you ask for help, management says bad luck just deal with it. C1:Greta:Pg16:Ln12-15

What was particularly illuminating was the way interviewees emphasised the emotional strain of nursing work as much as the physical strain. Comments about the emotional intensity of the work included the following:

The work is very tiring physically but it's the emotional stuff that gets overwhelming...like when patients get a bad diagnosis or they die....many times I've gone home and thought I really don't want to do this anymore...but then it's that knowledge that you have helped them and their relatives at their most vulnerable time ... so satisfying and where else do you get the kind of gratitude that goes with that? C1:Dawn:Pg:2:Ln31-35

....dealing with people's grief, people dying that was a factor for me changing profession because it wears you out I think.you don't have time to deal with the feelings you're just left to cope with it, you're a nurse, you just keep on going...maybe I should have gone to someone to discuss those things, but there's no time allowed for that, and when you finish your shift you're so tired you just want to go home. C2:Teresa:Pg2:Ln18-22

Apparent in the interview data, and commensurate with the results from the open question survey data, were the strong feelings of regret held by all of those who were planning to leave nursing, or had already made a career change, For example:

It is interesting work, and gives huge satisfaction from knowing you give good care... so I am a nurse, it is part of who I am and leaving will be a huge wrench. C1:Julie:Pg3:Ln16-17

What has always appealed is feeling useful, doing something useful and important, but in the end it just got too hard and actually it was sad for me to leave...I think I will probably always miss that caring side of it. C2:Teresa:Pg1:Ln4-7

5.6.2 The importance of supportive work colleagues

All interviewees indicated that friendly and supportive work colleagues were essential to the quality of their working lives and made heavy workloads more tolerable. For example, “*We are like a happy, well-connected family and very supportive to each other... you can’t survive in this job without that.*” (C1:Mia:Pg2:Ln31-32) and “*The team I work with are good at giving credit when it’s due and so you go home feeling good about the day no matter how busy*” (C1:Adrianna:Pg4:Ln6-7). This reinforced findings from the open question survey data which showed that having supportive work colleagues was the second most influential factor in participants choosing to stay in nursing. On the other hand, having unfriendly and unsupportive work colleagues was revealed by five

interviewees as having a direct influence on their thoughts about leaving the profession. For example:

Everyone is so bitchy and so cliquey and I think if you knew how it was beforehand I don't think you would actually go into it [nursing]. To be around that day in and day out well it's really, really hard, it's too hard...I'm looking at other hospitals but I'm thinking outside of nursing too. C1:Kathy:Pg:5:Ln21-24

Four of the interviewees told of their personal experiences of being bullied by work colleagues. One described her experience as follows:

...standing over me watching and criticising until I was so nervous it was terrible, I had a horrible time, by the end of my time there I was a mess, I couldn't think, I couldn't sleep, I hated every minute of it. I seriously thought about getting out of nursing then. C1:Kahlia:Pg10:Ln9-12

While four interviewees had personal experience of being bullied, all fifteen were aware of bullying that occurred in their workplace. All spoke of nurses who had a reputation for bullying behaviour which, in spite of protective policies, continued over time. They blamed continuing bullying behaviour in the workplace on the reluctance of some individuals to make an official complaint and on ineffective management strategies.

5.6.3 The importance of the unit manager

During conversations about management, interviewees reflected on relationships with their past and current unit managers. Closely echoing findings from the open question data, their personal stories illustrated how the skills and attributes of individual unit managers were crucial to the quality of their working lives. Relationships with their unit managers affected their general wellbeing at work, the quality of their work/life fit and influenced whether or not they felt valued as ‘good nurses’.

5.6.3.1 The unit manager and general wellbeing

In the case of four of the interviewees, working with an effective unit manager promoted a sense of wellbeing at work. For example:

She is so experienced, so good in a crisis, like when there's an arrest she calmly directs the team, a really good leader working with her is a buzz. C1:Sandy:Pg5:Ln27-28

My NUM [nursing unit manager] is great ... if we get behind she gets in and helps and what she's taught me is huge.. because of her we are an ace team and even though it is always busy that makes work fantastic. C1:Adrianna:Pg:7:Ln3-5

In contrast, for five interviewees, relationships with unit managers were perceived negatively and were influential in their decisions to leave the profession. Their comments included the following:

...the whole feel of the place was influenced by the NUM [nursing unit manager]. I felt she was quite interesting in that she would play staff off against each other and she was kind of very harsh. She wasn't very warm and inviting in terms of support. I think I was very put off by her. When I left I was bitter. I thought I don't need this, to work under these conditions in such an unsupportive environment. C2:Michelle:Pg7:Ln30-35

...she was horrible to me, every opportunity snide comments like 'How does the uni let people like you get through?' that sort of thing, and in front of other people, she just didn't like me and she made my life a misery. Not many things make me cry but she often got me dissolved into tears. I was totally demoralised by the time I left. C2:Laura:Pg3:Ln29-33

5.6.3.2 The unit manager and work/life fit

All interviewees agreed that having an acceptable work/life fit was important to whether or not they would remain in the nursing profession. Similarly to the findings of the open question survey data, most of the interviewees commented about high work demands that left them with a lack of energy to apply to the other aspects of their lives. In spite of this, the interview data revealed that a family friendly roster was the most important factor in achieving an acceptable work/life fit, and that staff rosters were under the control of unit managers. All agreed that, in many cases, the

type of roster administered was dependent on the quality of the relationship between the individual nurse and the unit manager. One interviewee stated:

I have a pretty good work/life balance but that's only because I get on well with the NUM ... she gives me the same roster all the time because she knows it fits with my partner's work hours.

C1:Sandy:Pg3:Ln7-9

All interviewees held the opinion that while some unit managers acted fairly, others were discriminatory in administering rosters, which directly resulted in work/life conflict. Two interviewees explained their unit manager's discriminatory behaviour as follows:

I've had enough of shift work and lousy rosters... I missed my daughter's school concert because I did not get the shift I requested... she [unit manager] doesn't like me so others tend to get their requests but I don't. **C1:Kathy:Pg17:Ln8-10**

The rostering was very unfair, the unit manager had her favourites. I wasn't in favour so I worked far more evenings and weekends than the rest and I got more on-call....I got terrible rosters so not much of a social life. **C2:Michelle:Pg9:Ln22-23**

5.6.3.3 The unit manager and feeling valued as a good nurse

All interviewees said they liked to know that they were valued as a 'good nurse' by their unit managers. Yet, only three had received formal feedback about their performance in the six months prior to the interview. Feeling valued by the unit manager was mainly dependent on informal feedback. For example, one interviewee explained how the unit manager's informal feedback impacted positively on her feelings of professional worth:

What I like where I am now is that I feel like a valued part of a team and a lot of that's down to the NUM. It's the little things, like she thanks us for our hard work at the end of the shift, once after a really bad stretch she brought in a cake for us as a thank you ... it's the hardest unit in the place but the staff stay, so I'd say its feeling we are valued that keeps us all there.

C1:Adrianna:Pg9:Ln2-5

Most of the interviewees felt they received inadequate or no feedback about their efforts and this made them feel undervalued. For example:

...you don't get feedback unless you do something wrong you are noticed then, otherwise you are just one of the many running around at a thousand miles an hour trying to keep up...not even a thank-you when you stay late to get it all done ...I have been giving it my all for months and she still doesn't get my name

right... that tells you something about how I am valued.

C1:Kathy:Pg10:Ln1-5

The following comments are examples of how the lack of any performance appraisal from the unit manager was directly involved in the decisions of interviewees to leave nursing:

When I was leaving the NUM did say to me “this has been a very tough, incredibly busy time to have come into this unit and you have coped well”. I had been thinking I wasn’t quick enough, not cutting the mustard, never going to be good enough, so perhaps if she had told me that earlier, even just one pat on the back, perhaps I wouldn’t have left. C2:Isabel:Pg7:Ln14-18

I won’t stay in a job if my contributions are not valued and you don’t get that in nursing....it wasn’t until I was about to leave that I got any positive feedback but it was too late. I was at the stage where I had already made my decision and by then it wasn’t going to make me change my mind. C2:Nina:Pg10:Ln28-32

5.6.4 A sense of injustice

‘A sense of injustice’ was the final thematic category. This is an overarching theme because it encompasses the interviewees’ feelings of grievance about multiple sources of injustice. All interviewees felt aggrieved about multiple aspects of their

working conditions, and particularly about how hard they worked in relation to their level of pay. They reflected their sense of injustice through the use of words such as unfair, resentful, angry and bitter. Consistently with the open question survey data, the sources of the sense of injustice included the impact of work pressure on personal wellbeing and the limitations this caused in the way they were able to care for patients. Similarly, it also arose from the view that they were not fairly rewarded in relation to their efforts, skills and knowledge. Feelings of grievance were also associated with opinions about an ineffective response of hospital management to threats of violence and aggression directed towards them from the public. This contributed to a sense of injustice stemming from feelings of their importance as workers being generally undervalued by others in the health care system.

5.6.4.1 Grievance related to work pressure

All interviewees felt aggrieved that there were often times when the pressure of work impacted negatively on their physical and mental wellbeing. One portrayed her experience as follows:

Sometimes it is so short staffed its scary.... its incredibly stressful...I feel like I get thrown in time after time to sink or swim. So far I have managed to swim but I am waiting for the day I am going to sink and I don't want that to happen... you know it's not that hard to kill people in this job...after the costs of study to get here I am seriously p----d off about being in this position.

C1:Greta:Pg9:Ln29-34

All interviewees indicated there were times when work pressure limited their ability to practice the art of nursing in the manner they felt was the appropriate professional standard. The following statement reflects the feelings of resentment that were apparent:

It is so busy it is hard to connect with patients, it's impersonal much of the time so it's not what I was taught nursing would be about... on bad days I feel quite bitter about it.

C1:Carol:Pg14:Ln:17-19

Consistent with the survey data, all of the interviewees indicated that, at least some of the time, high workloads created a less than desired quality of patient care. This was an affront to their moral and ethical code of practice. For example:

...sometimes it is so heavy I cannot give my patients the full care I would like to give ... it is very unfair on nurses and patients ... so morally wrong... there are many days now when I go home thinking it is not how nursing should be and it isn't worth it.

C1:Dawn:Pg1:Ln20-23

The system is geared to quantity but not quality of care I don't have time to give the care that I want to give.... as a good nurse with a strong work ethic I feel incensed that I am being forced into leaving a job I thought was for life. C1:Julie:Pg4:Ln3-5

5.6.4.2 Grievance related to reward/effort imbalance

All interviewees were of the opinion they were not adequately rewarded financially. They also felt negatively about non-financial rewards such as support for professional development and career advancement on completing postgraduate studies. All felt their pay was not commensurate with the stress and degree of responsibility associated with nursing work and not equitable when compared with other types of work. One interviewee summed up this view succinctly:

I have a friend who artificially inseminates cows and makes a lot more money than I do. After years of nursing experience, a degree and all the stress and responsibility what is that about?

C1: Jenny:Pg11:Ln22-23

All of the interviewees agreed that non-financial rewards were rare in nursing. For example, while one felt positive about the support for professional development she had received, generally this type of support was perceived as very limited. As one interviewee explained:

I was one of very few given time allowance to do a course but what happened was that people were off sick and then I was told by the NUM that the department was too busy to spare me and so I missed several sessions, I thought that sucked... you give your all and you put up with an incredible amount of crap and they can't

even give you a couple of hours for just a few weeks.

C2:Nina:Pg3:Ln36-41

Reward for the effort of undertaking post graduate education was perceived as practically non-existent. Another interviewee summed up the situation with the following observation:

While the hospitals say they support further study, it is always the nurse that puts in with nothing being given back. The costs of my study and the time taken out of my family life are huge but further education does not lead to financial remuneration or acknowledged career paths. **C1:Carol:Pg6:Ln1-4**

5.6.4.3 Grievance related to workplace safety

Most of the interviewees spoke about feeling vulnerable at work due to a threat from an increasing amount of aggression. They all indicated they had experienced some form of aggression from the public at least once within the previous six months. This came either from patients or their friends and relatives. All agreed the incidences of aggression were related mainly to a frustration among members of the public with the lack of resources in the healthcare system. For example:

...he had to go home because his surgery had been cancelled again and he just lost it, he was shouting at me, he smashed a

vase, and he thumped the door on his way out, it was seriously scary. C1:Sandy:Pg11:Ln8-10

His dad was uncomfortable and he wanted me to get him up [out of bed] but I couldn't because our lifter [lifting machine] was broken ... I said I would get him up as soon as the lifter on the other unit was free but he [the son] shouted at me "you ---ing do it now". I suppose he had a right to be angry, his dad shouldn't have had to wait, but nurses have rights too and he had no right to shout at me. C1:Mia:Pg10:Ln16-20

A view that came to light in the interview data was that all interviewees held the view that senior management failed to acknowledge the professional worth of nurses. They perceived that the failure of management to respond adequately to protect them from the threat of workplace aggression was indicative of the general lack of respect they held for the nursing staff. For example:

Nurses struggle to get their work done with minimal support from management... even when we are being screamed at by members of the general public they don't come near, we are not considered important enough.... the system is wearing nurses down and they do nothing. C1:Greta:Pg11:Ln13-16

Patients are getting more aggressive, and nurses are expected to be able to be abused, assaulted and hurt in their job without complaint...you work hard and they cannot even be bothered to protect you...typical of how they see nurses....we are seen as numbers not valued health professionals.

C1:Jenny:Pg5:Ln17-20

Additionally, what emerged from conversations about dealing with this sort of abuse, was the view that it was something the interviewees generally felt ill-prepared to deal with. One felt that her nursing education had provided her with the necessary conflict management skills, but this was not so for any of the others. As one interviewee explained: *“When I came into nursing I expected to get thanks not to get abused by patients, it is something I was totally unprepared for...the uni [university] needs to do better in preparing nurses for the real world.”* (C1:Greta:Pg 11:Ln24-26)

5.6.4.4 Grievance related to feeling undervalued as a health professional

As indicted in the previous section, interviewees felt the lack of concern for their safety reflected how they were undervalued by senior management. Likewise, feelings of being undervalued were evident in some earlier statements about unit managers. Further comments reflect an inherent sense of injustice about how the interviewees believed they were perceived and treated more generally. For example:

Never enough equipment, not enough staff, not even a decent place for meal breaks, you can complain but nothing changes...it all

reflects the way nurses are so badly undervalued in the healthcare system. (C1:Carol:Pg11:Ln18-20)

For all five of the interviewees who had left the profession, feeling undervalued had contributed to their decision to leave. For example:

...nurses are not highly regarded by other health professionals, not by the hierarchy or anyone within hospitals but when your own unit manager shows you no respect after nearly ten years of nursing experience it is time to get out. C2:Isabel:Pg2:Ln12-15

... nursing destroys your soul it's that lack of acknowledgement, no one values what you do and no one cares if you go under. C2:Nina:Pg4:Ln:8-9

PART C

5.7 Further exploration prompted by qualitative results

Additional examination of the quantitative data was necessary in order to assess for similarities to the qualitative results in relation to the following topics: work/family fit; the quality and availability of resources nurses' need to do their work; bullying and harassment; and doctor/nurse relationships. Survey participants' opinions about these matters were not clearly evident from the initial analysis of the quantitative data.

5.7.1 Further exploration related to work/family fit

Exploration of the open question survey data showed work/family fit to be important to the interviewees' quality of working life, and to decisions to stay or leave nursing. This finding was supported by the interview data. Further, the interview data showed that achieving an acceptable work/family fit was dependent on the support of unit managers because they were responsible for rostering nurses' work hours. Almost half of the interviewees did not feel they had this support. As views about unit manager support for achieving a work/life fit were not evident in the initial exploration of the quantitative data, the researcher examined the responses to one survey item specific to the topic: 'my unit manager is sensitive to my work/life issues'. Although the participants generally agreed that their unit managers were sensitive to their work/life issues ($M=3.6 \pm 0.95$ SD, $n=348$), the Mann Whitney U test revealed a statistically significant difference between the groups planning to stay and leave nursing in relation to opinions about unit manager sensitivity to their

work/life issues (Median= 182.34 vs Median=119.43, $p=0.00$), and while the nurses planning to stay agreed that their unit managers were sensitive to their work/life issues, those planning to leave did not.

In order to further assess for compatibility between the qualitative and quantitative findings in relation to opinions about support for achieving a work/family fit, five items highly specific to the topic were selected from these two different sections of the survey, 'management' and 'equal opportunities'. The following items were combined to form a new 'work/family fit' scale:

- My unit manager is sensitive to my work life issues
- This hospital actively promotes flexible working arrangements for staff
- This hospital provides good support for staff with family responsibilities
- This hospital is a family friendly employer
- Requests to change work patterns are received positively here

According to the mean scores for this scale, it was found that survey participants generally felt positive about support from their employers in achieving an acceptable work/family fit ($M=3.3 \pm 0.70$ SD, $n=348$). However, a Mann Whitney U test revealed a statistically significant difference in opinion between the nurses planning to stay and those planning to leave their profession in relation to the extent of this support (Median=179.2 vs Median=135.1, $p=0.00$). This appears compatible with qualitative results that revealed having an acceptable work/family fit to be a main

reason for choosing to stay in nursing and work/family conflict to be a main reason for planning a career change.

5.7.2 Further exploration related to views about resources

Findings from exploration of the qualitative data identified that some participants were experiencing difficulties regarding the quality and availability of essential resources needed to carry out their work. The quantitative data was therefore evaluated further in an effort to ascertain if this was a problem experienced widely. Responses to two survey items on the health and safety scale, specific to this topic, were examined. As indicated in Table 5.12, participants felt generally satisfied with both the quality (M=3.3) and the availability of supplies and equipment (M=3.2).

Table 5.12
Participants' opinions about the quality and availability of resources

Variable	N	Mean	SD	Min.	Max.
The quality of the equipment you use in your job	348	3.3	1.02	1	5
The availability of supplies and equipment you use in your job	348	3.2	1.07	1	5

Measured on a scale from 1 'strongly dissatisfied' to 5 'strongly satisfied' with 3 being the neutral point. A mean between > 3 – 4 = satisfied.

However, Mann-Whitney U tests revealed a statistically significant difference in satisfaction with both quality and availability of supplies and equipment between those planning to stay and leave nursing. While those planning to stay felt generally positive about resources to do their work, those planning to leave did not (Table

5.13). While exploration of the qualitative survey data did not reveal concern about resources to be a main reason for participants' planning a career change, these results suggest that the poor quality and availability of supplies and equipment was experienced as a frustration by the nurses planning to leave.

Table 5.13
Between-group differences in opinion about resources

Variable	Stay M (SD)	Stay Median	Leave M (SD)	Leave Median	p value
The quality of the equipment you use in your job	3.4 (1.02)	181.5	2.9 (0.95)	128.3	*0.00
The availability of supplies & equipment you use in your job	3.3 (1.05)	181.9	2.7 (1.05)	125.6	*0.00

Measured on a scale from 1 'strongly dissatisfied' to 5 'strongly satisfied' with 3 being the neutral point. A mean between >2 - <3 = dissatisfied. A mean between >3 - 4 = satisfied.

5.7.3 Further exploration related to negative behaviours

Exploration of the open question survey data and the interview data suggested that interpersonal conflict, in the form of bullying and harassment, was a common problem in the work environment. As views about this specific topic were not evident in the initial exploration of the quantitative data, the researcher examined the responses to one survey item that was highly focused on the issue: 'my work environment is free from bullying and harassment'. The participants generally agreed that the workplace was free from bullying and harassment (M=3.3 ± 1.01 SD, n=348). However, the Mann Whitney U test revealed a statistically significant difference between the groups planning to stay and leave nursing in relation to their

opinions views about the occurrence of this behaviour (Median=179.2 vs Median=139.4, $p=0.00$), and while the nurses planning to stay agreed that the work environment was free from bullying and harassment, those planning to leave did not.

5.7.4 Further exploration related to doctor/nurse relationships

The next exploration of data to evaluate compatibility between quantitative and qualitative findings sought to gain a broad perspective of views about doctor/nurse relationships. The qualitative data suggested that these inter-professional relationships were not problematic. As information in the literature about the quality of doctor/nurse relationships suggests they are often difficult and challenging (Morinaga, et al., 2008; Mulcahy & Betts, 2005), further investigation was warranted. The responses to the one single item explicit to the topic: 'I am treated with respect by doctors I work with' were examined. The participants felt generally positive about the respect they received from doctors ($M=3.7 \pm 0.84$ SD, $n=348$). The Mann Whitney U test revealed no statistically significant difference between the groups planning to stay and leave nursing in relation to their views about respect from doctors (Median=175.6 vs Median=163.9, $p=0.4$). This suggests, similarly to indications in the qualitative data, that relationships between the nurses in this study and the doctors they worked with were generally not problematic.

5.7.5 Further exploration related to autonomy in nursing practice

The final exploration of the quantitative data sought to gain a broad perspective of opinion about nurses' autonomy, which primarily relates to their control over decisions about patient care. Autonomy did not arise as a theme in this study, even

though the literature indicates having autonomy at work is important to nurses' quality of working life (Aiken, et al., 2002; Cortese, 2007; Curtis, 2007; Fairbrother, Jones, & Rivas, 2010; Fochsen, Sjogren, Josephson, & Lagerstrom, 2005; Kovner, et al., 2006). Only one nurse made a comment related to autonomy in practice, and she complained that she was not sufficiently experienced to have responsibility for the types of decisions about patient care she was expected to make. However, the importance attached to nurses' autonomy and control over their practice in the literature suggested further exploration of the data was warranted. The responses to the one survey item related to autonomy in decision-making: 'My unit manager respects the decisions nurses make about how patient care is delivered' were examined. The participants felt generally positive about the way their decisions about patient care were respected by their unit managers ($M=3.7 \pm 0.84$ SD, $n=348$). However, Mann-Whitney U tests revealed a statistically significant difference in opinion in relation to unit manager respect for nurses' decisions about patient care between those planning to stay and leave nursing (Median=181.8 vs Median= 122.5, $p=0.00$).

5.8 Chapter summary

This chapter has reported on the results from the quantitative and qualitative components of the study. Results from examination of the quantitative data were presented in Part A of the chapter. This revealed participants' opinions about the various aspects of work life reflected in the survey questions and their views about their overall quality of their working life. It also identified differences in these opinions between participants planning to stay and leave their profession. The

qualitative findings were presented in Part B of the chapter. First the results from qualitative content analysis of the open question survey data were presented. This identified the main reasons given by participants for planning to stay or planning to leave nursing. Reasons for these career decisions were placed within thematic categories and illustrated by participants' quotations from the open-question survey data. The application of numerical data facilitated listing the participants' reasons for planning to stay or leave nursing in order of prevalence. When exploration of the open question survey data was extended to explore all data provided by the participants, two additional thematic categories were identified: a rewarding but arduous career and feelings of grievance.

Results from the interview data included identification of four major thematic categories relevant to nurses' quality of working life: nursing as an intrinsically rewarding but arduous profession; the importance of supportive collegiality; the importance of the unit manager and a sense of injustice. Multiple examples of text were provided from the transcribed interview data to illustrate the emergence of these categories. Part C of the chapter offered results arising from further examination of the quantitative data that was stimulated by qualitative findings.

The next chapter integrates and discusses the results emanating from exploration of the quantitative and the qualitative data, and considers the consistency of these results in relation to the associated literature. The next chapter also comments on the links between the study findings and key concepts within the Theory of Work Adjustment.

CHAPTER 6 – DISCUSSION

6.1 Introduction

This chapter presents a discussion of the study findings. Central to the discussion are the two research questions: ‘What are nurses’ opinions about key aspects of their quality of working life?’ and ‘Is there a difference in opinion about the key aspects of quality of working life between nurses who plan to stay and those who plan to leave the nursing profession?’ Links are made between the study findings and the related literature and between the study findings and the value dimensions inherent within the Theory of Work Adjustment (Dawis, 2000; Dawis & Lofquist, 1984).

First, the demographic characteristics of the study participants are compared with those of the general population of nurses in Australia and discussed within the context of nursing work. Then the study findings are discussed in terms of participants’ opinions about their overall quality of working life. This is followed by discussion of the major themes that emerged from the study.

6.2 The demographic profile of the study participants

The demographic characteristics of the participants considered in this study were gender, age, family background, qualifications, mode of employment, years of experience as a nurse, tenure, and main area of work. In most instances, these characteristics were reasonably congruent with the general population of nurses in Australia.

Not unexpectedly, because nursing is a predominantly female profession, all interviewees and 93% of the survey participants were female. Compatibly, approximately 90% of all nurses currently employed in Australia are female (Australian Institute of Health and Welfare, 2009).

Over half of the participants in the current study were over 40 years of age, and this seems to be commensurate with Nurses' Board of Victoria (2009) figures which indicate that RNs over 40 years of age represent the largest age category of nurses eligible to practice in Victoria. The average age of participants was 40 years. According to the Australian Institute of Health and Welfare (2009) this is only slightly lower than the average age of RNs in Australia, which their current data shows is 44 years.

In this study, less than a quarter of the nurses were from a non-Australian family background. No national studies were identified that were useful for accurate comparison of data. This was because national studies tend to provide information about country of birth. For example, the Australian Health Workforce Institute (2008) identifies that just over quarter (27%) of nurses in the Australian workforce in 2006 were born in a country other than Australia. However, it is not feasible to compare this data with findings in the current study because family background and country of birth may differ in some individuals.

Just under 80% of the participants held a Bachelor degree or higher qualification. Likewise so do 80% of the RNs in Australia (Australian Institute of Health and

Welfare, 2006b). Almost 40% of the participants held post-graduate tertiary qualifications. Similarly, according to the Australian Institute of Health and Welfare (2009), 45% of RNs in Australia hold post-registration qualifications that correspond to their clinical area of work. However, some discretion is required in comparing the AIHW data with the findings in this study because the AIHW data does not distinguish between tertiary and other types of post-registration nursing qualifications, such as hospital-based certificates.

Almost 65% of the participants in this study were working part-time. This percentage is highly compatible with the findings of Wise (2007) who reported that 66% of approximately 2000 nurses surveyed in Victoria were working part-time. According to the Australian Institute of Health and Welfare (2009) figures, the national percentage is lower, with only just under half of all the 223,000 RNs employed in Australia currently working on a part-time basis.

Participants in this study had an average of 16.5 years of experience in nursing practice. This closely resembles the general population of RNs in Australia, who according to the Australian Institute of Health and Welfare (2006b), also have an average of 16.5 years of experience.

Approximately 40% of participants had tenure of less than five years. While few studies of nurses were identified that included information about length of tenure, this finding was compatible with that of Eley et al. (2007). Their study revealed that of 1,369 hospital-based nurses in Queensland, 41% had tenure of less than five years.

The similarity between findings suggests that the tenure of nurses in this study might be reasonably representative of the general population of nurses employed in Australia's public hospitals.

The majority of participants' in this study were working in general medical and surgical nursing units (53%); many other worked in critical care areas (32%) and the remainder worked in peri-operative units (15%). Similarly, Australian Institute of Health and Welfare (2009) figures show that the largest proportion of nurses nationally work in medical/surgical areas (34%), while large numbers of others work in critical care (14%) and peri-operative units (7%).

6.3 The participants' quality of working life

Nurses in this study generally felt positive about their overall quality of working life, which is reflective of other studies suggesting that nurses' quality of work life may be at a reasonable level. For example, approximately 350 nurses in a USA study conducted by Brooks and Anderson (2004) were reported to be "pleased overall with their nursing work life situation" (p. 272). However, these researchers warned that the survey instrument they used to determine quality of working life was new and untested. Similarly, nurses in Norway were reported to be fairly satisfied with their present positions (Daehlen, 2008). Nurses in Turkey were moderately satisfied (Golbasi, et al., 2008), and Lu et al. (2007) reported that just over half of 275 nurses surveyed in Mainland China were also satisfied. Results from Robinson and Perryman's (2004) UK study are also compatible with this current study, revealing that health care workers throughout the National Health Service felt generally

positive about their quality of work life. Likewise, Considine and Callus (2005) also found that approximately 84,000 employees from a mixture of occupations in Australia “had a relatively good quality of working life” (p. 18). However, while nurses were included in both Robinson and Perryman’s and Considine and Callus’ studies, their views were not able to be determined in isolation to those in other types of employment. Conversely, in a study by Aiken et al. (2001) that involved nurses in five countries, a high proportion of participants were found to be dissatisfied with their jobs. Further, Curtis (2007) reported only low to moderate satisfaction in nurses employed in Ireland.

To interject a note of caution in interpreting the finding that nurses in this study were generally feeling positive about their overall quality of working life, the results identified that many of them shared an underlying sense of injustice about how they were being treated. The fact that words such as unfair, frustrated, dispirited, angry, resentful and bitter were used by almost a third of participants when commenting on their employment conditions suggests high levels of emotion and tension may be festering within the nursing workforce. This finding appears to support other research conducted in Australia. Hegney, Plank and Parker (2003), for example, reporting on a study involving almost 1500 participants in Queensland, stated that “many nurses in this study expressed anger and frustration about their inability to complete their work to their professional satisfaction in the time available” (p. 307). Webster et al.’s (2009) qualitative study of 13 nurses who had left the profession, suggests that the main reasons nurses had left a Queensland hospital were associated with them feeling dispirited by being overworked and feeling unsafe and

undervalued in the work environment. Similarly, Considine and Jakubauskas' (2008) finding that nurses in NSW were "working in appalling conditions" and were feeling "over-worked and exhausted" (p. 15) implies that they also have reason to feel they are being treated unjustly.

To add a further note of caution in viewing the generally positive perception of quality of working life, the group of participants planning to leave nursing did not feel positive about their overall quality of working life and they recorded a lower quality of working life rating on each of the subscales than did the group planning to stay in nursing. They did not feel positive about most aspects of working life: they only felt positive about their 'colleagues', 'equal opportunities' and their 'job satisfaction'. This has similarity with Robinson and Perryman's (2004) finding that employees in London's National Health Service consistently rated 'job satisfaction' and 'colleagues' more highly than any of the other aspects of their work examined, and that their views about 'equal opportunities' were generally positive.

It seemed counterintuitive to the researcher that nurses planning to leave their profession felt positive about their degree of job satisfaction when they did not feel positive about their overall quality of working life. This apparent anomaly is perhaps related to the subjective nature of items in the 'job satisfaction' scale. For example, the statement, 'I get a feeling of accomplishment from my job', seeks information about subjective feelings towards work. As pointed out by Denvir et al. (2008) "ratings of subjective factors are not always consistent with objective measures" (p. 8). The reason for the apparent inconsistency in results within this study may also be

that the 'job satisfaction' rating is more an indication of how the participants felt about their profession, rather than how they felt about their current work situation. In a survey study of early career burnout among nurses, Gustavsson et al. (2010) pointed out that a lack of clarity between satisfaction with current job and satisfaction with career was the likely cause of a misfit between some of their study results. It may be that concern about clarity was the reason why, in their respective studies, Ulrich et al (2007) and (Buerhaus, et al., 2009) considered job and career satisfaction as two separate concepts.

6.4 An intrinsically rewarding but arduous profession

It was a consistent theme throughout the data analysis that study participants enjoyed nursing work. The mean score of 3.8 recorded for 'job satisfaction' suggested that the participants generally found their work interesting and challenging, enjoyed the variety it offered, rarely felt bored, experienced a sense of achievement, enjoyment and accomplishment and on most days felt enthusiastic about their job. This appears to be reflective of feelings in the broader nursing community. Results from the International Council of Nurses (2009) survey, which was conducted across eleven countries, also showed that, in spite of challenging working conditions, most nurses were still finding their work enjoyable.

Further, in this study, with the single exception of relationships with work colleagues, participants rated 'job satisfaction' more favourably in terms of quality of working life than all other aspects of work. This result was highly consistent with Robinson and Perryman's (2004) finding that 'job satisfaction' and 'colleagues'

were the two aspects of work rated most highly by healthcare workers in the UK (p. 4).

A large majority of participants cited intrinsic rewards as their main reason for planning to continue working as a nurse. They reported that intrinsically rewarding interactions with patients contributed greatly to their personal sense of satisfaction with work. The comment of one nurse: “I enjoy it, I get great satisfaction from making a difference in someone’s recovery to good health” was typical of many. The findings of this study therefore suggest that altruism, the desire to help others, was held firmly as a work value by most of the participants, and satisfying this value was important to their quality of working life. This is consistent with the findings of Mimura et al. (2009) and De Cooman et al. (2008) who reported that altruism is an important motivator to enter and remain in the nursing profession, including for the younger generation of nurses. The findings of this study suggest that in the main, for the participants in this study, the altruism value was satisfied, and that rewards from helping others continued to be a motivator to stay in the profession. Further, the finding that nurse/patient relationships were important to nurses’ quality of working life is consistent with the results of Hallin and Danielson’s (2007) research. From a qualitative study of RN’s experiences of daily work they concluded that “patient contact appeared to be RN’s greatest source of reward” (p. 1226).

While participants felt positive about their overall quality of working life and were enjoying the intrinsic rewards of nursing, the evidence overwhelmingly indicated that they considered their workloads were unreasonably high and arduous. The

results of this study showed a general depth of concern with the degree of ‘stress and work pressure’; most participants wrote pessimistic comments about the difficulty of managing their high work demands, and stress and work pressure were given as reasons for leaving by almost all of the nurses planning a career change. In confirmation, all of the interviewees spoke fervently about work demands using words such as heavy, exhausting, never-ending, and debilitating. This result was not surprising given the evidence that work pressure and stress on nurses has previously been identified as a problem both in Australia (Considine & Jakubauskas, 2008; Hegney, et al., 2003; Webster, et al., 2009; Wise, 2007) and internationally (International Council of Nurses, 2009; Poghosyan, et al., 2009; Sheward, et al., 2005). Similarly to the findings in this study, Hegney et al.’s (2003) mixed method research showed that nurses in Queensland were struggling to cope with high workloads. The same situation was reported by Considine and Jakubauskas (2008). Their extensive study of staff employed in Area Health Services across NSW found hospital-based nurses to be ‘always’ or ‘usually’ exhausted. Further, the findings of this current study corroborate Wise’s (2007) statement that, in Victoria, nurses’ workloads have risen sharply since 2003, and that they are now battling to cope with increases in administrative load, work intensification, patient acuity and patient turnover.

The situation faced by nurses in this study, and in Australia more generally, appears no different from that faced by nurses around the world. For example, Poghosyan et al.’s (2009) analysis of data from a survey conducted across eight countries showed that demanding workloads, and the associated stress and burnout in nurses, was an

immense global problem. Further, the report from The International Council of Nurses (2009) Global Survey indicated that nurses from eleven countries rated workload as the most unfavourable aspect of their work. In addition, the finding in this study that workloads are high and stressful is compatible with that of Sheward et al. (2005) who reported that increasing patient-to-nurse ratios in Scotland and England were associated with an increasing risk of emotional exhaustion and job dissatisfaction in nursing staff.

The pressure of work resulted in more than fifty participants writing unsolicited comments expressing their concerns about having the stamina to continue coping with the demands of nursing work in the future, as they advance in age. Other unsolicited comments showed that the impact of high work demand on personal wellbeing was also the cause of several participants electing to work part-time rather than full-time. The latter seems compatible with Wise's (2007) finding that increasingly more nurses in Victoria are choosing to work part-time. Wise's research showed that 60% of nurses in Victoria were working part-time in 2003 but that this had risen to 66% by 2006. However, while nurses' work demands were shown to have risen within the same time frame, there was no evidence of a direct association between increased work pressure and the increase in part-time employment in nursing.

Of concern, many of the participants' in this study found achieving a sense of satisfaction through caring well for their patients, which helps to fulfil the work value of altruism, was often thwarted by their high work demands. The following

experience described by one nurse is typical of many others: “It is frustrating that you are so busy you cannot give the quality of care you are trained to give”. This is strongly reflective of Cheung et al.’s (2004) earlier study of nurses in Australia that found being too busy to uphold professional standards of care was one of five major ‘dissatisfiers’ associated with participants’ decisions to leave the profession. It also concurs with the findings of Leurer et al. (2007) who identified that the struggle to maintain high standards of care was causing feelings of frustration and fatigue among nurses in Canada.

It was apparent that the participants in this study were motivated to provide high quality nursing care, but there was a sense that they felt powerless to set limits on their workloads so that they could deliver care in the way they desired. This prompts the question: Can nurses gain some control over management of work demands? A recent review of the UK initiative, ‘The Productive Ward Program: Releasing Time to Care’, suggests that they can (NHS Institute for Innovation and Improvement, 2010). Implementation of this program in the UK has given nurses the power to identify problems and make changes at ward level that enable them to restructure work practices according to their needs. This has given them more time to spend with patients. An initial review suggests that the program “appeals to the intrinsic work values of frontline (particularly nursing) staff and has had a positive impact” (p. 7) and that key benefits include “more time for better care, improved patient experiences, cost savings, and higher staff satisfaction and retention” (p. 7). The indications in this study were that the participants seemed to have very little say or

control over their workload allocations and the quality of care they had time to provide.

In addition to heavy workloads, some participants told stories that revealed how issues with the quality and lack of essential resources further restricted their ability to provide high quality patient care. For example, one participant spoke of having a problem with a broken lifting machine and her frustration at having to wait a long time until a machine from another area was free for her to use. The comment "...nurses are constantly expected to work above and beyond what is [sic] reasonable limits with less and less resources", was typical of the views shared by the nurses in the current study. While participants were generally satisfied with both the quality and availability of supplies and equipment, those planning to leave were not. However, issues with resources were not cited as a reason for planning a career change. Therefore, overall the findings in the current study imply that difficulties with supplies and equipment, while a source of frustration for some nurses, were not as great a problem as they were for participants in Considine and Jakubauskas (2008) study of doctors and nurses employed in NSW public hospitals. These researchers reported that, while nurses were not as scathing about the adequacy of resources as doctors, "between five and seven out of ten nurses feel resources are not sufficient" (p. 12). Nevertheless, the findings in the study indicate that work pressure, sometimes exacerbated by issues with resources, interfered with the ability of participants to consistently provide the quality of patient care they desired to deliver. This appears to be consistent with studies suggesting that cost containment strategies applied in healthcare organisations throughout the last two decades have caused

increased work pressures that have made the intrinsic rewards of nursing more difficult to attain (Apker & Zabava-Ford, 2003; Buchanan & Considine, 2002; Hofmeyer, 2003). In particular, the findings in the current study emphasise the appropriateness of Buchanan and Considine's (2002) warning that, because it is predominantly the intrinsic rewards gained from interactions with patients that keep nurses in the profession, working conditions conducive to them gaining these rewards should be maintained.

Unsolicited comments suggested that high work pressure caused some participants to feel compelled to act outside their personal moral and ethical beliefs about how nursing work should be conducted. This has some similarity to the findings of Milisen et al. (2006) who identified that four out of ten nurses could not provide the level of care they deemed desirable. Over a third of almost 10,000 nurses in Milisen et al.'s study found it difficult to practice in accordance with their personal ethical values. It also echoes earlier findings from Kelly's (1998) study, which showed that nurses who were unable to do their work in a way they felt was ethically and morally right experienced higher levels of stress than others.

6.4.1 The links between quality of care, intrinsic rewards and work values

The ability to provide patient care in a way that fits with personal and professional standards can be intrinsically satisfying and rewarding for nurses. It also offers huge potential for nurses to fulfil the work value of altruism, the desire to help others. In terms of Dawis and Lofquist's (1984) work values, the provision of high quality

patient care also offers opportunities to fulfil the work value of achievement, which in part, as explained in Chapter 3, is to do with using one's skills and knowledge and feeling a sense of accomplishment from doing so. However, the work value of altruism also encompasses being able to work within one's own moral beliefs and ethical code (Dawis & Lofquist, 1984). For several participants in this study it became more difficult for them to satisfy the work value of altruism when they could not use their abilities to provide the quality of care they desired, and felt forced to work outside of their personal moral standards and their professional code of practice. The inability to deliver high quality nursing care also made it less likely that they could achieve a sense of accomplishment from their work, and this therefore limited their ability to meet the work value of achievement. For most of the participants, workloads were a major cause of concern, and when workloads are higher than can reasonably be managed, fulfilling the work value of comfort also becomes problematic, this work value reflecting diverse aspects of employment that minimise stress (Dawis, 2000, 2002; Dawis & Lofquist, 1984). Further, given that the work value of autonomy is related to the need to take responsibility and have control over one's work (Dawis, 2000; Dawis & Lofquist, 1984), when nurses feel they do not even have control over their workload allocations, it makes fulfilling the work value of autonomy challenging.

6.5 The imbalance between extrinsic rewards and work effort

Participants in this study felt that extrinsic rewards⁸ in nursing were not commensurate with the demands of the work and their level of knowledge and responsibility. In particular, they considered that, in relation to how hard and diligently they worked, they were inadequately rewarded financially. Further, they did not feel that they were adequately rewarded in terms of professional development opportunities.

6.5.1 Opinions about financial rewards

While participants in this study felt positive about their overall quality of working life, they held a negative view of their ‘pay and benefits’ and ‘stress and work pressure’, and these were the two aspects of work rated least favourably. Similarly, health care workers in Robinson and Perryman’s (2004) UK study also felt negative about pay and benefits and rated this aspect of work less positively than any other feature of their employment. However, unlike participants in this study, they felt positive about their degree of ‘stress and work pressure’, even though they too, rated this less favourably than almost every other aspect of their work. The finding in this current study that both ‘pay and benefits’ and ‘stress and work pressure’ were rated negatively has similarity with that of a USA study conducted by Brooks and Anderson (2004). They found that while nurses were generally happy with their

⁸ Extrinsic rewards are defined under operational definitions in Chapter 1.

quality of working life, about half of the participants considered their salary was inadequate and their workload too heavy.

Further reflecting discontent with pay and stress and work pressure, these were the two most frequently cited reasons for participants planning a career change. This has close affinity with Flinkman et al.'s (2008) study which also revealed that dissatisfaction with pay and high work pressure were the two most commonly raised reasons for why participants were considering leaving the nursing profession. Conversely, Cowin, Johnson, Craven and Marsh (2008) reported that nurses' pay had little effect on their retention in the workforce.

The survey participants indicated they considered themselves to be underpaid and to be enduring workloads that were too heavy and stressful. Many, including those planning to stay, wrote unsolicited comments indicating that they believed nursing work should be much better paid in light of their high work demands. Further, all of the interviewees agreed that their salary did not equate fairly with their high work pressure, level of responsibility and stress. Several quotations provided in the previous chapter emphasised how the unfairness of the pay in relation to the pressure of work was a cause of discontent. For example, one participant asked: "I have a friend who artificially inseminates cows and makes a lot more money than I do, after years of nursing experience, a degree and all the stress and responsibility what is that about?" Several other participants also made similar comments expressing the view that their pay compared unfavourably with that in other occupations. This is reflective of Kovner et al.'s (2006) finding that the amount of the pay itself was not

significant to nurses in the USA, but the fairness of the wage was important. They found the amount of wage was not associated with nurses' job satisfaction, but was associated with distributive justice, which pertains to the fairness of pay in relation to the work and in relation to the wages of other workers. Similarly, Buchanan and Considine's (2002) research of nurses in NSW, showed that in their study money became much more of a problem for nurses when work demands were seen as disproportionate to the amount of their financial reward.

6.5.2 Opinions about professional advancement opportunities

Although the survey participants felt generally positive about support for their 'professional development', the group planning to leave did not feel positive about the degree of support received. Further, all of the interviewees who had actually left or were planning to leave the profession explained that inadequate career advancement opportunities contributed to their decision to make a career change. The latter is reflective of Webster et al.'s (2009) finding that lack of opportunity for professional development was one of the main reasons nurses employed in a large city hospital in Australia were leaving either a particular work unit or the organisation. It is also reflective of the finding in Cheung et al.'s (2004) research which identified that, for nurses in Australia who had left the profession, the inability to advance professionally within a nursing career was one of the main motivators for them having made a career change. Compatibly, studies by Robinson et al. (2004) and Cavanagh (1992) revealed that employees who perceived they had opportunities for professional advancement felt more satisfied at work than those who did not share that perception. As health professionals, nurses need to take responsibility for

their own professional development in order to keep their clinical knowledge and skills current. However, it is important that post-graduate education, and the personal effort this entails, is rewarded by suitable professional advancement opportunities.

While survey participants felt generally positive about support for professional development, multiple comments showed that many felt aggrieved that while they had undertaken post-graduate study, there was no commensurate reward in terms of opportunity for career advancement. The following example aptly sums up the perception of an imbalance between extrinsic rewards and nurses' work efforts that was voiced by many of the participants: "it is always the nurse that puts in with nothing being given back". Further emphasising this view, all but one of the interviewees agreed that nurses did not receive adequate reward for their hard work in relation to support for continuing their professional education. The concerns raised here are consistent with Leurer et al.'s (2007) report that experienced nurses in Canada believed improved educational opportunities to be an important factor in enhancing the retention of nurses in the profession.

6.5.3 The links between extrinsic rewards and work values

In the spirit of the way the comfort value is interpreted within Dawis and Lofquist's Theory of Work Adjustment, having an adequate amount of pay helps meet this work value because it minimises stress (Dawis, 2000; Dawis & Lofquist, 1984). The participants in this study did not appear anxious about their pay level in terms of having enough money, but their perceptions of not being paid adequately for their professional worth did seem to be a cause of tension. This may have been a factor

adding to the participants' work stress and so limiting their capacity for meeting the work value of comfort.

Further, financial reward is one way of recognising professional expertise, and the amount of pay can reflect an employee's status in the work environment. The perception that salary does not adequately reflect an employee's educational level, knowledge and expertise, or how hard they work, can limit the potential of meeting the work value of status (Dawis, 2000, 2002; Dawis & Lofquist, 1984). In nurses for whom status at work is of high importance, perception of inadequate pay compared to responsibilities at work may contribute to decisions to make a career change. Given that in this study dissatisfaction with financial reward was a reason for leaving given by almost all of the nurses who planned a career change, it is feasible that views about inadequate pay may have impacted negatively on the perceptions of their status within the healthcare system. In addition, the work value of achievement is closely associated with opportunities for professional growth and advancement, as well as with the importance of using one's abilities to gain feelings of accomplishment (Dawis, 2000, 2002; Dawis & Lofquist, 1984). When nurses wish to undertake professional development activities, but are restricted in doing so through a lack of time, financial or other forms of practical support, they may find it difficult to gain a sense of work-related achievement. If nurses who complete post-graduate studies are not suitably rewarded with positions in which to apply their specialist skills and knowledge, and do not therefore receive feedback about their new abilities, their sense of accomplishment may also be diminished. Consequently, this may hinder them from fulfilling the achievement value. The fact that all of the

interviewees who had left or were planning to leave nursing expressed concern about limited career advancement opportunities, seems to suggest that the work value of achievement was important and that they believed alternative careers offered greater opportunities for meeting the work value of achievement than did nursing.

6.6 Relationships in the work environment

The study findings suggest that relationships at work are of utmost importance to nurses' quality of working life and to their retention in the profession. 'Colleagues' was the aspect of work rated most highly, suggesting that supportive relationships with peers and other professional staff made an important contribution to the participants' current quality of working life. Further, a positive association was identified between 'colleagues' and 'job satisfaction', and this association was supported in that supportive colleagues was the second most frequently cited reason for participants planning to stay in nursing. Other studies have also revealed that collegiate relationships are of high importance to employees' quality of working life. Robinson and Perryman (2004) found that 'colleagues' was the aspect of work rated highest by health care workers in the UK. Compatibly, Considine and Callus (2005) reported that Australian workers from a wide range of occupations rated 'co-workers getting along together' as one of the most important factors in making work a positive experience. They stated that this indicator of quality of working life was:

“far more important for workers than factors typically attributed to employee satisfaction such as having your efforts recognised, having control over the way you do work, being

treated well by your immediate supervisors or even having fair and reasonable pay” (p. 17).

The importance of respectful and harmonious relationships to nurses’ wellbeing at work has also been illustrated previously. For example, Cummings et al. (2008) reported that positive relationships with peers, managers and physicians enhanced the job satisfaction of nurses working in an oncology unit. Similarly, Curtis (2007) found that informal social and professional interactions with colleagues during working hours, second only to acknowledgement of professional status, was the aspect of work that made the greatest contribution to nurses’ overall job satisfaction. Further, friendliness with colleagues has been shown to provide individuals with a general sense of belonging, which as Maslow’s human need theory suggests, is a need that, when satisfied, enhances motivation and achievement in life, including life at work (Maslow, 1954, 1970, 1987). As van der Heijden et al. (2009) identified, feeling supported, and feeling a sense of belonging are two factors that tend to result in a positive evaluation of the work situation and enhance work performance. This appears to be the case in this study. The words of one nurse, “the staff I work with are not just colleagues but friends and we are a well-oiled team”, was typical of many experiences described by participants that seemed to imply that harmonious relationships with colleagues enhanced efficiency in the work unit.

6.6.1 Relationships with work colleagues

Akin to the finding in this study that supportive and harmonious relationships with colleagues appeared to be a factor that motivated participants to remain in the

nursing profession, the research undertaken by van der Heijden et al. (2009) also suggests collegiate support encourages nurse retention. These authors found that nurses who perceived greater support from close work colleagues had higher job satisfaction, and that this in turn had a positive effect on their occupational turnover decisions. Studies by Garrett and McDaniel (2001) and MacPhee and Scott (2002) also reflect that supportive communication from peers and managers motivates nurses to stay in the profession. Further, Kovner et al. (2006) and Adams and Bond (2000) both identified a correlation between cohesion in work teams and nurses' job satisfaction. In addition, Boyle et al.'s (1999) earlier study identified that work-group cohesion was a factor influencing the quality of working life and retention of nurses. Compatibly, Day et al.'s (2007) study, which involved three hospitals in Queensland, demonstrated that good relationships within nursing work teams was "a significant determinant of nurses' morale" (p. 280). Further, the finding in this study that friendly and supportive relationships were important to quality of work life and decisions to stay in nursing appears commensurate with the results of a study conducted by Park and Kim (2009). After examining the influences of different types of organisational culture on nurses' job satisfaction and turnover intentions, they concluded that nurses' job satisfaction is likely to be higher, and intention to leave lower, when the workplace culture is one that values human relationships and promotes cohesive teamwork.

A study by Mulcahy and Betts (2005) showed that efforts to improve the workplace culture within a neonatal unit in a hospital in Victoria were successful in improving job satisfaction and reducing an unacceptable rate of attrition of nurses from this area

of specialty. The existing workplace culture was one where conflict between staff was a consistent problem. The transformational strategies employed to address this issue were focused on efforts to improve the cohesion between healthcare professionals working in the area. Approaches to achieve a friendlier and more collaborative workplace culture included fostering respect between work colleagues, especially between medical and nursing staff, and enhancing the leadership skills of the nurse managers. Mulcahy and Betts' study demonstrates that cultural change is possible even in very busy nursing units. Hofmeyer (2003) suggests that a workplace culture that fosters strong social relationships and inclusivity among staff is essential in healthcare settings. The strategies used by Mulcahy and Betts to bring about change are typical of those necessary for building a workplace culture with the 'inclusive social capital capacity' that Hofmeyer (2003) emphasises is "an urgent moral imperative to improve the quality of working life for nurses" (p. 9).

6.6.2 Doctor/nurse relationships

The extent of the literature concerned with difficult nurse/doctor interactions suggested that relationships between participants and members of the medical profession might arise as an issue in this study. However, doctors were mentioned infrequently and then generally in a positive context. In order to specifically examine survey participants' views about doctors, responses to the survey item, "I am treated with respect by the doctors I work with", were examined. The findings indicated that participants generally felt positive about the respect they received from their medical colleagues. These results suggest that, for participants in this study, relationships with doctors were mostly harmonious. This is in keeping with the findings from Van

Bogaert et al.'s (2009) study of nurses working in Belgian hospitals. These researchers found that nurses' relationships with physicians had a positive influence on their job satisfaction. It is also aligned with the findings of Ogbimi and Adebamowo (2006) who reported that the majority of nurses working in Nigerian hospitals considered their working relationships with doctors to be cordial. Further, Budge et al. (2003) reported nurse/doctor relationships within a general hospital in New Zealand to be mainly non-problematic. In addition, Aiken et al.'s (2001) multi-national study of hospital-based nurses, who were working in the USA, Canada and three European countries, also suggested these inter/professional relationships were generally not problematic. In Aiken et al.'s study the majority of participants from each of the five countries agreed with the statement 'physicians and nurses have good working relationships'. However, this is in contrast to the literature evidencing that doctor/nurse relationships are often difficult, are a cause of nurse dissatisfaction with work, and influence nurse attrition (Gunnarsdottir, et al., 2009; Kanai-Pak, Aiken, Sloane, & Poghosyan, 2008; Morinaga, Ohtsubo, Yamauchi, & Shimado, 2008; Mulcahy & Betts, 2005; Rosenstein, 2002; Snelgrove & Hughes, 2000; Tabak & Koprak, 2007).

Historically the status of nurses in the healthcare workforce has been inextricably linked to their societal position in relation to doctors, and the literature suggests that historical factors that position nurses as subservient to their medical colleagues still impact negatively on the way doctors perceive and treat nurses (Buresh & Gordon, 2006; Gordon, 2005; Lusk, 2000; Snelgrove & Hughes, 2000). Yet the results of this study suggest that nurse/doctor relationships may be less troublesome than in the

past. This may be related to the fact that contemporary members of the medical profession are no longer educated to believe that nurses are their hand-maidens (Gordon, 2005). Possibly the traditional view of nurses as less important than doctors, rather than equally valuable members of the health care team, is now not as prominent among members of the medical fraternity.

6.6.3 Relationships with unit managers

There were multiple issues raised about the skills and attributes of managers, including those that impacted on their relationships with nursing staff. As the issues about management are numerous, and inter-related, they are discussed together in a later section of the chapter (section 6.7).

6.6.4 Bullying and harassment

While the findings of this study suggest that supportive colleagues had a positive effect on the participants' quality of working life, they have also suggested that, for some participants, unpleasant and difficult relationships with colleagues were detrimental to their enjoyment of working life. Almost a quarter of the survey participants planning a career change cited the experience of bullying and harassment from co-workers as a reason for leaving nursing. In addition, the interviewees who were planning to leave, or had already left, told stories of how negative relationships with nurse colleagues, including unit managers, had influenced their decisions. Further, several spoke of frequently observing nurse-to-nurse bullying in their work environment. While some participants experienced aggressive behaviour from patients and their family members, it was bullying from

co-workers that was cited as an influence on decisions to leave nursing. This may be because hostility from work colleagues is experienced as the most stressful form of workplace conflict (Farrell, 1997) and tends to have a bigger impact on staff perceptions of their wellbeing than conflict from any other source (Robinson & Perryman, 2004). It is also possible that some participants experienced a lack of appropriate and timely response at management level in supporting those experiencing bullying behaviour. According to Morrison and Nolan (2007) it is an expectation of employees that their managers will provide them with support and assistance to overcome negative workplace relationships. Yet, according to Randell-Andrews and Dziegielewski (2005) the high workloads unit managers face may mean they feel compelled to neglect managing important staff problems due to prioritising the completion of clinical and administrative tasks. Morrison and Nolan (2007) suggest that when conflict occurs at work and expectations of support are not met, disagreements and problems between employees escalate, work enjoyment deteriorates and this eventually causes some workers to leave their employment.

While some participants experienced problems with bullying and harassment, the survey participants generally agreed that their workplace was free from this behaviour. This seems contradictory to Ball and Pike's (2006) finding that nearly a quarter of participants in their UK study had been bullied or harassed by a member of staff in the 12 months prior to the study.

The results of this study appear to suggest while incidents of bullying and harassment were occurring, they were not perceived as widespread. However, Burnes and Pope

(2007) suggest that perceptions of the extent of bullying and harassment may be influenced by poor recognition of all the actions that constitute the behaviour. For instance, they indicate that it is not always perceived that constant criticism or backbiting constitutes a form of verbal bullying and harassment.

Differences in opinion between the groups planning to stay and leave nursing were compared in relation to the statement 'my work environment is free from bullying and harassment'. Results show that while the nurses planning to stay agreed that the work environment was free from bullying and harassment, those planning to leave did not. This finding seems compatible with those of Camerino et al. (2008). Their extensive research, involving health care institutions within eight European countries, showed that experiences of bullying and harassment were associated with an increase in dissatisfaction with work and nurses' premature departure from nursing positions.

Other Australian studies appear to indicate that while bullying and harassment from work colleagues is a problem, negative behaviour from other sources is more common. For example, in Roche et al.'s (2010) study of nurses in two states of Australia, bullying and harassment was considered as a form of emotional abuse. The researchers found that almost a third of the participants had experienced emotional abuse in the five shifts worked immediately prior to the study. However, while some of this abuse came from co-workers, most came in the form of verbal aggression from patients and their families. Similarly, in Farrell et al.'s (2006) study of nurses in Tasmania, bullying and harassment was considered as a form of verbal

abuse. Farrell et al. identified that nearly two thirds of nurses in their study had experienced some form of verbal and/or physical abuse in the four working weeks immediately prior to completing the survey. Again, while medical and nursing colleagues were responsible for some of this mistreatment, patients or their visitors were the main perpetrators.

Hegney et al. (2006) suggest that incidents of workplace violence towards nurses, including bullying and harassment from colleagues, were increasing. They commented on the results of a survey first conducted with nurses in Queensland in 2001 and repeated in 2004. They reported that, with the exception of incidents involving medical officers, there had been an increase in incidents of violence from all sources, including nurse/nurse and nurse/manager conflicts, as well as those involving patients and visitors. Further, the majority of nurses in the study had experienced “some form of workplace violence” in the three months prior to the 2004 survey.

Generally the findings from Australian studies (Farrell, et al., 2006; Hegney, et al., 2006; Roche, et al., 2010) seem to indicate that workplace aggression, including bullying and harassment, is a relatively common occurrence in hospital settings. This is compatible with overseas research which has identified that violence and aggression directed towards nurses is widespread (Burnes & Pope, 2007; Camerino, et al., 2008; Gacki-Smith, et al., 2009; Robinson & Perryman, 2004; Sofield & Salmond, 2003). Yet, overall the findings of this study appear to suggest that the problem of bullying, and other forms of negative behaviour, may not be as extensive

as indicated in studies conducted in other Australian states and overseas. It is possible that this reflects the effectiveness of activity to prevent occupational violence in healthcare settings initiated by the Victorian State Government (Victorian Government Department of Human Services, 2007).

6.6.5 The links between interpersonal relationships and work values

As outlined in Chapter 3, according to Dawis and Lofquist's (1984) Theory of Work Adjustment, harmonious and helpful relationships between co-workers contribute to employees satisfying the work value of altruism. In turn, because these types of positive relationships are likely to reduce the impact of stressors in the workplace, they help individuals to meet the work value of comfort, which is associated with factors that minimise stress. Further, expressions of appreciation from others in the work environment and respect from doctors are communications likely to help satisfy the personal work value of status in individuals, which is associated with respect and recognition for effort and expertise (Dawis, 1992, 2000, 2002; Dawis & Lofquist, 1984). On the other hand, bullying and harassment, and other forms of aggression are known to be causes of stress that can have severe negative outcomes on nurses' personal health and wellbeing (Australian Nursing Federation, 2000; Buerhaus, et al., 2009; Camerino, et al., 2008; Karatepe, et al., 2009; Morrison & Nolan, 2007; Rippon, 2000b). Any form of aggression, including bullying, presents a potential threat to an individual's sense of safety and can therefore violate the work value of safety which is linked to non-hazardous conditions and protective workplace policies and practices (Dawis & Lofquist, 1984). The findings of this study suggest that

participants' thoughts tended to turn towards alternative career pathways when the work value of safety was violated through workplace bullying and harassment.

6.7 The importance of effective management

Participants in this study held a generally positive view of 'management' and their perception of management was positively related with their views on 'health and safety'. This suggests unit managers were influential in promoting the nurses' quality of working life through a range of factors including controlling for staff safety in the work unit, monitoring the cleanliness of the working environment, ensuring adequate supplies and equipment were available for staff to do their work, and making sure staff were orientated to any unfamiliar or new equipment they were required to use. The finding of a positive association between the perception of 'management' and views on 'professional development' and 'performance and appraisal' may imply that unit managers were important to nurses' quality of working life in terms of activities that included providing them with feedback about their work performance and facilitating opportunities for them to extend their professional knowledge and expertise. A positive relationship between opinions about 'health and safety' and 'communication', and an association between opinions about 'equal opportunities' and 'professional development', may suggest that the skills of unit managers were important in terms of their effectiveness in communicating policy information relevant to staff health and safety, and ensuring fairness in allocating resources that enhance nurses' professional growth. This is logical given that they are the communication conduits between senior management and unit nurses and they are therefore responsible for ensuring all unit staff are

aware of, and adhere to health and safety policies and practices at the local level. Unit managers also have power over issues of equity and opportunities for professional growth. As Wilson (2005) explains, they can determine which staff are hired and fired. They also have influence over who is supported in relation to career development (Tomey, 2009).

Emphasising the importance of sound management to nurses' quality of working life, having an effective unit manager was cited by over a third of participants as a main reason for continuing in nursing, whereas having a unit manager who did not demonstrate effective leadership was a reason given for leaving by over half of those planning a career change. In addition, participants planning to stay in nursing felt positive about 'management', those planning to leave did not. This appears to have a degree of resonance with Lin, St. John and McVeigh's (2009) finding that the quality of relationships with managers could both contribute to and mitigate stress and burnout in nursing staff. Further stressing the importance of effective management skills to nurses' continuance in the profession, 'management' was the aspect of work where the greatest difference in opinion occurred between the groups of nurses planning to stay and leave the profession.

Supporting the generally positive opinion about 'management', participants comments revealed how unit managers acted as teachers and role models and how these and their other managerial attributes made life at work "a buzz" and "fantastic". In contrast, others told of feeling intimidated and unsupported by unit managers and of feeling frustration with the lack of leadership skills in running and

resourcing the work unit. Further, all of the interviewees who had taken up new careers indicated that troublesome relationships and the lack of leadership skills in their unit managers played a crucial role in their decisions to leave nursing. The following example was one of many that emphasised the need for good interpersonal communication skills in unit managers: “When your own unit manager shows you no respect after nearly ten years of nursing experience it is time to get out”. In particular, many comments revealed the importance of unit managers providing feedback about work performance and how this related to the participants feeling their contributions to the unit were, or were not, valued. For example, the comment, “I won’t stay in a job if my contributions are not valued and you don’t get that in nursing....it wasn’t until I was about to leave that I got any positive feedback”, was typical of many that illustrated the importance of unit managers ensuring that nurses know their efforts are appreciated.

The finding that the skills and attributes of unit managers were of such importance to the participants’ quality of working life, and were linked to their career decisions, is compatible with the results of many other studies (Cummings, et al., 2010; Cummings, et al., 2008; Davidson, 2010; Gunnarsdottir, et al., 2009; Kovner, et al., 2006; Sellgren, et al., 2007; Tomey, 2009; Wade, et al., 2008). For example, van der Heijden et al. (2009) reported that nurses who perceived more support from their supervisors were more satisfied with their job than those who worked in a less supportive environment and that the quality of the leadership experienced was the strongest predictor of nurses’ intentions to leave their profession. Further reflecting the importance of competent management, McGillis-Hall and Doran (2007) found

that nursing leadership had a statistically significant positive influence on nurses' job satisfaction and a statistically significant negative influence on their job pressure and role tension.

It is an issue in nursing that, while some unit managers have business knowledge and good management skills, others are ill-prepared for such roles (McGuire, Houser, Jarrar, Moy, & Wall, 2003). As Wilson (2005) points out, there seems to be a perception that an individual who performs well as a clinical practice nurse will also perform well as a unit manager, and many are promoted only on the basis of clinical experience and expertise. Unit managers who lack the necessary skills in leadership can find the role extremely stressful (Randell-Andrews & Dziegielewski, 2005). This situation risks the development of tension in relationships between ineffective managers and nursing staff. Indeed several comments in this study indicate that this is so. For instance, the example, "...the final straw a unit manager with less experience than me telling me how to do my job and not even making sure we have the equipment and resources to do it", is suggestive of a considerable degree of tension. Similarly to the findings in this study, Milisen et al. (2006) also concluded that nurses' concerns about the quality of leadership and management were a cause of tension in the nursing work environment. They reported that over a third of almost 10,000 nurses in their study felt they received only minimal support from management and that almost three-quarters of participants considered communication with their nursing managers to be inadequate. However, it should be noted that the current study did not explore interpersonal relationships in the workplace from the perspective of the nurse unit managers.

6.7.1 The links between effective management and work values

Relationships with managers were positive for some participants in this study, but not for others. When these important relationships are a source of tension, they are likely to undermine an individual's self-esteem or sense of professional worth. Poor relationships with managers therefore have the potential to limit employees' ability to meet the work values of altruism, comfort and status (Dawis, 1992, 2000, 2002; Dawis & Lofquist, 1984). Tensions between nurses and nurse unit managers may simultaneously violate these work values in both parties, and this may impact on the future career decisions of both nurses and these senior colleagues. Certainly while the attrition rate of nurses is a cause for concern, there is an equally worrying situation about high work demands, stress and departure rates of more senior level nurses in management positions (Randell-Andrews & Dziegielewski, 2005).

6.8 The need for an acceptable work/family fit

As explained previously, hospitalised patients require 'around-the-clock' attention and therefore nurses must be available to provide care over the full 24 hours, seven days a week. In Australia, this means hospital nurses tend to be rostered to work a combination of morning, afternoon and night shifts. It is widely recognised that such irregular hours makes it challenging to find the right balance between work demands and family responsibilities (Barnett, et al., 2008; Grzywacz, et al., 2006; West, et al., 2009; Yildirim & Aycan, 2008). In this study survey participants felt generally positive about employer support for achieving this balance and almost a quarter of all the participants cited having a good work/family fit as a reason for continuing to work as a nurse. This may be related to the fact that about two thirds of the

participants were employed part-time. This suggests that, in managing work and family demands, they were able to take advantage of flexibility in terms of the total hours that were required to commit to work.

When the views of those planning to stay and leave nursing were compared, those planning to stay felt positive about the hospital as a 'family-friendly' employer, whereas those planning to leave did not. In spite of the majority of those planning to leave being employed part-time, most cited work/family conflict as a main reason for considering a career change. The finding in this study that work/family conflict is linked to nurse attrition is reflective of Miracle and Miracle's (2004) research which identified that shift work, particularly the need to undertake week-end work and night shifts, was an often-cited reason for leaving the nursing profession. It also corresponds with Cheung et al.'s (2004) report that the conflict between the needs of families and the demands of the work was one of five major 'dissatisfiers' associated with nurses in Australia choosing to make a career change. Further, it is compatible with Leurer et al.'s (2007) finding that experienced nurses in their study recommended more flexible working hours as an important strategy to encourage more of their colleagues to remain in the profession.

Participants' comments specifically highlighted the power individual unit managers held over their efforts to effectively manage their work and family demands. Some unit managers were perceived as highly supportive, whereas others were perceived as unfair and inequitable in administering staff rosters. For some participants, a lack of responsiveness to their needs was making it very difficult to balance work and

other commitments. For example, while one nurse perceived she always received the roster she needed because she was on friendly terms with the unit manager, another complained she was consistently rostered to work more weekends and evening than others because she was “out of favour”.

What is pertinent here is that nursing is a predominantly female profession, and large numbers of women have dependent children, and many combine paid work with unpaid caring roles that involve looking after ageing or ailing relatives (Australian Bureau of Statistics, 2005; Carers Australia, 2010). However, services to support family caregivers in meeting their unpaid care-giving responsibilities are limited (Burton-Smith, McVilly, Yazbeck, Parmenter, & Tsutsui, 2009; Moore & McArthur, 2007). Further, as Lindsay et al. (2009) point out, formalised child care availability in Australia is patchy and expensive, and such services need to be booked well in advance. In addition, it can be difficult to find facilities that offer child care at times that fit with nursing hours, for instance morning shifts that commence at 7am or evening shifts that can finish any time between 9 and 11pm. Nurses with children, or other dependents, therefore need rosters that are produced well in advance and do not change without adequate warning. Work schedules also need to be flexible enough to fit with available childcare and other support services. In addition, there are many nurses close to the retirement age who may need particular rostering arrangements that accommodate their decreased energy levels. Further, there are many younger generation nurses who greatly value their week-ends for family, sport and other kinds of social activities. In order to meet the wide variety of rostering needs among the different generations of nurses in the workforce, unit managers

need to understand the individual needs of unit team members, to be responsive to their particular situations, and to be flexible, equitable and skilful in managing shift allocations. It is probable that nurses accept it as inevitable that not every rostering request can be met. It may therefore be that perceptions of the unit manager as being fair and equitable in efforts to meet requests is the most critical issue to nurses' feelings about their scheduled work allocations. Inequitable treatment may result in some nurses experiencing frequent work-family conflict and, as occurred in this study, give rise to feelings of resentment about work, and therefore potentially creating a negative view of the quality of their working life more generally. This situation can have a detrimental effect on nurses' psychological wellbeing (Yildirim & Ayca, 2008) and is likely to increase levels of nurse stress and burnout (Admi, et al., 2008; Grunfield, et al., 2005; Hang-yue & Loi, 2005; West, et al., 2009).

6.8.1 The links between work/family fit and work values

Within the essence of Dawis and Lofquist's Theory of Work Adjustment (Dawis & Lofquist, 1984), an acceptable work/family fit can be seen as essential in meeting the work value of safety, within which employee health and wellbeing is central. As mentioned in Chapter 3, the work value of safety is associated with employees' knowledge that workplace policies and practices are protective. Those that are family-friendly and promote flexible working arrangements help promote an acceptable work/life fit for employees. However, if protective policies promoting fairness and flexibility in working hours are not reinforced in the practices of those administering staff rosters, organisations are not effectively enabling employees to meet the work value of safety. Further, when nurses work in environments that use

the self-rostering process recommended by Bennett (2001), it is likely that the sense of personal control over work hour allocations would help individuals meet the work value of autonomy, which is linked to the freedom to express control at work.

6.9 A sense of injustice

While survey participants generally felt positive about their overall quality of working life, it was disturbing to find, from multiple comments, that underlying feelings of grievance coexisted with this optimistic view. Almost a third of all participants expressed feelings of grievance about the toll of excessive workloads on their personal physical and emotional wellbeing, and this caused them to feel they were being treated unfairly. This sense of injustice was fuelled by participants' perceptions that they were not adequately rewarded for their hard work, threats to their personal safety from workplace bullying and aggression, the lack of resources to do the work, and inequities in rostering. The sense of injustice was further inflamed by participants' perceptions of being undervalued as health professionals. While participants generally felt positive about 'management', comments implied that some of the nurses in this study viewed there was a lack of effective leadership response to their current problems and that this reflected how they were generally undervalued by senior managers and others in the work environment. As evidenced in the previous chapter, the participants used words such as "not highly regarded", "lack of acknowledgement", "badly undervalued" and "not considered important enough" when expressing these views. This is reflective of studies conducted by Spence-Laschinger (2004) and Webster et al. (2009), both of which showed that nurses perceived they did not receive the respect they deserve from their managers.

The results of this study also bear resemblance to the findings of Considine and Jakubauskas' (2008). They reported that while participants in their study felt valued by their patients and co-workers, they did not feel valued by their more senior colleagues and nurse leaders.

High workloads were shown to be impacting upon the ability for participants to provide quality care, and thus to experience the associated feelings of satisfaction. , Buchanan and Considine (2002) explain that it is primarily the satisfying interactions with patients that provide nurses with the intrinsic rewards that keep them in the profession. As they emphasise, if nurses are to be retained in the workforce, the 'pull' of the intrinsic rewards must be sufficient to offset the 'push' factors which are the extrinsic weaknesses of the profession; the negative aspects of nursing such as the relatively low pay, the heavy work, shift work and limited career advancement opportunities. In 2002, Buchan and Considine stated that in NSW hospitals, nurses were working in a system where "the balance between intrinsic rewards/extrinsic liabilities has been broken" (p.46). Considine and Jakubauskas' (2008) recent description of current working conditions in NSW hospitals as "appalling" suggests this situation has not changed. In this study, the generally positive view of overall quality of working life held by the participants suggests that the situation is not as dire in Victoria's public hospitals. However, with a third of participants expressing negative feelings about their working conditions, there are indications that the balance between the intrinsic and extrinsic 'push' and 'pull' factors could be quite precarious.

6.10 Future career decisions

The proportion of participants in this study who were planning to leave nursing is very similar to the 14% of over 30,000 nurses in the NEXT (Nurses' Early Exit) Study who frequently thought about giving up nursing (Hasselhorn, et al., 2005). However, this percentage is considerably smaller than has been reported in some other research (Considine & Jakubauskas, 2008; Gardulf, et al., 2005). It is much lower, for example, than the approximately 60% of over 500 nurses in Considine and Jakubauskas's (2008) Australian study who had seriously considered leaving the NSW public health system in the 12 months prior to the study being conducted. Nevertheless, given that intention to quit is a reliable predictor of actual turnover (Brewer, et al., 2009; Hayes, et al., 2006; Irving, Coleman, & Cooper, 1997; Liou, 2009; Parasuraman, 1989), the number of nurses in this study who plan to leave their profession within the next two years represents a substantial risk of losing a great deal of valuable nursing competence and experience from the Victorian nursing workforce.

The findings of this study indicate that the nurses planning to leave, and those having already left nursing, experienced feelings of regret and sometimes resentment about this decision. For example, the comment: "In the end it just got too hard and actually it was sad for me to leave", is one of many suggesting that while participants enjoyed nursing, they felt unable or unwilling to continue working under current conditions. This resonates with Cheung's (2004) finding that nurses who had resigned from working in Australia's hospitals left with feelings of ambivalence and had found making the decision to leave nursing was difficult and often

psychologically painful. It also resonates with Gordon (2005) who stated that there is not a true shortage of nurses, only a shortage of nurses willing to remain under current working conditions. The key messages from this study are that the participants generally enjoy nursing and do not want to leave. Improved working conditions, particularly more manageable workloads and feeling valued for what they do, are key factors that may encourage those planning to leave to change their minds and continue with their career in nursing. Improvements in these areas might also deter others from considering the need for a future career change, for example the participants who stated they planned to stay in nursing only because they currently perceived they had no other choice.

6.11 Chapter summary

The study results have been integrated and discussed within the context of the associated literature and linked to the six work values central to Dawis and Lofquist's Theory of Work Adjustment. It has been shown that the majority of participants gained pleasure and satisfaction from nursing work, enjoyed the friendship and support of their work colleagues, and felt generally positive about their quality of working life. However, there is evidence that there are aspects of work that, for many participants, were a cause of anxiety and tension that detracted from their enjoyment of work. For some, the degree of tension was such that it had given rise to thoughts about leaving their chosen profession, albeit mostly with feelings of reluctance. Evidence has been provided to show that, even among those planning to stay, many participants were experiencing anxiety resulting from high work demands impacting negatively upon their personal physical and mental

wellbeing, and on their ability to work within desired professional standards of care. Some participants reported that the skills and attributes of their unit managers enhanced their work life, and encouraged them to stay in nursing. Others reported that a lack of competency in their unit managers was a source of tension that disposed them towards thoughts of leaving their jobs and the profession. The need for a roster that facilitated an acceptable work/family fit, perceptions of fairness between financial and other rewards for work effort, and feeling valued as a health professional were all shown as important to quality of working life and to decisions about continuance in the nursing profession. The problem of bullying and aggression in the nurses' work environment was revealed as a source of tension and threat to the health and safety of a minority of participants.

It was demonstrated that the accumulation of multiple sources of tension were a cause of a pervasive sense of injustice among the study participants. It was further illustrated how the multiple concerns causing the tension in the workplace had the potential to violate personal and professional work values. This is a cause for disquiet because, as Dawis and Lofquist (1984) explain, it is the incompatibility between these values and those seen as promoted by the employer that lead to employee dissatisfaction, reduced quality of working life, and an increase in the risk of attrition.

The following chapter draws together the conclusions, the implications and recommendations for change suggested by the study findings. It also suggests directions for future research.

CHAPTER 7 – CONCLUSIONS AND RECOMMENDATIONS

7.1 Introduction

The impetus for this study was concern with the working conditions of nurses employed in Victoria's public hospitals during a time of a serious, and on-going, shortage of qualified nurses.

To the researcher's knowledge, this study is the first conducted within Victoria's public hospitals that has comprehensively explored RNs' opinions about multiple factors impacting upon the quality of their working lives. It is also the first to have explored differences in opinion about the factors affecting quality of working life between nurses planning to stay, and those planning to leave the nursing profession.

This chapter presents the implications and conclusions arising from the study findings. It also offers recommendations for action and future research. The chapter also includes reflection on the mixed-method research approach used, and outlines the limitations of the study.

7.2 Implications of the study

Although the nurses in this study felt generally positive about the overall quality of their working lives, multiple aspects of their work were shown to be sources of tension. It is of primary concern that a pervasive sense of injustice about some

aspects of their working conditions appeared to exist generally among the study participants.

Past reports have resulted in many recommendations to improve nurses' working conditions, but the findings in this study suggest that much more still needs to be done to improve their quality of working life. The findings identified that the organisational and professional issues that need to be addressed more effectively relate to: the culture of the work environment; the pressure of work; nurses' health and safety; the skills and attributes of unit managers; financial and other rewards for nurses; and policies and practices that promote an acceptable work/family fit. Suggested recommendations relating to each of these areas are presented in turn.

7.3. The culture of the work environment

Positive relationships with nurse colleagues appeared to play an important role in promoting the participants' quality of working life, and seemed to strengthen their capacity to cope with the everyday pressures of the work. Conversely, a lack of support and negative relationships, especially bullying from work colleagues, were shown to cause stress and to be a cause of plans to leave the profession. These findings support those of previous studies, and reinforce the need for nurse unit managers who can foster a culture of camaraderie and support within their work units. Hospital Boards of Management need to ensure that nurse unit managers, and all senior personnel actively role-model respectful and supportive communication, and are equipped with the skills to deal appropriately with inter-personal conflicts that arise between members of staff. Further, there needs to be a process, at senior

management level, for monitoring whether or not policies aimed at enhancing workplace culture are put into practice at unit level.

In order that new graduates bring skills to the workplace that will help facilitate a positive workplace culture, it is recommended that nurse education includes a strong and dynamic focus on communication styles that promote positive inter/professional and other workplace relationships. For example, simulated learning activities, including role-plays and various other multimedia approaches, can be used to emphasise the positive and negative effects of particular types of communication.

7.4 Pressure of work

This study revealed that while the participants enjoyed the intrinsic rewards of nursing, the high pressure of work limited the time they could spend with individual patients. This impacted negatively on the quality of patient care that they were able to provide, and this was a cause of stress and tension. There was also a sense that while they were often exhausted, and felt angry and resentful about the high demands of their work, the participants felt powerless to control their work allocations. It is recommended that a strategy be designed and implemented in Australian hospitals that is based on 'The Productive Ward Program: Releasing Time to Care' initiative that has recently been introduced in UK hospitals. An innovation of this type will empower nurses to have a voice in how systems within their organisations are conceived, and in how all the intersecting aspects of patient care are managed (NHS Institute for Innovation and Improvement, 2010). This may help nurses in Australia to maximise time spent with their patients and so increase the

potential to provide the quality of patient care that is professionally satisfying. It may also help in overcoming other difficulties this study has identified as hindering them in getting their work done. For example, it may help identify practical strategies for better managing issues such as the lack of equipment and the sharing of resources between work units.

7.5 Nurses' health and safety

Aggression in the workplace, particularly in the form of bullying and harassment, was identified as a problem in this study, and was, in some cases, a reason for participants planning to leave nursing. Recipients of such behaviour felt unsupported by those in management, and this caused feelings of bitterness and grievance. In addressing this issue, it is recommended that nurses are included in planning strategies to prevent aggression in the workplace, and that they are empowered with coping mechanisms. Given the severity of stress associated with any conflict between colleagues, it is vital that university and hospital nurse educators ensure that nurses are aware of the full range of behaviours that constitute bullying and harassment. It is important that they know how to action the policies that can protect them from such behaviour. Nurses at every level must be encouraged to advocate that only courteous and respectful styles of communication are acceptable in their workplaces. It is also recommended that nurses be encouraged to combine their efforts and speak out together in defence of any nurse seen to be treated inappropriately, even when such behaviour stems from managers.

Further, in line with the actions identified as necessary to protect employees in the tourism and hospitality industry from customer aggression (Karatepe, et al., 2009), it is recommended that written policies and procedures related to workplace aggression be clearly displayed in all areas where nurses work. Even though it takes valuable time, it is also recommended that nurses at every level are encouraged to formally report all incidents of bullying and other forms of aggression. These reports require at least a monthly review so that the effectiveness of the actions taken to deal with the issues can be evaluated and improved as indicated. This activity also has extended benefits. These real-life events could be used as case scenarios in conflict management training for student nurses or employees. One of the key notions here is that there needs to be a fit between the demands of the job and employee capabilities. If the demands of aggressive interpersonal interactions in the work area are beyond a nurse's coping abilities, the situation is likely to prove extremely stressful and destructive to that individual's quality of working life. Therefore it is best that those with less well-developed ability to cope with such behaviour are supported particularly strongly, especially when scheduled to work in higher risk departments such as accident and emergency units. If necessary, the time any individual appearing susceptible to psychological damage from aggressive behaviour remains continuously employed in a high risk area should be limited.

7.6 Unit managers

The study findings suggest that while some unit managers seemed to have the appropriate high level of managerial expertise, others were ill-equipped for the challenges of the position. It is therefore recommended that nurses new to these

senior roles be offered opportunities to undertake educational programs specifically designed to develop their leadership skills. It is also recommended that initially they work alongside experienced mentors. The role of the unit manager in demonstrating equity in the treatment of staff, sustaining morale and creating an environment of efficiency, safety and optimism cannot be underestimated. As Davidson (2010) explains, mentoring and succession planning are all vital in ensuring current and future clinical managers and leaders are equipped with the necessary skills to achieve all that is required. It is particularly important that nurse unit managers develop the skills to foster the health and safety of all unit staff. It is a priority, for example, that they are given opportunities to develop high-level conflict resolution skills in order to support staff and deal with their concerns effectively when workplace conflict occurs. In order to monitor the skill level of nurse unit managers, it is recommended that senior-level managers and nurse leaders ensure that managers at the unit level have the benefit of a formal performance appraisal at least twice a year. The views of the unit nurses concerning the effectiveness of their nurse unit managers need to be taken into account when these appraisals are conducted.

7.7 Financial and other rewards for nurses

This study highlights the importance of fair pay for nurses, particularly in relation to equity of wage compared to other types of employment. Money can be perceived as a measure of professional status, therefore nursing needs to offer competitive pay rates that appropriately reward skills, knowledge, responsibilities and post-graduate education achievements. Improving the financial reward is one way to address the problem of nurses' feeling that their contributions at work are undervalued.

However, because of the current economic situation, it is acknowledged that the monetary recognition nurses might consider appropriate is unlikely to be achieved within the foreseeable future. In the meantime, it is possible to implement other less costly strategies to demonstrate to nurses that their efforts are valued. For example, as is the case in some hospitals with magnet status, monthly awards for excellence in nursing practice and funded social functions for staff could be implemented. These demonstrations of appreciation may help nurses to feel more valued, but they are not of great financial demand on the limited monetary resources currently available within Australian healthcare organisations.

This study also highlighted that the degree of support for professional development and the extent of opportunities for career advancement were not considered sufficient to adequately reward the participants for the effort they put into their work. This study identified the need for an increase in rewards and benefits for nurses. There is a need for paid time release for nurses to undertake professional development activities. There is also a need for a variety of suitable career advancement pathways within nursing to make continuing in the profession more appealing. As evidenced in this study, many nurses gain job satisfaction from work that involves direct patient care. The findings indicate an urgent need for more career development and advancement opportunities to be established for nurses. In particular, it is recommended that these opportunities include more that involve direct patient care in stimulating clinical environments.

Appropriate rewards for nurses, in terms of salary and professional development and advancement opportunities, are all important in that they acknowledge nurses' professional status and worth. Any strategies that improve the professional status of nurses can only have a positive impact on their retention in the profession.

7.8 Policies and practices to support work/family fit

While, for some participants in this study, shift work was viewed as a way of successfully combining work and family commitments, it was, for others, a cause of work/family conflict that caused them to consider leaving nursing. It is recognised that there are insufficient strategies in place to adequately address the factors leading to work/family conflict in the wider Australian workforce (Lindsay, et al., 2009). As applies to employees in many other occupations in this country, work/family conflict in nursing could be relieved by the availability of on-site childcare and more flexible leave options. In addition, in nursing, further re-arrangement of shift times and length is required so that nursing work can blend more readily with family life. Further, to reiterate the recommendations made almost a decade ago by Bennett (2001), more attention still needs to be paid to work schedules to ensure that there is "flexibility, fairness and equity of rostering through such means as self-rostering and job sharing" (p. 21). Such practices will help prevent the feelings of resentment evident among participants in this study about unfair treatment in regard to their work hour allocations.

All of the factors identified as problematic in this study are amenable to interventions. All of the strategies suggested will help improve nurses' working conditions, and will help to demonstrate that they are valued as health professionals.

If implemented effectively, it is anticipated that the outcomes of the recommended strategies will promote feelings of professional worth in nurses. This may help relieve the sense of injustice about their treatment at work that the findings of this study suggest currently prevails.

7.9 Limitations of the study

Although this research produced interesting findings, many of which were comparable with those of other studies, it did have a number of limitations. Participants were restricted to RNs employed in the acute care areas of Victoria's public hospitals. The findings cannot therefore be generalised to other health care settings, to ENs, or nursing populations working in areas other than acute care, for example, the community, aged care, mental health or midwifery. Further, in relation to the survey, there was a relatively low response rate (41%). However, this exceeded the average response rate for large surveys (between five and six pages) that Bogan (1996) reports ranges from 21% - 38%. The relatively small number of interviewees could also be considered a limitation. However, the findings from the qualitative component of the study were generally compatible with the quantitative results.

In regard to the qualitative data, it is possible that nurses who felt strongly aggrieved about issues at work may have been more likely to volunteer for an interview than did those who were more satisfied with their working conditions. However, while there was a risk of volunteer bias, overall the interviewees seemed to present a

balanced view, as they commented on both the enjoyable and troublesome aspects of their work.

The use of the Theory of Work Adjustment as the theoretical underpinning for this thesis also presented some limitations. The indirect approach taken to gaining understanding of the participants' work values made it challenging to draw conclusions as to the nature of the work values that were important and the degree to which they were, or were not, met in the work environment. This led to some difficulties fully linking study findings with the key concepts of the theory. This linking was particularly challenging given that multiple factors relating to quality of working life were explored and that a large amount of data was generated from both the quantitative and qualitative approaches. While some links were made between the six work values central to the theory and the qualitative findings, links were very difficult to make in relation to quantitative findings. It is recommended that, in future studies, a more direct approach to determining participants' work values be adopted. Specifically, direct questions about which aspects of work are valued most highly should be asked of both survey participants and interviewees.

Another limitation of the study concerns the focus on the participants' plans to leave the profession rather than on actual turnover. As Morrell (2005) noted, conclusions based on intent to leave rather than on action need to be viewed with some caution. However, Ajzen and Fishbein (1980, 2000), in their theory of planned behaviour, suggest that intention to leave one's profession is a strong precursor of actually leaving. Therefore the information gained about nurses' reasons for planning a career

change is useful in providing a guide as to which strategies to constrain attrition may be the most appropriate.

Finally, while this research has provided extensive information about a broad range of factors impacting upon nurses' quality of working life, the breadth of this study has limited the depth of inquiry into each of the individual issues raised. Due to the broad range of factors explored in this study, and the restricted time-frame, a comprehensive statistical analysis was not possible within the scope of this thesis. It is anticipated that more sophisticated quantitative analyses will be conducted at a later stage.

7.10 Recommendations for further research

In order to understand the factors that impact the quality of working life of nurses employed in Victoria more fully, it is important to extend the research to a greater number of hospitals, including those in the private sector, and in rural areas. It is also important that future research includes a more diverse cohort of nurses, such as those employed in the community and other areas of specialist practice.

A number of the problems identified as having a negative effect on the participants' quality of working life bear resemblance to those noted in earlier reports. As a result, some of the actions proposed to address these problems tend to reiterate suggestions made previously. This raises the question as to whether or not prior recommendations to address the issues confronting nursing are being fully actioned and the effects permeating down effectively to the clinical areas. It is strongly

advocated that future research needs to monitor the degree of success of strategies recommended in governmental reports. It is advised that healthcare organisations conduct longitudinal studies, either annually or bi-annually, in order to evaluate the effectiveness of these strategies in improving nurses' quality of working life over time.

It is recommended that prior to undertaking future research into nurses' quality of working life, key stake-holders collaborate in the development of a standardised QWL survey for use in Australia. This would be advantageous because it would provide national consistency in the evaluation of nurses' quality of working life. It would provide a breadth of specific data that could be a useful means of generating policy change. However, while a standardised survey would have these advantages, it may be necessary to allow for some variability in survey design in order to accommodate any issues unique to particular types of work areas.

The study results suggest that further refinement of the survey could be beneficial prior to future use. For example, as it emerged as such an important issue, thought could be given to regrouping items so as to have a separate scale to measure opinions about employer support for work/family fit. In addition, it is suggested that in order to avoid confusion, careful consideration be given to constructing measures to ensure satisfaction with nursing as a career can be clearly distinguished from satisfaction with current position. Alternatively, given concerns with the extent of subjectivity in job satisfaction measures (B. Brooks & Anderson, 2004; Denvir, et al., 2008), it may even be advisable that they be excluded from future research into quality of working

life. It is notable that Denvir et al. (2008) do not include a job satisfaction scale in their refined version of the Institute of Employment Studies QWL survey planned for future use nationally in the UK.

In this study, the qualitative data revealed some issues not apparent in the quantitative evidence. These include the depth of concern about bullying and aggression and the underlying sense of injustice among participants. Therefore, it is recommended that mixed research methods, that include qualitative interviews, be used for future exploration of nurses' quality of working life.

It is also recommended that future research evaluates specific aspects of nurse education. In particular, it is important to determine the efficacy of programs aimed at enhancing nurses' communication skills. It is suggested, for example, that longitudinal studies be used to evaluate the effect of educational efforts on nurses' self assessed capacity to deal with challenging workplace behaviours, especially workplace aggression. This type of research could inform the development, and potential improvement, of nursing curricula.

Further, it is suggested that studies be undertaken that focus on nurses' opinions and ideas about the design of their work units and work systems. It is important to identify, from the perspective of nurses, the potential changes that could be made in their areas of work that will help them to better manage their work demands.

Finally, while it is acknowledged that it might be difficult to resource, it is strongly recommended that formal exit interviews be conducted with nurses as they leave health care organisations. This offers an opportunity to record information about why people choose to leave and their future career plans. This could enhance understanding of why nurses exit the profession as opposed to seeking work in alternative nursing work venues and/or fields of nursing. Further, it could help identify the types of rewards that might entice individuals to stay, which could vary between the different generations of nurses (Frag, Tullai-McGuinness, & Anthony, 2009). In order that nurses who choose to exit organisations are encouraged to be open and honest about their reasons for leaving, their exit interview should be conducted by someone independent of their nurse unit manager. Collating and analysing data from formal exit interviews will increase understanding of the contemporary factors that are impacting upon nurses' decisions to leave. This has the potential to identify areas within organisations where the workplace culture and management systems are supportive of nurses' needs, or where improvements are required. Exit interviews could therefore prove valuable in helping to determine the interventions most likely to improve nurses' quality of working life and so encourage them to remain in the nursing workforce.

7.11 Concluding comments

In spite of many recommendations to improve working conditions for nurses in Australia that have been proposed in governmental reports over the last decade, the results of this study are compatible with the findings of much earlier research. The factors shown to be negatively impacting upon the quality of working life of

participants in this study are similar to those experienced by nurses in the past. They are also similar to those that are currently affecting their counterparts in other states of Australia and overseas. However, the findings of this study identify the most powerful factors currently motivating nurses to stay in the profession and driving them towards a career change. On a positive note, contrary to the findings in Considine and Jakubauskas' (2008) NSW study, the percentage of participants in this study planning a career change does not indicate that nurses employed in Victoria's public hospitals are likely to leave the profession in droves. Nevertheless it does represent a potential loss of considerable nursing expertise from an already depleted nursing workforce.

The hurdle confronting nurses in this study was that their desire to meet personal work values, which include providing a quality of care that feels professionally, morally and ethically appropriate, was difficult when they were also required to meet the budget-driven goals of their employing organisations. The challenge they were facing was to provide a quality of patient care that was personally rewarding and to achieve other professional aspirations and career goals in a hospital environment where cost-saving practices seemed to be prioritised above their needs and those of their patients. It was abundantly clear that, in the view of study participants, employers considered financial concerns before quality patient care and staff health and safety. As a result, current working conditions appeared to be causing multiple tensions and an underlying sense of injustice among the participants that may possibly be smouldering within the broader nursing workforce. As Cheung, Bessell and Ellis (2004) found, when tensions have been brewing, a single action or event

can serve as a shock that triggers a decision to exit the profession. It is important to avoid such triggers and a 'tipping of the balance' whereby the sense of injustice that currently exists is exacerbated to the point where even more nurses decide to make a career change.

Given that the causes of concern are similar to those affecting nurses internationally, it may be that efforts to redress nurses' discontent with working conditions that have proven successful overseas, such as the magnet hospital model, can also prove beneficial if adopted more broadly in Australia than is currently the case. In particular, endeavour is required to restructure nursing work environments and nursing practices so as to reduce work pressure and maximise the ability for nurses to reap the intrinsic rewards of the work.

The findings of this study clearly showed that the voices of front-line nurses must be heard in order to identify the improvements needed at unit level if the nursing shortage is to be successfully addressed. The issues identified highlighted problems in Victoria's public hospitals that require immediate attention to ensure that the prevailing working conditions do not drive increasing numbers of nurses into alternative careers. These issues are largely under the influence of politicians and hospital administrators who must therefore be at the forefront of discussions with all key stakeholders, including those involved in industrial relations.

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APPENDICES

Appendix A: Survey participant information letter

Victoria University
PO Box 14428
MELBOURNE CITY MC VIC 8001
Australia

School of Nursing & Midwifery
Telephone: (03) 9919 2830
Facsimile: (03) 9919 2719



St Albans Campus
McKechnie Street
St Albans

Dear Nurse Colleague

As you know the nursing profession is facing a critical shortage of nurses that is expected to become much worse over the next few years. Qualified nurses are leaving the profession at alarming rates, but no-one knows exactly what sort of experiences at work are most closely linked to long term commitment to being a nurse or decisions to leave the profession. We, the research team of *Professor Terence McCann, *Dr. Daniel Chew and Ms Rita Funnell, (PhD student researcher) at Victoria University, believe it is important that the voices of nurses currently working in hospitals are heard in relation to the impact of everyday experiences in the workplace on commitment to a career in nursing.

Rita Funnell is a Division 1 registered nurse with a wide range of nursing experience, including the fields of medical/surgical nursing, district nursing and palliative care. It is her passion for nursing that provides the impetus for this PhD study.

Your hospital is one of a small number in which Division 1 nurses are being asked to provide information about their experiences and views about their work. You are invited to participate in this study. Your participation is completely voluntary but we would very much appreciate you sparing about 15 - 20 minutes of your time to complete the attached questionnaire.

It is highly unlikely, but possible, that certain questions may raise troublesome feelings. In this event you may choose to ignore such questions. Should you feel the need of help with feelings raised you may seek assistance from Staff Support Services in your hospital of employment.

You have been drawn from a random sample of Division 1 nurses and to be truly representative it is important that you complete your questionnaire as fully as possible. We would be very grateful if you would do this and return it anonymously in the stamped addressed envelope provided.

The hospital where you work will be identifiable to the research team through the colour of the paper on which the questionnaire is printed, but your answers will be completely confidential. Neither your name nor any number that could identify you will be on the questionnaire. The questionnaires will be available only to members of the research team. All members of the team are legally and ethically required to maintain all aspects of confidentiality related to this research. The questionnaires will be retained for five years after the research project is completed and then destroyed.

The results of the survey will be made available in statistical form and will be integrated into a final thesis and may be included in a number of research publications and conference presentations. Ms Rita Funnell will be glad to return to the hospital, if invited, to present a summary of the findings to interested people.

As a thank-you for taking time to complete the questionnaire you are invited to participate in a draw for a \$100 gift voucher, redeemable through TICKETMASTER 7, that will entitle the winner to attend any event, concert or show of personal choice. To participate in the draw you will need to complete the tear-

off slip at the end of the questionnaire and send it to Ms Rita Funnell. In order to ensure your anonymity you may choose to send it separately from the questionnaire. Also, to ensure confidentiality, the name of the winner cannot be published. To guarantee fairness, Associate Professor Terence McCann will conduct the draw in the presence of Dr. Daniel Chew and Ms Rita Funnell. The voucher will be posted to the winner via the internal mail system at Victoria University. Again, to ensure confidentiality the entry slips will be shredded once the gift token has been sent to the winner.

We are happy to answer any queries you have about this research. Please email or call Rita Funnell about any aspect of the project. Rita is available by phone on 9919 2830 or by email at rita.funnell@vu.edu.au

Thank you for your assistance

Yours sincerely

Assoc. Prof. Terence McCann
Dr. Daniel Chew
Ms Rita Funnell

<p>If you have any queries or complaints about the way you have been treated in this research please contact Associate Professor Terence McCann (Telephone 9919 2325) or the Ethics Officer, Human Research Ethics Committee, Victoria University, PO Box 14428, MCMC, Melbourne, 8001 (Telephone 9688 4710).</p>

*Please note there has been a change to the research team members since the survey was distributed.

Appendix B: Nurses Quality of Working Life Survey



NURSES QUALITY OF WORKING LIFE SURVEY

I would be very grateful if you would answer all of the following questions by ticking the boxes or writing in the spaces provided. Please return the completed questionnaire in the reply-paid envelope provided. If you have any queries about the survey or completing the questionnaire, please contact me, Rita Funnell, by telephone on 9741 2604 or email: rita.funnell@vu.edu.au Thank you for your assistance with this research.

A. About you

In order to understand your views I would firstly like to know a few things about you. The answers you provide will be used only to help with the research analysis, and will not be used in any way to identify you personally.

1. Are you: Male? ₁ Female? ₂

2. What nursing registration do you hold? *(Tick more than one if applicable)*

RN (Division 1)	<input type="checkbox"/>	₁	RN (Division 2)	<input type="checkbox"/>	₂
RPN (psych)	<input type="checkbox"/>	₃	RM (midwifery)	<input type="checkbox"/>	₄
Mothercraft	<input type="checkbox"/>	₅	Other	<input type="checkbox"/>	₆ <i>(Please specify)</i>

3. What is the highest university qualification you hold?

None	<input type="checkbox"/>	₁	Bachelor degree	<input type="checkbox"/>	₂
Post graduate cert	<input type="checkbox"/>	₃	Post Grad Diploma	<input type="checkbox"/>	₄
Masters	<input type="checkbox"/>	₅	PhD	<input type="checkbox"/>	₆
Other	<input type="checkbox"/>	₇	<i>If other please specify</i>		

4. How many years of experience do you have as a registered nurse?

5. What was your age last birthday?

6. What is your **main** area of work? *(Please tick **one** box)*

Medical/surgical	<input type="checkbox"/>	₁	Critical Care	<input type="checkbox"/>	₂	Coronary Care	<input type="checkbox"/>	₃
------------------	--------------------------	--------------	---------------	--------------------------	--------------	---------------	--------------------------	--------------

- | | | | | | |
|-----------------|-----------------------------|----------------|-----------------------------|-------------|-----------------------------|
| Emergency Dept. | <input type="checkbox"/> 4 | Peri-operative | <input type="checkbox"/> 5 | Day Surgery | <input type="checkbox"/> 6 |
| Rehabilitation | <input type="checkbox"/> 7 | Gerontology | <input type="checkbox"/> 8 | Paediatrics | <input type="checkbox"/> 9 |
| Outpatients | <input type="checkbox"/> 10 | Community | <input type="checkbox"/> 11 | Other | <input type="checkbox"/> 12 |

If other please specify

7. Length of employment as a Div. 1 nurse at current hospital:

yrs	mths
-----	------

8. Do you work: Full-time? 1 Part-time? 2 Job share? 3
 Nurse Bank 4 Agency? 5 Other? 6

If other please specify.....

9. What is your family background? (*Please select more than one family background if appropriate*)

- | | | |
|---|-------------------------------------|---|
| Australian <input type="checkbox"/> 1 | Oceanic <input type="checkbox"/> 2 | UK and Eire <input type="checkbox"/> 3 |
| European <input type="checkbox"/> 4 | African <input type="checkbox"/> 5 | North American <input type="checkbox"/> 6 |
| South American <input type="checkbox"/> 7 | Asian <input type="checkbox"/> 8 | Middle Eastern <input type="checkbox"/> 9 |
| Other <input type="checkbox"/> 10 | <i>If other please specify.....</i> | |

B. Your views about your job

The following questions ask how you feel about your current work. There are no right or wrong answers. Please work through this section quickly and, focusing on your main area of work, please indicate how far you agree or disagree with each statement by circling one number on each line.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Communication					
10. Nurses are kept informed when changes occur in this hospital	1	2	3	4	5
11. The information I need to do my job is readily available	1	2	3	4	5
12. The informal communication network is the most effective communication channel around here	1	2	3	4	5
13. This hospital provides useful feedback regarding decisions made by management	1	2	3	4	5
Pay and benefits					
14. Good performance is rewarded fairly here	1	2	3	4	5
15. I am rewarded fairly in view of my experience	1	2	3	4	5
16. I am satisfied with my pay	1	2	3	4	5
Performance and appraisal					
17. I am given regular feedback on my performance by my unit manager	1	2	3	4	5
18. My unit manager takes performance appraisal seriously	1	2	3	4	5
Management					
19. My unit manager is sensitive to my work/life issues	1	2	3	4	5
20. My unit manager lets me know how I am doing	1	2	3	4	5
21. I have a good working relationship with my unit manager	1	2	3	4	5
22. My unit manager supports me when things go wrong	1	2	3	4	5
23. My unit manager respects the decisions nurses make about how patient care is delivered	1	2	3	4	5
24. I am confident I will receive support from my unit manager even if I make a mistake	1	2	3	4	5
25. My unit manager works to prevent an attitude of blame within the team when a mistake is made	1	2	3	4	5
Colleagues					
26. I am treated with respect by the doctors I work with	1	2	3	4	5
27. I do not feel part of an efficient team	1	2	3	4	5
28. I have a good working relationship with my nurse colleagues	1	2	3	4	5
29. My nursing colleagues can be relied upon to support me when things get difficult in my job	1	2	3	4	5
30. Nurses here are respected by other members of the health care team	1	2	3	4	5
31. The team works hard to support nurses new to this unit	1	2	3	4	5

C. Equal opportunities

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
32. Nurses with family commitments have equal career opportunities here	1	2	3	4	5
33. Part-timers have equal access to career progression	1	2	3	4	5
34. This hospital actively promotes flexible working arrangements for its staff	1	2	3	4	5
35. This hospital provides good support for staff with family responsibilities	1	2	3	4	5
36. This hospital provides a service to patients which is free from discrimination	1	2	3	4	5
37. My work environment is free from bullying and harassment	1	2	3	4	5
38. This hospital has taken effective actions to prevent all forms of racial harassment	1	2	3	4	5
39. I am confident that effective action will be taken to tackle racial harassment if it occurs	1	2	3	4	5
40. Racial harassment is uncommon in this hospital	1	2	3	4	5
41. This hospital makes its positive commitment to Equal Opportunities clear	1	2	3	4	5
42. I feel I have a fair chance of success when applying for internal vacancies here	1	2	3	4	5
43. This hospital is slow to deal with cases of discrimination	1	2	3	4	5
44. This hospital is a 'family-friendly' employer	1	2	3	4	5
45. This hospital is good at supporting employees with disabilities	1	2	3	4	5
46. I feel that I am fairly treated here	1	2	3	4	5
47. The work environment is free from racial/ethnic discrimination	1	2	3	4	5
48. Men and women have the same chance of career advancement in this hospital	1	2	3	4	5
49. My work environment is free from sexual harassment	1	2	3	4	5
50. I am confident this hospital will act effectively on any reported incident of staff harassment	1	2	3	4	5
51. Requests to change work patterns are received positively here	1	2	3	4	5
52. People from different racial/ethnic backgrounds have equal access to career progression in this hospital	1	2	3	4	5

D. Your professional development

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
53. I am encouraged to develop my career	1	2	3	4	5
54. My unit manager takes my career development seriously	1	2	3	4	5
55. I am able to get time off work for career development	1	2	3	4	5
56. I am given many opportunities to develop my career	1	2	3	4	5

57. My career development needs are regularly discussed with my unit manager	1	2	3	4	5
58. This hospital actively supports my continuing professional development	1	2	3	4	5

E. Your general wellbeing

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Stress and work pressure					
59. I often feel I am under too much work pressure	1	2	3	4	5
60. The demands of my work seriously interfere with my private life	1	2	3	4	5
61. I have felt under constant strain recently	1	2	3	4	5
62. The pressure of work prevents me from doing my job in the way I would like	1	2	3	4	5
63. I have recently been losing sleep over my work problems	1	2	3	4	5
64. I sometimes feel overwhelmed by the pace of change here	1	2	3	4	5
65. The pace of change is too fast here	1	2	3	4	5
66. I feel emotionally drained by my work	1	2	3	4	5
67. I feel burned out by my work	1	2	3	4	5

Health and safety

How satisfied are you with the following? Please indicate how satisfied or dissatisfied you are with each statement by circling the appropriate number. (*Please circle **one** number on **each** line*)

	Strongly dissatisfied	Dissatisfied	Neither satisfied or dissatisfied	Satisfied	Strongly satisfied
68. Your physical working environment	1	2	3	4	5
69. Health and safety training in this hospital	1	2	3	4	5
70. The cleanliness of the working environment	1	2	3	4	5
71. Your access to staff counselling	1	2	3	4	5
72. Your manager's attitude to health and safety issues	1	2	3	4	5
73. The quality of the equipment you use in your job	1	2	3	4	5
74. The availability of supplies and equipment you need to do your job	1	2	3	4	5
75. Facilities for tea/meal breaks	1	2	3	4	5
76. Your access to Occupational Health Services (excluding counselling)	1	2	3	4	5
77. Orientation to unfamiliar/new equipment you are required to use	1	2	3	4	5
78. Staff protection measures in your workplace	1	2	3	4	5

F. Your job satisfaction

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
79. There is a lot of variety in my job	1	2	3	4	5
80. I do interesting and challenging work	1	2	3	4	5
81. I get a feeling of accomplishment from my job	1	2	3	4	5

82. I find real enjoyment in my job	1	2	3	4	5
83. I am seldom bored with my job	1	2	3	4	5
84. Most days I am enthusiastic about my job	1	2	3	4	5
85. Overall, I am satisfied with my job	1	2	3	4	5

G. Your future career plans

86a. **What are your career plans for the next two years? (Please tick one box only)**

- Plan to continue working as a nurse in this hospital because I like working here 1
- Plan to continue working as a nurse in this hospital only because I feel I have no other option 2
- Plan to seek alternative work as a nurse in another hospital 3
- Plan to seek alternative work as a nurse, but not in a hospital 4
- Plan to take a temporary break from nursing 5
- Plan to retire from working life 6
- Plan to undertake a career change 7
- Other *(please specify)* 8

86b. **If planning to continue a career in nursing, what are your main reasons for choosing to stay?**

86c. **If planning a career change, what are your main reasons for leaving the nursing profession?**

Thank you for completing this questionnaire

Please return this questionnaire to Rita Funnell in the envelope provided

If you would like to participate in the draw for the \$100 Gift Voucher from Ticketmaster please complete the slip below and return it to the address on the envelope

**** Important**

To maintain your anonymity you may choose to return the slip separately to the questionnaire



**VICTORIA
UNIVERSITY**

**A NEW
SCHOOL OF
THOUGHT**

I have completed the Nurses' Quality of Life Survey and would like to enter the draw for the \$100 Gift Voucher from Ticketmaster, to use for an event, concert or show of my choice.

Name (Print clearly please).....

Address.....

.....

Telephone.....

Email.....

To maintain participant confidentiality the winner's name will not be published. The researcher, Rita Funnell, undertakes to inform the winner by telephone or email, and to send the voucher by post. The draw will be made under supervision at the completion of data collection.

Appendix C: The expert review panel

The following seven academic researchers reviewed the Quality of Working Life Survey used in this study:

Professor Roger Gabb

Director Postcompulsory Education Centre
Victoria University, Melbourne, Australia

Professor Terence McCann

Professor of Research, School of Nursing and Midwifery, Victoria University,
Melbourne, Australia

Professor Helen Baker

Research Supervisor, School of Nursing and Midwifery, Victoria University,
Melbourne, Australia

Dr Mary-Anne Biro

Senior Lecturer and Coordinator Bachelor of Midwifery School of Nursing and
Midwifery, Victoria University, Melbourne, Australia

Dr Daniel Chew

Senior Lecturer and Research Supervisor
School of Nursing and Midwifery, Victoria University, Australia

Dr Lucy Lu (Principal Supervisor)

Lecturer and research supervisor
School of Nursing and Midwifery
Victoria University, Melbourne, Australia

Ms Caryl Robson

Nurse Educator and PhD Candidate
School of Nursing, Deakin University, Australia

Appendix D: Interviewee information letter

Victoria University

PO Box 14428
MELBOURNE CITY MC VIC 8001
Australia

St Albans Campus
McKechnie Street
St Albans

School of Nursing & Midwifery

Telephone: (03) 9919 2830
Facsimile: (03) 9919 2719



Dear Nurse Colleague

This research study involves an exploration of how the expectations of nursing held by nurses at the start of a nursing career compare to the reality of actually working as a qualified nurse and how a match or a mismatch between early expectations and workplace realities impacts on decision to continue working as a nurse.

The project involves interviews with qualified nurses who are currently working in the acute care areas of public hospitals and nurses who have left the profession. It is anticipated that the interviews will provide insights concerning how best to recruit nurses into the profession and how best to support them in the workplace. Improvement in these two areas has the potential to have a positive effect on the experience of working as a nurse and on the current nursing shortage.

The research team of Professor Colin Torrance*, Professor Terence McCann* and Rita Funnell, (PhD student researcher) is asking for your assistance in providing information from the perspective of nurses who are currently working in acute care areas.

Rita Funnell will interview nurses, who are willing to participate in the project, about their early expectations and current perceptions of nursing. The interviews will last for about 45 minutes to one hour and can take place at a mutually convenient place. So that the interviewer will not have to take notes and to ensure accuracy in interpreting what is said each interview will be audio-taped, and later transcribed. If you choose to participate in this project you will be free to stop the interview at any time and to refuse to answer any question that is asked. You may also turn off the tape recorder at any point.

The data from each interview will form part of the information to be integrated into a final thesis and may be included in a number of research publications. The interview data will be kept strictly confidential. Only your first name will be used during the interview and a pseudonym (false name) will be used in the transcribed notes, in the final thesis and in any publications connected to this study. The research material will be stored in a locked cabinet in a research office at Victoria University.

The research data will be available only to members of the research team. All members of the team are legally and ethically required to maintain all aspects of confidentiality connected to this research.

The Consent Form, the audio taped interview and the transcribed notes will be retained for five years after the research project is completed, and then destroyed.

Participation in this study is entirely voluntary and there is no financial payment for taking part. You will be free to withdraw from active participation at any time and to require that all records of your participation be destroyed and not used in any way. If you wish you will be free to access a summary of the results of the study.

It is highly unlikely, but possible that discussion during the interview may raise troublesome feelings. In the event that you feel the need of help you may seek assistance from Staff Support Services in your hospital of employment.

If you have any queries about any aspect of this research project please do not hesitate to contact Rita Funnell on 9919 2830 or by email at rita.funnell@research.vu.edu.au

<p>If you have any queries or complaints about the way you have been treated in this research, you may contact the Ethics Officer, Human Research Ethics Committee, Victoria University, PO Box 14428, MCMC, Melbourne, 8001. (telephone no 9688 4710)</p>
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***Please note there has been a change in the research team and refinement of the study title since this component of the research was conducted.**

Appendix E: Consent form



**Victoria University
Consent Form for Subjects Involved in Research**

We would like to invite you to be a part of a study into how differences or similarities between the images nurses hold of what nursing will be like when they first enter the profession and the realities of being a qualified nurse impact on decisions to stay or leave the nursing profession

CERTIFICATION BY SUBJECT

I, _____

of _____

certify that I am at least 18 years old and that I am voluntarily giving my consent to participate in the study entitled: * *“An exploration of the relationship between nurses’ images of nursing work and their commitment to the nursing profession”* being conducted at Victoria University by the research team of Professor Colin Torrance, Professor Terence McCann and Rita Funnell BHSc MA.

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to be carried out in the research, have been fully explained to me in the information sheet provided and that I freely consent to participate in the study involving the use of me as an interviewee.

I consent to participate in an audio-taped interview with the researcher, Rita Funnell, that will last approximately 45 minutes to one hour and that will take place at a time and place to be mutually agreed

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way. I have been informed that the information I provide will be kept confidential.

Signed: Contact Tel:
Email.....

Witness other than the researcher:

Date:

Any queries about your participation in this project may be directed to the researcher Rita Funnell on 9741 7693. If you have any queries or complaints about the way you have been treated, you may contact the Ethics Officer of the University Human Research Ethics Committee, Victoria University of Technology, PO Box 14428 MCMC, Melbourne, 8001 (telephone no: 03-9688 4710).

***Please note the title of the study has been refined and there has been a change to the research team since the this component of the research was conducted**