Nurses' perceptions of factors that encourage or discourage registered nurses to remain in practice in a public hospital setting.

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Abstract

As a registered nurse with over twenty years in clinical practice I was concerned at the lack of experienced nurses employed in public hospital settings. There appeared to be a stability in the workforce in terms of employment of nurses but this did not reflect the experience of the nurses employed there. Hospital settings are the predominant employment area for registered nurses. Public hospitals are usually where new graduates from nursing programmes begin their nursing experience. They require the support and mentoring of experienced nurses to guide their progression from a novice practitioner to an experienced practitioner. This exploratory pilot study was designed to determine a) what factors encouraged or discouraged registered nurses from remaining in practice in a specific public hospital setting and b) what recent changes in the work environment were perceived as positive or negative. Three focus groups were utilised consisting of experienced registered nurses with more than five years experience, new graduate nurses of less than twelve months experience, and Maori registered nurses. The use of focus group interviews allowed the researcher to gain knowledge of the participants' attitudes, values and perceptions of the particular topic in a non threatening environment. Krueger (1988) and Morgan (1988) identified characteristics of a focus group as being people who possess certain characteristics and who provide data of a qualitative nature in a focused discussion. Questions concerning participants' perceptions of changes over the last twelve months and factors enhancing or reducing job satisfaction and morale were used to initiate discussion. These were followed up by questions to elicit more specific information. Common themes and ideas were identified from each group and summarised by the groups at the end of the interview. The cut and paste method was used to collate the data for analysis. Results of the study indicate that all three groups were encouraged by job security, professional development, and professional autonomy while discouraged by internal politics, external politics and political correctness. All of these factors contributed overall to the theme of job satisfaction. Communication was an underlining problem for all three groups. Recommendations resulting from the findings of this study

include: orientation and professional development programmes; adequate resources in terms of equipment and staff skill mix; and clearly defined lines of communication.

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Glossary

Aroha	A Maori word meaning love and support
Code of Rights	Ten rights of consumers and duties of the providers set out in Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulation 1996 see Reference list
Crown Company Advisory Unit (CCMAU)	Unit responsible for monitoring and advising shareholding government Ministers on State Owned companies including Crown Health Enterprises(public hospitals).
Cultural Safety (Kawa Whakaruruhau)	Cultural Safety gives power to the patient and or families to define the quality of service on subjective as well as clinical levels (Nursing Council of New Zealand, 1996, p9).
Debriefing	An opportunity for people involved in a difficult or unusual incident to recount what happened and to determine changes in dealing with similar situations in future.
Enrolled Nurse	A nurse who had twelve to eighteen months theoretical and clinical training, as well as basic nursing skills such as hygiene cares, taking basic observations and doing dressings. Second level nurse.
Fixed Contract	A contract that has been negotiated for a set period of time.
Incident Forms	A document used to notify other areas in the hospital of a problem that has occurred and may require further action from other departments such as Occupational Safety and Health or Infection Control.

Inservice/s	Lectures on nursing topics or practical demonstrations of nursing skills and techniques pertinent to the hospital or ward.
Iwi	Tribe a person or family originated from. *Hapu*- a group of whanau with common ancestral links or sub-tribe; *whanau*- relationships that have blood links to a common ancestor, or a family.
Kawa Whakaruruhau (Cultural Safety)	Cultural Safety gives power to the patient and or families to define the quality of service on subjective as well as clinical levels (Nursing Council of New Zealand, 1996, p9).
New Graduate Programme	A programme provided by the hospital, utilised in this study which assists the transition from student nurse to beginning practitioner (registered nurse). The programme consists of an orientation to a ward with combined theoretical and practical sessions. The programme can be twelve months in duration and have two six month periods in different wards such as medical and surgical.
Nurse Consultant Group	A group of senior nurses at management level in the organisation who provide clinical expertise to the ward nurses. They also provide nursing advice to higher management who have or may not have nursing experience.
Patient Loading System	Patients are awarded a number between one and five depending on the amount of nursing required by the patient per shift. The patient requiring the greater nursing care may have a loading number of five while the patient with the least nursing care may have a patient loading number of one. The loading number of one to five is a subjective assessment in relation to the nursing

	experience of the nurse allocated to the patient on the shift. Fifteen is the maximum loading number allocated to a nurse per shift. When all nurses on a shift have a patient loading of fifteen then the ward is said to have the required maximum match of nurses to patients for that shift. Any further admissions to the ward would require an increase in nursing staff for that shift.
Political Correctness	A term identified by Hopton (1995) as being used in the 1960s and 1970s as a tongue in cheek way in which people on the political left developed a political conscience. In the 1990s Molyneux (1993) described the term as being used by the right wing academics, politicians and ideologists as a derogatory term for moral and ethical principles which do not coincide with ones own values.
Professional Development Programme	A professional portfolio which demonstrates a nurse's level at which he/she practices, extra responsibilities undertaken and other types of involvement in the organisation or sector (e.g. conference attendance, or study days).
Registered Nurse	First level nurse who has at least three years combined theoretical and clinical training. The training was in a hospital setting: Registered General Obstetric Nurse (RGON). Currently in a Polytechnic or other tertiary training institute: Registered Comprehensive Nurse, (RCompN).
Tangata Whenua (Maori)	People of the land; Maori people who have ties and connections to the land specific to New Zealand.
Trade Union	In this study refers to the New Zealand Nurses Organisation (NZNO) both the professional and industrial sections.

Treaty of Waitangi	An agreement made between representatives of Great Britain and representatives of the Maori tribes in 1840 and signed in New Zealand.
Treaty of Waitangi Workshops	A series of study days organised to give staff members a background to the Treaty of Waitangi and how this relates to the delivery of health in the organisation.
Unsafe Staffing Forms	A document used to notify other areas in the hospital utilised in this study and Union of a problem that has occurred and may require further action.
Whanau (Maori)	Relationships that have blood links to a common ancestor, or a family.
Whakapapa (Maori)	Origins ; genealogy; where a person comes from and all the associated background information that makes them; their blood links to a common ancestor or a family; their Iwi, Hapu and Whanau.

Chapter 1
Introduction

A public hospital setting is the predominant employment location for registered nurses. New graduates commonly begin their nursing experience in a hospital setting and require support and mentoring from experienced nurses to guide their progression from novice practitioners to expert practitioners. As a registered nurse with over twenty years clinical practice I am concerned at the lack of experienced nurses employed in Hospital and Health Service settings (HHS, previously known as Crown Health Enterprises or CHEs).

In this last decade of the C20th Ministry of Health workforce data have shown a fairly consistent pattern. The 1992 workforce data showed that 63% of all registered nurses in New Zealand were actively working in public hospitals with Maori nurses comprising 2.5%. In 1994 and 1995 the figures were 61% and 59% respectively with 3% being Maori (Ministry of Health, 1992; 1995; 1996). As these figures indicate, the nursing workforce in public hospitals appears relatively stable. Approximately two thirds of registered nurses are employed in public hospitals where the predominance of nursing care is given. However, the data concerning the nursing workforce does not reflect the level of experience of the nurses employed.

Background

Prior to 1972 all nursing training in New Zealand was undertaken in a hospital setting. Depending on the type of training nurses undertook, they registered as either psychiatric, general/obstetric, or psychopaedic nurses. In 1973, the transition of nursing education from hospitals to polytechnic and technical institutes began and a title 'comprehensive nurse' was created.

During the 1970s, dissatisfaction with the health system in New Zealand led to investigations by several committees which included the education of nurses in hospitals (Carpenter, 1971; Department of Education, 1972; Kennedy, 1992). Reforms to the health system were put in place under the Labour Government in the 1980s and continued under the National Government in the 1990s. On the 1st July 1993 the National Government implemented changes which resulted in further restructuring of the health system from fourteen Area Health Boards to twenty three competing Crown Health Enterprises (CHEs) who were monitored by the Crown Company Monitoring Unit (CCMAU). Each CHE competed for the delivery of health services in their own geographical area. The CHEs replaced the public hospitals, which had been centrally funded by the Government. The new structure of the health system meant that each health delivery organisation (CHEs, community or private) had to actively seek funding from their delegated Regional Health Authority (RHA).

Competition for funding led to cuts to public hospital budgets. No longer could employment be assured for staff working in hospitals. According to O'Connor (1992) this situation led to nurses feeling vulnerable about their position in the health care service as restructuring meant closure of hospitals and wards. Registered nurses practising in a CHE setting were now reliant on a variety of organisations (including RHAs and CHEs) for their staff funding (Campbell, 1992).

Economics became the controlling force in the New Zealand health care system and all health organisations, including community and private health providers were required to compete for the same funding. In some hospitals managers with business acumen, but not necessarily nursing experience, have replaced the Charge Nurses (Stodart, 1993). These managers were responsible for staffing ratios. Nursing clinicians had to justify their need to staff wards with the numbers of registered nurses they required for each eight hour shift. This justification went to the financial managers of the hospital who were responsible for approving extra staffing levels.

The concept of 'cost effectiveness' rang in nurse clinician's ears adding to their unease about long term employment prospects. Nursing clinicians in charge of CHE wards faced

prospects of fewer registered nurses being allocated to their wards, a lack of resources in terms of equipment, and less time to implement nursing care to their patients (Keene, 1990; Stodart, 1990; Nimmo, 1991; Warr, 1995; Brown, 1996).

Every item on the CHE budget sheet came under scrutiny by the financial managers of the CHE. Staffing in terms of registered nurses accounted for a major spending item on the budget sheet and was an area where reductions in spending could achieve a positive effect on the finances of an organisation. Potentially reductions could also be achieved if newly registered nurses replaced more experienced thus more expensive registered nurses.

Following the general elections in December 1996 New Zealand became governed by a coalition of two political parties the National and the New Zealand First parties. Compromises were reached and the coalition Government promised some significant changes to the health system as indicated in the news media (NZPA,Evening Post, 1997). On July 1,1997 a new funding organisation termed the Transitional Health Authority (THA) came into being. The four RHAs were brought into a single national funding organisation and both the THA and the RHAs were separated from the Ministry of Health. The CHEs competed with the private sector for funding. The new funding was also based on past levels of funding and the cost effectiveness of the CHEs. Public hospitals were no longer expected to make a profit. Oliver (1997, p. 27) states: "*the funding announced does not seem enough to both maintain existing levels of access to services and pay for improved access in the areas specified by the policy*".

In April 1998 the THA released its figures to CHEs and the protests from all regions of the country were long and constant (personal knowledge in organisation). Since this first release there have been further renegotiations between the THA and CHEs and a sense of unrest prevails in the health system currently with no firm decisions about funding having been finalised. In July 1998 the CHEs underwent a name change to Hospital and Health Services (HHS). The funding to the organisations in 1999 will be from the Health Funding Authority (HFA) which replaced the THA in July 1998. Hospitals will still negotiate with the HFA on an individual basis.

Kawa Whakaruruhau (Cultural Safety)

As previously mentioned only three percent of the nursing workforce are Maori and given that Maori make up 12% of the New Zealand population this workforce is very small. It was thus very important to ensure the voice of the Maori nurses was heard and to investigate the reasons why Maori nurses do or do not work in public hospital settings. Early in 1988 a Maori nurses' hui held at Otautahi (Christchurch) raised concerns about the negative experiences of indigenous people in the health and nursing education systems. One of the concerns of the student nurses was that nursing education was not preparing them to give culturally safe service to the tangata whenua, their own people (Ramsden, 1990).

Culturally safe practice has been defined by Maori nurses as *"... any actions which recognise, respect, and nurture the unique cultural identity of tangata whenua, and safely meets their needs, expectations and rights"* (Hill, 1991, p. 8). Cultural safety is not about learning the ways of the Maori, or the language, it is about Maori accessing the most appropriate care available to them in a manner determined by them.

Currently in New Zealand Maori people are a high "*at risk*" group in terms of health. In 1993 the Ministry of Maori Development (Te Puna Kokiri, 1993) prepared data from statistics they obtained which showed that Maori were, as a group, a higher at risk population in comparison with non Maori. Hospitalisation of Maori as compared with non Maori for respiratory disease were 2.2 times, diabetes 2.1 times, kidney disease 1.5 times and complications of pregnancy and childbirth 1.3 times greater.

The health sector has to be aware of the impact of its actions, attitudes and beliefs when delivering care to people of differing cultures. Cultural safety as broadly defined by the New Zealand Nursing Council is about nurses supporting their patients in their undisputed right to have full control over their own choices and options. The Nursing Council of New Zealand (1996, p. 9) observes: " *Cultural safety gives power to the patient and or families to define the quality of service on subjective as well as clinical levels".* Conversely, culturally unsafe practice has been defined by the Nursing Council

of New Zealand (1992, p. 9) as :" *Any actions which diminish, demean or disempower the cultural identity and wellbeing of an individual."* Hill (1991) defines cultural safety from a Maori perspective while the New Zealand Nursing Council (1992) defines cultural safety in relation to any culture. Maori nurses in CHE settings are in the minority and this places stress on them when they are being asked to be an expert on how to nurse Maori patients. Active recruitment of Maori nurses occurs in some areas of the health sector but not in others.

Recent Developments

Dickson (1992) conducted research which involved sending out questionnaires to a sample of nurses selected from the New Zealand Nurses Organisation membership database (the largest nurses organisation in New Zealand). The nurses targeted were in the active workforce eleven to fourteen years after registration. Results from the survey suggested that hospital administration and the health sector restructuring had a marked effect on stress levels, turnover and retention. The findings supported conclusions by Ng, Jenkins, Dixon and Cram (1992) that job satisfaction correlated strongly with the need for organisational commitment to patient care.

Four years later the New Zealand Nurses Organisation (NZNO) surveyed nurses working in health services about patient safety and nurse staffing. The major conclusions from the survey suggested that:

- *Patient/client safety was a significant issue in a large section of the New Zealand health services;*
- *The safety of patients/clients was linked to trends in staffing such as the number of nurses employed, the experience level and skill mix of the nursing workforce and the trend towards increasing casualisation;*
- *There was a considerable variability in standards of patient/client safety and nurse staffing across New Zealand's health services* (NZNO, 1996, p. 11).

Casualisation is a term that has come to mean the use of non permanent staff to fill staffing vacancies. The casual nurses may be experienced but are not necessarily current in practice in the areas to which they will be sent. Nor may they be experienced in mentoring new graduates as their knowledge base for practice is not necessarily current. The advantages to the hospital administration and budget of casualisation are numerous. The casual or non permanent staff do not have to be paid at the same penal rates as the permanent staff and the annual leave entitlements are paid out in cash per pay period and not as leave days that require extra staff to cover the work. If work is not available then the organisation does not have to employ casual staff whereas permanent staff will be paid regardless of the number of patients/clients in a ward. Casual staff can be employed for specific hours to suit the organisation. Casualisation is an alternative for staffing that can reduce an organisation's financial spending. The casualisation of the nursing workforce has resulted in redundancies, low morale and insecurity of longterm work prospects for experienced nurses (Keene, 1990; Nimmo, 1991; O'Connor, 1992; Underwood, 1994; Warr, 1995).

Some hospitals, in an effort to reduce staffing costs, introduced health care assistants to assist registered nurses in their roles. Their jobs vary from taking basic recordings such as blood pressures, temperatures, pulses and respirations to giving out medications. Hawkes Bay Health, for example, introduced these new workers in early 1997 and offered them a two week training course (personal correspondence with NZNO delegates,1998). Other hospitals are preparing to introduce similar assistants but the specified training period before they commence working with patients/clients has not been stated. These assistants work under the supervision of a registered nurse who remains responsible for the safety and legal requirements of nursing patients. If issues about retention of registered nurses are not addressed, newly registered nurses will not have much practical experience to supervise assistants, and this could lead to potentially unsafe staffing of wards.

Researchers interest in the subject

The research has grown out of a desire on my part to see future generations of registered nurses in public hospitals working with the support of experienced nurses. I would also like to contribute to the health of my own Iwi (Kai Tahu, Kati Mamoe, Wai Taha) and other Iwi in Aotearoa by studying the factors which encourage or discourage Maori nurses from practising in a public hospital setting. Uncovering such factors could provide insight into whether Maori patients have the potential to be nursed in a culturally safe health setting. The study was located in an area of New Zealand with a high Maori population.

Research Design

The study was designed to explore those factors that encourage or discourage registered nurses from remaining in practice in a public hospital setting from the perspectives of three different groups of nurses. The study was also designed to examine whether the recent changes in the work environment were perceived as positive or negative. Three focus groups were utilised consisting of new graduates of less than twelve months practical experience, experienced nurses with more than five years practical experience and Maori registered nurses.

In order to study the factors that encourage or discourage registered nurses from remaining in practice in a public hospital setting four questions guided the focus group discussions.

1) What factors encourage you to work in a public hospital setting?
2) What factors discourage you from working in a public hospital setting?
3) Have there been any changes which you perceive as being a positive influence in your working environment?
4) Have there been any changes which you perceive as being a negative influence in your working environment?

Questions three and four were used as a means of determining whether recent changes in the work environment were impacting upon the nurses' responses. The study is pilot in nature. Due to the limitations on the researcher of time and finances the study is restricted to one public hospital.

Why did I choose new graduate nurses?

The new graduate group had less than twelve months experience in a hospital setting and came from a training background where they had practical experience in a hospital or community setting combined with theoretical lectures in the polytechnic setting. This group was not paid while training and the hospital setting was the first time they had received monetary reward for their labours. I chose them as a group as they are the future of nursing. This group has the least experience in nursing and requires the most support to make the transition from student nurse to registered nurse.

Why did I choose experienced nurses?

As an experienced nurse I believe I have a duty to future generations of nurses who come behind me. I believe future nurses should be nurtured and counselled until they are ready to take over the reins of running the hospital and health services. The experienced nurse has a duty to educate those she/he works with whether it be patient, relative, nurse, doctor or administrator. To be of assistance to those the nurse encounters requires that this experienced nurse keep abreast of all technological, medical, nursing and human rights advances in their field whether it be practical or theoretical knowledge. The experienced nurses have at least five years practical nursing experience in the hospital setting and have seen several changes to the financial controls instigated by successive government policies. This group consists of the senior or advanced practitioners in the hospital and works with new graduates and nursing assistants. The experienced nurses have the responsibility of seeing that the delivery of patient care from these groups is given.

Why did I choose Maori nurses to be a separate group in the study?

Ehara i te mea no inina te aroha .
Love is a gift handed down from ancestor to ancestor.

My journey to find my whakapapa is only a few years old and in that time I have already learnt a lot I did not know. One thing I did learn was that I am not able to speak on behalf of a culture I have not previously been brought up in or lived in. This can only be achieved by people who have knowledge of the culture themselves. The public hospital I conducted this study in is surrounded by an Iwi I have become familiar with and participated in several different nursing roles with. As this allowed me an introduction to the participants it made it easier for me to interview them as I was already known to them. The Maori nurses were separated as a group to provide them with an opportunity to answer the focus group questions from a cultural perspective. As for my own Iwi I hope that this study may motivate someone to advance the cause and investigate why Maori nurses are in the minority in public hospital settings.

Kia Toa	*Be Brave*
Kia Kaha	*Be Strong*
Kia Manawanui	*Persevere*

Organisation of the Thesis

This thesis is organised in such a way that the reader is first located in the background literature before proceeding on to the research design, description of the focus groups and the interpretation of the findings. At the conclusion the reader can find a series of recommendations.

Chapter two is an outline of the literature related to factors contributing to the retention of nurses within public hospital settings. Two major themes of job satisfaction and patient safety are examined in relation to national and international studies and discussion documents presented in the last decade.

Chapter three examines the focus group method, its background and application to nursing research. The researcher also discusses how the method has been used in the current study, and includes an outline about how the data was collected and analysed.

The research process is documented in depth to provide an audit trail for readers allowing them to assess transferability to their own context.

Chapter four is a description of the focus group as related to the new graduate group of nurses and provides, in the order that the participants prioritised them, the responses to the four questions posed to the group.

Chapter five is a description of the focus group as related to the experienced group of nurses and similarly provides the responses to the four questions posed to the group.

Chapter six is a description of the focus group as related to the Maori group of nurses and again provides, in the order which the participants prioritised them, the responses to the four questions posed.

Chapter seven is a reflection upon the categories identified from chapters four, five and six. Uncovered are three encouraging categories and the three discouraging categories.

Chapter eight returns to the national and international literature in order to further examine the three encouraging categories: job security, professional development and professional autonomy and the three discouraging categories: internal politics, external politics and political correctness.

Chapter nine concludes the thesis with a brief summary of the main points of the study and recommendations for further programmes of study and support for nursing staff at all levels within the hospital environment. Referencing system follows that recommended by the American Psychological Association, 1994.

Chapter 2
Background Literature

In literature related to factors contributing to the retention of nurses within public hospital settings there appears to be two major themes: job satisfaction and patient safety issues. Studies conducted nationally in New Zealand and internationally in the United States of America and the United Kingdom will be examined in this literature review. Gaps in current literature will be highlighted. As matters of retention and satisfaction arise within a historical context only literature pertaining to the last decade will be reviewed.

New Zealand

Prior to 1973 all nursing training in New Zealand was hospital based . The student nurses worked for the hospital during their training and received a wage in return. Concerns were raised by students, teachers and the general public about the quality of the programme, the curriculum, the level of the teachers knowledge, the safety of patients and the conflict between service needs of the hospitals and the educational needs of the student (Carpenter, 1971; Kennedy, 1992). Dissatisfaction with this system of nursing education led to the Carpenter Report in 1971 which made recommendations to the Minister of Health to change the way nursing education was delivered and the content of the curriculum (Carpenter, 1971; Kennedy, 1992). Following the Carpenter report a committee was appointed by the Minister of Education to consider recommendation 1.6 and 1.7 of the Carpenter Report (Department of Education, 1972).

Major changes resulted from the Carpenter Report. Firstly nursing education was taken out of hospitals and placed in tertiary institutions. The administration and coordination of nursing education changed from the Department of Health to the Department of Education and the curriculum changed . The length of the programme changed to reflect an equal division of time between clinical and theory components (Department of

Education, 1972). The implementation of all these changes took place over a twelve year period. The hospitals lost their workforce of student nurses and clinicians were no longer directly responsible for student nurses' education.

Unrest among New Zealand registered nurses began in Auckland when wage round negotiations broke down in 1989. The breakdown left nurses unsure of their future employment and the continuously changing health care climate and restructuring of the health sector led nurses to feel dissatisfied with their work conditions (Keene, 1990; Nimmo, 1991).

In New Zealand, conditions of work, including wages, led to strike action by nurses in 1992 (Stodart, 1990; Campbell, 1992; O'Connor, 1992). In Taranaki the hospital was staffed by volunteers and registered agency nurses (nurses employed by a private nursing bureau) who were flown in from Wellington when the nursing staff went out on strike. Management had also organised registered nurses to be flown in from Australia had the strike extended beyond the time specified in the strike notice given to them by the nursing organisers (Campbell, 1992).

In Canterbury hospital senior management risked working 24 hour shifts themselves in the labour ward (obstetrics) when nursing and midwifery staff went out on strike (Campbell,1992). Such unrest continued throughout the 1990s when restructuring of the health sector added to the confusion.

With the change of funding, from four Regional Health Authorities to one central Health Funding Authority, and the new but unstable coalition Government, the unrest amongst health professionals surfaced to result in threats of strikes or strike action in Auckland, December 1997, and March 1998. The wage round negotiations broke down with nurses going on strike over conditions of work and pay rates. Just as this had been resolved Christchurch nurses went out on strike in April 1998. The workers were asking for a 2% wage increase in keeping with inflation but Health Link South rejected the submission on financial grounds (Wilson & Gaffkin, 1998).

During this decade three important surveys involving nurses were undertaken. In 1992 Dickson undertook a questionnaire survey to study the views and perceptions of nursing staff towards the major issues facing the health workforce: restructuring, continuing education and hospital management (Dickson, 1992). A random sample of nurses was selected from the New Zealand Nurses Association (now known as New Zealand Nurses Organisation) membership database. The target group of nurses had eleven years post graduation experience and consisted of a total population of 403. The response rate was 62% (n = 250). Dickson's research suggests that hospital administration and the health sector restructuring had a marked effect on stress levels, turnover and retention of registered nurses and enrolled nurses in a hospital setting. The research provides a background to this current study but is limited in that it includes only nurses with eleven years or greater practical experience. It did not include new graduates nor did it specify the ethnic background of the participants.

Dickson's study paralleled a more intense survey undertaken in 1988 by Ng, Jenkins, Dixon and Cram (1992) who found that job satisfaction correlated strongly with the need for organisational commitment to patient care. Ng et al, undertook a longitudinal study exploring job satisfaction and job attrition among staff nurses in public hospitals. The sample was drawn from nineteen out of twenty Area Health Boards. There were 1803 questionnaires sent out and 69% (n = 1249) responded. When repeated five months later 80% of the original respondents replied. The data collected from both surveys was factor analysed.

The authors factored eight elements to develop a profile of job satisfaction for nursing staff. These elements were administration, co- workers, career development, work scheduling, patient care, education, physical environment and communication with patients and doctors. The authors acknowledge one major flaw in the research in that the one Area Health Board that did not participate was the largest in the country. However they believe that the random sample of nurses that participated allowed generalizability of the findings to the majority of public hospital settings.

It was found that turnover of staff related to overall job satisfaction in career prospects and relations with nursing supervisors. Relationships were significant predictors of staff attrition. The higher the turnover of staff the poorer the job satisfaction and relationships between nursing staff and their supervisors. The administration at the time comprised a triumvirate structure ie. a Medical Superintendent, Matron and Administrator. Nursing staff were responsible to the Matron.

The NZNO conducted a postal survey of working conditions and patient safety in 1996 (NZNO, 1996). An eight page questionnaire was sent out to 1000 nurses in the private and public health sectors. The response rate was 58% (or 553 nurses). The survey was aimed at experienced nurses who had been in their present position for three years or longer. Results indicated that one in five nurses who took part in the survey believed that there were not enough nurses in their workplace to provide safe patient care and backed up NZNO's claim that quality nursing care had been a casualty of the health reforms. The survey did not include new graduates or identify ethnic backgrounds of the participants.

Reduction in registered nursing staff numbers has led to nurses speaking out about safety of clients. Brown (1996) gained media attention after writing an article in which he documented his nightshift where, in his opinion, the quality of care and safety of his patients was compromised. Other authors have also questioned nurse : patient ratios and the effect on the departure of experienced nurses from the profession (Dyson, 1994; Underwood, 1994; Warr, 1995; Wilson, 1995; Manchester, 1997; Oliver, 1997). There has been an increase of indemnity claims involving errors of judgement and lack of ensuring client safety by inexperienced nurses (O'Connor, 1995).

After receiving reports alleging unsafe practices at Christchurch Hospital, including the 'Patients are Dying' report on 24 December 1996(Christchurch Hospitals Medical Staff Association,1996) the Health and Disability Commissioner (Robyn Stent) commenced an investigation into Canterbury Health Limited in 1997. The investigation was to consider if Canterbury Health had breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996. Prior to this investigation in 1995, Canterbury Health was directed by the Crown Company

Monitoring Advisory Unit (CCMAU) to prepare a plan which would resolve Canterbury Health Limited's financial problems (Health and Disability Commissioner, 1998). In August 1995, the proposal for restructuring was released to Canterbury Health staff. Thirty days were allocated for submissions to be received. The proposal for nursing included disestablishment of Unit Nurse Managers which would have resulted in the removal of skilled nursing managers from the hospital structure.

Senior nursing and medical staff wrote opposing the proposals and the lack of consultation before the proposals were drafted. Criticisms of the proposals included the adverse effects casualisation of staffing would have on patient safety. These concerns were not addressed in the restructured plan published in November 1995 (Health and Disability Commissioner, 1998). Concerns regarding unsafe staffing were also identified by NZNO Area Regional Manager Trevor Warr, in a letter written to Gillian Grew the Professional Nurse Advisor to the Ministry of Health in 1996 (Health and Disability Commissioner, 1998, p.122). The details of the letter were not sent to Canterbury Health to protect the employees from identification (Health and Disability Commissioner, 1998).

In the winter of 1996, staffing shortages and patient safety were identified by patient relatives as an area of concern particularly in relation to deaths in the Emergency Department at Christchurch Hospital (Health and Disability Commissioner, 1998). Safety issues were also raised in the media. A news report at the time (Rentoul, 1996, p. 16) suggested:

> *Overblown claims by the New Zealand Nurses Organisation that patients have died as a result of changes to nursing at Canterbury Health may bring the dispute between clinicians and managers at the Crown Health Enterprise to a head.*

The results of the inquiry were released in April 1998 and vindicated staff who raised the alarm about patient safety (Newth, 1998a; Coney, 1998). Standards of safety and care have been compromised by changes to the health system. Newth (1998b, p. 6) quotes Barbara Donaldson, head of the New Zealand Council on Healthcare Standards

as stating that: " *underfunding had undermined CHEs' ability to maintain quality in some areas".* This statement was made in relation to the findings of the inquiry into Christchurch hospital but also in relation to general issues facing other CHEs at the time.

Kawa Whakaruruhau

In New Zealand, Maori student nurses identified the need for nurses to be able to provide culturally safe service to the tangata whenua, their own people, Te Iwi Maori (Ramsden, 1990). A model for negotiated and equal partnership in nursing education was proposed and the project was led by Irihapeti Ramsden. In the 1990's according to Ramsden (1995 , p. 7):

> *a quiet gathering of senior Ngai Tahu had promised nursing their support in the development of cultural safety in return for a commitment to help improve the health status of Maori people through nursing education.*

Kawa Whakaruruhau (cultural safety) was developed in consultation with Maori and adopted as part of the pre registration nursing and midwifery curricula. This became testable in the state examinations for registration of nurses and midwives in 1992 (Ramsden, 1995). The current application of cultural safety has been related to the education of students and no research has been conducted with Maori nurses in the hospital setting. Since the introduction of the cultural safety component into nursing education in 1992, no research has been conducted on the effect of this component on the deliverance of care to Maori patients in hospital settings. No research has been conducted into why Maori nurses are in the minority in hospital settings or why they choose to work in hospital settings. We do know that Maori nurses work in public hospitals but we do not know what percentage that is of the total.

International

Unrest among nurses has also been reflected internationally in the education of nurses, workforce job satisfaction and retention of nurses. The United Kingdom introduced Project 2000 in 1986. This was to address concerns about the belief that nursing

education was not preparing nurses to be active participants in the delivery of health care services in the year 2000 and beyond. Smith (1994, p.411) writing about the implementation of Project 2000 in the United Kingdom, says

> *Most of the Project 2000 nursing students consider themselves to be less competent in practice skills than they believe traditionally trained student nurses to be at the equivalent stage of training.*

This leads to the new graduates requiring an effective orientation programme which takes into account the deficits recognised by the new graduates and the organisation employing them. It also questions the education of the nurses and whether it is relevant to the areas they will work in.

In the United States the orientation programme of new employees had an effect on the retention rate of new staff. According to Mathews and Nunley (1992) in one twelve month period during the late 1980s, Foster G. McGaw hospital, a suburban hospital in Illinios, had 53 % of the nurse orientees for that period resign. This led to the interviewing of new employees in the first three months of employment, by means of unstructured interviews, to ascertain the effects of orientation on these new employees. The results of the interviews showed dissatisfaction with the existing orientation programme. The programme was revamped with input from all sectors of the nursing staff including management and administration. The new programme was implemented in May 1990 and the attrition rate of orientees dropped from 53% to 17% during the first six months of employment. The programme was designed to meet the job orientation needs of nurses with different levels of experience and the authors suggest that the restructuring of the programme has contributed to nurse satisfaction and decreased levels of staff turnover.

A survey conducted in Wales by Nolan, Nolan and Grant (1995) found performance related pay, as well as positive and negative factors, influenced job satisfaction and morale. A total of 1640 questionnaires were sent to registered nurses. Although only 676 questionnaires were returned, giving a 41% return rate, the findings indicated that having

enough time to give a good standard of care to patients in conjunction with satisfactory staffing levels, was a major influence in nurses' job satisfaction and morale.

Matrunola (1996) conducted a study, involving fifty nurses working in a British elderly care unit, using correlational analysis. The study attempted to address the problem of stress and burnout in hospital nurses by exploring factors which affect job satisfaction and the relationship between that and absenteeism. The participants had been in their position at least eight months prior to the study commencing. The study was conducted on a small sample of female nurses thus reducing its validity. The author acknowledged this in the study and suggested that further studies would be necessary to consider the causal links and influencing factors of job satisfaction.

The findings of the study suggest that development of coping strategies in the form of stress awareness seminars, regular staff support groups and counselling services may need to be adopted by organisations to provide positive working conditions. This study is significant to the current study as positive work environments and coping strategies are important for the participants who have undergone several changes to the health system and how health care is delivered.

Leveck and Jones (1996) conducted a study involving fifty Nursing Units at four Acute Care Hospitals in the southeastern United States metropolitan area. The researchers wanted to explore the relationships between the practice environment, quality of nursing care and the retention of registered nursing staff on Nursing Units. The study used a questionnaire from the nursing staff and unit data from patient charts used in quality of care audits.

The questionnaires sent to 611 nurses gave a response rate of 59% (358).The chart audits were conducted on a random sample of either a minimum of ten charts per Unit or ten percent of the total discharges during a 30 day period, whichever was larger. Retention data was collected for all 611 nurses on the study Units. Findings indicated that aspects of the practice environment including job satisfaction affected staff nurse

retention and the quality of care delivered on the hospital nursing units examined in the study.

Another study conducted in the United States showed no significant relationship between management style and staff retention. Drew and Fisher (1996) conducted a study involving registered nurses (RNs) in a mid west American university children's hospital. The researcher wanted to examine the management styles necessary to encourage quality and productivity of nursing services. The sample of 150 nurses was randomly selected and given an eighteen item questionnaire divided into six categories: leadership, motivation, communication, decision making, goals and controls. The response rate was 29 %. The questionnaire was analysed using a one way ANOVA test. Findings indicated that as supervisors' management style approached a participative style, higher levels of RN job satisfaction existed but had no significant relationship to retention of nurses.

Other international studies have been conducted which examine strategies implemented to improve job satisfaction (Grindel, Petersen, Kinneman & Turner, 1996; Pierce, Hazel & Mion, 1996).

Tonges, Rothestein and Carter (1998) conducted research in a Healthcare setting in New Brunswick. Two studies were conducted with 63 and 146 staff nurses respectively from Medical/Surgical and Coronary Care Units. Participants were asked to complete a Staff Nurse Job Characteristic Index (SNJCI). The SNJCI had been developed from focus groups of staff nurses. The focus groups were used as a pilot study to develop the job characteristics index which was used as the basis for the research. Findings indicate that continuity in nurse-patient relationships, authority to initiate independent nursing action, individual accountability for clinical outcomes and regular performance feedback from managers are important for staff nurse job satisfaction.

Another international study conducted in Stockholm and pre-war Zagreb involving district nurses (Tholdy Doncevic, Romelsjo and Theorell, 1998) indicated that differences in work organisation and essential resources had a substantial impact on perceived stress and job satisfaction amongst the district nurses in the study.

Gaps in the literature

Both national and international studies identify factors affecting the retention of nursing staff. However there appears to be a specific gap in research which this study can begin to address and has specificity for the New Zealand scene. The studies conducted have never included Maori nurses. Dickson (1992) examined nurses, who had been in practice for eleven to fourteen years, using both quantitative data collection and qualitative strategies. Ng et al, (1992) published the results from qualitative and quantitative data, which were collected in 1988, before the health reforms began to take place. There has not been a study which explores three different perspectives, those of experienced nurses, newly graduated registered nurses and Maori registered nurses.

The New Zealand Nurses Organisation (1996) produced quantitative and qualitative data which included public and private hospitals and registered and enrolled nurses. Previous studies have only been concerned with the reasons why nurses were leaving nursing as opposed to why nurses were leaving public hospital settings.

This study explores what factors encourage or discourage registered nurses to remain in practice in a public hospital from the perspective of three specifically homogenous groups of nurses. This also includes the positive or negative effects of recent changes in the workplace environment. In the case of experienced nurses the findings will also be compared with the literature that has been conducted nationally and internationally.

Conclusion

To date studies of job satisfaction and morale amongst registered nurses in New Zealand have indicated the possibility that changing Government policies affect the retention of experienced nurses (Stodart, 1990; Campbell, 1992; O'Connor, 1992; Underwood, 1994; Warr, 1995; O'Connor, 1996; and Oliver, 1997). Overseas studies also indicate that factors such as job satisfaction and safety are major contributing factors to nurses remaining in practice.

No studies have been conducted with Maori registered nurses and new graduates on the topic of retention in the public hospital system. This exploratory study, utilising focus groups, was designed to see what factors encourage or discourage new graduates of less than twelve months practical experience, experienced nurses of more than five years experience and Maori registered nurses to remain in a public hospital setting.

In the next chapter the research design, including an explanation of the focus group as a research technique, will be outlined and described.

Chapter 3
Research Method

The focus group method has been selected to address the research question. In this chapter the focus group method, its background and application in nursing research will be described. An overview of aspects of the focus group method is presented in the first part and how the method has been used in the current study is discussed in the second part. An outline of the collection and analysis of data process is also included in the second part.

Part One : Focus Group Method

An overview of the focus group method is presented as follows:

- historical background
- definition of a focus group
- the focus group method
- validity and reliability in focus group method
- strengths and weaknesses of the focus group method
- design issues
- data recording
- data analysis
- comparison with other methods

Historical Background

The focus group method has its origins in the office of radio research at Columbus University in 1941. Paul Lazarsfeld invited Robert Merton to assist him in evaluating audience responses to radio programmes (Merton, 1946). During World War II Merton used focus groups to examine the persuasiveness of Army Training and morale films as

propaganda tools for the Research Branch of the United States Army Information and Education Division (Merton, Fiske & Kendall, 1956). According to Krueger (1988) over the past thirty years the focus group method has been predominantly used in marketing research. Focus groups have been described by Des Rosiers and Zeller (1989, p. 21) as:

> *...a specific communication process, whereby a different breadth and depth of interaction, spontaneity and cross infection can occur allowing participants to pick up ideas from one another. Ultimately, group ownership of ideas occur.*

The focus group has become popular among nurses as a research method in the last ten years. For example Nyamathi and Shuler (1990) used focus groups to identify the concerns and needs of black women at risk from Human Immunodeficiency Virus (HIV); Hart and Rotem (1990) examined clinical learning of registered nurses in the ward setting and Lankshear (1993) investigated the attitude of teachers and clinical assessors in conducting student nurse assessment. In addition, Alzheimers disease has been studied in the gerontological field by Gray-Vickrey (1993) while primary health needs of adults with learning disabilities has been studied by Thornton (1996).

In New Zealand several nurse authors have used the focus method. White and Thomson (1995) used an anonymised telephone based focus group to examine family physicians' attitudes to social and sexual contact between family physicians and their patients; Booth (1997) used the focus group method to explore the partnership between nurse educators, practitioners, and student nurses to facilitate student learning during clinical experiences; while Price (1997) explored the nature of therapeutic nursing in a general rehabilitation team.

Definition of a Focus Group

Krueger (1994) defined a focus group as comprising four important characteristics. These are:

- a group of people

- possessing certain characteristics
- providing data of a qualitative nature
- in a focused discussion

The Focus Group Method

The distinguishing feature of the focus group method is "*the explicit use of the group interaction to produce data and insights that would be less accessible without the interaction found in a group*" (Morgan, 1992, p. 12). The focus group method is a qualitative type of research. It is useful in gaining knowledge about the participants' attitudes, values and perceptions of a particular topic in a non threatening environment (Morgan, 1992). Krueger (1988) believes that, as a qualitative approach, focus groups can a) precede quantitative research, b) work concurrently with quantitative research or c) be used after quantitative research has been conducted to interpret and provide further insight to the data. These approaches have also been supported by Stewart and Shamdasani (1990); Millar and Crabtree (1992); and Morgan (1992).

Calder (1977) has described three approaches to focus group designs:
exploratory used to generate theoretical hypotheses for future research, or pilot studies of quantitative research,
clinical describes the application of the method to the investigation of phenomena which are analysed from a clinical perspective,
phenomenological used to understand the everyday experience of the individual.
Qualitative data falls into two types: *emic* data from a natural form with little researcher involvement or direction and *etic* data which are characterised by a high researcher involvement and direction. Focus groups produce data which sit towards the etic end of the continuum and are particularly appropriate to studies where the phenomena are not well understood (Stewart & Shamdasani, 1990).

Validity and reliability in focus group method

Traditional research based in the scientific paradigm is concerned with issues of validity and reliability. The focus group method as qualitative research is considered under the

scientific paradigm. It can be understood in terms of validity and reliability in the following ways:

Validity is the extent to which the tool or procedure measures what it is supposed to measure (Burns and Grove, 1993). Focus groups have a high face validity due to the credibility of comments from the participants. Content related validity examines the extent to which the method of measurement includes all elements relevant to the construct being measured. Construct validity examines the fit between conceptual and operational definitions of variables and determines whether the instrument actually measures the theoretical construct it purports to measure. Both content and construct validity in qualitative research may be difficult to obtain in comparison to a quantitative research due to the nature of individual variability within a group interview.

External validity is the extent to which study findings can be generalised to a population beyond the sample (Burns and Grove,1993). A focus group may not be representative of the wider population and as the purpose of the research is exploratory it is not a priority that generalisability is met.

Reliability is the extent to which consistent administration of the instrument will provide the same data (Nyamathi and Shuler, 1990, p.1284). Qualitative research emphases the uniqueness of the human or individual experience which may be influenced by many factors. Examples of such factors may be the age, sex, personality or racial group the individual comes from. The degree of homogeneity in the group will influence the extent the findings can be replicated in another group. The skills of the moderator can also affect the reliability according to how the moderator conducts the group interview. As the aim of the focus group is to produce all possible views on the topic under study then it is not necessary for the focus groups to produce data that require to be replicated.

Validity and reliability contribute to scientific rigour. Rigour has been defined by Burns and Grove (1993, p 779) as: "*The striving for excellence in research through the use of discipline, scrupulous adherence to detail, and strict accuracy*". The adherence to strict guidelines when using qualitative research may diminish the findings and destroy the

spirit of the research (Sandelowski, 1993). What is essential in quantitative research in terms of rigour may not be appropriate in qualitative research.

Koch (1994) argues that to establish rigour within the qualitative research method the criterion of trustworthiness should be applied in terms of credibility, transferability, dependability and confirmability.

Credibility can be established by consulting the participants about the authors' interpretation of the data.
Transferability can occur when findings from one study are applicable to a study in a similar setting, context or group.
Dependability can be demonstrated through an audit process.
Confirmability requires the researcher to produce an audit trail of the study which can be followed by an independent investigator and demonstrates transferability, credibility and dependability. The audit trail entails information about:

- research decisions
- methodological choices
- analytical decisions
- evidence of how the data and interpretations were drawn (Koch, 1994.).

Strengths and Weaknesses of the focus group method

Strengths

- Reduces large quantities of information into a manageable form
- High face validity - results are accessible and believable
- Quiet members may feel able to share their experiences in the group as others are doing so
- The security of the group provides an opportunity to express opinions or experiences
- Group members sharing their experiences can stimulate and create increased awareness of other members recollections
- The members of a group reduce the conspicuousness of the researcher in comparison with individual interviews

- Cost effectiveness in terms of collecting a large quantity of data in a short time frame (Bertrand, Brown & Ward, 1992).

Weaknesses

- The findings cannot be automatically projected to the population at large.
- By reducing the points made by participants to simple phrases, the richness of the detail maybe lost
- The small numbers of groups reduces the generalizability of the findings (Hansler & Cooper, 1986)
- Social posturing in the form of the desire for people to be polite and fit within the norm, (can happen unless ground rules for the group are established from the beginning which explain that any one statement or notion is not more desirable than another)(McQuarrie & McIntyre, 1987)
- Time consuming process of data transcription (Nyamathi & Shuler , 1990, p. 1285).

Design Issues

There are a number of issues to be considered when using the focus group method. These issues will be discussed in this section under the following headings :

- selection of participants
- group size
- homogeneity
- selection bias
- role of the moderator
- running the group
- using an interview guide

Selection of participants

It is important that potential participants have the common experience that the focus group is studying (Asbury, 1995). The two authors who are considered the authorities on the focus group method have differing opinions on familiarity of participants with each

other when selecting participants. Morgan (1988) supports unfamiliarity of participants with each other but acknowledges that one couple in a group being known to each other should not unduly influence the findings of the group. Krueger (1995) believes that focus groups have been successfully conducted within work environments where participants were known to each other and suggests that in many communities it is impossible to find strangers. Recruitment of participants may be conducted through pre existing lists such as membership lists, telephone contact, personal contact, word of mouth or advertising. Market researchers using focus group interviews have offered incentives such as financial reward (Krueger, 1988), babysitting and presence of food, accommodation and an easily accessible environment (Stewart & Shamdasani, 1990). The use of incentives raises ethical issues in terms of influencing the outcome of the focus group interviews in social sciences and as such is not widely used.

Group size

There is debate as to the size of groups. According to Morgan (1988), six to twelve participants would be allocated per group. This limits the problem of managing a large number where individuals may not get the opportunity to participate actively. Morgan (1988) concludes that the usual, moderate sized group, ranges from six to ten. Krueger (1995) suggests that the most effective focus group size is from six to eight participants, although smaller groups may be used depending on the expertise of the participants in relation to the topic under study. Both Krueger (1995) and Morgan (1988) suggest recruiting more than the number required to allow for non attendance. The number of groups usually range from three to four or until the moderator can anticipate what will be said next (Stewart & Shamdasani, 1990; Asbury, 1995).

Homogeneity

Homogeneity can be defined as the degree to which participants are similar (Burns & Grove, 1993). Krueger (1988, p. 26) states: "*The rule for selecting focus group participants is commonality not diversity*". Most authors generally recommend a mix of participants who share certain characteristics such as :

- social class, gender and race (Morgan, 1988)
- age, gender, occupation and educational level (Krueger, 1994)

It is important when recruiting the group to select participants who share the common phenomenon or experience under investigation. Some groups may not have the perceived backgrounds to form focus groups. Age differences bring different perspectives to a topic (Morgan, 1988). Another example given by Krueger (1988) is of the perceived knowledge base difference between participants who graduated with university degrees and participants who were high school graduates. This, he also believes, could affect the extent of sharing among the group if some participants believed themselves to be inferior or superior in some way to other participants in the group.

Selection bias

The aim of the selection process is to bring together a cross section of participants who are representative of the topic under study. Familiarity between the interviewer (moderator) and participants is warned against by Krueger (1988). He suggests that there may be a bias if participants are selected by the organisation within which the study is conducted. If the moderator or selector is in a hierarchical position and made decisions on employment and salaries, this could jeopardise the results. Running focus groups with established groups may lead to pre existing ways of communication within the group. A means of avoiding this may be provided by not including participants of mixed status for example, management and workers in the group.

It should be remembered that :

> *the focus group interview is a qualitative research method for gathering information which when performed in a permissive non threatening group environment, allows the investigation of a multitude of perceptions on a defined area of interest*
> (Nyamathi & Shuler,1990, p.1282).

Role of moderator

The role of the moderator may influence the outcome of the focus group interviews. In order to conduct a successful focus group the moderator must take a facilitative role rather than a leadership role in the group (Stevens, 1996).

The role of the moderator is important to the focus group. Functions of a moderator include determining the requirements of the study and the characteristics of the group and then providing the most appropriate leadership style that will be effective for accomplishing the goals of the study. Depending on the dynamics of the group the moderator may take a supportive or a more directive role. Langer (1987, p. 10) notes that: *"Moderating is essentially a creative art which must be practised by those with a certain flair".*

Langer also identified the personal traits of good qualitative researchers/moderators as:

- a genuine interest in listening to other peoples ideas and feelings
- expressive of their own feelings and able to give personal reactions if needed
- animated and spontaneous so as to pick up on any stimuli raised in sessions
- having a sense of humour which is related to imagination, creativity and spontaneity
- sympathy and an ability to understand how others feel
- admitting their own biases by being honest and able to detach themselves from their biases while working *This was something the researcher in this study was able to do.*
- an ability to express thoughts clearly and quickly when framing questions so as to not interrupt the flow of discussions and
- flexibility and responsiveness to any directions that the sessions may take.

Stewart and Shamdasani (1990) suggest there are four styles of leadership a moderator can use: supportive, directive, participative and achievement-orientated. The use of an assistant to take notes during the focus group interview and attend to the audiotape has been suggested by several authors (Nyamathi & Shuler, 1990; Krueger, 1994; White & Thomson, 1995).

Running the group

The location of the focus groups should be a neutral room away from the working environment, easy to find, comfortable, as well as having ample parking for the participants (Asbury, 1995). Carey (1995) notes the advantage of food in establishing a comfortable environment. Krueger (1988) also suggested banning smoking from the group interviews.

Using an interview guide

According to Stewart & Shamdasani (1990), developing the interview guide is directed by two principles. Firstly, that questions are ordered from general to specific. Secondly, that the order of questions is determined by their relative importance to the study topic. Questions of greater importance should be placed earlier rather than later in the interview.

Morgan (1988) suggests that for an unstructured group two broadly stated topic questions may be appropriate while for a structured group the limit of questions should be four to five with pre-planned probes under each major topic. Morgan (1988) moves from the opening questions to transition questions which leads into key questions. Krueger (1988) suggests that the interview opening should provide participants with consistent and sufficient background information by introducing the topic in an honest but general way.

Both Krueger (1988) and Morgan (1988) agree that questions beginning with 'why' should be avoided as they can appear interrogative. Closing the focus group is also an important skill. A means of providing a clear indication to the group that the session is ending is the use of a final summary statement where the moderator provides a short summary of the interview to the group for confirmation.

Data recording

The principal means of recording focus groups is through audiotaping and consent for such should be sought before commencement (Krueger, 1988; Morgan, 1988; Nyamathi & Shuler, 1990; Forrest, Brown & Pollock, 1996). All authors suggest that the use of a backup tape recorder with fresh batteries be used or on hand at the time of the interviews. The assistant and/ or the moderator may use written notes which can aid clarity of conversation and allow for documentation of non verbal interactions. Transcriptions of the interviews can consists of up to 20 single spaced pages or more per group interview (Krueger, 1988).

When selecting tape recorders for the interview the time required to be taped and the transcribing required afterwards should be kept in mind. A good quality recording system aids the transcribing of notes after the interviews have been completed. Reporters notes are recommended when time is short, results are needed quickly or the research question is simple (Bertrand, Brown, & Ward, 1992). A disadvantage to this method is that the notes may be selective or biased as the reporter expands and clarifies notes from memory after the session. However, accuracy can be checked against the tape and moderator or assistant.

Data analysis

In order to assist in the analysis of the data, at a later time, the moderator or assistant should draw a diagram of the seating arrangements as well as take careful notes to capture non verbal communication of participants (Krueger, 1988). Analysis of the data must be systematic and verifiable. The process is time consuming and produces a considerable amount of data . Data analysis should be commenced as close as possible to data collection date. The basis of data analysis may consist of *verbatim* transcript, copies of all written notes, and demographic information of the respondents (Nyamathi & Shuler, 1990, p.1285).

Bertrand, Brown and Ward(1992) suggest three approaches to focus group data analysis:

Inventory of points discussed

Each question is written on a separate sheet of paper. Every time the conversation turns to this topic the researcher writes down the main point made by the participant. If the same idea is repeated later in the session it is allocated a point according to the inventory The advantage of the system is that it reduces large quantities of information into manageable form. The disadvantage of this system is that it is time consuming and the reduction process may lose the richness of detail.

Moderator recalls points covered

The researcher (moderator) outlines the main ideas that emerge on each subject of the interview based on his/her recollection. Following the recording on paper of the researchers ideas, the transcripts are re read, to correct any inaccuracies and add points

missed. The advantages of this approach are that it is quick and supplies a spontaneous description of the group process. It also commences the researcher on the task of condensing the hours of interview transcriptions. The disadvantage is selective perception and recall on the part of the researcher who may use this approach to confirm their own views on the topic under study.

Margin coding

The researcher establishes a set of codes that relate to the questions in the interview guide or themes identified on a preliminary read through of the transcripts. The researcher reads the transcripts or notes and codes in the margin the different points or themes discussed. In writing the report up the researcher takes one topic at a time to establish what different groups said or felt about the topic under discussion. Following this the researcher writes a summary paragraph and adds quotations. The advantage of this approach is that it is less time consuming and avoids some of the subjectivity in the recall approach. The disadvantage is the difficulty of organising in one's head all the different perspective's on a given topic. One remedy to this is to jot down all the main ideas and refer to these when writing the topic summary.

An alternative approach once the transcripts have been coded is to organise them by theme, codes and /or groups on separate pieces of paper using the " *cut and paste technique*" (Stewart & Shamdasani, 1990). There are also available a wide range of computer programmes for structuring data.

Comparison with other methods

There are alternative qualitative methods to focus group interviews such as individual interview , participant observation, Nominal Group technique and the Delphi Technique. None of these methods are appropriate for the question in this research study. *Interviews* provide increasing amounts of control by the researcher over the content of the interview. The technique allows a collection of data from subjects unable or unlikely to complete questionnaires due to illness, reading or writing ability and inability to express themselves in a group situation (Burns & Grove, 1993). The method is time consuming,

expensive and does not allow for the same generation of ideas as a focus group interview.

Participant observation requires the researcher to find a means of blending into the setting, and of entering and leaving the setting without attracting attention to themself or disturbing the setting (Burns & Grove , 1993).

Nominal Group technique is the lowest level of measurement that is used when data can be organised into categories that are exclusive and exhaustive, but the categories cannot be compared such as, gender, race, and marital status (Burns & Grove, 1993).

Delphi Technique is a method of measuring the judgements of a group of experts for assessing priorities or making forecasts. The group never meets face to face and the facilitators play a critical role because they control these key elements (Burns & Grove, 1993).

Conclusion

The focus group method has been widely used in marketing and social sciences to access opinions and perspectives from individuals in a group situation with an interest in a particular product or topic. Strengths, weaknesses, design issues and implications of the focus group method have been examined. The data recording and analysis are determined by the researcher after selecting the method. The focus group method has been selected as the most appropriate method for the current study. The application of the focus group method to the study will be discussed in the following section.

Part Two: The Study

The focus group method has been selected as the method for this study. The study although confined to one specific hospital is concerned with issues related to the retention of registered nurses in public hospitals. The national and international literature suggests that job satisfaction, restructuring of the hospital system, orientation

programmes and safety issues for nurses and their patients were factors that influenced the retention of registered nurses in their practice in hospital settings. To what extent these factors encourage or discourage registered nurses to remain in practice in public hospitals, in New Zealand, is not clear.

The focus group method addressed the study questions:

What factors encourage or discourage registered nurses to remain in practice in a public hospital setting?

What changes in the work environment are perceived as positive or negative?

Three focus groups were conducted consisting of experienced nurses who had a minimum of five years post graduation practical experience, new graduates of less than twelve months practical experience, and Maori registered nurses, all of whom work within a public hospital setting. To assist discussions the two major study questions were subdivided into two:

1) What factors encourage you to work in a public hospital setting?
2) What factors discourage you from working in a public hospital setting?
3) Have there been any changes which you perceive as being a positive influence in your working environment?
4) Have there been any changes which you perceive as being a negative influence in your working environment?

Consideration will be given to how the focus group method has been applied to the current study under the following headings:

- selected approach
- selection of participants
- group size
- group homogeneity
- ethical considerations
- running the group
- ground rules

- role of moderator
- data recording and transcription
- data analysis
- reporting the data

Selected approach

The study falls into the category of a phenomenological approach to focus groups as described by Calder (1977), in which the method is used to understand the everyday experience of the individual. Registered nurses working in a public hospital setting were invited to participate in a focus group to talk about the factors that encourage and discourage them from remaining in practice in a public hospital setting. By studying what factors encourage or discourage these nurses the quality of care and expertise patients receive may be enhanced.

The focus group allows the researcher in this study access to a greater number of participants without affecting the environment in which they work and the researcher was able to blend into the group rather than take a predominant role.

Selection of participants

The population for the study was drawn from registered nurses at a provincial hospital. Three focus groups were conducted consisting of experienced nurses who had a minimum of five years post graduation clinical experience, new graduates of less than twelve months clinical experience and Maori registered nurses all of whom work within a public hospital setting. The participants were all known to each other by the circumstances of working in the same setting. No remuneration was provided for the participants. However on the night of the interviews light refreshments in the form of tea, coffee, juice, biscuits and cakes were available for the participants.

Group size

The number of participants who responded initially was eighteen from the experienced nurses group, seven from the new graduate nurses group and seven from the Maori nurses' group. Participants were asked to contact the researcher for further detail of the date and time of the interviews. The numbers of the participants who arrived on the nights were seven experienced nurses, four new graduates nurses and three Maori nurses. The numbers in both the new graduate and Maori nurses' groups were less on the night than expected due to sickness resulting in shift changes, a funeral, and participants getting the wrong date.

The decision to run the groups with four and three participants was considered in relation to what Krueger (1995) suggested, that although the most effective focus group size is from six to eight participants smaller groups may be used where the participants have expertise in the topic under study. Although the three groups were selected to offer different perspectives the study, being exploratory and pilot in nature, was small. In particular it is acknowledged that answers concerning recruitment and retention of Maori nurses will not be explicated.

Group homogeneity

Members of the three groups shared a number of characteristics. They all worked in the same public hospital, worked for the same period of time in the clinical experience group they were assigned to, and were practising Registered Nurses. In the new graduate group all members were female, had trained in the Polytechnic training system and were either completing or had just completed their undergraduate degree. In the experienced group two were males, the rest females. They had trained in different hospitals, or polytechnics and in different countries. The Maori nurses were all female and known to each other outside the working environment as well as all having worked in the public hospital system for a minimum of five years. The group had already been acquainted with the researcher on an informal conversational level and this may have influenced their decision to participate.

Ethical Considerations

Academic and employer approval was given before the study commenced. The proposal was submitted to a regional Ethics Committee, which approved it. At the same time the proposed study was submitted to the local Iwi representative for the local hospital for approval. The second submission was to the Massey University Inter Ethnic Research Committee which approved it. The last submission was to the Massey University Human Ethics Committee who approved on the grounds that no direct quotes were used in the study findings. The latter committee believed that anonymity could not be assured if direct quotes were used from some of the participants. The committee also identified a potential conflict of interest in that the researcher belonged to the organisation. However this was noted and countered from the position that the researcher did not, at the time of the study, hold any position of influence in the organisation and was employed on a casual basis.

The possibility of coercion was minimised with the assistance of the Nurse Advisor. The researcher provided the Nurse Advisor with details as to the characteristics of each focus group and these were fed into the hospital human resources computer and the names of possible participants were then provided to the Nurse Advisor. All nurses who met the criteria were sent an information sheet (Appendix I) and a letter of invitation (Appendix II). The participants then contacted the researcher.

Prior to the interviews being held, the researcher contacted the participants twice, once the week before and one day prior to the interview to confirm date, time and answer any questions that arose at the time. Despite this process one participant missed the interview.

Each participant was reminded of the Informed Consent form (Appendix III) which had been sent out prior to the interviews and was to be returned to the researcher or brought in on the night. Extra copies were available on the night in case any were missed or were overlooked. The role of the moderator and assistant were reiterated before the interviews commenced.

Running the group

Participants were asked not to bring certain items to the focus groups. One such item was cell phones however on the night one participant was required to have a portable phone. With the groups permission, the individual was allowed to answer any urgent calls at the end of the room so that the flow of conversation was not interrupted. This occurred twice on the night.

At the beginning of each group interview, ground rules for the interview were established. Krueger (1988) suggests the moderator has several options for closing the focus group. The first is to thank the participants, provide them with any promised incentive and wish them a safe journey home. Alternatively the moderator summarises the main points of view and asks the participants if the perception is accurate.

At the beginning of the session all the participants were welcomed by the researcher and introduced to the assistant who was taping the interviews and taking handwritten notes. Krueger (1988) suggested the assistant was on standby for anyone who arrived late and needed a drink before starting. The assistant was available should more participants arrive than expected to provide the written questions to them. This approach was thought to be more diplomatic than turning them away at the door. All consent forms were sighted and filed away by the researcher. Any missing forms were filled out and all participants helped themselves to a hot drink.

The participants were seated around a table with the microphone in the middle. Stewart and Shamdasani (1990) found that having the researcher (moderator) sit opposite the least talkative individuals and to either side of the most talkative individuals increased the frequency of the least talkative individuals and reduced the comments from the more talkative participants. The researcher was able to quickly ascertain who was likely to fit the aforementioned roles while having a quick cup of tea before settling into the interviews. The table provided a resting place for cups of drinks so participants were not rushed to finish their drinks thus creating a relaxed environment. Each group lasted 1-1.5

hours. Closure was made through summarising the priorities established and confirming accuracy.

Ground rules

Ground rules for the interview were discussed at the beginning of each group and included the following:

- only one person to speak at a time
- no side conversations
- everyone to be given an opportunity to speak
- participants having the right to ask for the audiotape to be turned off at any time
- that there was no 'right ' answer
- no smoking
- telephones switched off (note the one exception mentioned previously)

Role of moderator

The researcher was the moderator and took notes to aid summarisation at the end of the interview. The assistant, who had signed a confidentiality form, was responsible for operating the tape recorders in the new graduate group and the experienced group interviews, as well as taking a demographic diagram of seating and detailed notes to back up the tape. The assistant was not present in the Maori nurses group as it was not felt to be appropriate by the researcher. The researcher, from personal experience knew of other gatherings where non Maori researchers have asked questions and the Maori nurses involved did not feel comfortable answering in front of the researcher so had remained silent. After conducting the interview the researcher asked the participants in the group how would they have felt if an assistant had been present and they confirmed the above thinking. The assistant had completed her own focus group interviews for her Masters study and was familiar with the proceedings. The room was prepared in advance of the participants arrival to minimise distractions.

The researcher had low input into the group but used four questions as the basis of the interview. The researcher listened and provided prompts during the discussion in a supportive style of leadership for the new graduate and experienced nurses groups.

In the Maori nurses' group the researcher had a greater input into the discussions due to the number of participants and their reluctance to speak unless prompted. The beginning of this group started slowly, however, after the first question had been answered by the participants, the researcher was able to adjust the leadership role from a directive to a supportive role.

Following the fourth question being answered the researcher was able to summarise the interview from her hand written notes and the assistant wrote the main factors identified on the white board. Each group was asked to add anything they thought had been missed off the list. The groups were then asked to prioritise the identified factors themselves so as to identify the most important factors (see chapters four, five and six). The moderator then thanked the participants and wished them a safe journey home. The assistant and moderator then debriefed as to how the interviews had gone.

Data recording and transcription

Data was obtained as previously described. Two tape recorders were utilised, one main and one back-up. Audiotapes from group discussions were transcribed by the researcher. The microphone on the tape recorder was inadvertently not turned on in the Maori nurses group and the expensive recording equipment became unavailable on the night of the experienced nurses interview. Both sessions were taped on a small hand held tape recorder which was the backup recorder. The use of written notes became invaluable in both these circumstances, as did the list of factors, in order of importance, as identified by the participants at the end of the interview session. As direct quotes were unable to be used the use of other types of information collected during the focus group interviews were utilised. Henderson (1995, pp.466-467) suggests that other types of information could include:

- *statements made by the respondents in response to the moderators questions*
- *non verbal cues- body language, voice tonality, degree of emphasis.*
- *free wheeling discussions- The discussions could include statements, facts, untruths, opinions, beliefs, questions, comments asides and so forth*
- *voting among choices.*

In this study these methods were used by the researcher when transcribing the data from the tapes and written records taken by the assistant. The use of non verbal cues in the form of shoulder, facial and hand gestures were recorded. The voting among choices took place when the participants selected the priorities of identified factors at the end of the interviews. The results of the prioritising was by agreement of the group. The groups were aware in the ground rules that they were to conduct this exercise at the end of the interview and it would be by agreement. The researcher only challenged the participants where safety issues were raised and then to clarify the procedure for dealing with the issues. The researcher asked for clarification of words used if unsure of their meaning or use.

Data analysis

Method

The researcher used a cut and paste approach in analysing the data. Analysis was undertaken in three steps. The first step was to summarise the data, the second step was to sort the data into relevant topics and in the third step the data were interpreted.

Data analysis began with several readings of the transcripts. There were approximately 60 pages of data. The research question underpinned the data analysis in that it guided the discussion in the focus group. The requirement of the Massey University Ethics Committee that no direct quotes be used in the reporting process was a frustrating limitation in that it presented a threat to reliability. However this was overcome by utilising a strategy whereby the groups identified the priorities on the night of their interview and thus participated in the interpretation thus increasing reliability and validity. The researcher was not aiming for consensus, but rather, for conformity. All

members in each group indicated agreement to the priorities. Some priorities were viewed as being equal to others (see Appendix IV)

Step one

This step involved going through the transcripts and identifying those sections relevant to the research question(s). Based on the initial reading a classification of major issues was developed and the material pertinent to each topic was identified and coded. The amount of material identified depended on the relevance to the research question. Coded material took several forms: phrases, sentences, or exchanges between participants. This phase required several readings of the transcripts.

The written notes and transcripts were read by the researcher and compared with the final list compiled by the participants several times over several weeks to allow the researcher to identify common themes, patterns and similar words and sort them into categories derived from each group in relation to the four questions. Up to twenty summary factors per question were identified by the participants on the interview night. These identified factors were examined by the researcher for similarities and differences in each group interview and the list was significantly reduced by this process.

Step two

Each significant coded piece of the data was cut out and sorted by hand so that material with identified factors were placed together and transferred to the computer. The reduced lists were then sorted into the identified factors prioritised by the three groups. The final number of factors varied per question per group as shown in Table 3.1

Table 3.1: Number of factors per question per group

Group	Question	Factors
New Graduates	1	4
	2	4
	3	4
	4	4
Experienced Nurses	1	5
	2	5
	3	3
	4	4
Maori Nurses	1	2
	2	5
	3	2
	4	5

Step three

Each identified factor per question was pasted together to provide a basis for the researcher to synthesis using an interpretative analysis (see Appendix IV).

> *The interpretative analysis takes into account evidence beyond words on a transcript and includes evidence from field notes. In addition, it also considers the intensity of participants' comments, specificity of examples and consistency of statements by respondents*
>
> (Krueger, 1988, p. 111).

The process was completed by summarising the categorised factors into overarching factors. The findings for each individual group are contained in the following chapters and Appendix IV. In chapter seven the categorised factors are summarised and similarities and differences between the three focus groups are highlighted.

The left column on each of the tables in Appendix IV shows factors identified and prioritised at the conclusion of the various focus groups. The right column shows the

categories which were identified by the researcher. *N.B Some factors shared equal priorities.*

Summary of Steps

Step One:	Factors identified by participants	(Factors)
Step Two:	Factors prioritised by focus groups	
	Categorised by researcher	(Categorised factors)
Step Three:	Overarching factors determined	(Overarching factors)

Reporting the data

Krueger (1988) suggests three functions need to be served when reporting data. Firstly, the report is intended to communicate results. Secondly, the researcher develops a logical description of the total investigation and thirdly, the purpose of the report is to provide a record of the findings.

Reporting of the data relates to the findings and interpretation from the three focus groups and is supported by research literature. The researcher's supervisor also reviewed the data which served as both a check on the researcher's academic analysis and a form of cross checking.

Conclusion

Focus groups, as a method for providing the researcher with answers to the four research questions related to factors that encourage or discourage registered nurses to remain in practise in a public hospital setting have been discussed both in general and specific terms. The researcher has provided details of the study so the reader may follow the same steps.

The research was conducted away from the environment that the participants worked in. All the participants came from a hospital setting but had characteristics that related to specific groups. The groups were new graduates of less than twelve months practical

experience, experienced nurses of more than five years post graduation experience, and Maori registered nurses.

In the following chapters the factors that encouraged or discouraged registered nurses to remain in practice in a public hospital setting have been categorised by the researcher. Factor prioritisation underpinning the final categories (factors) can be found for each focus group in Appendix IV.

The new graduate perspective is presented first. The same four research questions were posed to each group.

1) What factors encourage you to work in a public hospital setting?
2) What factors discourage you from working in a public hospital setting?
3) Have there been any changes which you perceive as being a positive influence in your working environment?
4) Have there been any changes which you perceive as being a negative influence in your working environment?

Chapter 4

New Graduates

This chapter contains, in the order in which the participants prioritised them, the responses to the four questions posed to the new graduate focus group. The new graduate nurse group of participants in this study had less than twelve months clinical experience in a hospital setting. The prioritised category of factors specific to each of the four questions can be found below in their order of importance with 1 ranking highest and = signifying categorised factors given the same ranking.

Categorised factors that encouraged new graduates to work a public hospital setting

1= General Experience

New Graduate Programme

2 Patient Load

3 Paid Study Day

1.= General Experience

The new graduate group prioritised this as a major factor that encouraged them to work in a hospital setting. As new graduates they were eager to put their theory into practice and found that the hospital setting offered a wide range of areas in which to gain practical experience. The acute hospital experience that they encountered in a hospital of a moderate size allowed them to experience, they believed, a broader range of nursing than they would have encountered in a larger hospital which had speciality areas. The smaller hospital allowed them to refine their time management skills and learn to work in a team environment. Some of the participants spoke of working in private nursing homes while waiting for positions to become available in hospital settings. They felt an instant challenge when commencing work in a hospital setting. The challenge was to work as a registered nurse in a 'proper' hospital where patients had a variety of diagnoses and required care that involved the new graduates planning different practice scenarios as

opposed to nursing homes where the care related to elderly only. The new graduates had acquired considerable theoretical knowledge and were eager to put that knowledge into practice.

1.= New Graduate Programme

The participants believed that the new graduate programme provided by the hospital was a major factor encouraging them to work in a hospital setting. From the participants who undertook the programme came stories of being given the support and time to gain confidence in their abilities and skills as registered nurses in wards. Some wards had programmes in place that provided a 'buddy' alongside the new graduate. This system was, in the participants' opinion, a great help as it provided someone whom the new graduate could readily identify with. One of the participants did not receive a new graduate programme but was able to go to a ward which provided a good orientation. "Good" was the word used by the participants to describe a set programme on the ward, a booklet to achieve tasks and set goals to be signed off when completed in the ward.

One participant spoke of a three day orientation programme which combined theoretical and practical requirements for their area. The participant also had to complete a booklet with tasks to be signed off in the area of work. All participants spoke of the great feeling of relief when they realised other fairly new graduates were working on their wards whom they could go to for moral support and advice when needed. Until they gained confidence in their ability to make a clinical judgement they were not always eager to share their confidences with other senior registered nurses on the ward. They preferred their own peer group for advice at times so as to not appear lacking in knowledge in front of experienced registered nurses.

2. Patient Load

A patient load system is where patients are awarded a number between one and five depending on the amount of nursing time that is required for that patient per shift. The top of the range is five being a patient that requires almost full time care by one nurse and is considered to be a 'heavy' patient in terms of physical attention required. A patient with a one rating requires minimum input from a nurse per shift. They may be one

who is up and walking in the ward, close to being discharged home but needs a basic set of recordings such as blood pressure, temperature, pulse and respirations completed once every twenty four hours. The nurse considers this patient independent and requiring a minimum of nursing care.

The participants viewed the advent of the patient loading system as a factor that encouraged them to remain working in a hospital setting. As the workload increased they believed it was less stressful on them knowing they could set a ceiling on the number of patients and how heavy their workload was to be. Once the overall load number was fifteen per nurse on the shift the nurses in the ward were able to ring the admissions clerk and the nursing coordinator and advise them that they had reached their ceiling number (of fifteen per nurse on the shift) and were no longer able to accept admission of any other patients unless they obtained more nursing staff. As the participants were responsible for giving a loading factor to a patient, they were also able to decide that number in relation to their own ability. The number given to a patient by an experienced nurse of over five years experience may differ from the number given by a new graduate of less than twelve months experience.

3. Paid Study Day

As new graduates, the participants were eager to continue with postgraduate study. They found the contribution of the hospital and New Zealand Nurses Organisation (Union) to a fund which provided financial support for continuing education, a factor that encouraged them to work in a hospital setting. In comparison with private nursing homes, private hospitals and other hospitals in the local area, these participants found that their hospital provided greater financial assistance and support to them than the other organisations.

The participants mentioned that in other hospitals their peers had spoken of the lack of recognition of their theoretical qualifications. Their peers in other hospitals had also been criticised by the permanent nursing staff as having no value in terms of practical experience. The participants in this study conversely felt that their studies and qualifications were recognised as valuable.

When replying to the set questions, regarding the factors that discouraged them the participants identified a number of factors. When I transcribed the data, similar factors were combined resulting in the categorised factors shown below.

Categorised factors that discouraged new graduates from working in a public hospital setting

1 Pay and Shiftwork

2 Staff levels and Skill mix

3 Resources Staff and Equipment

4 Workplace Politics

1. Pay and Shiftwork

The participants believed their pay level to be inadequate for the responsibilities that they were entrusted with. Each participant cited stories of friends or family who worked in job situations with fewer responsibilities and less training than registered nurses but were paid greater salaries. The financial remuneration was a major factor in discouraging them from remaining in practice in a hospital setting.

Even the contribution of penal rates for shift work did not encourage them. As new graduates, and the lowest on the registered nurse pay scales, they regularly found themselves on weekends and night shifts. It was the rule rather than the exception for these participants to work seven day stretches. They all agreed that they loved nursing but that they wanted better recognition in the form of monetary reward. Participants spoke of working with nursing assistants who received only a dollar less than them in wages per hour and yet took no legal responsibility for their practice. The people responsible for these nurse assistants were the participants.

2. Staff Levels and Skill Mix

This group of participants recognised the uneven skill mix in wards. They found that new graduates tended to make up the majority of the staff. There was usually only one experienced registered nurses per shift of four or five nurses. At times they found the level of staffing unsafe for themselves and for patients. They spoke of filling out incident forms

but believed that doing so did not help them when they were in the middle of the situation. An incident form is a document used to notify other areas in the hospital of a problem that has occurred and may require action from another department, such as Occupational Health and Safety, Infection Control, Human Resources or legal representatives of the organisation. The incident form usually goes to the line manager above the person initiating the form. It is that persons responsibility to respond to the incident notification and to advise the initiator of any outcome.

An area of concern for them was the use of nurse assistants to make up the numbers of staff on a ward. They believed, and had experienced, the extra stress put on the registered nurses who had to pick up the observations and extra treatments as well as their own workload when nurse assistants were on a shift.

One example given was of two registered nurses and two nurse assistants on a shift. The participants believed that assistants could not replace enrolled nurses who had twelve to eighteen months theoretical and clinical training, as well as basic nursing skills, such as taking observations and doing dressings (registered nurses are first level and enrolled nurses are second level. Their training is not as theoretically extensive as a registered nurse). Nurse assistants may have up to one week training in the skills necessary to perform tasks for a patient, some have only had two days orientation to the hospital. These assistants then started working in a medical or surgical ward to assist the nursing staff. The assistants have replaced registered staff on the wards in relation to staff numbers. They are cheaper to employ than an enrolled nurse who has nursing training and experience in nursing a patient.

3. Resources : Staff and Equipment

A major factor that discouraged this group of participants was lack of money to provide staff and equipment resources. The participants were disgruntled at the lack of basic equipment in the ward. Equipment for taking observations of blood pressure, temperatures and blood glucose levels of patients were limited and staff were required to share what resources they had. One set of equipment to be used for twenty patients required staff to balance their work so that no patient was missed. The participants spoke of having two

sets of equipment on the ward which had twenty inpatients at the time. When one set was required for continuous monitoring of an acutely ill patient that left only one set for the rest of the ward patients. When equipment became faulty the replacement could take weeks. This added to the stress and frustration of the participants carrying out their nursing role.

The participants raised the issue of lack of staff in the ward situation under the discouraging factors which was incongruent with the encouraging factors of patient loading. In the encouraging factors the ability to close the ward to further admissions when the nurses had a patient load of fifteen per shift meant the ward could no longer take admissions unless more nursing staff were obtained. Yet in discouraging factors the participants identified lack of staff as a factor.

4. Workplace Politics

Frustration due to lack of staff and inadequacy of resources was further highlighted by this group of participants by the politics they encountered in the workplace. Each time a new incentive came from management and another management consultant was appointed to overlook the new project, the participants felt the money could have been better used by improving the resources such as equipment which directly benefited the patients. The participants believed that their enthusiasm towards new projects, which tightened the hospital financial belt, was lacking especially when they could see staffing numbers dropping. They did not express a desire to support Government proposals for continuing to make financial savings in the hospital as they believed the changes already made had adversely affected their ability to deliver quality care to their patients.

Communications from the nursing leaders, nursing consultants and hospital administrators, whether medical or support services, were poor. This group felt the frustration of experienced nurses they worked with regarding skill mix. They mentioned being aware of what they termed "ward politics" which did not involve them directly but resulted from having inexperienced nurses to support one experienced nurse on a heavy shift. They talked of health cuts from the Government and believed that some of the management pay in hospitals and Members of Parliament salaries should be put back into the health system

to benefit patients. This, they believed, could increase the hospitals' resources rather than fund another health management project.

Changes in the work environment perceived as being positive by the new graduates

1. Loading
2. Inservice Lectures
3. Peer Support
4. New Graduate Programme

1. Loading

As in the section on factors that encouraged this group to work in a hospital setting, the loading factor rated highly as a positive influence in their work environment. As students, the participants witnessed the effect on the ward and patient care when the ward admitted acutely ill patients until all the beds were full. They saw how it affected the registered nurses supervising them when the ward was short staffed and heavy. As new graduates, they were pleased with a loading system that permitted the registered nurse to take, in their opinions, professional leadership as to how much workload they could safely manage.

2. Inservice Lectures

When the participants commenced working in the hospital there was an inservice programme in place which provided nursing theory and practical clinical skills for them. The new graduates attended these study days as part of their introduction module to the hospital and found them to be of great value. The inservice training on the new graduate programme was important to the participants and aided their transition to the role of registered nurse on a ward. Since they completed the programme they have found that getting released from the wards for inservice training a major problem. They believed that this training would be planned by the nurse consultant. For example, as registered nurses they were now expected to complete an intravenous certification workshop which provided them with the skills to become proficient at giving intravenous medications, solutions and blood products.

The promise of inservice training in the future was seen as a positive change to current practises. The new graduates believed that inservice training in practical skills and theory pertaining to the area of speciality was imperative to their development as members of the nursing team in the hospital setting. They also stated that medical staff were the best educators in their areas to give these inservice training lectures as their own nursing staff on the wards did not have the experience practically or theoretically to assist them in their learning needs.

3. Peer Support

The introduction of a mentor or peer to work with on the wards was seen as a positive change in the work environment. The participants felt they had someone to identify their learning needs. In some areas the system had broken down due to the staffing situation and skill mix but in the areas that had managed to maintain the system, the participants felt they had benefited greatly from it.

4. New Graduate Programme

For the participants who had a successful new graduate programme, the introduction to the ward as a new registered nurse was managed well. Success of the programme was measured in terms of whether the new graduate had continuous support and education and was eased into the ward routine for the time that had been allocated in the beginning of the programme. Several participants spoke of starting the programme in areas that were understaffed and had a skill mix that was heavily biased towards inexperienced staff which resulted in the programme collapsing within two weeks of the new graduates commencing it. Some wards had a programme set out which was adhered to while other wards constantly adapted the programme to fit the ward staffing needs rather than the learning experience of the new graduate.

As in the previous section when replying to the set questions, the participants identified a number of factors perceived as negative in the work environment, however when I transcribed the data, the similar factors were combined as shown below.

Changes in the work environment perceived as negative by the new graduates

1. Lack of communication with Middle Management (Nursing)
2. High Staff Turnover
3. Lack of Support in Decision Making
4. Incident Reporting and Covering your "back"

1. Lack of communication / Middle Management(Nursing)

The participants believed that communication with nursing consultants, clinical leaders and coordinators was non existent. This was seen as a negative influence on their work environment. The participants believed that they missed out on communications when changes were occurring or needed implementing in the hospital environment. The new graduates were concerned at the lack of communication with them as they believed the changes to health funding and availability of permanent registered nurse vacancies being advertised meant their jobs were in jeopardy. The positions that were advertised were few and generally not permanent or full time.

2. High Staff Turnover

As new graduates commencing in the hospital system, the participants spoke of an unsettled feeling in the workplace due to the lack of experienced registered nurses to provide guidance and mentoring to them. One of the contributing factors to this unsettled feeling was the high staff turnover on the wards that the new graduates practiced in. It disturbed the new graduates to find that having been on the wards for only several months they would find themselves in the position of being the experienced registered nurse giving guidance to other registered nurses when they still needed guidance themselves.

3. Lack of Support in Decision Making

The participants spoke of lack of support in decision making on the wards. This was, they believed, a negative influence on their work environment. They had been unable to get managerial support for policy changes to make the nursing rosters fairer and more reasonable. This widened the gap, in the participants' opinion, between the nurses on the

floor and the managerial layers above whether nursing, medical or administrative. The participants often found themselves in the position of mentoring student nurses. When they mentioned the pressure it put on them, as newcomers, to their senior management, they were informed that they should "*get on with it*". The new graduates felt as though no one was listening to what they were saying or even asking for their input.

4. Incident Reporting and 'Covering your back"

The participants were aware of the impact of filling out forms to cover them in unsafe staffing situations. They felt that the need to '*always cover your back*' in case of legal proceedings or disciplinary action added an extra burden to their working environment. When they were student nurses, someone was always covering them and guiding them in their practice. Suddenly they became registered nurses and no-one was watching how they practiced to guide them. The feeling of being totally responsible for a patient's life with no one to work alongside them as a buddy, as had happened when they were students, made the new graduates feel uncomfortable and at times unsure of their practice.

Summary

In this chapter the responses to four questions asked of the new graduates group of nurses in the focus group interview have been provided. The new graduate group had less than twelve months experience in a hospital setting and came from a training background where they had practical experience in a hospital or community setting combined with theoretical lectures in the polytechnic setting. This group was not paid while training and the hospital setting was the first time they had received monetary reward for their labours.

The results of the study showed that the positive influence on this group was directly related to the practical experiences of being a registered nurse. The general experience of working in a hospital setting in combination with a set new graduate programme and paid study leave were a combination that influenced this group positively. On a practical level

being able to have a patient loading factor enabled this group to have control over their work environment and the quality of care they delivered to their patient.

The negative influences on this group were the responsibilities they felt for the legal, and physical aspects of their chosen profession which were not matched by the financial rewards. Working hours were identified as a negative influence. Staffing and the lack of equipment and resources was a negative factor for this group. Ward politics and communication between different nursing levels in the hospital was also identified as a negative factor. The negative effect of "politics" impacted on the work environment and on new graduates who were full of enthusiasm to practice and provide quality care for the patient.

Positive changes in the working environment were related to peer support on the ward during the new graduate programme and the possibility, in the future, of inservice lectures related to the practical environment in which the group worked. The introduction of the loading factor featured also as a positive change in the work environment.

Negative changes in the work environment were directly related to managerial (nursing) communication, lack of support in decision making and high staff turnover. A surprising factor mentioned by the new graduates was that they were always '*covering their backs*' by writing incident reports. This factor had a negative influence that the researcher had not expected. The new graduate group saw this factor as an added burden in their practice setting.

In chapter five responses to the four questions asked of the experienced nurse perspective will be outlined.

Chapter 5
Experienced Nurses

This chapter contains, the responses to the four questions posed to the experienced nurses' focus group, in the order which the participants prioritised them. The experienced nurse group of participants in this study had a minimum of five years post graduation clinical experience in a public hospital setting.

The prioritised category of factors specific to each of the four questions can be found below in order of importance with 1 ranking highest and = signifying categorised factors given the same ranking.

Categorised factors that encouraged experienced nurses to work in a public hospital setting

1= A Trade Union
Support Network

2= Job Stability
Fixed Term Contracts

3 Ongoing Education

1= A Trade Union

This was prioritised as being first equal as a major factor which encouraged this group of nurses to work in a public hospital setting. The Union *(Union in this context refers to the New Zealand Nurses Organisation, the industrial section*), negotiating for a collective contract which set out conditions of employment such as meal break periods, hours of work, penal rates, nine hour break and better conditions than the private agencies in the same geographical region, featured as a positive factor in encouraging experienced nurses in the group to remain in practice in a public hospital setting.

1.= Support Network

The public hospital employed a large number of nurses who provided a good support network and resource pool for knowledge that this group was able to access and utilise. This group of nurses had experience of the health system and changes over the past five years. Such experience, had taught them how to use the available resources and how to get the most value for the finance available in their budgets. They were very much aware of the cost of resources /equipment and used every opportunity to be effective and efficient. This group felt that by being cost conscious they were able to survive changes to their work environment and secure their employment prospects. The existing nurses network of experienced nurses in the hospital were able to be accessed by others for assistance and suggestions as to how to utilise the ordering system and work within money restraints.

2.= Job Stability

Job stability plays a major part in encouraging them to work in a public hospital setting. The climate in which these nurses find themselves practising, has changed over the last five years. Having a job that is paid and permanent, when there is limited employment opportunities for their skills, plays a major part in encouraging them to remain in practice in a public hospital setting. These nurses are not geographically located in a high employment area and due to family and marriage commitments are not in a position to travel great distances to work. The fact their public hospital is located in the area in which they reside is a factor that encourages them to work for, and in, a public hospital setting.

2.= Fixed Term Contracts

A fixed term employment contract provides the nurses with stability. Coming into the area as someone who did not start their nursing career in the public hospital provided several of the participants with an opportunity to work for a set time and then review their decision to remain or move on. They believed that a fixed term contract provided a set time frame in which to decide whether the chosen work area was to their liking or to apply for a change of position if one became available. The other choice left was to move geographically.

3. Ongoing Education

The public hospital is one of the few public health providers which actively encourages the nursing workforce to attain further qualifications in their specific area of work. The public hospital provides financial support for training and further education to full time and part time nurses. Again this was negotiated by the Union and is viewed as a factor that encouraged the experienced nurses to remain in practice in a public hospital setting.

Categorised factors that discouraged experienced nurses from working in a public hospital setting

1 Lack of communication
2 Skill Mix and Casualisation
3= Lack of leadership
Stress
4 Incident Forms

1. Lack of communication

All members expressed concern and anger at the lack of communication between all levels in the public hospital. This included nursing management, administrative and medical levels. Being in a senior staff nurse level of the structure they were often disappointed to find decisions made at managerial level, to which they had no input, on matters that directly involved them. Such matters included protocols and policies related to patient care and education of junior staff members. Communicating information from the managerial level to the ward level was, in the participants' experience, poor and in some instances, non existent.

Communication across their own nursing level interdepartmentally was also an area of concern. Changes in policies were not communicated and led to a climate of distrust according to the participants. This group of nurses expressed feelings of being undervalued and not listened to. Each nurse was unaware of what the other nurses' areas were experiencing in terms of change and believed their own area to be the worst off in the public hospital.

This resulted in the belief that horizontal violence (verbal attacks between nursing work groups and lack of patience in their encounters) existed between the working hospital wards. An example was given of the pressure to move a patient from the Recovery area of Theatre (an area set up to receive patients following an operation who are usually recovering from a general anaesthetic and require close monitoring by nursing and medical staff until they regain consciousness) back to the post operative ward (a ward set up to receive conscious patients following an operation and to care for the patient until they are able to be discharged from the hospital to their own home). Both recovery staff and post operative ward staff were unaware of the staffing difficulties each was experiencing.

The above affected the ability of the post operative ward staff to collect the patient from the Recovery area which was in turn being pressured by Theatre staff to provide assistance in theatre due to staffing difficulties in that area. None of the staff were aware of how each other actually functioned. Working in isolation cultivates a climate of mistrust and results often in verbal abuse as the main means of communication.

The participants expressed the belief that there was 'an air of distrust' that the nurse consultant group (a group of senior nurses at management level of the organisation who provide clinical expertise to the ward nurses. They also provide nursing advice and input to higher management who may or may not have had nursing experience themselves) had a hidden agenda which benefited the nurse consultants but not the nursing workforce as a whole. No specific incidents or terms were mentioned but further mention of this under the heading of incident forms and lack of leadership may provide some scope to the problem.

2. Skill Mix and Casualisation

The current workforce in the public hospital is heavily weighted in terms of new graduates and nurses with less than five years experience as opposed to experienced nurses. This leads to problems in the mix of skilled staff nurses on the ward. Experienced nurses are constantly working with staff who are inexperienced which results in their workload being greater. The participants felt the pressure on them to 'cover' the junior

staff and also maintain the balance in care of their patients while being in charge of the ward for the shift.

The nurses in this group referred to their frustration at not being able to provide a teaching role adequately for their junior staff due to their responsibilities and work commitments. They viewed part of their role as providing professional education to patients, nursing staff and medical staff but were unable to fulfil this function due to staff skill mix and workloads. They believed failure to provide an educative role led to frustration and job dissatisfaction.

Workloads and seasonal changes had, in most areas resulted in sickness amongst the nursing staff. Increased use was then made of casual staff from the nursing agency attached to the public hospital. The experienced nurses then had to work with nurses who may be experienced but not necessarily in the ward they were working in, for example, unfamiliarity with the equipment. This provided problems for the experienced nurses who needed extra time to support casual nurses while completing their own workload. Some nurses spoke of being on an eight hour shift with three other nurses of whom two were casual nurses and the third nurse a junior nurse. The ward workload was heavy and all beds were occupied.

3.= Lack of Leadership

The group expressed concerns about the poor and, in general, lack of leadership from the nursing management level above them. Nursing management did not appear to the participants to be leading by example in clinical or theoretical practices. The participants reported that there was a lack of education in wards in the form of 'inservices' (lectures on nursing topics, or practical demonstrations of nursing skills and techniques pertinent to the ward).

There appeared to be a feeling among this group of participants of being undervalued when they had offered practical advice on patient care to the nurse consultants' group. The participants believed the consultants were working to some hidden agenda which bore no resemblance to nursing practice and focussed on the management needs of cost

cutting projects which had direct impact on nursing numbers on the hospital wards. This group of participants also suggested that lack of clinical teaching by the consultants' group was a sign of lack of leadership.

3.= Stress

Several of the participants spoke of 'taking time out' due to the stress of working in a system that gave insufficient financial or professional recognition for their experience but functioned partly because they worked beyond the realistic demands of their job descriptions to provide nursing care that was patient centred. The strain of working with a poor skill mix of nursing staff, unsafe staffing levels, substandard equipment and no clinical support from the nurse consultants' group resulted in burn out, 'stress leave' being taken, and resignations.

4. Incident Forms

As in chapter four, incident forms and unsafe staffing levels also feature as a factor which discouraged the experienced registered nurse from remaining in practice in a public hospital setting. These forms were filled out to alert nursing, medical and administrative levels of management of incidents or unsafe staffing levels on the ward by any registered nurse. The process required feedback to the person who initiated the form on the action taken or recommendations made by management.

All the participants reported that they had not received the appropriate response to their incident forms unless they involved the Union for assistance. An appropriate response would have been a reply from the line manager acknowledging receipt of the form and documentation of any further investigation if required in the first instance. This process was documented in the organisations policy manual. The majority of forms never received acknowledgment of receipt from the direct line manager. As previously mentioned this led to a feeling of being undervalued, not being listened to, and resulted in further stress to the participants from the situation which they had alerted management to but which had remained unresolved.

Changes in the work environment perceived as being positive by the experienced nurses

1 Code of Rights for patients

2 Debriefing

3 Loading Factor

1. Code of Rights for patients

Participants believed the introduction of the Code of Rights for Patients had been a positive change in their environment. Patients were fully informed of what their rights were in the hospital setting. Most participants acknowledged that their practice encompassed the code of rights prior to its introduction but were pleased as professionals to see a document which clearly spelt out for the patient exactly what rights they had in the hospital in terms of care and information. The public hospital these participants worked for had compiled a workbook on the Code of Rights which each staff member was required to complete and submit for assessment. The participants believed this led to a better understanding by the staff in general of the principles of the Code of Rights and their application.

2. Debriefing

Debriefing is an opportunity for people involved in a difficult or unusual incident to recount what happened and to determine changes in dealing with similar situations in future. Several participants had been involved in incidents in the work setting which required debriefing afterwards and found this to be a positive change in their work environment. The participants had been involved in other situations, prior to the introduction of debriefing and preferred the debriefing to resolving the problem by themselves.

3. Loading Factor

The ability of nurses to apply a loading factor had been seen as a positive change in their work environment. Previously, the nurses believed that they were stressed in the wards due to the serious nature of their patients' conditions and the constant acute admissions until all the beds were full. According to the participants there were occasions when they

did not have time to complete their work and their patients only received half the care they required. Once the loading factor was introduced the nurses were able to control their workload and ensure that each patient received the care they deserved.

Changes in the work environment perceived as being negative by the experienced nurses

1 Economic Policies
2 Budget Cuts
3 Staffing Cuts
4 Resources/ Equipment.

1. Economic Policies

The participants were acutely aware of the impact of Government Policies on the health system and had already been through the changes associated with economic policies and how the public hospital was funded. These policies affected budgets and staffing levels as well as patient funded services delivered by the public hospital.

2. *Budget Cuts*

The public hospital relied on Government funding to enable it to provide a service to the people of the local community. Cuts to hospital funding resulted in a competitive environment where public and private sector organisations vied for the same Government allocated funding. No longer could public hospitals afford to maintain services at the level they had maintained prior to the introduction of competition for funding. The largest cost in any hospital organisation was the staff budget and this was where savings could be made. Savings were made on the wards' budgets by cutting the numbers of nursing staff working on each ward and reducing the salaries budget. Staff reductions added stress to the participants who still had the same workload.

3. *Staffing Cuts*

In order to reduce costs participants believed rightly or not that the organisation had cut the number of registered nurses in the hospital and replaced them with health assistants who were cheaper to employ.

4. *Resources*

Budget constraints have led to cuts in money available for patients, support organisations, and equipment maintenance or replacement. The participants commented that basic equipment such as blood pressure and glucose measuring equipment and trolleys for doing dressings had become rare items in wards. Items took months to come back from repairs. All of these led to staff dissatisfaction with the work environment.

Summary

In this chapter responses to four questions asked of the experienced group of registered nurses in the focus group have been provided. This group had come from a combination of training facilities. Fifty percent of the group had trained in the hospital system and were paid as student nurses while the other fifty percent had trained in polytechnic institutions where they undertook theoretical instruction and carried out their practical experiences in a hospital or community setting. The members of this focus group had all worked in a paid capacity in public hospitals for at least five years as a registered nurse.

The positive influences on this group were directly related to their employment under a Union contract which provided job security, job stability, a greater network of staff to use as resources and ongoing education paid by the organisation in combination with contributions negotiated by the Union.

The negative influences on this group were directly related to communication between all levels of the organisation, and lack of nursing leadership which was increasing stress levels. The management policies of the organisation were seen as responsible for the skill mix in the work environment. This added stress to the experienced nurses whose workload increased when responsible for inexperienced registered nurse and nurse assistants on a shift. The lack of response to incident forms detailing unsafe staffing levels or incidents in the workplace was a negative factor on nurses wanting to remain in practice in a public hospital setting.

Positive changes to the work environment were identified by the group as being the introduction of the Code of Rights giving patients a guideline as to the quality of care they were entitled to and thus should receive from the organisation. The introduction of the loading factor was a positive factor for this group as it enabled them to take some degree of control of their practice. Debriefing after incidents occurred was also identified as positive by the group.

The negative changes in the work environment were directly related to political influences, internally and externally, on the organisation in terms of financial policies, budget cuts, and lack of equipment and resources to work safely with patients. The experienced nurses implied that they saw the quality of care diminishing as the organisation implemented policies to save money.

In chapter six responses to the four questions asked of the Maori nurse perspective will be outlined.

Chapter 6

Maori Nurses

Ehara i te mea no inina te aroha .
Love is a gift handed down from ancestor to ancestor.

This chapter contains, the responses to the four questions posed to the Maori nurses focus group, in the order which the participants prioritised them. The prioritised categories of factors specific to each of the four questions can be found below in order of importance with 1 ranking highest and = signifying categorised factors given the same ranking.

Categorised factors that encouraged Maori nurses to work in a public hospital setting

1 Familiarity

2 Union Contract

1. Familiarity

The participants had trained in the public hospital and worked there as new graduate registered nurses. The factor of familiarity encouraged them to remain in practice in the public hospital setting. They spoke of the old training system prior to the introduction of Polytechnic training of nurses where jobs were easy to get and they lined up outside the Matron's office to be allocated the ward they were to work on as a new registered nurse. The safety of knowing the hospital and ward areas had been a major factor in the participants remaining in the public hospital setting. They had married and had children in the same geographical region they trained in so staying at the public hospital was an advantage as they already had a working history with the organisation. The participants mentioned how, when they had children, the hospital was not keen to employ them as part time workers and yet now the system has gone full circle and they find it hard to be employed as full timers. The average length of experience of the Maori group of

participants was ten years. The safety of knowing the environment in which they were working was a positive factor in the participants remaining in practice in a public hospital setting.

2. Union Contract

All participants had experienced working in the private sector of the health system but found it did not give them a secure feeling as far as permanent employment was concerned. The attraction of a Union negotiated site contract in the public hospital was a major factor in encouraging them to remain in practice in the public hospital setting. The public hospital was larger than any private organisation and therefore provided, the participants believed, greater job security and bargaining power than working in the private sector where they had previously encountered technical redundancies and changes of contract when new employers had taken over the organisations.

Categorised factors that discouraged Maori Nurses from working in a public hospital setting

1 = Casualisation and Lack of Permanency
Constant Change of Managers

2 = Powerless to make Change
Mistrust of Nursing Management

3 Lack of Training Programmes

1.= Casualisation and Lack of Permanency

The group spoke of instances where Maori nurses had applied for work in the public hospital but were not offered more than 0.8 full time equivalent which did not guarantee a full time wage and conditions that went with full time work. They mentioned also that casualisation of staff was a discouraging factor. The group found it difficult to work alongside casual staff who were not experienced in their clinical working areas and required more supervision and input of time than was available to the participants. The move to replace enrolled nurses with nurse assistants was not welcomed by this group and the use of these assistants on the wards caused extra work for the participants and other registered nurses.

1.= Constant Change of Managers

Constant changing of managers in the hospital was identified by the participants as a discouraging factor for them remaining in practice in the public hospital setting. As experienced practitioners they had seen frequent changes to the managers in charge of their departments and each change had resulted in one department in particular having managers appointed who had knowledge of accounting practices but no theoretical or practical knowledge of clinical nursing, or how the hospital and health system worked. This resulted in further frustration for the participants who had to explain the effect of some of the financial decisions to the patients in their care.

2.= Powerless to make change

The participants believed they were powerless to make any decisions which affected their practice. Any suggestions they put forward to nursing, medical or administrative management were not listened to. The result for the participants was that they stopped making suggestions and became in their words 'frustrated and discontented' with the system they worked in. A common expression was 'you can bang your head so long against a wall and then you just give up or go under'.

2.= Mistrust of Nursing Management

The group spoke of incidents involving nurse consultants and managers where what was said orally was not carried out in practice or writing. They had examples of being called in to assist because of their particular skills when areas were short of skilled staff but not being offered full time work in the particular skill area when it became vacant. The mistrust of the nurse management level in the hospital was a factor that discouraged the participants from remaining. This combined with the powerlessness to affect change caused the participants to believe they could no longer trust the nurses above them who, in the participants' opinion, were supposed to represent their voices at management level but no longer did. The group believed the nurse consultants were advancing their own careers and not the nursing role in the hospital.

3. Lack of Training Programmes

Lack of training programmes was identified by the participants as a discouraging factor. These participants had worked for at least ten years with the hospital and the lack of programmes aimed at upskilling registered nurses caused them to believe they were undervalued by the organisation. Opportunities had presented themselves to the participants however lack of experienced registered nurses to replace them in their work areas had meant they were unable to commit themselves to these opportunities.

The participants spoke of the frustration they felt at not being able to be replaced or released for job related courses. They believed that previous factors such as management and nursing support also influenced their progress in achieving the upskilling. The longterm result on the participants was that they were not seen to be upskilling and were disadvantaged in the organisation which appeared to be aligning itself with the national trend to get nurses onto some type of professional development programme (PDP). The PDP scheme concerned the participants as the public hospital was investigating ways of tying nurses wages to the level they achieved on the scheme and the lack of opportunity to upskill could disadvantage the participants financially.

Changes in the work environment perceived as being positive by the Maori nurses group

1 Change to Hospital Layout

2 A New Ordering System

1. Change to Hospital Layout

The relocation of different services in the hospital resulted in a better flow of services which the participants viewed, as a positive change. The physical environment had changed to accommodate the patients' needs. Wheelchair access to all areas of the hospital, signposting with clear diagrams, the locating of corresponding facilities in the same area had a positive effect on the patients who no longer got lost and staff who were able to give clearer directions. The physical environment of the hospital became more user friendly.

2. A New Ordering System

Advances in technology, in the form of a new ordering system via the computer, was a positive change cited by the participants. The participants had worked in the public hospital from the time when all ordering was done by hand in triplicate and entered into a book of accounts. The introduction of computers had resulted in a requisition being approved and actioned more quickly and with less paperwork.

Changes in the work environment perceived as negative by the Maori nurses group

1= Changes of Managers
Budget Cuts

2= Harassment
Conflict of Interest

3 Tokenism and Cultural Safety

1.= Changes of Managers

The constant changing of managers was seen as a negative influence on the working environment as it was for discouraging factors (previously mentioned). The lack of consultation about changes that were occurring and the impact on the staff directly affected by the changes was a negative influence according to the participants. When changes occurred the participants believed they were not supported by the nurse consultants, nurse administrators, medical or administrative staff, to adjust to the changes. They believed they were not listened to or consulted when new programmes were being developed. Communication channels, according to the participants, were wanting in all levels of the hospital setting and the constant changes were just another negative influence on the environment. The participants believed they could positively contribute to ideas if consulted.

1.= Budget Cuts

Changes to the health system has resulted in budget cuts which were seen as a negative influence. The work environment saw a decrease in ward equipment. Staff were leaving but not being replaced while the remaining staff increased their work load. Lack of

resources to undertake health screening and education programmes for patients did not balance with the changes to management working conditions where money was being spent on new curtains and furnishings. The participants were disillusioned when they saw the spending in such areas and yet they themselves were making do with equipment that was old and faulty.

2.= *Harassment*

A negative influence in the hospital environment was the constant harassment of nurses by fellow colleagues and medical staff. This influence had become increasingly worse over the last five years and the participants attributed this to the pressures that other disciplines were feeling under the budget and staffing cuts. The participants cited incidents of verbal abuse of fellow workers. The participants had supported the worker involved in the incident by assisting them to lay a formal complaint. The end result was that the person being harassed was moved from the area and suffered the gossip that followed rather than the organisation dealing with the people causing the harassment.

2.= *Conflict of Nursing Roles*

The change of title from the Clinical Nurse Specialist to Nurse Consultant was originally a move supported by the participants as they believed nurses would have a greater voice in management as well as remaining in contact to educate nurses in clinical skills. Unfortunately the participants believed the change of titles resulted in a conflict of interest for the Nurse Consultants who appeared to have taken on more of a management role and forgotten the clinical skills input they had as a component of their role. This caused a negative influence in the work environment as the participants no longer felt supported by those meant to be clinical nursing experts.

3. *Tokenism and Cultural Safety*

The New Zealand Nursing Council policy and changes to the health sector supported the introduction of cultural safety. The participants spoke of how at first everybody in the hospital appeared to be attending workshops and doing courses to aid them in nursing Maori patients in the public hospital. Incidents of patients being unable to be supported when dying as the ward restricted numbers of visitors, or nurses insisting on clearing and

cleaning up patients bedspaces when they were dying rather than waiting and letting the whanau have time with their relative. The initial commitment of the hospital for the local Iwi representative to have input to the programme of Treaty of Waitangi workshops appeared to the participants to have faded.

Some of the problems occurred because of staffing numbers. The participants believed at times that staff did not have the time to stop and think about how they would have liked their relatives to be treated, the aroha for the dying person was not there and they were left to die alone. The participants stated that an attitudinal change would not come about with just one course and believed that some of the most prejudiced staff members in the public hospital were the ones that had completed a Treaty of Waitangi course. The participants were aware of the lack of Maori nurses in the public hospital. This shortage has a negative effect on the care of Maori patients. Maori patients appeared to be accepting what ever care they were given rather than complaining in case their relative received adverse care or no care at all. The trend to care for Maori patients in the community with the new Iwi initiatives was one small way of coping with the problem of patients not feeling safe in the hospital environment but did not solve the problem of the patient that had to be nursed in a hospital environment. However, cultural safety now appeared to the participants as being tokenism on the part of the organisation.

Summary

In this chapter the responses to four questions asked of the Maori group of nurses in the focus group interview have been provided. The Maori group of nurses had been chosen so that a cultural perspective could be given which would enhance the perspectives of the experienced and new graduate groups. The group answered the same questions as the previous groups but had a different perspective of the cultural component in the nursing practice as noted in their responses. The group had all trained in the hospital environment initially and had worked in the public hospital setting for at least five years in different capacities. They, like the experienced nurses, had seen and experienced changes to their work environment from different political party health policies.

The positive influences on this group were directly related to employment. The Union negotiated contract gave them job stability and security. The group felt that familiarity with the organisation was a positive influence on their remaining in practice in the public hospital setting.

The negative influences on this group were directly related to management policies and their effect on the working environment and the participants. An inability to attend training programmes because of staffing replacements and skill mix of staff were identified as negative influences. The group felt powerless to influence change in their work areas and were frustrated at the lack of input of nurse consultants into the management of practice issues. Working with casual staff from the nursing agency attached to the public hospital, and no permanent full time work being offered, had been a negative factor for the participants.

Positive changes in the work environment were related to the physical environment. The change of layout of the hospital so patients could find their way around more easily and the introduction of a computer to the workplace which was able to speed up the ordering process was seen as positive by this group. As a group who had spent long hours hand writing orders and waiting long periods for delivery from the stores department the computer was an aid to the practicalities of running a ward.

Negative changes in the work environment were related to political influences in terms of budget cuts and the loss of staff and equipment in the workplace. The personal side of the organisation in terms of harassment of staff and how the organisation dealt with such incidents was identified as a negative change in the environment. The group was the only one to identify cultural safety as a problem. They perceived the attitude of staff as 'tokenism' and that the organisation's commitment had waned since the introduction of the Treaty of Waitangi workshops into the work place. The participation in a Treaty of Waitangi workshop in some cases had not changed the way registered nurses treated patients from a different cultural background to their own. The participants believed attitude changes will not happen necessarily after one course and it is a constant process of change that is required. If change does not occur for Maori patients then the public

health system runs the risk of isolating the population that needs it most from providing the care needed. The Maori patients may not feel safe accessing a health system that they believe cannot accommodate their beliefs and health needs.

In chapter seven the positive and negative factors raised between the three focus groups will be explored and discussed. In addition the issues raised will be related to current and previous literature findings both internationally and nationally.

Chapter 7

Encouraging and Discouraging Factors

In this chapter the categorised factors identified by the three focus groups will be explored and any apparent similarities or differences will be discussed. The findings will be related to international and national literature. The identified factors, as seen in Appendix IV, are as the participants from the focus groups prioritised them at the end of each focus group interview. In chapters four, five and six these factors have been categorised by the researcher. During each interview the participants were asked four main questions.

1) What factors encourage you to work in a public hospital setting?
2) What factors discourage you from working in a public hospital setting?
3) Have there been any changes which you perceive as being a positive influence in your working environment?
4) Have there been any changes which you perceive as being a negative influence in your working environment?

In responding to the questions and then prioritising the identified factors at the end of the interview, the participants may have been forced to find differences. On close examination of the differences they were quite subtle. The participants clarified what they were saying so they could prioritise the identified factors more succinctly but in this process may have reduced their responses too finely.

The factors indicated that there were no major distinctions between questions one and three and that no information would be lost if the data were collapsed into one set concerning encouraging factors. Similarly there were no major distinctions between questions two and four. No information would be lost if they were collapsed into a further set concerning discouraging factors.

In the first part of this chapter the focus will be on the categorised factors that encourage the three groups to remain in practise in a public hospital setting. The second part of this chapter will focus on the categorised factors that discourage the three groups from remaining in practise in a public hospital setting. These factors were collapsed into three encouraging categories of job security, professional development and professional autonomy (see Table 7.1) and three discouraging categories of internal politics, external politics and political correctness (see Table 7.2).

Encouraging Factors

The positive categorised factors encouraging new graduates to remain in practice in a public hospital setting were directly related to the practical experience of being a registered nurse and included the general experience of working in a hospital setting in combination with a set new graduate programme, paid study leave and a loading factor. The positive categorised factors identified by the new graduate group in chapter four can be further reduced to three overarching factors : job security, professional development and professional autonomy.

The positive categorised factors encouraging the experienced nurses to remain in practice in a public hospital setting were all directly related to their employment conditions and patient rights. The positive categorised factors identified by the experienced nurses group in chapter five can be further reduced to three overarching factors : job security, professional development and professional autonomy.

The positive categorised factors influencing the Maori nurses to remain in practice in a public hospital setting were directly related to the employment conditions and the employment setting. The categorised positive factors identified by the Maori nurses group can be further reduced to three overarching factors : job security, professional development and professional autonomy.

The emerging overarching factors from all three focus groups indicated that although they may have come from a different perspective in terms of length of nursing experience

or cultural identity, fundamentally all three groups were identifying the same positive factors encouraging them to practice in a hospital setting. The factors can be summarised as job security, professional development and professional autonomy.

Table 7.1: Encouraging Factors

	Job Security	**Professional Development**	**Professional Autonomy**
New Graduates	General Experience	Orientation Programme (Peer support) Paid study leave	Patient Loading
Experienced Nurses	Union Contract Job Stability	Ongoing Education Inservice Lectures	Patient Loading Code of Rights
Maori Nurses	General Experience Union Contract	Ongoing Education	Ordering System Hospital Layout

Job security

New Graduates

For the new graduate nurses group the general experience of working in a public hospital provided them with the security of working in an environment that was large enough to gain practical experience while remaining small enough so they were not lost in the system.

Experienced nurses

The experienced nurse group identified job stability as a positive influence in their remaining in practice in a hospital setting. The influence of the Union in the employment setting was seen by the participants as a factor that provided them with set employment conditions, in particular wages and educational leave. They were geographically and personally tied to the region in which the hospital was located and employment opportunities were limited so the Union negotiated contract provided them with job stability and security.

The conditions negotiated had provided this group of participants with firstly the ability to provide a good standard of care for their patients and secondly with satisfactory staffing levels. Nolan, Nolan and Grant (1995) suggested that maintaining job satisfaction and morale was influenced by providing nurses with enough time to ensure a good standard of care through satisfactory staffing levels.

Maori nurses

The Maori nurse group identified the general experience of working in a familiar environment, where they had trained as students, as a positive influence on them.
The Maori nurse group were also influenced positively by the negotiated Union contract. The group of Maori nurses identified job security from the union contract as an encouraging factor providing job stability in the public hospital and influencing their remaining in practise in the public hospital setting. The familiarity of the hospital setting allowed the Maori nurses to feel comfortable with their working environment and not overwhelmed by the vastness of a larger hospital setting. The conditions negotiated had provided this group of participants with the ability to provide a good standard of care for their patients with satisfactory staffing levels. The Union negotiated contract provided for employment conditions which in turn led to good morale amongst the registered nurses and this had an effect on job satisfaction.

Professional Development

New Graduates

The new graduates nurse group was encouraged by an orientation programme, peer support, continuing educational lectures and skills demonstrations while making the transition from student to registered nurse. The new graduates spoke of continuing and paid study leave as an encouraging factor on their remaining in practice in a public hospital system.

The new graduate focus group also identified education in terms of orientation programmes as an encouraging factor influencing their remaining in practice in a hospital setting. Orientation programmes designed to help the new graduate registered nurse adjust to working in a hospital setting were viewed by this group of participants as essential for their progression as a registered nurse. Wards that provided the new graduates with a programme encompassing theoretical and practical "tasks" were considered by the participants as positive areas to work in. Tasks in this context refers to carrying out techniques in the hospital ward which are witnessed and signed as being seen as accomplished by other registered nurses.

The new graduates appeared to gain confidence in their own abilities to practise as registered nurses once they had tasks ticked as witnessed and accomplished by other registered nurses. The new graduates identified educational support as a positive factor which encouraged them to practise in a public hospital setting. Other authors Hunter, Pollman & Moore (1990) and Kotechi (1992) suggest that internship programmes can ease the transition from student to registered nurse. This is supported by Trim (1996) in the form of effective orientation, preceptorship and internship programmes.

Another factor identified by the new graduate group was that of the support provided to them during their orientation period to the hospital by their own peer group working in the hospital wards. The new graduates spoke of the confidence they gained in their own abilities to practise as registered nurses from working alongside other registered nurses in a "buddy" system or being able to identify someone in the ward who they could go to

for advice. Preceptorship of new graduates in a ward setting leads to job satisfaction as the new graduates are made to feel part of a team. This has influenced their remaining in practice in a hospital setting.

The importance of preceptorship during orientation of new graduates to the hospital setting has been highlighted in a study by Oermann and Moffitt-Wolf (1997). The study was limited by having only 35 participants in three hospitals. However, it did raise the importance of effective preceptorship programmes for new graduates and supported previous work by Brasler (1993) and Reilly & Oermann (1992).

Experienced Nurses

The experienced nurses group was encouraged by ongoing educational opportunities to upgrade their practical and theoretical knowledge while working in the public hospital setting.

The experienced nurses spoke of ongoing educational opportunities as being positive influences on their remaining in practice in a hospital setting. The availability of other experienced nurses as resources and support for the gaining of clinical skills were also encouraging factors identified by this group. The provision of paid inservice training in terms of lectures and practical demonstrations were factors that influenced this group positively towards participating in ongoing educational programmes and gaining advanced practice nurse status.

Brooks, Fletcher and Wahlstedt (1998) used focus group interviews to identify the continuing educational needs of the advanced nurse practitioner. They found the educational needs of the advanced nurse practitioner in terms of professional development were factors that related to job satisfaction and professional needs. Although this study took place in the United States of America there are similarities to nursing in New Zealand.

The experienced nurses had seen several changes of health policy and were aware of their effects on the general running of the ward and on patients. They were fully aware of the influences of political decisions on their workplace whether positive or negative. The trend for nurses to gain tertiary qualifications is increasing and over half of the registered nurses in the public hospital, have already gained or are working towards, their undergraduate qualifications.

Maori Nurses

For the Maori group of nurses, professional development came up as a factor but more in relation to the discouraging factors as a problem encountered by the group when finding replacements for them in their work environment to attend courses or skill related conferences. For this group there were other factors that were priorities for them ahead of professional development.

Professional autonomy

For the new graduate nurses group and the experienced nurses group the introduction of the loading factor was seen as encouraging them to remain in practise in the public hospital setting. Being able to influence their practise and working role gave them a feeling of professional autonomy.

The Maori nurse group identified professional autonomy as the control they influenced over their working environment. Changes they were able to make to that environment assisted the delivery of care by the Maori nurses for their patients.

New graduates

Both the new graduate and the experienced nurse focus groups identified the patient loading factor as encouraging them to remain in practice in a hospital setting. For the new graduate, the ability to influence their work environment enabling them to deliver quality care to their patients in a stress free environment, was a positive factor. The patient loading factor provided them with professional autonomy. Pierce, Hazel and

Mion (1996) found similar influences on job satisfaction in the form of autonomy as a professional.

Experienced nurses

Pierce et al., (1996) examined registered nurses working in the rehabilitation area of nursing. A new professional practice model was instigated which focussed on sharing both decision making and power with all levels of nurses in the organisation. Overall findings indicated increases in job satisfaction related to the professional autonomy of the registered nurses in the study. Although conducted in the United States of America the findings are relevant to the New Zealand health setting and this current study.

For the experienced nurse group, being able to apply a loading factor was seen as a positive influence in their work environment. The experienced nurses were feeling stressed from the pressure they were under when patient numbers in their wards increased beyond what they, as practitioners, believed were manageable in terms of the quality of care. The experienced nurses were able to control their workload and quality of care delivered to their patients by using the loading factor and in doing so were using professional autonomy. This professional autonomy gave them a greater feeling of job satisfaction. Pierce, Hazel and Mion (1996) found similar influences on nursing job satisfaction in the form of professional autonomy as previously mentioned.

The experienced nurse group supported the introduction of the Code of Rights for patients and identified this code as a positive influence in their work environment. The introduction of documentation supporting patients rights was given as a positive factor encouraging the experienced group of nurses to remain in practice in the public hospital setting. This factor, although stated separately, comes under the professional autonomy heading. Recognition of patients rights reflects the professional nature of nursing where experienced nurses practice in an environment that supports theoretical concepts recognised outside their profession and enhances their professional practice. Professional autonomy was also stated in the form of debriefing for resolution of problems involving staff.

Maori nurses

For the Maori nurse group professional autonomy was identified in terms of being able to control their job and work environment. The introduction of a new ordering system in the hospital was described by the Maori nurse group as allowing more time to devote to providing their patients with a good standard of care, as they were no longer spending large quantities time on ordering. The provision of good standards of nursing care for patients with adequate staffing levels was also identified by authors Nolan, Nolan and Grant (1995) as previously mentioned.

The change, as mentioned in chapter six, to the hospital layout resulted in a better flow of services in the hospital environment which the Maori participants viewed as an encouragement for them to remain in practice in a public hospital setting. They believed that the patients found the hospital environment more user friendly and this resulted in staff being able to give clearer directions to the patients and provide a service that was essential for patients wellbeing in an unfamiliar environment. When prioritising the factors the researcher noted that the Maori nurses group was concerned with the above practical aspects.

Discouraging Factors

Factors that discouraged the three groups remaining in practice in a public hospital setting were directly related to political influences in the form of policy decisions on funding internally and externally. For the new graduate group these factors affected staffing numbers, resources, equipment and the delivery of care. The categorised factors identified by the new graduate group can be reduced to two overarching factors: internal politics and external politics. For the experienced nurse group these factors affected staffing numbers, skill mix, equipment levels and the communication in the hospital. The categorised factors identified by the experienced nurses group can be reduced to two overarching factors: internal politics and external politics. For the Maori nurses' group, the factors also included political correctness. These factors affected staff numbers, skill mix, staffing levels, training programmes, cultural safety and harassment of staff. The categorised factors identified by the Maori nurses group can be reduced to three overarching factors: Internal politics, external politics and political correctness.

As in the encouraging factors, the emerging overarching factors for all three focus groups indicated that although they may have differed in nursing experience or cultural identity, fundamentally all three groups were identifying the same two overarching factors discouraging their remaining in practice in a public hospital setting. These can be described as internal politics, external politics. In addition the Maori nurses group identified political correctness.

Table 7.2: Discouraging Factors

	Internal Politics	**External Politics**	**Political Correctness**
New Graduates	Ward politics Communication problems	Pay conditions Shift work Inadequate Staffing Budget cuts Skill mix	
Experienced nurses	Nursing leadership Lack of consultation Lack of communication Skill mix Casualisation	Incident forms Budget cuts Staff cuts Lack of resources	
Maori nurses	Powerlessness Nursing leadership Casualisation /Lack of permanent staff Skill mix Lack of training opportunities	Budget cuts Staff cuts Lack of resources	Tokenism Cultural Safety Harassment

Internal politics

The three groups related the negative influences discouraging them to remain in practice in the public hospital setting to internal politics which influenced their working environment. The lack of communication, staff skill mix, casualisation of staff and stress resulted from policy decisions and how the policies were carried out in the hospital environment. The communication problems affecting the participants also appear to be affected by the pressures put on the nursing management of the organisation. They in turn are responding to reduced funding from the Health Funding Authority.

New Graduates

The new graduate group identified ward politics as a negative influence which discouraged them from remaining in practice in a public hospital setting. The participants who were full of enthusiasm to practice and provide quality care for their patients, felt the negative impact of ward "politics" on their ability to practice.

The new graduate group also identified communications with nursing staff in middle management as a negative influence on their remaining in practice. The researcher asked the participants to explain what they meant by the phrase 'communications were non existent with middle management (nursing)'. They explained that the nursing management did not communicate with the new graduates when implementing new policies and protocols or ask for any input into the policies and protocols. When the new graduates had suggested changes to the nursing roster, that they worked, the management (nursing) did not listen or ask for their input. This led them to believe they did not exist, as a group in the organisation, nor did they have any channels for them to communicate with the nursing management.

The influence of internal policies on financial and resource planning directly affected the participants practise setting. They were unable to change either finance or resources decisions and could only see the problem as being addressed by the middle management (nursing) level above them. The problem was caused by hospital managements reaction to Government health funding.

A study conducted in New Zealand in 1988, by Ng, Jenkins, Dixon and Cram (1993), showed that job satisfaction and relationships with nursing supervisors were significant in predicting the number of registered nurses quitting the profession. Oliver, as reported by O'Connor (1996), also questioned the quality of care and safety of clients in the workplace and the influence this had on nurses' decision to quit the profession.

Experienced nurses

The experienced nurses' group stated that there was no nursing leadership, which caused them extra stress, and left them feeling undervalued and unrepresented in the management area of the organisation. When decisions affecting their practice and patients were made without consultation or representation from the nursing workforce, the experienced nurse group indicated that they were not listened to as a professional body.

Davidson, Folcarelli, Crawford, Duprat and Clifford (1997) conducted a survey of 736 hospital nurses in one hospital in the United States of America to examine changes in aspects of job satisfaction in relation to predicting nurses terminating their jobs during the study period. Findings indicated improvement in communication throughout the organisation could enhance nurse job satisfaction. Increased workloads led to decreased quality of care provided. These findings are relevant for this study in terms of the replacement of permanent staff in the wards with casual staff and the communication problems.

The experienced nurses also identified the staffing skill mix as placing stress on them. The use of casual staff added to their workload, as they were required to supervise the nurse assistants and inexperienced registered nurses. They found the extra load a burden and had no time for teaching or supporting other staff members as they were only managing to survive themselves. A survey conducted in 1996, by the New Zealand Nurses Organisation (NZNO, 1996), identified skill mix of the nursing workforce and inexperienced nursing assistants as being directly linked to patient safety and nursing staff levels.

Maori nurses

The Maori nurse group of participants suggested they felt powerless to affect change in their work environment. The lack of leadership provided by the nurse consultants to the nursing workforce left the Maori nurse group feeling powerless to effect change. When their managers with financial control made decisions affecting their practice and patients but did not invite, or listen to, recommendations from the nursing workforce, this added to the negative feeling experienced by the participants.

Another factor identified by the Maori nurse group was the lack of permanent full time staff which discouraged Maori nurses from applying for positions in the public hospital setting when advertised as they had no full time work or security. They also expressed concern at the enrolled nurses being replaced by nurse assistants who constantly had to be supervised and increased the participants workload. Although lack of permanent full time staff was identified by the Maori nurse group as a priority (Appendix IV), it is not a Maori issue only and both the new graduates and experienced nurse group referred to this issue in their focus group discussions but have not prioritised it in their group findings.

Similar to the experienced nurse group, the Maori nurse group identified skill mix and the experience of the nurses they worked with as discouraging factors. Inexperienced nurses, new graduates, casual staff and nurse assistants required them to add extra work to their own load. Staff cuts also meant nursing staff were not being replaced on the wards and previous part time experienced staff members were not replaced.

O'Connor (1992) pointed out the effect of health sector cuts and budget constraints on the quality of nursing care and the increased stress on nursing staff. Reduced staff numbers has led to other nurses in New Zealand speaking out about safety of patients (Brown, 1996). Brown was a registered nurse working on nightshift on a busy medical ward in a large training hospital. He spoke of staff stretched to the limit and compromised patient care standards on his eight hour shift. While the article was anecdotal there was no doubt Brown felt strongly about the issues. The current study

also identified skill mix and lack of staff as a discouraging factor and the resultant stress this situation caused for the participants and other colleagues.

Lack of training programmes, or opportunities to participate in any education opportunities in the hospital left the Maori nurses feeling disadvantaged as a group due to their inability to attend inservice or upskilling programmes. They were unable to be replaced in their work situation and felt they would be seen as a group who were not prepared to do any upskilling or enter the *Professional Development Programme*. As there was a possibility this programme would be linked into pay negotiations, it would directly affect them financially. Although it was identified by the Maori nurse group as a priority it is not a Maori issue only and both the new graduates and experienced nurse group referred to this issue in their focus group discussions but have not prioritised it in their group findings.

Davidson et al., (1997) also found that the educational needs and requirements of the staff must be designed into the hospital structure so as to keep highly skilled nurses in patient care. Although conducted in the USA the findings are relevant to health care settings in New Zealand and the current study.

McRae and Ramsey (1992) suggested staff take charge of their careers instead of waiting on management to initiate change but it is a hard task if management are not listening to nurses suggestions.

External Politics

The three groups related the negative influences which discouraged them from remaining in practice in the hospital setting to external politics which affected their working environment. Lack of resources, budget cuts and staffing cuts resulted from reduced funding provided by the Health Funding Authority. As Oliver (1997, p. 27) stated : "*... the funding announced does not seem enough to both maintain existing levels of access to services and pay for improving access in the areas specified by the policies*".

New Graduates

The new graduate group identified pay levels, staff mix and staff levels as negative influences in their work environment. The lack of mentors available for advice and support directly affected their practice and development as registered nurses. There was a high turnover of experienced registered nurses so the participants soon found themselves working with inexperienced nurses or nurse assistants. This made them the experienced registered nurse in some situations when they were still learning themselves.

The new graduates spoke of taking responsibility for patients lives and yet getting paid less than the cook in the kitchen who if he/she made a mistake the worst that would happen was the food got returned. One of the participants had personal knowledge of the cooks' salary and when asked by the researcher to identify the source of the knowledge was able to. The participants could not verify the comment concerning the health assistant wages being only a dollar per hour less than their own although reference had been made to it. However, they indicated that their worst mistake could result in someone dying yet the pay did not reflect the professional nature or responsibility attached to their job. The unsocial hours in shift work that they worked was mentioned as a negative factor related to the job.

The new graduates were aware when they entered the nursing profession that they would be required to work shifts but found that as the lowest on the pay scale of registered nurse they were constantly being rostered to work weekends and at times having only one weekend off a month. The wards they worked in had other more experienced registered nurses but they were more expensive in comparison to a new graduate to roster on a weekend shift.

They also spoke of the penal rates which although more than the normal wages for weekend work, were not adequate compensation for lack of a social life or working 'when your friends were off.' The money they earned while working weekends was inadequate for the responsibilities they were expected to take in practising as registered nurses. They stated that the demands of the job left no room for them to partake in the normal events in society and they were becoming isolated from their peer groups. They

encountered isolation and had nowhere to turn. The lack of financial incentive for the weekend work was a negative influence on them. Keene (1990) identified nurses dissatisfaction with pay conditions as reasons why they were leaving the profession. Underwood (1994) identified that changes to negotiated wages led to a decrease in senior experienced nurses which resulted in a lack of role models for nursing staff to follow.

There was added stress placed on new graduates when their practice was being compromised by inadequate staffing for the patient numbers in the wards. The group previously spoke of the loading factor as a positive factor in their remaining in practice in a hospital setting but when referring to the negative factors lack of adequate experienced staff outweighed the advantages of a loading factor. In the encouraging factors the ability to close the ward to further admissions when the nurses had a patient load of fifteen per shift meant the ward could no longer take admissions unless more nursing staff were obtained. Yet in discouraging factors the participants identified lack of staff as a factor and this meant that the loading factor system was not working as it was designed to. The participants acknowledged this in discussions as to why the incongruity existed between the two factors. The new graduates stated that their ability to provide safe care was directly related to the numbers of experienced registered nurses in the wards.

This factor of compromised delivery of care to the patients has been identified by Warr (1995) who spoke of care in relation to nursing numbers. O'Connor (1996) had similar comments regarding the increase in indemnity claims which rose alarmingly in relation to the increased patient numbers in the hospital and decrease in staffing numbers to look after these patients. Another factor mentioned by O'Connor (1996) was the increase in incidents of compromised safety of staff and patients which was coming to the attention of not only the New Zealand Nursing Council, for disciplinary action, but also NZNO as the industrial section to provide representation and advice to members (Warr, 1995).

Not being able to provide adequate and quality care to their patients due to lack of basic equipment had a negative influence on the new graduate group. They saw money being

spent on new management projects and management consultants to run the projects but no money on basic equipment.

The effect of political policies on the provision of equipment and staff are documented by Keene,(1990); Stodart, (1990); Nimmo, (1991); Warr, (1995); and Brown, (1996). Rodney and Starzomski (1993) spoke of the moral distress that occurs among health professionals when they believe they have an obligation and responsibility to provide care but are unable to because of forces they have no control over. This has relevance for the current participants in the study and the New Zealand health sector.

The new graduates stated that filling out incident forms when in unsafe staffing situations felt like 'covering your back' in case of legal action and added another burden to their practice

Experienced nurses

The experienced nurse group identified similar factors to the new graduates in relation to staff numbers being cut on the ward but were seeing the problem from that of the senior nurse working in the ward environment with no experienced backup themselves. Whereas the new graduates referred to the absence of mentors, the experienced nurses required the moral support of other experienced nurses.

The experienced nurses reported incident forms as a source of stress when they were not responded to. Literature shows the investigation by the New Zealand Health and Disability Commissioner into Christchurch Hospital Emergency Department vindicated staff who raised the alarm about patient safety (Coney, 1998; Newth, 1998a). Although they completed incident forms the participants found that no action was taken by nursing management. This proved stressful for the participants who remained in the environment from which the forms had originated.

O'Connor (1992) pointed out the effect of health sector cuts and budget constraints on the quality of nursing care and the increased stress on nursing staff. The experienced nurse group also identified financial constraints which reduced resources as a negative

factor affecting their practice environment. The effect on the working environment of lack of basic equipment has been identified by Stoddard (1990) and Nimmo (1991). Tiriana (1997) also wrote in the Daily Post newspaper about the effect of rationing of health services to the public due to the reduction in allocated health funding to some areas of the health sector. For example the Eastern Bay of Plenty received less funding in 1997. The two hospitals in Whakatane and Tauranga announced a merger on the 20th November 1998 (Kopae, 1998).

Maori nurses

The reasons identified by the experienced nurses in terms of budget and staffing cuts were also identified by the Maori nurse group as negative factors affecting their practice environment. The constant influence of changing political parties and their health policies resulted in cuts to services provided to the patients and the hospital providing the services. Whether it be things such as home help, or relief for relatives many services had disappeared from the hospital budget and put further strain on the nurses and the patients' families they were trying to support.

Political Correctness

This factor resulted from the Maori group of nurses concerning cultural safety, harassment and tokenism. The political influence on how people react to situations that are different to their own, in terms of participating in a course, will not necessarily change peoples attitudes. Attitudinal changes take time and work.

Political correctness is a term that is used in the 1990s to signify that someone is conducting an action or portraying an attitude that is in line with the current "politically" defined attitude to an emotion / moral subject in society. The person may be in public displaying support for a homosexual movement, Maori land rights, rights for children or Treaty of Waitangi issues but in private vehemently opposing such rights in actions or verbal demonstrations.

The discouraging factor specifically mentioned by the Maori nurses group was the *Tokenism* of *Cultural Safety* and the needs of the Maori patient being met. Literature reviews show the Nursing Council of New Zealand (1996) defining cultural safety as how the patient and the family defines the quality of service on subjective as well as clinical grounds. This current study indicates that the principles that have been expounded in theory are not always carried out in practice. The commitment to cultural safety is a constant commitment that can not be partially administered when it is convenient or the political favourite topic. It must be constant and also requires input from all parties involved in the delivery of care to a patient.

Cultural safety as a concept has changed since it was first raised for debate at the Maori student nurse hui (meeting) in 1988 at Otautahi (Christchurch). During the change process it has managed to attract supporters and opposers who vehemently fight for their cause sometimes to the detriment of others. This has been witnessed recently in the Dominion newspaper (11 Sept 1998) when Wanganui Polytechnic was taken to task for the racial behaviour against Pakeha students who were discriminated against by some polytechnic staff.

Harassment of staff by other groups in the hospital and fellow nursing staff was also identified by the Maori nurse group as a negative influence discouraging them remaining in practice in a public hospital setting. The nursing staff involved in these situations were not supported by management and this resulted in stress on the participants. The organisation came under fire for the political correctness displayed by the nursing management when making decisions. The Maori nurses' group believed that the nurse consultants were looking out for their own careers and not representing the nurses under their direction or even giving direction to the nursing workforce by providing clinical leadership and guidance.

Ng et al., (1993), as previously mentioned, conducted a study in 1988 identifying that job satisfaction and relationships with nursing supervisors were significant in predicting the number of registered nurses quitting the profession. Dyson (1994) spoke of nurses uniting to find leaders from within their own ranks to create change but in this study the

nursing leaders have already been identified in the form of nurse consultants and they were not, in the participants opinion, providing the leadership they should.

Conclusion

The three groups (new graduate nurses, experienced nurses and Maori nurses) all come from different perspectives which influence their work practice. The encouraging factors influencing the three groups can be reduced to three overarching factors. They are job security, professional development and professional autonomy.

The discouraging factors influencing the three groups can be reduced to two overarching factors. They are internal politics and external politics. A third factor of political correctness relates to the Maori group of nurses. All of these overarching factors could be subsumed into one core category that of job satisfaction.

The identified factors warrant further exploration. Following analysis of the data the researcher returned to the literature in order to find supportive arguments to add validity to the current study. The findings are presented in the following chapter.

Chapter 8
Return to the Literature

Several overarching factors emerge from the data. In this chapter each major factor that either encourages and /or discourages registered nurses to remain in practice in a public hospital setting will be examined in reference to literature which specifically addresses their significance. These factors are job security, professional development, professional autonomy, internal politics, external politics and political correctness. Firstly however, as job satisfaction appears to be at the core of all these factors the literature on job satisfaction in general will be revisited.

Job Satisfaction

Job satisfaction is influenced by several factors for the nurses in this study. The ability to nurse patients safely and with adequate staffing numbers is an important aspect of job satisfaction. Another aspect for the new graduates was the orientation programme. For the experienced nurses and the Maori nurses the stability of a Union contract which set out employment conditions provided both groups with job satisfaction.

Benner and Wrubel (1989) defined caring as recognising that persons, events and things matter to people and nursing, and the application of these perspectives by the nurse when providing care for individuals helps them to cope with health and illness in stressful situations. Caring is a qualitative concept. In this study, being able to provide quality nursing care to the patient featured in relation to job satisfaction. Quality in this context was defined by the participants as adequate staffing on the wards, adequate resources for monitoring patients and adequate time to provide the care each participant assessed a patient needed. Depending on the level of practical experience, the time required for providing care was subjective.

Nolan, Nolan and Grant (1995) have produced findings on job satisfaction in relation to performance based pay, the ability to deliver good patient care and good collegiate relationships with co workers. Good standards of nursing care to patients are also related to adequate staffing levels which provide safety in patient care and staff numbers. Davidson, Folcarelli, Crawford, Duprat and Clifford (1997) also produced data to show that increased workloads led to decrease in the quality of care provided to patients and this can if not addressed lead to compromising patient and staff safety.

Safety as an issue has been addressed in New Zealand literature in the form of both anecdotal and research data. O'Connor (1992) looked at the effect of budget cuts on nursing care and the stress on nursing staff. O'Connor (1996) also raised the issue of increased indemnity claims by nurses. The survey conducted by NZNO (1996) found a direct link between skill mix and inexperienced staff to patient safety and staff levels. Brown (1996) gave an anecdotal account of his unsafe staffing level and in his opinion compromised patient care on his night duty. The article written by Warr (1995) indicated that fewer nurses meant poorer care. This was an introduction to the Christchurch hospital (Canterbury Health) claims of unsafe staffing and compromising of the quality of patient care (Health and Disability Commissioner, 1998). Oliver (1997) stated that the funding of the health system was inadequate to meet the demands of the health service.

The new graduate group identified an orientation programme as a factor contributing to job satisfaction. According to Mathews and Nunley (1992) the orientation programme for registered nurses at Loyola University Medical Centre, Illinois, has been changed to reflect the experience of the staff. Each programme is designed to cater for the learning requirements and practical experience needs of the staff in different clinical settings. The programs have resulted in experienced nurses gaining more job satisfaction and in retention of staff. Prior to the change, the experienced nurses were finding that their input into staff orientation was limited and not applicable to the area in which the staff were being orientated. This led to experienced nursing staff expressing feelings of frustration and unfulfilment in their education roles. In the current study the new graduates found that the orientation programme, when operated well, provided them

with the feeling of being part of the ward and able to operate at an acceptable level until they gained their confidence.

As previously mentioned, international studies have been conducted which examined job satisfaction in relation to absenteeism (Matrunola, 1996); job satisfaction in relation to retention (Drew & Fisher, 1996; Leveck & Jones, 1996) and projects that could be implemented to improve job satisfaction (Grindel, Petersen, Kinneman & Turner, 1996; Pierce, Hazel & Mion, 1996).

Davidson, Folcarelli, Crawford, Duprat and Clifford (1997) examined the relationship between job satisfaction and nurses terminating their employment. The findings indicated that improvement in communication throughout the organisation enhanced nurse job satisfaction and decreased termination during the study period. Increased workloads led to decreased quality of care.

All of these studies are attempting to address the satisfaction that is gained by being a nurse in a hospital but we in New Zealand have to examine the basic reasons why nurses would practise in a hospital setting. Once we have addressed this question then we can begin to put in place structures to retain nurses in practise within hospitals.

Job Security

Job security comes in several forms for the participants in this study. The new graduates found security from working in an environment that provided them with practical experiences while they were able to gain further registered nurse skills. The experienced nurses referred to the stability of a Union contract which provided them security in relation to employment conditions and educational leave. The Maori nurses also referred to the Union contract. They stated they felt secure working in a hospital that was large enough to give them general experience but at the same time not overwhelm them by its vastness.

Professional Development

All participants in the study identified as a priority, professional development. For the new graduate an orientation programme to the hospital wards with support in the practice environment was a priority. The experienced and Maori nurses also identified the opportunity to have inservice lectures and skill sessions as priorities. The need for further education was a priority for all participants. Being able to be released from the work environment was a problem for some of the participants and resulted in their cancellation or non attendance at courses and seminars.

Health care changes have meant that there are no longer senior positions in public hospitals held by nurses (Stodart, 1993; Berkett, 1994; Dyson, 1994). Senior positions in this context refers to part of the senior management structure of the public hospital. One of the changes that occurred with the health reforms in New Zealand was to the titles and structures of the governing body directly responsible for policy making and decisions in the public hospital. The role of an advocate for nurses in senior management has been lost or replaced by non nursing staff. Three public hospitals in the South Island, Southern Health, Health South Canterbury and Canterbury Health have either advertised or appointed directors of nursing (Warr, 1997). The directors will have responsibility for the nursing workforce including budget control, resource allocation and time management responsibilities. No longer will this be the responsibility of executives appointed from outside the health sector who appear to have no concept of why it is important to retain a nursing structure.

The new graduates in the study spoke of educational opportunities and the availability of experienced nurses as mentors and preceptors as a positive influence on their remaining in the hospital setting. Provision of inservice training such as lectures and skill sessions were identified by the experienced nurse group as positive.

Several authors have suggested ways of dealing with the changes by having staff take responsibility for their own career development and stress levels (McRae & Ramsey, 1992; Williams, 1993). McRae and Ramsay (1992) suggested the staff nurse take charge

of their career direction instead of waiting for the management to initiate the moves. This would involve the staff nurse presenting his/her aspirations, expectations, learning needs and skills to the management and interacting with them to set a pathway for his/her career. The advantages are that there is a clear identification of staff nurses with high potential to the employer and that nurses are able to participate in the management of their own career pathway.

Williams (1993) suggested that if staff members support each other by valuing the other person's contributions to the workplace then this would relieve some of the stresses staff members are experiencing with the health sector changes. She also suggested that nurses should consider where they fit in the structure of the health sector and what their future career path would look like.

Brooks et al.,(1998) found that experienced nurses related job satisfaction and professional needs to the professional development available in their areas. Reilly and Oermann (1992) and Oermann and Moffitt-Wolf (1997) examined new graduates' perceptions of clinical practice and highlighted the importance of a preceptor during orientation. Oermann and Moffitt-Wolf (1997) used a descriptive exploratory design to examine the stresses, challenges and threats experienced by new graduates during their orientation period and the relationship of social support to these stresses. The sample consisted of 35 new graduates (34 female, 1 male) from three hospitals in the Midwest of the United States of America. Findings highlighted the need for consistent preceptors during orientation who supported and guided the new graduate's learning in clinical practice. The study was limited by the small sample size (n=35) which restricts generalizability.

Hunter et al.,(1990) and Kotechi (1992) found that internship programmes helped ease the transition from student nurse to registered nurse. Trim (1996) proposed effective orientation preceptorship and internship programmes which supported previous working by Reilly and Oermann (1992). Brasler (1993) examined different components of orientation programmes including skills of the preceptor and participation in formal

support groups. The new graduates completed a performance scale evaluating their support before and after their orientation.

Tillman, Salyer, Corley and Mark (1997) used a qualitative study to explore staff nurses' perceptions of how turbulence in the internal environment affected their ability to provide patient care. The participants were selected from three hospitals located in one Mid Eastern state (USA). The nurses had a minimum of three years nursing experience with at least one year in the area they were recruited in. The number of participants was nine. Data was analysed by constant comparison and triangulation techniques. The research was limited by the number of participants but as in qualitative research of this nature the in depth description of human experience in the study and small sample size are acceptable. The findings indicate that turbulence is having a major impact on nursing practice and patient care in the three hospitals included in the study.

Professional Autonomy

The participants were positive about changes to the work environment which provided them with professional autonomy, control of their practice environment and time to manage their workload

The ability to control the work environment has a major influence on the nurses' job satisfaction and their ability to deliver the quality of care they desire for their patients. As previously mentioned, Pierce, Hazel and Mion (1996) found that when nurses had a share in the decision making process and power within all levels of the organisation there was an increase in job satisfaction and professional autonomy. Although their research was conducted in the USA the findings are relevant to this current study in that the groups in the study also found more satisfaction when they had autonomy over their workload and work environment whether it be in terms of fast and efficient ordering systems, the number of patients admitted to the ward or the streamlined layout to the hospital services.

In February 1998 the Minister of Health, set up a Taskforce to recommend strategies to remove the "barriers" that prevented registered nurses practising more effectively in New Zealand. The taskforce was the first major review of nursing in New Zealand in fifteen years. The Taskforce reported back to the Minister of Health in July 1998 (Ministerial Taskforce in Nursing, 1998). The New Zealand Nurses Organisation (NZNO) were originally members of the Taskforce but withdrew from the meetings and would not endorse the second draft of the report as they believed the recommendations neglected vital areas of practice in the form of pay and conditions of employment which included understaffing and inadequate skill mix.

The six areas that the ministerial taskforce explored were scope of practice, access to funding, education, research, management and leadership, workforce issues and issues related to Maori nurses. Thirty six recommendations were made.

The NZNO (1998a) produced a document in response to the Taskforce document titled "Building Partnerships: Developing the Future of Nursing". Judy Mulholland, President of NZNO, describes the document as :

> *a document that reflects NZNO's approach to nursing and provides a clear analysis of where we are now, where we want to go and how we will get there. It successfully addresses nurses' concerns. We need better regulation to confront patient safety issues like those identified in the Health and Disability Commissioner Robyn Stent's report into the deaths of patients at Christchurch Hospital. Safe staffing levels, nursing skill mix and working conditions are central to improving standards of care and securing patient safety.*(In NZNO, 1998a, p.2)

Safety is an issue that arises in this study, as already identified in this chapter, under job satisfaction. In New Zealand numerous studies of job satisfaction and morale among registered nurses have indicated the possibility that changing government policies affect the retention of experienced nurses (Stodart, 1990; Campbell, 1992; O'Connor, 1992; Underwood, 1994; Warr, 1995; O'Connor, 1996; and Oliver, 1997). Overseas studies

also indicated the relationship between safety in the form of adequate staffing levels and the retention of experienced staff (Nolan , Nolan and Grant, 1995; Drew and Fisher, 1996; Leveck and Jones, 1996; Tillman, Salyer, Corley and Mark, 1997).

The NZNO, after consultation with the membership of the organisation, sent a letter to the Minister expressing the organisation's desire to work with the Ministry of Health on some of the recommendations but requiring clarification on other recommendations.

> *We would support greater assistance for nurses in their first year of practice but not if that is to be achieved by new graduates paying for that support through a cut in their salary.*
> (In NZNO, 1998b, p.6)

Both the Ministerial Taskforce (1998) and NZNO (1998a) documents looked at strategies to aid registered nurses practice more effectively by removing barriers that prevented nurses achieving these strategies. The current study found that the participants' ability to control their environment had a major influence on the nurses' job satisfaction and ability to deliver quality care to their patients. Quality care and job satisfaction in this study were also linked to safety issues of staffing levels, skill mix and quality of patient care delivered. The previously mentioned documents also support the findings of the current study. Professional autonomy in the form of decision making and the manner in which nurses can influence the delivery of care they give to their patients are important factors influencing registered nurses practising in a hospital setting.

Internal Politics

In the current study the participants found that replacement of permanent staff with casual staff with little experience in the ward put stress on the nurses and added to the communication problems encountered between nursing staff and management. The nurses were unable to provide quality of care for their patients. The lack of ability to provide quality of care has already been mentioned in the beginning of this chapter. This again compromises the safety of the nursing staff and the quality of care delivered to the patient (O'Connor, 1992; Warr, 1995; Brown, 1996; O'Connor, 1996; Oliver, 1997 and

Health and Disability Commissioner, 1998). Overseas studies by Pierce et al.,(1996) and Tillman et al.,(1997) also indicated that communication within an organisation played a major part in job satisfaction and retention of nurses. This is also related to internal politics and communication channels in the organisation.

All participants identified communications within the organisation as a priority area to work on. Previous studies by Ng et al,(1993) identified relationships between supervisors and registered nurses as a predicting tool for nurses quitting the profession.

The skill mix of registered nurses in the practice areas led to situations where the participants could not provide adequate care for the patients. This necessitated the filling in of incident forms which added further stress to the participants. The skill mix and incident forms are covered in the beginning of the chapter under the heading of job satisfaction and safety issues.

O'Connor (1996) and Brown (1996) have questioned the quality of care and safety in the workplace. The new graduates had less than twelve months practical experience as registered nurses and yet were responsible for supervision of health assistants when their own learning needs were not catered for. The experienced nurses and Maori nurses were both confronted with skill mix problems on their shifts which compromised their ability to deliver quality care and maintain safe staffing levels.

In November, 1998, the Daily Post headlines read "Bosses face off over health post" (Kopae, 1998, p.1). Since being appointed by the Minister of Health, in May 1998, the Board that had been responsible for running both Tauranga Hospital (formerly known as Western Bay Health) and Whakatane hospital (formerly known as East Bay Health) has gained approval from the Commerce Commission to merge and form one organisation. The paper mentions the loss of one Chief Executive Officer's job but does not mention whether there will be any loss of nursing staff or access to facilities for patients from the merger and reduction of facilities. Clare (1993, p. 1034) reported that "... *cost effectiveness based on objective criteria and budget savings often means cuts in the*

largest budget item - the nursing workforce." The impact of this merger will not be seen in the period of this study but may be seen in future research.

External Politics

The participants identified lack of resources and staff as discouraging factors that influenced their remaining in practice in a hospital setting. These factors are influenced by political policies and funding available. Changes to the Government in power from a one party basis to coalition government has meant instability to the hospital finances as the strategists constantly change their tactics for applying for funding to match the government policy (Oliver, 1997).

The participants spoke of the effects of financial constraints on their practice. These occurred when the skill mix of nurses on the ward was not balanced or replacement of staff and health assistants resulted in further stress and unsafe situations for the participants. As Rodney and Starzomski (1993) indicated, this causes moral distress to the health professionals who are caught in the situation of feeling a moral obligation to provide care but are unable to because of forces beyond their control.

The Ministerial Taskforce (1998) and NZNO (1998a) are both documents that are exercising some degree of influence on the political parties at the moment.

In July 1998, a reintroduction of the term *patient* and *hospital* to the health vocabulary was made. Crown Health Enterprises are now known as Hospital and Health Services (HHS) and clients are now known as patients. Nurses and doctors remain under the same names, so far. Changes are disruptive to any organisation especially if, as seen in this study, there have been many changes to the structure and delivery of care as stated by the participants. The effects of these changes may result in the HHS spending money to change signs and stationary. The cost of such expenditure would not be viewed as a positive move to the participants in the study who have already identified financial constraints in the form of staff and budget cuts as a discouraging factor for remaining in practice in a public hospital setting.

In September 1998 the Minister of Health, launched a Hospital Service Plan (English, 1998) which proposed ranking hospitals into five categories according to the complexity of their procedures and the kind of emergency care they provided. The five categories were:

1: Health Centres
2: Subacute Units
3: Secondary hospitals
4: Lower level tertiary hospitals
5: Higher level tertiary hospitals

At the same time the new phrase in health care organisations was 'Integrated Care Organisations'(I.C.O.). These new organisations encompassed hospital and community based services including both private and public health providers with the aim of providing total care for patients enrolled with them. Problems can occur if monopolies develop or if groups capable of taking financial risks are the only ones backed by large insurance companies as seen by tentative arrangements between the Tauranga based hospital and Aetna Insurance Company (Keene, 1998). Ian Powell, the ex director of the Association of Salaried Medical Specialists quoted in Health Review (1998, p.14) said: "*The real danger of so-called integrated care is that it will fragment the whole system*".

The experienced and Maori nurses groups related changes to their working environment as discouraging factors on their remaining in practice in a public hospital setting. Lack of resources, budget cuts and staffing cuts have resulted from the organisations response to reduced funding provided by the Health Funding Authority (Oliver, 1997). The effects of political policies on the provision of equipment and staff are documented by Keene (1990), Stodart (1990), Nimmo (1991), Warr (1995), Tirana (1997), and Kopae (1998). Further changes to the system may result in fragmentation of the delivery of health care.

Political Correctness

The Maori participants stated that attitudes displayed by other staff in the hospital environment were not in line with cultural safety as defined by Nursing Council (1996). The constant commitment to cultural safety by all parties involved in the delivery of care to a patient was not being adhered to. Rather it appeared to participants to be a token gesture and politically correct. Hopton (1995) referred to political correctness as having it's origins in the 1960s and 1970s tongue in cheek way in which people on the political left developed a political conscience.

In the 1990s, the term was adopted by right wing academics, politicians and ideologists to be used as a derogatory term for moral and ethical principles which did not coincide with their own values (Molyneux, 1993). This term was also used by the participants when describing harassment of staff by other staff. The way the situation was dealt with reflected '*political correctness*' not justice and fairness.

Summary

In this chapter the six overarching factors that both encourage and discourage registered nurses to remain in practice in a public hospital setting have been explored further. They have been supported by reference to national and international literature which specifically addresses their significance.

In the next chapter the strengths and limitations of the study will be examined. The conclusions from the study will be discussed followed by recommendations arising from the study and suggestions for future studies.

Chapter 9
Conclusions and Recommendations

In the first part of this chapter the strengths and limitations of the study will be examined. The conclusions will be discussed followed by recommendations arising from the study and suggestions for future studies. Finally, a brief overview of the changes that have occurred during the period of the study will be presented.

Strengths and Limitations of the Study

Focus groups

The researcher acknowledges the limitations of this study in terms of findings and recommendations due to the nature of the study itself. The participants agreed to meet at a specified time and place, however on the specified nights the numbers were less than expected. The participants belonged to a group of shift workers and this affected their availability. The time of year the study was conducted (November) was a time when some potential participants were studying or completing examinations and this also limited their availability.

The focus group provided a starting point for future research. A questionnaire designed around the factors that emerge from the study may be of use to future researchers. The study was of a pilot nature and could be expanded by use of qualitative and quantitative research methods. Individual interviews may have provided more indepth individualised data but the focus group design allowed for the inclusion of more participants in the time available and a mutually supportive environment.

The use of questionnaires to the entire public hospital staff with focus groups of other participants such as nurse consultants, resource nurses, district nurses, psychiatric nurses, and midwives would have provided a more extensive collection of data and range of opinions. The nurse consultants group was not included in the study as the group was

small and management focussed which may have influenced the other groups in the manner in which they contributed. Future studies would have to include this group as a separate group. Given the limitations of a Master's thesis, the focus groups utilised provided the researcher with enough data to provide a basis for future studies and for the findings that emerged.

Time frame of this study

The study was undertaken as part of a Masters thesis and had a two year time frame. This also limited the researcher in accessing further data and limited the researcher's geographical area for recruiting participants due to work and family commitments.

Number of participants

As previously mentioned the numbers of the participants in each group were small and in keeping with Morgan's suggestions (1988) . However this provided for characteristics among the participants that may not have occurred with a larger group. The people who had an interest in the study were more focussed in attending than the ones that did not reply. One such example was of a reply to the letter of invitation where the recipient left the researcher in no doubt as to the person's feelings towards being a *'guinea pig'* and participating in *'yet another load of nonsense'*.

Strengths

The focus groups have provided a forum for the participants to discuss what is happening in their area of practice with nurses in other areas of practice within the public hospital. They allowed the participants not to feel isolated in a large organisation. The participants themselves welcomed the opportunity and believed it was beneficial to them and expressed the desire that the free exchange between departments continue.

Credibility was established as the participants in each group were able to summarise the debate and prioritise the factors perceived as encouraging or discouraging, including the effect of changes in the work environment viewed as positive or negative.

Dependability has been demonstrated by a clear audit trail outlined in the chapters concerning design, results, analysis and in the attached appendices. The findings may be transferable to similar settings within the limitations. Although the study meets the requirements for confirmability the limitations are acknowledged in the next section.

Limitations

1)Lack of quotes

As mentioned previously in the study the fact that the ethical approval was granted on the condition that no direct quotes were used has limited the presentation of the data and challenged the researcher to provide analysis of the data in such a way that remains credible and faithful to the data. The utilisation of literature has assisted this process.

2)Numbers of participants and where they are employed

As the study is limited in numbers the recommendations must be tempered. The study is qualitative and therefore the findings can not be generalised to other similar health settings. However, the study should be recognised as preliminary and may provide the basis for other health agencies to assess what is happening in their own organisation.

Another limitation is that the study was confined to registered nurses remaining in employment in the public hospital setting. The researcher was limited by time constraints and family commitments so chose to access a population that was easily accessible. Previous studies looked at why nurses left the nursing profession (Ng et al, 1992). The researcher was interested in a public hospital setting. The public hospital setting was chosen as workforce data showed that 63% of all registered nurses in New Zealand worked in public hospitals in 1992, with 61% and 59% respectively in 1994 and 1995 (Ministry of Health, 1992, 1995, 1996).

Recommendations

As this study was conducted with registered nurses from a public hospital setting it is appropriate that further studies be conducted in other settings and with other groups of nurses as participants such as:

- Other health agencies (private and public) conduct similar studies

- Comparison studies between public and private organisations
- Other studies involving nursing groups such as nurse consultants, resource nurses, district nurses, psychiatric nurses, nurses in management and midwives
- Other studies exploring nursing from a Maori perspective.

Job Satisfaction

Conclusion

The study identified that the work environment and conditions play major parts in giving the participant's job satisfaction. The major influences are adequate resources and staff to care for the patients.

Recommendations

The recommendation for the area in which this study was conducted would include looking at the environment in which the nursing is carried out and how nurses can be assisted in gaining job satisfaction in caring for their patients. Some ways include:

- Provision of adequate equipment to nurse patients
- Provision of appropriate staff skill mix and experience

Job Security

Conclusion

The study identified that all participants found job security from working in an environment where they were supported by an Union contract or the general experience provided by the public hospital setting.

Recommendation

Changes seen in the political environment since the study commenced, have changed working conditions and as such nurses need to have the protection of a professional body outside the organisation for legal, industrial and professional support. Recommendation for this would be that nurses in this public hospital setting are:

- Represented professionally in the workplace

- Have indemnity insurance for their practice

Professional Development

Conclusion

All participants in the study identified professional development as on the job training, courses, skill sessions and nurse educators. These are a necessity for nurses practising in a public hospital setting.

Recommendations

The organisation in the study needs to implement programmes to accommodate the needs of the different registered nurses in their employment. Programmes could include:

- Orientation programmes for new graduates be designed to ease the transition from student to registered nurse. Preceptors should be arranged for all newly registered nurses employed within public hospitals.
- Provision of educational skill sessions from clinical nurse educators working in the wards.
- Provision of planned educational lectures and skill sessions in the practice area related to organisational and professional needs of registered nurses
- Provision in the organisation's budget of replacement staff for nurses to attend conferences and educational courses related to professional development

Professional Autonomy

Conclusion

The participants belong to a professional group. Acknowledgment of their professional status by management when considering changes affecting their work environment and patients are essential.

Recommendation

The nurses in this study wanted to be recognised as professionals and one way of ensuring this was to provide the nurses with the opportunity to:

- Provide input from nursing staff and management on changes in the work environment.

Internal Politics

Conclusion

Good communication between all levels in any organisation should be a priority. Communication channels are essential in any public hospital for the implementation of change and for providing a sense of belonging to the organisation. The participants in the study identified communications in all levels of the public hospital as an area requiring urgent attention. For staff to become part of the changes and decision making requires them to have a sense of ownership which gives them responsibility, value and respect and this leads to belonging and involvement. The result is improved communication channels. The findings of communication problems in the organisation were specifically mentioned by the participants in relation to difficulties with the nurses in middle management (nurse consultant group).

Recommendations

Communication in any form provides the lifeline in any organisation between all the employees and the nurses in this study as well as the organisation would benefit from the following recommendations:

- Nurse consultant group set up a consultation group to regularly meet and consult with nurses in the ward.
- Nursing staff be formally part of the public hospital consultation process.
- Scheduled meetings between all levels of the organisation with the aim of communicating across the organisation and giving a sense of belonging to the organisation.
- Written communications in the form of newsletters throughout the organisation
- Review the skill mix of nurses on all wards and shifts.
- Provision of coaching, preceptorship and mentoring to support all levels of nursing
- Establishment of clinical based educators in the ward structure

- Each level in the organisation must be accountable for their area of operation and there must be clear lines of responsibility.
- Nursing titles must reflect the responsibilities of the position to aid greater communication internally.

External Politics

Conclusion

The participants believed that the financial input to the public hospital and its allocation provided them with extra stress in their working environment. They believed they had more responsibility and workload than was safe and that staff and equipment levels were reducing.

Recommendations

Communication in any form provides the lifeline in any organisation between all the employees and the nurses in this study as well as the organisation would benefit from the following recommendation:

- There should be nurses representing the views of the nurse on the ward at the decision making level in the organisation.

Political Correctness

Conclusion

Training in cultural safety has occurred in the organisation in this study. Findings in this study indicate that nurses are unable or unwilling to implement cultural safety issues in the public hospital. There remains a low level of acceptance of cultural safety requirements by many nurses.

Recommendations

Cultural safety is an ongoing requirement and requires constant input for it to be successful. The following recommendations will assist the process to continue:

- Nursing leaders be assessed on their implementation of cultural safety recommendations as part of their annual appraisals.

- Cultural safety courses must be validated if they are to remain relevant to nursing.

Changes during the study

During the current study period, changes to the health sector have been ongoing. The funding structure has changed from RHAs which were responsible for their own regional funding to a centralised HFA which is now responsible for the entire health sector.

Nursing has seen the undertaking of a review which resulted in the Ministerial Nursing Taskforce (1998) recommendations for overcoming barriers to nursing practice. This process also resulted in the release of the NZNO's (1998a) 'Building Partnerships' document to reflect their strategies for change to the future of nursing. Much debate and controversy surrounded the Taskforce when NZNO declined to support the final recommendations as they believed the recommendations and the final process did not reflect some major barriers to practice in terms of skill mix and employment conditions.

The Ministerial Nursing Taskforce (1998) and the NZNO (1998a) Building Partnerships documents are important to this study as they both look at recommendations for nursing practice in the future. The participants in this study identified new graduate programmes, skill mix and employment conditions as factors that encouraged or discouraged their remaining in practice in a public hospital setting. These factors identified by the participants had also been similarly identified by the Taskforce and NZNO.

The debate between the Taskforce and NZNO continues with the Minister of Health currently receiving input from both parties. There is nothing wrong with debate provided you move forward. As Patterson (1992, p19) wrote

> *...Nursing needs to become visible...It is time for nurses to take into their own hands the description and measurement of their art and craft, define their role, describe their priorities and begin to quantify their nursing input for the number*

crunchers...Nurses will need to bury their differences and avoid competitive skirmishes.

The concept of client and CHE has reverted to the former terms of patient and hospital. As this thesis is being completed a review has been undertaken by an independent consultant, of the nursing leadership structure in the organisation where the study took place. The conclusions and recommendations are before the Chief Executive Officer and the Board.

The study excluded research prior to 1990 as matters of retention and satisfaction arise within a historical context. Previous to 1990 research has been conducted on retention, job satisfaction, and stress. These factors are not new. However, they have not been resolved. Indications from this study and current literature are that they are getting worse not better.

Finally, of the original fourteen participants in this study only eight were left in the public hospital environment at the end of the study. For those who participated, the researcher is indebted and offers this as guidance for future professional development programmes and orientation programme suggestions.

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Appendices

Appendix 1

INFORMATION SHEET

My name is Jackie McHaffie. I am a graduate student of the Department of Nursing and Midwifery at Massey University. I am undertaking my thesis in partial fulfilment of a MA (Nursing). I am also currently working in Theatre...

I am concerned about the retention of and support for experienced nurses, newly graduated nurses and Maori nurses within CHE settings. I also would like to contribute to the health of my own Iwi (Kai Tahu, Kati Mamoe, Wai Taha) and other Iwi in Aotearoa nursed in culturally safe CHE settings.

Group interviews will be used to focus on your perceptions of factors that encourage or discourage you to practise in CHE settings. It is anticipated that the data generated from the focus group interviews will contribute to the development of future research into retention of nurses in the Crown Health Enterprise settings. The findings may also be disseminated to the wider nursing community by way of a published journal article and a conference paper.

As a participant, you are required to consent to:

a) Allowing me, as a researcher to facilitate a discussion group of which you are a participant:
b) Allowing me to record in written form the essence of the discussion to be further analysed by me at a further date.
c) the presence of an assistant

Each focus group (experienced, newly graduated, and Maori nurses) will comprise about six to eight participants The sessions will take approximately one and a half to two hours in duration. The audiotapes will be transcribed by a secretary who will sign a confidentiality agreement. An assistant will be present at the interviews as a silent observer. She will also sign a confidentiality agreement. Her role will be to ensure a conducive environment is maintained.

If you take part in the focus group interviews you have the right:

a) to decline to participate.

b) to refuse to answer any particular questions.

c) to withdraw from the study at any time.

d) to ask any questions about the study at any time during participation.

e) to provide information on the understanding that your name will not be used unless you give permission to the researcher.

f) to be given access to a summary of the findings of the study when it is concluded.

At the conclusion of the research the findings will be provided at your request. The transcripts will be shredded and burned two years after completion of the research, computerised data will be electronically destroyed and the audiotapes wiped immediately after presentation of the thesis.

The only persons having access to the raw data will be the researcher, the transcriber and my thesis supervisor Dr. Gillian White, Department of Nursing and Midwifery, Massey University, Albany Campus, Auckland

Researcher Jackie McHaffie

Address xxx

Home xxx

Work xxx

This study has received ethics approval from Massey University Ethics committee and the Bay of Plenty Ethics Committee. Any concerns of an ethical nature can be addressed to: The Bay of Plenty Ethics Committee, P.O.Box. 241, Whakatane.

Appendix II

Letter of Invitation to Participants

Dear .....

I am undertaking a study as part of my thesis for an M.A. (Nursing) and would like to invite you to participate. The aim of the study is to explore factors that encourage or discourage registered nurses practising in a CHE setting from three different perspectives, newly graduated nurse, experienced nurse, and Maori Nurse.

Your experiences as a (newly graduated nurse) (experienced nurse) (Maori Nurse) will be valuable in identifying what factors can either encourage or discourage registered nurses remaining in clinical practice in a CHE setting.

The information will be collected on audiotape and by note taking during a group discussion of approximately six to eight of your peers. Any information you choose to give during these discussions and your identity will be kept confidential by the researcher, her assistant, her supervisor and the transcriber. It is anticipated that the discussions will last approximately three quarters of an hour. At the end of that period a further fifteen minutes will be spent identifying and prioritising the major factors that encourage or discourage registered nurses to remain in practise in a CHE setting.

Participation in this study is voluntary and you may withdraw at any time or refuse to answer any questions without prejudice.

At the conclusion of the research the findings will be provided at your request. The transcripts will be shredded and burned two years after completion of the research, computerised data will be electronically destroyed and the Audiotapes wiped immediately after presentation of the thesis.

For further information about the study, please reply before (xx.xx.xx) to:

Jackie McHaffie

Address xxx
Home xxx
Work xxx

Thank you very much
Jackie McHaffie

Appendix III

Focus Group Interview

CONSENT FORM.

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

If I agree to participate, I have the right to withdraw from the study at any time and to decline to answer any particular questions.

I agree to provide information to the researchers on the understanding that my name will not be used without my permission.
(The information will be used only for this research and publications arising from this research project.)
I agree/ do not agree to the interview being audiotaped.

I also understand that I have the right to ask for the audiotape to be turned off at any time during the interview.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signed: .....

Name: .....

Date : .....

Appendix IV

Factors identified and prioritised by the three focus groups matched to their related categories

Factors that encouraged new graduates to work in a public hospital setting

Prioritised Factors	**Related Category**
1.Large hospital experience versus small hospital experience 1.Time management: not too large hospital 1.Private hospital experience versus public hospital experience 1.Theory into practice: practical experience	General Experience
1.Good orientation programme 1.Buddy system as a new graduate: Peer support	New Graduate Programme
2.Allocating a loading system	Patient Load
3.Continuing paid education leave 3.Paid study Leave	Paid Study Leave

Factors that discouraged new graduates from working in a public hospital setting

Prioritised Factors	**Related Category**
1.Inadequate salary for responsibility 1.Monetary recognition for hours	Pay and Shift work
2.Uneven skill mix on wards 2.Incident forms on staff levels	Staff levels and Skill mix
3.Lack of money for staff levels required 3.Lack of equipment for wards 3.Time taken for repairs and return to wards for use	Resources Staff and Equipment
4.New incentives projects; more money to fund them 4.Less money to fund new or replacement equipment 4.Communication problems throughout hospital structure/nursing, medical and administration. 4.Health cuts: resulting in unbalanced skill mix of nurses on ward/ inexperienced greater than experienced	Ward Politics

Changes in the work environment perceived as being positive by new graduates

Prioritised Factors	**Related Category**
1.Ability to be professional 1.Control of work environment	Loading
2.Inservice Programmes: theory / practical sessions 2.Study days: skill sessions for work area 2.Promise of future training in own area	Inservice Lectures
3.Identification of mentors: peer support	Peer Support
4.Programme for new graduates that was successful 4.Transition time for new graduate to registered nurse	New Graduate Programme

Changes in the work environment perceived as being negative by new graduates

Prioritised Factors	**Related Category**
1.No communications on changes from nursing management 1.Lack of communications in relation to information about funding and job vacancies. 1.Insecurity of jobs: not advertised permanent positions	Communication with middle management (Nursing)
2.Lack of experienced staff for mentors. 2.Lack of experienced staff for guidance to them. 2.High responsibility for lack of experience due to no other staff.	High staff turnover
3.Policy changes in regard to rosters not supported or explained. 3.No one listened to them or asked for their input or suggestions.	Lack of support in decision making.
4.Filling in forms to cover your back 4.Incident / unsafe staffing forms	Incident reporting and covering your back

Factors that encouraged experienced nurses to work in a public hospital setting

Prioritised Factors	**Related Category**
1.Collective contract 1.Meal breaks rostered regularly or paid for if not taken 1.Conditions of work and Union support	A Trade Union
1.Large number of nurses as resources 1.Financial ordering system/ better use of resources and time	Support network
2.Paid permanent employment in location they reside in	Job stability
2.Able to look before settling in area on contract 2.Ability to leave in short time if unsuitable employment	Fixed contracts
3.Paid educational leave/ Union negotiated 3.Further qualifications	Ongoing education

Factors that discouraged experienced nurses from working in a public hospital setting

Prioritised Factors	**Related Category**
1.Climate of distrust/ isolation 1.All levels of hospital have communication problems 1.No input into decision making or protocols	Lack of communication
2.Skill mix unbalanced new graduates: casual staff: experienced nurse. 2.No teaching time/ role workload :skill mix/ no time to teach. 2.Full occupancy/ heavy work load/ extra responsibility	Skill mix and casualisation
3.No clinical or nursing leadership from nurse consultants. 3.Lack of feedback from nurse consultants on change or performance.	Lack of leadership
3.Sub standard equipment/ stress 3.Sub standard skill mix/ stress	Stress
4.No response to incident forms	Incident forms

Changes in the work environment perceived as being positive by the experienced nurses

Prioritised Factors	**Related Category**
1.Patients informed formally of their rights in hospital 1.Staff workbook on Code of Rights	Code of Rights for patients
2.Resolution of problems involving staff in debriefing process	Debriefing
3.Control of workload 3.Control of patient care	Loading factor

Changes in the work environment perceived as being negative by the experienced nurses

Prioritised Factors	**Related Category**
1.Changes to funding of public hospitals 1.Budget cuts 1.Staffing cuts 1.Cuts to patient funded services	Economic Policies
2.Savings to hospital/ staff cuts. 2.Decrease in salary budget/ staff numbers on wards drop. 2.Increase stress to remaining staff	Budget cuts
3.Cuts to registered nurses replaced with health assistants 3.Cost cutting exercises	Staffing cuts
4.Decrease in equipment and maintenance of repairs 4.Money cuts to support organisation not patients welfare	Resources/Equipment

Factors that encouraged Maori nurses to work in a public hospital setting

Prioritised Factors	**Related Category**
1.Safety of familiar surroundings 1.Knowledge of public hospital system 1.Public hospital experience in general	Familiarity
2.Job security of larger organisation/ Union contract. 2.Bargaining power of being in a large Union hospital	Union contract

Factors that discouraged Maori nurses from working in a public hospital setting

Prioritised Factors	**Related Category**
1.Lack of full time work 1.Casualisation of staff/ inexperienced staff 1.Nurse assistants to replace Enrolled nurses	Casualisation and lack of permanency.
1.Change of managers frequently 1.Managers with no hospital or health background	Constant change of managers
2.Suggestions not listened to by management in general. 2.Decisions involving their practice made with no input from them.	Powerless to make change
2.Used for skills to plug gaps in ward shifts 2.Not offered permanent positions 2.What was said was never carried out in writing	Mistrust of nursing management
3.Lack of opportunity for training 3.No replacement for them to go for study days 3.No commitment to them achieving their professional standards (PDP).	Lack of training programmes

Changes in the work environment perceived as being positive by the Maori nurses

Prioritised Factors	**Related Category**
1.Physical changes to environment of hospital 1.Wheelchair access and facilities clearer marked	Change to hospital layout
2.Computer ordering system 2.Triplicate ordering on paper gone: time saving for nursing	A new ordering system

Changes in the work environment perceived as being negative by the Maori nurses

Prioritised Factors	**Related Category**
1.Constant changing of managers 1.Lack of consultation 1.No change process : to aid with changes 1.Communication channels non existent	Change of managers
1.Decrease in ward equipment 1.Decrease in staff on ward 1.Outward appearance changes (structural: painting) 1.No internal changes in appearance in the ward structure	Budget cuts
2.Harassment of nurses: from nurses. 2.Harassment of nurses: from medical staff. 2.Verbal abuse of nurses: from co workers. 2.Verbal abuse of nurses: from medical staff/ complainant moved from area not person causing problem	Harassment
2.Changes of titles led to role confusion 2.No clinical input to nursing from nurse consultants 2.No support from nurse consultants	Conflict of interest
3.Token gesture to cultural safety by attending course 3.No practical demonstration of cultural safety by staff 3.No attitudinal change by staff who had attended a course 3.Tokenism on part of organisation	Tokenism and Cultural Safety