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“How can midlife nurses be supported to deliver bedside care in the acute clinical services until retirement?”

Caroline Dodsworth

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Abstract

As the baby boomer generation move inexorably towards retirement and the requirement for health care services increases, the supply of nurses available to provide care at the patient bedside is forecast to fall significantly short of demand. This thesis has explored the perspectives of midlife nurses, asking what it would take to keep them in bedside practice until retirement. These nurses have provided insights which offer employers of valuable senior nurses, suggestions for maximising their potential.

Through the use of questionnaires and focus groups nurses aged 45 years and over were asked what the employer can do to ensure that they are able to continue to work at the patient bedside until they reach the age of retirement.

The results of this research demonstrate a workforce of nurses who are passionate and committed to their profession, but feeling disillusioned and disempowered. The nursing environment has changed over the span of their career and they find the increased workload, together with increasing professional demands, too hard to cope with. They feel they have no control over their workload, their shift patterns, or the expectations of their patients and colleagues. They want their experience to be recognized but they do not want to have to prove competency; they want to have a voice but they are unwilling to pursue postgraduate education to learn how to become visible and emancipated.

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Every nurse who goes home at the end of the day with sore feet and an aching back, but comes back to work the next day with a smile on their face.

The participants of this research who opened up their lives and their hearts and shared an insight into what it is to be an ageing nurse.

“Sometimes when I’m in charge I look around and pray to God that I have good nurses on the shift. Then I go home and thank God I made it through the shift and nothing bad happened.”

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Chapter 1 Introduction

It is forecast that the demand on the health service will outstrip the supply of qualified workforce in New Zealand by between 28% and 42% by 2011 (NZIER, 2004). However there is little evidence to demonstrate what will happen if the current ageing nursing workforce retires prematurely due to burn out or ill health. Nurses born in the 1950s comprise 50% of the nursing workforce (Beurhaus, Steiger & Auerbeck, 2000; Cooper, 2003). This is partly due to the baby boom bulge, and partly because nursing was seen as a popular choice of vocation for school leavers with few options available for women at that time (Aitken, 2004; Bednash, 2000; Benjamin, 2000). These women are now in their 40s and 50s and contemplating retirement within the next 15 years (Cooper, 2003).

In the USA Letvak (2002) raised concern about the lack of policies to address the needs of older nurses. Heinz (2004) demonstrates that years of experience of nurses in their particular specialty are associated with lower mortality rates, whereas nursing shortages have been shown to increase adverse patient outcomes (Aitken et al., 2001).

Andrews, Manthorpe and Watson (2005) discuss the lack of workforce development policies in response to the ageing UK nursing workforce. They suggest “push” factors that encourage nurses to leave as well as “pull” factors that encourage them to stay. Kline (2003) expands on this concept, describing “pull” factors as the search for professional development, better wages and

conditions, and less risk associated with health and personal safety available in developed countries such as the UK, USA and Australia. The “push” factors include the concern for personal safety such as risks associated with high rates of HIV, AIDS and tuberculosis in African countries.

The “push: pull” (Andrews et al., 2005; Kline, 2003) factors experienced by New Zealand nurses may be very different from their UK and USA counterparts but there is no published evidence to demonstrate this. The only published research carried out on the health of New Zealand nurses demonstrates that while the health status of nurses is significantly poorer than the national average, their vitality is even worse (Budge, Carryer & Wood, 2003). This may play an important part in the push: pull factors for older nurses and therefore warrants further study.

There is currently very little information relating to the views of New Zealand midlife nurses who wish to remain in clinical practice until retirement. As this is the largest cohort of the nursing workforce, every effort should be made to address the needs of these nurses in order to retain the expert knowledge and experience that they bring to their profession. The voice of the midlife nurse in New Zealand will add to the body of knowledge from Europe, Australia and America to identify the specific needs of this valuable resource.

Research Question

“How can midlife nurses be supported to deliver bedside care in the acute clinical services until retirement?”

My position in this study

As an ageing nurse, and the manager of an ageing nursing workforce, I have a stake at a personal and professional level for ensuring that health care sector workforce development policies are well informed. However, the ageing nurses themselves also need to take responsibility for having a voice that is heard at policy development level. Through this thesis, I have developed an understanding of the disillusionment and disempowerment of nursing, leading to their silence.

Because of my personal positional power, I was unable to challenge this recurring theme during the research process. I wanted to be a critical enquirer but I was not able to compromise the safety of the participants whom I classed as being vulnerable (Snook, 1999). However going forward into the future I will be able use the insights I gained as a researcher to influence change within the organisation as a manager and change agent.

Review of chapters

Chapter 1 introduces the research question, justification, the philosophical assumptions informing the research, and my position in the study.

Chapter 2 provides a review of the current academic, political and professional literature. The picture of an impending global nursing workforce crisis of epic proportions, the reasons for the shortage, the effects of the shortage, and the impact of the ageing nursing workforce are explored in depth from an international perspective.

Chapter 3 explains the research methodology and method, exploring the epistemology and theoretical perspective informing the study. A qualitative descriptive method provides the data for a qualitative study. The interpretivist perspective presents the language of how the participants understand their current situation, and constructionism underpins how these understandings are interpreted by society.

Chapter 4 describes the findings of the questionnaire, which was the first phase of the research project. It paints a picture of the participants and the world in which they live and work. Use of demographic data demonstrates the participant characteristics, while the use of adjectives demonstrates a positive or negative attitude to how work makes them feel. Vitality was briefly explored from the perspective of “how much energy do you have?”, as well as positive and negative factors influencing work. Finally, a free text section asked what the organisation could do to enable the participants to stay at the patient bedside until they retire, setting the scene for the content of the second phase of the research project.

Chapter 5 discusses the second phase of my research involving semi-structured focus group discussions with 18 participants who had volunteered during the initial questionnaire phase. The purpose of the discussions was to explain and further explore the questionnaire results and to give a more in-depth picture of the emerging themes. The focus group participants were given a framework of the key themes extracted from the questionnaire results and invited to discuss or explore any or all of the themes, beginning with the theme that interested them most.

Chapter 6 provides a discussion and summary of the findings of the research. The results demonstrate a workforce of nurses who are passionate and committed to their profession, but feel disillusioned and disempowered. They feel they have no control over their workload, their shift patterns, or the expectations of their patients and colleagues. They want their experience to be recognized but they do not want to have to prove competency; they want to have a voice but they are unwilling to pursue postgraduate education to learn how to become visible and emancipated. The nurse participants have no professional voice; one way they can find a voice is to undertake postgraduate education but they feel unable to commit to this because of their work and family pressures. The nursing profession, in collaboration with employers, needs to find a different approach to coaching nurses to become active participants in their own career.

Conclusion

This chapter has provided an outline of the thesis that asks “How can midlife nurses be supported to deliver bedside care in the acute clinical services until retirement?” The thesis aims to explore how it feels to be an ageing nurse in a physically demanding, stressful environment, and what the organisation can do to encourage these nurses to remain at the patient bedside until they retire. The constructionist and interpretivist assumptions underpinning the research and the decisions regarding choice of methodology and method processes have been introduced. An overview of the chapters provides a brief prologue to the study.

The literature review in the following chapter will provide background information on current international and New Zealand knowledge which explains why retaining midlife nurses is so important.

Chapter 2 Literature Review

Introduction

This chapter reviews the international literature concerning the current and future nursing workforce crisis, and the significance of the ageing nursing workforce. It evaluates the consequence to patient safety of nursing shortages, the extent of the shortages, the reasons for the shortages and the effects of the ageing nurse population on the ability of health care providers to meet the needs of an ageing population. It also identifies gaps in the national and international literature such as a lack of information on the experience of New Zealand nurses. By researching the unexplored experience of New Zealand nurses working at the patient bedside in the acute care setting I will add a local context and flavour to the international body of evidence, influencing future workforce development planning in New Zealand.

There is very little New Zealand based academic literature on the subject of the ageing nursing workforce; the only published research carried out on the health of New Zealand nurses demonstrates that while the health status of nurses is significantly poorer than the national average, their vitality is even lower (Budge, Carryer and Wood, 2003).

Development of this literature review has been a challenge in its enormity.

There is an extraordinary amount of literature that is both the same and different across countries. The literature synthesises conflicting themes across countries and generates enormous concern without providing any action to address the problem.

Patient safety

This section explores the evidence that patient outcomes are adversely affected by reduced staffing, thus signalling the importance of nurse retention.

Poor hospital staffing leads to decreased patient safety

According to Baumann and Blythe (2003) poor workplace conditions in hospitals encourage early retirement and high workforce attrition. Inadequate hospital staffing is a factor in poor patient outcomes, adverse patient occurrences, increased hospital errors and increased patient mortality (Aitken et al., 2001). Kalisch (2006) describes the serious implications of omissions of nursing care when nurses are simply too busy to carry out basic tasks. Failure to provide basic but important nursing care such as ambulation, turning, feeding, hygiene or patient education lead to delirium, pneumonia, decreased functional ability and ultimately increased length of stay and increased cost to the organisation (Kalisch).

Increased patient needs

Fewer nurses with less experience and fewer mentors are expected to look after more patients who are sicker with more co-morbidities and increased levels of care needs with increased technological complexity and more economic pressure (Orsolini-Hain and Malone, 2007). Patients need an expert and highly educated nursing workforce to deliver care; only expert nurses can intuitively grasp clinical situations and anticipate problems leading to early intervention and improved outcomes (Orsolini-Hain and Malone).

A shortage of appropriately qualified nurses leads to decreased patient safety in an environment of gradually increasing patient acuity and complexity. International literature clearly defines the extent of the shortage and projects the consequences on the ability of the health care sector to continue to provide services to the ageing population.

Shortages

In this section, the extent of the international shortage is explored. A definition for the term “shortage” is agreed, and similarities and differences between countries are identified.

A demographically inevitable shortage

Registered nurse (RN) presence in sufficient numbers can no longer be taken for granted. Nursing shortages, the ageing nursing workforce, the increasing demands of an ageing population with multiple and complex co-morbidities, and the effects of working as well as caring for children and/ or older family members are affecting the ability of health care organisations to provide sufficient experienced nurses to meet the demand (Hader, 2005; Hatcher et al., 2006). Lacey (2003) describes this phenomenon as a “demographically inevitable shortage” (p. 1).

Definition of “shortage”

From an employer perspective, vacancy rates in budgeted positions in conjunction with the average time it takes to replace a nurse are salient indicators of shortage (Aitken, 2001). According to Aitken et al. (2001) a

nursing shortage can be diagnosed as either a “structural” or a “real” shortage. A **structural** shortage refers to when more nurses are required to adequately care for the patients but no financial resources are made available to pay for them. A **real** shortage refers to vacancies that cannot be filled due to a shortage in supply of nurses. Evidence from the United States of America, the United Kingdom and Europe demonstrates a current **real** shortage (Aitken, 2004; Bednash, 2000; Benjamin, 2000; Buerhaus, Staiger, & Auerbach, 2000).

The history of this shortage

Buerhaus et al. (2000) describe how the large 1950s cohort dominates past and future trends in RN labour supply. In the 1980s and 1990s when these large cohorts were in their 20s and 30s the RN workforce was dominated by young RNs, with more than half the workforce younger than 40 years. However, by the year 2000 this distribution changed substantially. The 1950s cohorts were in their 40s and RNs of this age dominated the workforce, outnumbering RNs in their 20s by nearly 4:1. By 2010, the age distribution will have shifted as far as it will go (just before 1950s RNs begin to retire) and more than 40% of RNs are projected to be older than 50 years. Only when the 1950s cohorts are reaching retirement age in 2020 does the projected distribution begin to shift back to younger RNs (assuming that future cohorts will enter nursing at a rate similar to cohorts currently in their mid 20s).

The global situation

According to Baumann, Blythe, Kolotylo and Underwood (2004) the global

contemporary nursing labour market is characterised by shortage in all but a few Asian and European countries. However, while there is evidence of supply problems in the international nursing workforce, it is difficult to identify their precise nature. Some writers deny that there is a true (or real) shortage of nurses and suggest that problems of supply relate to working conditions, non-competitive salaries, and the absence of full-time jobs. Developing countries experience nursing shortages because local nurses migrate to countries that are more affluent (Baumann et al.). This reflects the “push: pull” factor described by Andrews et al. (2005) and Kline (2003).

The UK situation

The last nursing shortages in Britain in the mid 1980s and those of previous decades occurred primarily because an increased demand for health care and staff outstripped available supply. The current crisis relates to further increases in demand and to supply difficulties. Various supply factors - in particular the ageing of the nursing profession and the diminishing pool of potential nurse “returners” are likely to limit future supply while future demand for health care is expected to continue growing (Buchan and Edwards, 2000).

Because of recent initiatives to train and recruit more UK nurses the National Health Service (NHS) has experienced an increase in the number of newly qualified practitioners. According to the Nursing and Midwifery Council statistical analysis of the register (2005) registrations have continued to increase. The number of practitioners leaving the register peaked in 2003 at

4.7% of total practitioners but has since settled back to its normal wastage of 3.0–3.5%. In 1995, over half of those on the register were under 40, but today well over 60% are over 40 and one in four is now over 50. Overall, the analysis of the register demonstrates the continued long-term trend of a gradually ageing workforce. Rising levels of UK trained nurses and midwives are coming on to the register in parallel with declining levels of overseas trained nurses, and the number on the register is at its highest level ever.

The situation in the UK reflects the confusion of current international literature. On the one hand, future predictions indicate a severe shortage of health care workers, while on the other there are more nurses on the register than ever before. The impact that the ageing nursing workforce will have is yet to be determined.

The US situation

In a 2002 US national survey of RNs, 95% reported a shortage of nurses in the hospital where they worked. Two years later, after a nationwide increase in hospital RN employment of 185,000, the 2004 survey of nurses indicated that fewer, but still a majority of nurses (82%), reported a shortage of nurses. In 2004, 25% perceived the shortage as very serious, 64% a somewhat serious shortage, and 13% perceived no shortage in the past year (Buerhaus, Donelan, Ulrich, Norman and Dittus, 2006).

The US is in the midst of a nursing shortage that is affecting the entire healthcare profession. Some areas are affected by the shortage more severely

than others; 11 states are more than 10% below the national average of 782 RNs per 100,000 population (Coffey-Love, 2001). The North Carolina Centre for Nursing conducted a survey of all the hospitals in the state during the summer of 2000 to assess the severity of the nursing shortage. The average hospital RN vacancy rate was found to be 8.4%. Almost a third of hospitals reported vacancy rates of 6% to 11%, 16% had vacancy rates between 11% to 15%, and 10% were severely understaffed with vacancy rates of 16% or higher (North Carolina Centre for Nursing, 2001). Aitken (2001) refers to the significant cost to the health care industry when she estimates the cost of replacing a nurse to be US\$70,000 while Kovner, Brewer, Cheng and Djukic (2007) suggest the cost may be equal to or greater than two times a regular registered nurse salary.

Heller and Nichols (2001) describe the current nursing shortage as “a crisis of epic proportions” (p. 73), with predictions demonstrating that it will be longer term and more serious than previous shortages. According to the US Department of Health and Human Services Division of Nursing (2002) the rising demand for nurses will continue to outpace the supply. In the next five to ten years, the loss of nurses from the labour market is expected to exceed the number of new entrants (Heller and Nichols). The impact on the ability of the health care profession to provide health care in the future is significant; “The world is in the midst of a global age-quake: The workforce is turning grey and is shrinking” (Hatcher et al., 2006, p. 3).

Hader (2005), Heinz (2004), Goodin (2003) and Reineck and Furino (2005)

add to the concern, noting that over the next 20 years the largest cohort of nurses will reach retirement age leaving the nursing profession with insufficient numbers of replacements. Hader goes on to describe the significant increase in health care demand as the baby-boomer generation reach old age which will compound the strain on the already “labour starved” (p. 6) profession. In 25 years, one in four Americans will be aged 60 and over, compared with one in six today (Orsolini-Hain and Malone, 2007).

Although America saw a 20.8% increase in enrolment for nurse education programmes in 2003-2004, only a 40% increase will replace retiring RNs. According to Buerhaus, Staiger and Aurbach (2000) projections suggest that, following years of steady growth, the overall number of Full Time Equivalent RNs per capita will reach a peak in the year 2007 and will thereafter decline for the remainder of the forecast period. The absolute size of the RN workforce begins declining in 2012 and by 2020 will be approximately the same size as it was in 2000 (nearly 20% below requirement due to the ageing population).

Other countries

According to the International Council of Nurses (2004) Canada, Denmark, Germany, Iceland, Ireland, Sweden and USA predicted a projected nurse shortage for the next ten years. New Zealand predicted a balance in supply (this contradicts data from NZIER, 2004 which predicted a shortfall of all Health Professionals by 2011); Norway predicted a shortage for up to five years followed by a balance in ten years; the UK predict a balance in one year, a shortage in five years and a balance in ten years (International Council of

Nursing). Clearly contradictions reveal that predictions are imperfect but shortages are real.

Table 1 represents the predicted shortfall of nurses in five developed countries.

Table 1: Predicted shortfall of nurses in five developed countries.

Host Country	No. of RNs in workforce	Predicted shortfall (predicted year)
US	2,202,000	275,000 (2010) (12.5%)
UK	500,000	53,000 (2010) (10.6%)
Ireland	49,400	10,000 (2008) (20.2%)
Canada	230,300	78,000 (2011) (33%)
Australia	179,200	40,000 (2010) (22%)

(Aitken, Buchan, Sochalski, Nichols and Powell, 2004)

Reasons for shortages and potential solutions

This section explores the impact of organisational and social policy on the nursing shortage. It discusses the reasons for nurses' dissatisfaction, decline in enrolments in nursing programmes in some countries, and the reduction in numbers of young women joining the profession. The perception of nursing as a career and the greater societal issues and attitudes to women and women's work are addressed and New Zealand solutions to the shortage are sought.

Historical reasons

Market cycles determine the supply of nurses and the demand for their services. In the past decade, health care restructuring (including downsizing the nursing workforce) has occurred in most developed countries (McCloskey

and Diers, 2005; North, 2007). From a nursing shortage in the late 1980s, the nursing labour market moved to a surplus state in the 1990s because of restructuring, then returned to a condition of shortage in the new century.

United Kingdom

Buchan and Edwards (2000) trace the roots of the recent nursing shortages in the UK back to the early 1990s. As part of the National Health Service (NHS) reforms and the introduction of the internal market the employer determined nurse trainee intakes. The involvement of NHS Trusts provided a narrow focus controlling capacity of local training and education consortiums, and lack of a national overview meant that most Trusts underestimated required staffing numbers. The system also underestimated non-NHS demand for nurses, particularly in the rapidly expanding nursing home sector. The effect of this new “planning” system was to markedly reduce the number of student nurses.

James Buchan writes prolifically on the subject of the nursing workforce crisis in the UK (Buchan, 1999, 2000, 2002). The NHS is the largest employer of nurses in the UK nursing sector and its workforce is ageing. This trend, which also exists in other countries such as the US, means that one in five nurses registered with the United Kingdom Central Council (now the Nursing and Midwifery Council) is now aged 50 years and above and by 2010 this ratio will increase to one in four nurses (Buchan 1999). The number of retirements increased from 5500 per annum (from the late 1990s) to over 10,000 per annum by 2005. The ageing of the nursing workforce poses a challenge for

the NHS. Employers must work out how to look after their ageing workforce to maintain retention, and how to attract returners back to the workplace (Andrews, Manthorpe & Watson, 2005). Buchan (1999) concurs with this opinion, stating that many more nurses are now reaching their midlife and are likely to have different requirements and attitudes to nursing work.

According to Buchan (1999) an age bulge of nurses explains the ageing profile of nurses in their mid 30s to mid 40s working its way through the population. This reflects the comparatively large intakes of newly qualified young nurses, which occurred in the 70s and early 80s. Intakes of newly qualified nurses have reduced significantly since then: 71,260 newly qualified nurses registered in England in 1985, but by 1995, this number had reduced to 37,380.

United States of America

Aitken et al. (2001) looked at nurse recruitment and retention across several different countries and found that a common thread for all developed countries is a shortage of Registered Nurses, with clear indicators that the problem will escalate in the immediate future. Aitken et al. note that nurses' job dissatisfaction and intent to leave is at an all time high, there is an ageing workforce and job opportunities for young women offer infinitely more choice as compared with 20 years ago.

According to the Federation of Nurses and Health Professionals (2001), 1 in 5 nurses plan to leave the profession within the next 5 years, and 50% say they

often think about leaving the profession. However Kovner, Brewer, Cheng and Djukic (2007) argue that there is little data on the difference between intent to leave and actually leaving.

One projection from a 2003 American Nurses Association online survey (Centre for the American Nurse, 2003) revealed that, in the age cohort of 40 or older, more than 82% nurses planned to retire in the next 20 years (Hasselhorn et al., 2005). Kovner et al. (2007) suggest that older nurses are more satisfied with nursing, more committed to their organisation, but more likely to intend to leave. Aitken (2001) discusses similar findings, although she found that the age cohort of under 30 years demonstrated higher intent to leave. Atencio, Cohen and Gorenberg (2003) suggest that determining the basis of older nurses' dissatisfaction must happen before the exodus of nurses from the profession can be arrested.

Nursing dissatisfaction

Orsolini-Hain and Malone (2007) explore the theory that the “expertise gap” created by increased retirement of experienced RNs and the increasing number of novice nurses may extend the nursing shortage. Although enrolments in nurse education programmes has recently increased, the number of expert nurses available to orientate and mentor students, new employees and new graduates is shrinking and creating a situation where more nurses are competing for preceptors time. This inevitably leads to burn-out and dissatisfaction. Although increasing nurse recruitment and reducing nurse: patient ratios may appear to be a short-term solution to improve job

satisfaction and therefore retention of experienced nurses, it does not address the problem or maintain a work environment that sustains the expert nurse (Orsolini-Hain & Malone).

Declining enrolment in nursing programmes

There will be fewer nurses to replace those who leave the profession as enrolment in nursing programmes in the United States significantly declined in the second half of the 20th century (US Department of Health and Human Services, 2002). Between 1993 and 1996, enrolment in baccalaureate programmes declined 19%, and enrolment in associate degree programmes declined 11% (Letvak, 2002). In Maryland between 1998 and 1999, the number of nurses available to work dropped by 2,300. This equates to three graduates entering the field to replace every eight nurses retiring (Heller & Nichols, 2001).

The size of the cohort of women aged 15-19 years from which nurse education programmes drew students during 1960s and 1970s declined in the 1980s, thereby decreasing the number of younger prospective nursing students in the US population. The recent expansion of career opportunities and rising wages for women relative to men may have further reduced the pool of prospective nursing students. In addition, the ageing of the RN workforce in the USA has been attributed to the expansion of two year Associate Degree nursing programmes during the 1980s that apparently attracted individuals in their mid to late 30s interested in a second career (Buerhaus et al., 2000).

Buerhaus (2005) updates these statistics by suggesting that the five year (1995-2000) reduction in enrolments in nurse education programmes has reversed with a four year (2001-2004) annual increase. Despite the urgent need to increase the supply of RNs, thousands of qualified applicants are being turned away (American Association of Colleges of Nursing, 2004). The barriers to accepting qualified students include insufficient educators, clinical placements and classroom space (Orsolini-Hain & Malone, 2007). Nursing schools are not graduating enough baccalaureate and graduate nurse levels to stabilise the workforce (AACN, 2004).

The situation in New Zealand is that the number of enrolments in nursing programmes has been steadily rising since 2005. Renewed interest in nursing has led to many programmes being oversubscribed, with an increasing trend of school leavers enrolling (Cassie, 2008). Literature regarding the numbers of young women choosing nursing as a career is extensive and conflicting (Benjamin, 2000; Hatcher et al., 2006; Orsolini-Haine & Malone, 2007). However New Zealand appears to be experiencing an upward trend in this cohort of the workforce (Cassie).

Declining numbers of young women choosing nursing as a career

According to Benjamin (2000), the most important factor contributing to the ageing of the nursing workforce is a long-term trend of declining interest in nursing by women who today enjoy a wide choice of career opportunities. More and more women are choosing careers in business, law, education, science and technology (Hatcher et al., 2006). Furthermore, after working the

wards for 20 years, nurses in their 40s become supervisors, administrators and nursing directors or they retire from health care and, while still young, go on to second careers (Benjamin).

Perception of nursing as a career

Students are opting out of nursing careers deeming them not worth the cost (Heinz, 2004). Coffey-Love (2001) takes this argument further by suggesting that school students have a negative perception of nursing and nursing education. Without positive career guidance, the choices these individuals make potentially affect the profession as a whole, decreasing the pool of young people entering the workforce. The future sufficient availability of RNs is not ensured given the continued ageing of the RN workforce and the decreased tendency for potential students to choose nursing careers (Bednash, 2000).

Greater societal issues and attitudes to women/ women's work

Buchan (2002) focuses on the challenge of how to replace the many nurses who will retire over the next decade. The limitations of solutions such as improving retention, broadening the recruitment base, attracting returners and importing nurses from other countries is that they focus on nursing as the problem. In reality, nursing shortages are often a symptom of wider health system or social ailments. Societal attitudes to nursing encourage the “pink collar employment” culture, suggesting that it is women’s work and therefore less valuable, exacerbating the problem of declining interest (Bojtor, 2003; Cooper, 2002; Tracey & Nichol, 2007). Nurses in many countries are given

only limited access to resources to make them effective in their jobs and careers.

Attempts to increase recruitment by improving the image of nursing through the media and schools are being encouraged in conjunction with encouraging nurses to portray a more positive image to their families and the public (Goodin, 2003). For sustainable solutions, other interventions will also be needed. Buchan (2002) suggests that these should be based on the recognition that healthcare is labour intensive and that available nursing resources must be used effectively.

Framework for responding to shortages

Kimball (2004) discusses the drivers of the current nursing shortage and examines a framework for responding to the problem. Strategies used by other (non-health service) organisations to attract new talent include redefining entry to the profession; creating sustainable, achievable career paths; focussing on those under-represented in the current workforce; attracting 18-25 year olds; improving recruitment and career information to potential candidates; upgrading the image of the profession; integrating workforce recruitment and retention strategies; and creating public understanding of the shortage.

Kimball (2004) refers to four stages of actions taken along a continuum of time to address the nursing shortage. The continuum moves from “**scramble**”

in the short term, through “**improve**” and “**reinvent**” in the medium term and finally to “**start over**” in the long term. The benefit to the long term goal is the emergence of patient services and systems of care that are increasingly defined by consumer needs as opposed to individual or institutional needs. She warns that the current crisis calls for “bold new solutions and a re-envisioning of the nursing profession itself” (Kimball, 2004, p. 6) in order to emerge from the crisis in equal partnership with the medical profession. The outcome of failure to change will be perpetual cycles of shortage and oversupply.

Buerhaus (2005) and his research team conducted a large study on the state of the registered nurse workforce in the United States. They found that nurses believed that working conditions had improved since 2002 when the current nursing shortage was at its height. However, some problems remain which, if not addressed by policy makers, threaten to adversely affect the long term future of the nursing workforce. Buerhaus, Donelan, Ulrich, Norman and Dittus (2006) provide a list of strategies to address these problems. These include fixing problems associated with negative workplace climate, measuring and improving the contributions of nursing in patient quality and safety initiatives, fixing problems restricting capacity of nursing education programmes, promoting a balanced and professional image of nursing, improving diversity in the workforce, and recognizing that positive changes in the workforce are possible.

Other potential international solutions

Buchan (2002) takes an international focus when suggesting that many countries need to enhance, reorientate and integrate their workforce planning capacity across occupations and disciplines to identify the skills and roles needed to meet identified service needs. They can also improve day to day matching of nurse staffing with workload. Flexibility should be about using working patterns that are efficient but which also support nurses in maintaining a balance between their work and personal life.

Ageing workforce

This section discusses the impact of the “baby boomer” generation on the health care sector. It examines the extent of the ageing workforce using data from the USA and other countries. The loss of knowledge and expertise is explored, as well as the ageing nursing faculty and its impact on nursing.

“Baby boomers”

The “baby boom” of 1946 to 1964 was followed by a “baby bust” from 1965 to 1978, when the US birth rate fell to a low of 146 births per million. As of the 1990 census, there were 77 million American “baby boomers” compared with 44 million generation Xers- those born from 1965 to 1978 (Halstead, 2003; Nurse Executive Centre, 2002), creating the smallest pool of entry-level workers since the 1930s. At the same time, the demand for health care will rise as the baby boom generation reaches old age creating a demand for labour that cannot be met (Kovner et al., 2007).

Just as the “baby boomer” bulge (Kovner et al., 2007) is about to increase the need for health care, the nursing population is ageing and more nurses are moving away from the patient bedside in the acute clinical environment. Increased patient loads and acuity (McCloskey & Diers, 2005), alongside the pressure to treat more patients more quickly for less money have led to increased dissatisfaction from the current nursing workforce and decreased supply of entry-level nurses who choose other careers.

However the youngest generation currently entering the workforce number 88 million Americans. Early indications are that this generation, named “millenials”, “Y generation” or “nexters”, born between 1978 and 2002, may be attracted to a career in nursing, potentially redressing the balance of supply and demand over the next two decades (Christmas, 2008)

The ageing registered nurse workforce

In order to examine the phenomenon of the ageing nursing workforce the terms **old** and **older** need to be defined. According to Hatcher et al. (2006), for statistical purposes, older workers are often considered those between the ages of 55 and 64, but the law defines an older worker as anyone 40 or over. The legal definition tallies with a subtle attitude among many business recruiters who consider 40 and over to be unacceptably old. Some sources break down the definition even further: younger ageing worker (ages 45-54); middle-aged worker (ages 55-65) and older ageing worker (over 65). For the purpose of this paper, the older nurse is considered 45 years and over as this tallies with Hatcher et al. as well as Thrall’s (2005) definition of “baby

boomers” i.e. those born between 1946 and 1964.

United States of America

The nursing workforce is ageing more rapidly than the workforce as a whole (Letvak, 2002). In the USA between 1983 and 1998 the average age of working RNs increased by more than 4 years, from 37.4 to 41.9 years. During the same period, the proportion of RN workforce younger than 30 years decreased from 30.3% to 12.1%. In hospitals the average age of RNs increased by 5.3 years between 1983 and 1998. In contrast, the average age of the US workforce increased by less than two years during this period while the total labour force in the US younger than 30 decreased by less than 1% (Buerhaus et al., 2000, Coffey-Love, 2001; Cooper, 2003; Letvak, 2002). Norman et al. (2005) expand on these statistics by stating that between 1994 and 2001, RNs aged 50 and over grew at a rate of 4.7% per year, whereas the rate of growth exploded to 15.8% between 2002-2003. Norman et al. suggest that the proportion of RNs under the age of 35 continues to decline, a 20-year trend reflecting the inability to attract younger people into the nursing profession.

More than a quarter of RNs in the US are 50 years or older (Thrall, 2005).

The average age of the American RN workforce is currently 46.8 years (Kovner et al., 2007). Over the next 10 years, this trend will lead to further ageing of the RN workforce because the largest cohorts of RNs will be between 50 and 69 years (Benjamin, 2000). By 2010 40% of the RN pool will

be on average older than 50 years and by 2020 the supply of RNs will be 20% below the demand (Cooper, 2003; Hatcher et al., 2006). An analysis of employment and earnings trends in the US nurse labour market showed that of the 185,000 new RN recruits in 2002 and 2003, nearly 130,000 were accounted for by re-entry of RNs over the age of 50 (Buerhaus et al., 2000; Thrall, 2005).

Projections suggest that about half the international RN workforce will reach retirement age in the next 25 years (Cooper, 2003; Hatcher et al., 2006). Because nurses aged 50 years and older make up a substantial proportion of the RN workforce (28% in 2004) the question hanging over any assumption about future staffing is: when will they retire? Kovner et al. (2007) advise that the average age of retirement in America has reduced from 62 years of age in 2002 to 61.4 years in 2005. However, this may be generational as the traditional or veteran generation (those born between 1922 and 1945) retires; “baby boomers” are predicted to continue to work until their 70’s or 80’s, partly because they cannot afford to retire. Historically, registered nurses aged between 53 and 56 years who work at the bedside reduce their hours of work from full time to part time (Thrall, 2005). However, whether “baby boomers” (nurses between the ages 45-59) that make up about 50% of the RN workforce, will follow that example is unknown (Thrall). If this does happen, it poses a significant threat to workforce viability.

Loss of knowledge

Antonazzo, Scott, Skatun and Elliott (2002) researched the relationship

between age, length of service and turnover rates among different staff groups including nurses. The aggregate turnover rate for all staff covered in the study was 13.6%. Turnover rates declined with age then rose close to retirement. They also tended to be high in the first years of service, before declining, suggesting that the information about the nature of the job is accumulated slowly. They surmise that the accumulated knowledge of older nurses is a vital resource, which will be lost as this cohort leave the workforce. It is important to look for ways to retain the older nurse in a capacity in which they can enhance the accumulation of knowledge of the younger workforce. DeLong (2004) discusses the impact of the loss of the knowledge of experts through retirement in the generic professional environment; applied to the health care sector this leads to a reduction in quality and safety of patient care.

Ageing nursing faculty

The ageing of the nursing workforce is also evident in the nurse educator cohorts who are currently almost 10 years older than their clinical counterparts. This raises the prospect of an inadequate pool of nurse educators to train a newly recruited workforce (American Association of Colleges of Nursing, 2004; Bednash, 2000; Benjamin, 2000; Thrall, 2005)

Gaps in the literature

At the time I commenced this project a significant amount of literature was available on the nursing shortage, but little research had been done on the older nurse. In the intervening three years, several major studies have focused on the effects of the ageing nursing workforce and the importance of retaining

this valuable resource (Andrews, 2005; Gabrielle & Jackson, 2007; Gabrielle, Jackson & Mannix, 2007; Hatcher et al., 2006; Kovner, 2007; Letvak, 2008; Norman, 2005). However, this literature is predominantly based in the UK and USA, with no current published New Zealand research studies.

The older nurse

Letvak (2002, 2005) looked at retaining the older nurse, specifically focussing on the health care industry's response to the ageing nursing crisis. She reported that few institutions had policies in place to specifically address the needs of the older nurse. She refers to the professional literature and the popular media, which she reports are full of stories of future problems if the current shortage continues to deepen as expected. Staffing shortages have already led to a decrease in quality of care as well as an increase in errors as heavier workloads and longer hours fall on an already stressed staff (Aitken, 2001; McCloskey & Diers, 2005.).

Buchan (1999) looked at ways to retain the older nurse, reasoning that older nurses may have another 10 years or more of potential contribution to make to the profession. In his view greater consideration will have to be given to the provision of appropriate working hours, career development opportunities and phased retirement benefits if these nurses are to be retained and encouraged to contribute their experience and skills. Career ladders and pay systems need to remunerate older nurses who have continued to acquire skills and competencies long after they have reached the top increment on their salary scale.

Gaps in health care industry/ systems research

Letvak (2002) complained that there was almost no research on the healthcare industry's response to the ageing workforce. Research by Letvak determined that the older nurse desires increased autonomy, more direct patient care and a positive work environment that utilises their extensive experience. With the reality of an ageing nurse workforce, nurse administrators would be wise to develop interventions that would address the needs of these nurses.

Participating in research that determines the needs of older nurses would be a good first step (Hatcher et al., 2006).

Existing health care industry/ system research

Given that older nurses are the fastest growing cohort of the nursing workforce efforts should be made to retain them, perhaps by offering incentives to delay retirement (Norman et al., 2005). Thrall (2005) suggests asking the nurses themselves what would keep them at the bedside. Hatcher et al. (2006) ask, "...is there value in retaining the older nurse in an increasingly chaotic health care system?" (Hatcher et al., 2006, p. 1). They undertook a study aimed at encouraging the recruitment and retention of older, more experienced nurses. Central to the study was the philosophy that retaining older nurses is crucial to address the national nursing shortage, as well as the high cost of nurse turnover. How to establish an organisational culture that is more respectful of the contribution of older nurses should be researched in order to be able to change the work environment into a place where the older nurse is welcomed, accommodated, appreciated and effectively utilised.

Summary

This chapter has explored the extent of current literature on the subject of the nursing shortage, consequences of the nursing shortage on patient safety, the reason for the shortage, and the effects of the ageing nursing workforce.

The international health care sector faces a potential nursing workforce deficit of up to 40% by 2020. This shortage has been created by the “baby boom” bulge as the largest cohort of nurses approach retirement at the same time as the demand for health care services increases. Inadequate hospital staffing is a factor in poor patient outcomes, adverse patient occurrences, increased hospital errors and increased patient mortality (Aitken et al., 2001). Fewer women are choosing nursing as a career, and as expert nurses retire, they are leaving behind them a knowledge gap that will also increase the risk of adverse patient outcomes.

As the nursing workforce ages it is important for employers to address the physical and psychosocial needs of this group of nurses in order to enable them to remain at the patient bedside, providing expert nursing care and mentoring and guiding the next generation of nurses.

While international literature is available on the current nursing workforce crisis, and on the effects of the ageing nursing workforce, this relates specifically to the UK and USA. I was unable to locate any current literature on the situation in New Zealand. The aim of this study is to research midlife

nurses in a provincial New Zealand DHB to find out how they can be supported to deliver bedside care in the acute clinical services until retirement.

The astonishing amount of international literature provides conflicting themes across countries, and generates enormous concern regarding the future nursing workforce crisis; however there is very little action proposed to address the problem. As this thesis nears completion, some literature is becoming available potentially contradicting all the evidence of the previous decade of research. The economic down turn leading to global recession has meant that the ageing veteran and baby boomer generation are not financially able to retire; this is happening at the same time as the millennial or Y generation (who number significantly more than the boomer generation) are choosing nursing as a career in far higher numbers than was previously anticipated (Christmas, 2008). The “respite from the anticipated retirement tsunami” (Christmas, 2008, p. 2) may mean that employers are required to change their focus from managing high vacancy rates to managing a multigenerational workforce and ensuring that the new generation of nursing recruits are nurtured into successful nurse leaders of the future.

Chapter 3 Methodology and Method

Introduction

This chapter describes and critiques the methodology and method chosen to conduct this study. It will explain the research process, discuss the underlying values of the study, outline the process of data collection and data analysis, and reflect on the data analysis.

Methodology

Crotty (1998) explains the basic elements of the research process in a four-part model, describing how each step informs the next.

- What epistemology informs the theoretical perspective? Epistemology being “the theory of knowledge embedded in the theoretical perspective and thereby in the methodology” (p. 3)
- What theoretical perspective lies behind the methodology? The theoretical perspective being “the theoretical stance informing the methodology and thus providing a context for the process and grounding its logic and criteria” (p. 3).
- What methodology governs my choice and use of methods? Methodology is described as “the strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcome” (p.3).
- What methods do I propose to use? The method “is the techniques or procedures used to gather and analyse data related to the research question” (p.3).

I will use Crotty's (1998) model to explore these concepts and justify my choice of methodology and method in more detail.

Epistemology: Constructionism

Epistemology is the study of knowledge and how it is judged to be "true"; truth being an uncertain concept (Taylor, Kermode and Roberts, 2006). Crotty (1998) states that within the epistemological concept of constructionism meaning is constructed, not discovered. Different people may construct meaning in different ways. Constructionism is the view that all knowledge is reliant upon human culture, being constructed through interaction between humans and their world, and developed and transmitted within a social context. Humans construct meanings as they engage with the world they are interpreting. Constructionism is analogous with curiosity (Crotty).

Minichiello, Sullivan, Greenwood, and Axford (2004) explore the constructionist view of society suggesting that our views of reality and ourselves, including our interpretation of social situations and our expectations of behaviour, are built up over time based on interactions with others. In these interactions, meanings are shared using language and non-verbal communications, which can never represent the world in a neutral manner. Instead, language constructs our understanding of the world from the ground up.

According to Gray (2004) constructionism suggests that truth and meaning do not exist in some external world, but are created by the subject's interactions with the world. Meaning is constructed, not discovered, so subjects construct their own meaning in different ways, even in relation to the same phenomenon.

Theoretical perspective: Interpretivism/ Inductive Enquiry

Holloway and Wheeler (1996) describe interpretivism as “understanding”, in contrast to positivism which is “explaining”. Gillis and Jackson (2002) relate interpretivism to Weber's “Verstehen” theory - the empathetic understanding of behaviour. This thinking had its roots in the German intellectual tradition of hermeneutics and phenomenology that emerged in the 20th century, explaining the role of meaning and interpretations in social life (Minichiello, Aroni and Hays, 2008). The interpretivist perspective is how people make sense of their lives, how they define their situation, and how their sense of self develops in interaction with others. A single reality does not exist. Reality is based on perceptions, so it can be different for each person and can change with time. Meaning is produced by perceptually putting pieces together to make wholes, and many different meanings to a situation can exist because perception varies with the individual (Holloway and Wheeler).

According to Watson, McKenna, Cowman and Keady (2008), interpretive researchers assume that gathering knowledge about a particular population can only be done through shared consciousness, meanings and language and

believe that it is not possible to separate the researcher from the research in any objective manner. Quinn and Clare (2008) describe the process of interpretive phenomenological analysis (IPA) as an interpretation of the participants experience that is dependent upon and complicated by the researchers own belief, assumptions and understandings which operate both within the interview context and subsequently as the researcher engages with the interview transcripts. Researchers must attempt to acknowledge pre-existing values, assumptions and beliefs that may affect the interpretation of the data, and to reflect on factors that may influence their interactions with the participants or text. Through acknowledging these influences and possible biases, the researcher attempts to reduce their impact on the analysis. IPA is based on the assumption that what people have to say about their experience reflects something of their “inner world”. Due to the interpretive nature of the analysis, the researcher’s own preconceptions and knowledge about the topic could bias their approach to interaction with, and account of, the participants’ experiences. At the outset, and during the research process, the researcher should consider his or her own feelings and reactions to the participants and their accounts.

Those adhering to the critical enquiry perspective accuse interpretivists of adopting an uncritical stance towards the culture they are exploring, whereas they believe that the task of researchers is to call the structures and values of society into question (Gray, 2004). Throughout this project, I struggled with the desire to critically challenge the views of my participants, to question their

values and influence change. However, my positional power did not allow me to do so and I had to be satisfied with purely interpreting the data.

Minichiello et al. (2004) describe the inductive approach which involves researchers approaching the area under investigation without any preconceptions or theoretical stances. Prejudices are ignored and researchers see things as they are or as they think they are. Thomas (2003) portrays a general inductive approach for qualitative data analysis that allows research findings to emerge from the frequent, dominant or significant themes inherent in raw data, without the restraints imposed by structural methodologies. Key themes are often obscured, reframed or left invisible because of the preconceptions in the data collection and analysis procedures imposed by deductive analysis such as those used in experimental or hypothesis testing research. The purpose of this process is to condense extensive and varied raw data into a brief, summary format. It establishes clear links between the research objectives and the summary findings to ensure the links are transparent and defensible; and it develops a model or theory about the underlying structure of experiences or processes that are evident in the text. The basic assumptions of this process are that data analysis is determined both by the research objectives and by the interpretation of the raw data. The categories developed from the raw data are shaped by the assumptions and experience of the researcher, and judged important by the researcher (Thomas).

Both of these theories are problematic due to the potential power relationship created by my insider/outsider role of manager and researcher. In order to reduce the impact of this I chose to assume a passive, non-committal stance towards my participants. If I had taken part in their dialogue or challenged their assumptions, my theoretical perspective would have been that of critical enquiry; however this could have created role confusion and I may have been viewed as a potential threat. Likewise, it is impossible for me to approach the research without any preconceptions or prejudices as required by the inductive approach because I work closely with the participants on a daily basis, and as a manager I am often called upon to help them to work through or resolve the problems associated with being an older nurse. Maintaining the interpretivist stance reduced the introduction of my own bias into the research and therefore increased the trustworthiness and authenticity of the data. However, Thomas' (2003) inductive approach to data analysis proved to be a useful tool as I struggled to move beyond the initial categories to find the true themes of the data, and therefore I found myself utilising an interpretivist stance during the focus group discussions, and an inductive approach during the data analysis.

Methodology: Qualitative Descriptive

According to Berman, Ford-Gilboe and Campbell, (1998) methodology is defined as a set of principles for conducting research that evolve from and operationalize paradigm assumptions by guiding decision making in several areas. These include the relationship between the researcher and the participants, and epistemologic assumptions about the nature of knowledge

and who are legitimate “knowers” (what constitutes legitimate sources of knowledge, what can be known and who can be “knowers”). In addition, the extent to which subjective meanings are valued and incorporated into the research, and how participants are (or are not) incorporated into the process of analysis and dissemination of results.

Specific decisions about the design and conduct of a particular study are usually a trade-off between adhering to methodological principles of the paradigm guiding the study, achieving the specific study purposes, and attending to the many practical considerations of conducting an investigation (Berman et al., 1998). Rountree and Laing (1996) suggest that qualitative studies seek to understand the complexities and uniqueness of individual research participants, as well as looking to understand commonalities in groups. They reveal the complexity of the topic, uncovering issues that you would not have imagined before you began the research. According to Merriam (1998), generic qualitative research studies seek to discover and understand a phenomenon, a process or the perspectives and worldviews of the participants.

The research I conducted is a qualitative descriptive design, using both quantitative and qualitative approaches, with the intention of telling the story as described by the nurses in relation to the history and structure in which they find themselves (Harden, 1996). I endeavoured to portray the “essence” of the phenomenon of the ageing nurse population without flooding the picture with unnecessary details of pet theories, preconceptions, bias, conclusions and

recommendations (Sandelowski, 1993). Instead of attempting to force the data into rigid structures and criteria, my goal was to create “the evocative, true-to-life and meaningful portraits, stories and landscapes of human experience” (Sandelowski, 1993, p. 1) within an interpretive qualitative model in its most simple form: that of pure description.

Descriptive research is the first level of classifying research (Sandelowski, 2000). It involves identifying the nature and attributes of phenomena and sometimes the relationships between phenomena. Through descriptive research, health professionals are able to describe what exists in practice. The results of my research will enable me and others as nurse leaders, to argue for policy changes necessary to support midlife nurses to continue to work at the patient bedside. Retention of this valuable resource will ensure that the supply of qualified staff continues to meet demand for as long as possible.

Sandelowski (2000) argues that although it is described as being on the lowest rung of the research design ladder, and therefore weak science, qualitative descriptive research is in fact the method of choice when straight descriptions of phenomena are desired. The method produces a complete and valued end product. Although no description is free from interpretation, qualitative description entails a kind of interpretation that is low-inference, or likely to result in easier agreement among researchers. However, descriptions must always accurately convey events in their proper sequence, and attribute the meanings the participants gave to the events in order to demonstrate validity. Validity in this case refers to something that is “there” (Sandelowski).

Pope and Mays (2006) discuss the criticisms of qualitative research. It can be seen to be merely an assembly of anecdote and personal impressions, strongly subject to researcher bias. It can lack reproducibility because the research is so personal to the researcher that there is no guarantee that a different researcher would not come to radically different conclusions. It may also lack generalisability by tending to generate large amounts of detailed information about a small number of settings.

Pope and Mays (2006) suggest that the basic strategy to ensure rigour in qualitative research is systematic and self-conscious research design, data collection, interpretation and communication. They suggest two goals for which to strive. Firstly, to create an account of method and data that can stand independently so that another trained researcher could analyse the same data in the same way and come to essentially the same conclusions. Secondly, to produce a plausible and coherent explanation of the phenomenon under scrutiny.

The description in qualitative descriptive studies involves the presentation of the facts of the case in everyday language, not delving into or beyond the data (Sandelowski, 2000). The researcher does not need to feel obliged to defend their efforts as something more than mere description; it is purely a comprehensive summary of the voice of the participants.

Reliability, Validity, Credibility and Trustworthiness

According to Cresswell (1994), Ford-Gilboe, Campbell and Berman (1995), and Holloway and Wheeler (2002) early qualitative researchers in the post positivist paradigm felt compelled to relate traditional notions of validity and reliability to the procedures of qualitative research. Later qualitative writers in the interpretivist paradigm distanced themselves from the positivist paradigms by developing their own language and establishing terms such as “trustworthiness” and “authenticity” in place of the more scientific steps to verification.

Holloway and Wheeler (2002) suggest a list of interpretive terms to replace post positivist scientific formulae. Quantitative research involves the use of rigour, reliability, validity, generalisability, and objectivity. Qualitative researchers strive for trustworthiness, dependability, credibility, transferability, and confirmability. Nurse researchers’ priority should be to produce good science that ultimately improves the health and well-being of people (Ford-Gilboe et al. 1995). Thomas (2003) suggests that trustworthiness can be assessed by consistency checks (e.g. having another coder take the category descriptions and finding the text that these belong to), or by stakeholder checks (e.g. informal conversations with members of the organisation with interests in the setting being studied). In the case of this research I carried out stakeholder checks, paraphrasing and reflecting on, and receiving feedback on, my findings from nursing colleagues.

Sandelowski (1993) suggests that researchers have become too concerned with trying to neutralize bias, prove validity and rigour, establish reliability and consistency, and have lost sight of the truth of the human experience. She also argues that efforts to establish reliability are often completely unwarranted and may even serve to weaken claims to validity. Even if the description or narrative relates to one moment in time and can never be replicated, repeatability is not essential. The meaning making of the story is the only rigour and truth required. This can cause problems when the research is “member checked” (Sandelowski) either by the participants or by fellow researchers because they will inevitably look for, compare the reality of the description with the reality of their own experiences, and try to represent multiple realities in the data. It is important for the author to remain faithful to the original individual narratives.

Method: Questionnaire and Focus Group Discussion

Berman, Ford-Gilboe & Campbell, (1998) propose that the research method refers to the ways in which data are collected of which there are only three: posing verbal or written questions to individuals or groups; observing; or reviewing records. Any method has the potential to be used in exploitative or empowering ways. The researcher must decide how to use the chosen method in a manner that is consistent with the paradigmatic methodological assumptions. Another fundamental consideration is to select methods that will yield the most persuasive evidence to bring about change (Berman et al.).

According to Polit and Hungler (1999) data collection decisions for qualitative research usually evolve in the field. I made a number of advance decisions such as participant selection, the structured questions I wanted to ask in my questionnaire, and how I would analyse this information. Tolich and Davidson (1999) discuss the content of the ideal interview guide, referring specifically to interviews in their text; however the advice can equally be applied to questionnaires and focus group discussions. They suggest the interview (questionnaire/ focus group discussion) should be divided into three parts. Firstly introducing questions to start the talking; then listing recurrent themes that represent the projects research interests; and finally a set of generic prompts (How? Tell me more? etc).

Sandelowski (2000) advises data collection in qualitative descriptive studies is typically directed towards discovering the “how”, “what” and “where” of experiences. I asked my cohort through an initial questionnaire how they felt and what they thought the organisation could do to keep them at work in bedside practice until they retire. This was followed up by focus group discussions.

Surveys

Rees (1997) recommends that surveys are useful because they are cheap and quick. They can cover large geographically spread samples, and they can be quite detailed. There is a low level of embarrassment or threat to both the researcher and the respondent, and anonymity can be protected. Fixed choice

questions are easy to answer and analyse, and the method is familiar to respondents.

The survey (questionnaire, Appendix 1) I developed was sent to 180 midlife nurses aged 45 years and over, resulting in a response rate of 37.7%. This questionnaire was designed to obtain both quantitative and qualitative data. Demographics such as year of birth, year of entry into nurse training and years of service painted a picture of my cohort through use of closed questions. I looked for trends in age groups, length of experience, tendency to work in specialty areas, tendency to reduce contracted hours of work, and intent to retire.

Open-ended questions relating to vitality, vigour, and how work makes them feel, as well as their opinion of what will enable them to continue working provided free text from which to discover trends and themes. I based the vitality and vigour questions on the SF36 (Ware, Snow, Kosinski & Gandek, 1993) framework because the nurses are familiar with this question having been previously surveyed as part of other studies (i.e. Budge, Carryer & Wood, 2003). In order to find how positive or negative the nurses feel towards work I looked for a way to give them the opportunity to have mixed feelings, based on the assumption that is unlikely that all nurses feel very positive or very negative. The choice of adjectives, in conjunction with the free text responses also gave me the foundations for initiating the focus group discussion.

For in depth examination of the phenomena arising from the initial data I used focus group discussions with a pre-set framework of questions based on themes derived from the survey response.

Focus Groups

According to Rountree and Laing (1996), the object of focus group discussions is to get high quality data in a social context where people can consider their own views in the context of the views of others. Its weaknesses can be the limited number of questions that can be asked during one session, and the fact that it takes time for everyone to have their say. Focus groups typically have high face validity (definition) but low generalisability (findings can be applied to more than just the sample in the study) (Greenhalgh and Taylor, 1997).

Gray (2004) recommends the advantage of focus groups is that they allow for a variety of views to emerge, while group dynamics can often allow for the stimulation of new perspectives. Pope and Mays (2006) suggest that focus groups are useful in explaining or exploring survey results. They are defined as a form of group interview that capitalises on communication between research participants in order to generate data. They are a quick and convenient way to collect data from several people simultaneously using group interaction: asking questions, exchanging anecdotes and commenting on each other's experiences and points of view. Focus group discussions are an effective way of exploring the attitudes and needs of staff. Group resources help people to explore and clarify their views in ways that would be less easily

accessible in one: one interviews. They work particularly well when the interviewer has open-ended questions, encouraging participants to explore issues of importance to them in their own vocabulary, generating their own questions and pursuing their own priorities. When group dynamics work well the participants take the research in new and often unexpected directions. They tap into jokes, anecdotes, teasing and arguing.

Patton (2002) refers to this phenomenon as “languaculture”- increasing clarity, communicating respect and facilitating rapport. Group synergism can also create and nourish anger (this could potentially be a problem for me as an insider researcher if the anger is against “management”). It is important to recognise homogeneity in each group in order to capitalise on people’s shared experience; also to be aware of how hierarchy in a group may affect data. Friends and colleagues can relate each other’s comments to incidents in their shared daily lives. Focus groups are particularly suited to the study of attitudes and experiences, but the data generated can be cumbersome and complex (Gray, 2004).

Krueger (1994) suggests that focus groups have the benefit of the ability to bridge the gap of understanding, in this case between the employee (midlife nurses) and the employer (the District Health Board (DHB)). Crawford and Acorn (1997) warn they can have a tendency to try to reach a consensus when the aim is to discuss the views, beliefs, opinions and perceptions of members. Members of focus groups may conform to the majority opinion because of the group dynamic. According to Krueger, the interactions within a focus group

can be significant because individuals do not always form an opinion in isolation, but are created by listening to others.

The focus groups I carried out involved four groups of participants who volunteered during the questionnaire phase of the research. They consisted of mixed groups of nurses, some of whom worked together regularly, some of whom recognised each other but had never met. They shared a common bond of employment within the acute inpatient care setting of the same DHB. The groups shared jokes and anecdotes, explored their similar frustrations, and appeared to be comforted by their shared experiences. Their confidentiality was assured through verbal reassurance and a written information sheet (Appendix 2). The participants and note taker were also requested to sign confidentiality statements (Appendix 3 and 4).

The focus group participants were given a framework of the key themes extracted from the questionnaire results and invited to discuss or explore any or all of the themes, beginning with the theme that interested them most. All four groups chose to describe their passion for nursing in the first instance, and then covered every other theme randomly with no obvious tendency or favourite topic. Despite time constraints (i.e. lunch break, work pressure) all four groups conversed comfortably for at least an hour. The dynamics of each group were different (different numbers of participants, different levels of experience and seniority, different personalities) but every participant had a voice.

The 18 nurses were divided into four groups. The selection for the groupings was based on availability and personal choice of date and time.

Focus group 1 contained six nurses, a mixture of enrolled and registered nurses, who talked effortlessly for more than an hour and I found myself having to gently close the conversation.

Focus group 2 also contained six nurses; in this case they consisted of registered nurses in more senior positions and although they created the same themes they gave a slightly different perspective.

Focus group 3 was made up of two nurses; again, the themes were identical but this time a British RN brought the perspective of comparing the New Zealand health system with the National Health Service.

Focus group 4 brought together four of the oldest and most experienced registered nurses in the organisation. These nurses chose to come together, and shared a significant bond; the discussions took place over the course of two lunchtimes because they had so much to talk about. They brought the perspective of having had experience of working as health service managers in the past but choosing to return to bedside nursing at the end of their working lives. Again, the emerging themes were the same but from a different perspective.

Saturation

According to Gillis and Jackson (2002) saturation is achieved when the participants descriptions become repetitive and confirm previously collected data, adding no new information. Volunteer numbers can restrict sample size. My cohort was restricted by the number of volunteers; however saturation was reached to my satisfaction when no new themes emerged.

Participant Selection

According to Sandelowski (2000), researchers may choose to sample cases to represent a combination of pre-selected variables in order to describe it as it commonly appears. The ultimate goal is to obtain cases deemed information rich. The obligation for the researcher is to defend their sampling strategy as reasonable for their purpose.

The participants for my research were registered and enrolled nurses employed on a permanent basis in the acute inpatient setting selected through the Human Resource Information System of a central North Island District Health Board (DHB) based on age of 45 years and over. This realised a population of 180 nurses. The list provided a cohort with no bias to age, Full Time Equivalent status or length of service. These nurses received a copy of the questionnaire (Appendix 1) and the questionnaire information sheet (Appendix 5), with the option to take part in follow-up focus groups if they wished to participate further; 68 nurses responded, a response rate of 37.7%. On analysis of the data

obtained from the questionnaires, I followed-up with focus group interviews for those nurses who volunteered to participate.

Ethics

This project received provisional ethical approval from Massey University Human Ethics Committee (MUHEC) in October 2006 (Appendix 6). This followed application to the Central Health and Disability Ethics Committee (Central HDEC) based on the assumption that researching health professionals in a potential power relationship constituted a conflict of interest and therefore required national approval. Central HDEC stated that ethical approval was not required by a Health and Disability Ethics Committee (20 September 2006). However the screening questionnaire indicated a conflict of interest and therefore review was required by MUHEC. Approval was given, subject to fulfilment of conditions (Appendix 6), and final approval was received in December 2006 (Appendix 8).

In submitting the project my key concerns related to the power relationship over my participants, and the potential for bias due to the fact that I am an “insider researcher”. In the following sections, I will discuss these concerns in more detail.

Power Relationship of an Insider Researcher

As the direct manager of a large proportion of the participants, the outcomes of conducting research in my own DHB are more useful than researching nurses from a DHB with a different nursing structure. This inevitably led to

questions relating to the validity and trustworthiness of evidence produced through research carried out on my own staff, as well as a potential breach of confidentiality. The potential that I may overtly or inadvertently coerce the participants was also raised.

As a 45 year old nurse working in the acute clinical environment myself, I empathise with my research participants. As manager of a large number of the participants I am also familiar on a daily basis with the realities of their working lives. The risk of conducting the research with prejudice and bias was addressed at length in my initial ethics application, and further questioned by MUHEC (Appendix 6).

I addressed these concerns by arguing that participation in the research was voluntary, and that the nature of the evidence could not prejudice the participants. No nurse was named or identifiable in the data. The organisation has a strong research culture; the nurses are familiar with participating in research and have a good understanding of issues of confidentiality and protection of identity. It was up to me as a senior nurse to facilitate an environment of equity and safety for participants in order to mitigate the acknowledged conflict of interest and power relationship (Appendix 7). These issues were managed in this project by ensuring confidentiality, and by adopting a non-critical, interpretivist theoretical research perspective. No issues of ethical concern were raised during conduct of this research.

Key ethical issues for all researchers include informed consent, do no harm, anonymity and confidentiality, and avoid deceit (Tolich, 2001). According to Snook (1999) ethical guidelines address popular scandals with legislative responses. The Nazi treatment of the Jews resulting in the Nuremberg Military Tribunal, later ratified by the World Medical Association Declaration of Helsinki in 1964 is a recent example of this phenomenon (Burns and Grove, 2001; Polit and Beck, 2003; Tolich, 2001). The core idea of research ethics is to champion academic freedom while maintaining academic responsibility.

Mies (1995) described the vertical relationship of research and the dominance of the elitist researcher and subservient research subjects. The view from above must be replaced with a view from below in order to minimise the power relationship. I am researching as a university student not as a nurse manager.

According to Rountree and Laing (1996) the inequalities of the interview process can be redressed by advocating collaborative methods through a passive and non-committal stance. However, given the distance between researcher and participant as subject and object, ultimately the end product is essentially the work of the researcher who has final responsibility for evaluating the data, its interpretation and presentation. The power relationship will always tip towards the researcher.

Robson (1993) and Field (1991) discuss the risk of the insider researcher holding preconceptions about issues and solutions. Inherent bias can be a

consequence, but Field (1991) suggests this is a risk to all research and awareness of introducing bias is critical. Burns and Grover (1997) insist it is the insider researcher's responsibility to maintain anonymity and preserve confidentiality. Robson (1993) warns of the great potential for hierarchy difficulties meaning that the researcher can be viewed as a potential threat. Field (1991) also discusses the risk to the researcher of findings being rejected by the organisation. Webb (2002) overcame this by securing a collaborative relationship and sponsorship from the Director, Human Resources and the Chief Executive Officer.

As a student and a manager my integrity may not be in question, but I have a professional and personal interest in the research I am conducting, therefore the ethics of my project needs to be examined (Snook, 1999). Making a person an experimental subject risks making him or her a "thing", reduced to a mere token or sample. A major requirement of ethics is that humans must never be treated as a means to an end; they must be an end to someone's means. Justification for human research is the gaining of worthwhile knowledge with potential for improving the lot of human beings. For research to be ethical, accepted procedures must be followed to ensure that the findings can be relied on. Researchers are obliged to deal with their participants and their research community in an honest and truthful way. Research is the search for truth and commitment to truth is an ethical imperative. Cynicism about the possibility of objectivity destroys the basis of ethics; it also destroys the basis of research (Snook, 1999).

Levine, Faden, Grady, Hammerschmidt, and Sugarman (2004) explore the notion of vulnerability. Ethics committees could argue that my participants are vulnerable (relatively incapable of protecting their own interests because they have insufficient power) because I am their manager, but I would argue that they are not susceptible (predisposed to additional harm). Several sources define the vulnerability of employees as research participants. Kipnis (2001) suggests that they could be differentially vulnerable, i.e. demonstrating customary obedience to authority. The Office for Human Research Protections (2001) names employees in its list of special classes of subjects requiring special consideration. The Council for International Organisation of Medical Societies (2002) guidelines site “subordinate hospital personnel” as vulnerable.

However Levine et al. (2004) argue that if everyone is vulnerable the concept becomes too nebulous to be meaningful. The purpose of designating a group as vulnerable is to provide additional protection, to pay special attention or give special consideration. If vulnerability is taken to imply ability to give informed consent, then my participants’ capacity to consent is not in question. If it is taken to imply risk of physical harm then they are not at any risk. If vulnerability stereotypes whole groups of individuals without distinguishing between individuals in a group who might have special characteristics that need to be taken into account and those who do not, then some of my participants may be vulnerable. Arguably this is irrelevant in my research because all participants are voluntary. Nevertheless one respondent is clearly having professional issues with their current manager and this is reflected in

absolutely negative responses and bitter comments in the questionnaire. However, the nurse retains the right to total confidentiality and has not volunteered for the focus group discussion. His or her presence in a group discussion may have potentially introduced some interesting dynamics, but it could also have potentially tipped the balance in the group synergism as discussed previously.

According to Tolich (2001) if I want to do research on people I should ask their permission first; if they say “no” then I cannot legitimately do research on them. The notion of informed consent only applies to competent people. It should be voluntary (not obtained by coercion), and informed (the subjects know and understand relevant information about the research project). The former imposes negative duties (not to coerce or force subjects) and the latter imposes positive duties (to disclose information and ensure subjects understand).

Coercion alters people’s options by making some much worse than they would otherwise be, but it leaves people’s ability to choose intact. Manipulation tampers with peoples’ beliefs about their options, not the options themselves (Tolich, 2001). Both of these concepts must be avoided in order to be ethical. Ethical principles require that researchers maintain the confidentiality of information given to them and take every possible step to protect the anonymity of participants (Tolich). I maintained the confidentiality of my survey participants through use of an anonymous questionnaire sent and received through the Human Resources department of the DHB. The

participants were under no obligation to respond, and the data produced is not traceable to any individual. The expression of interest to take part in the focus group discussion was on a separate piece of paper removed from the questionnaire in order to prevent matching the volunteer to the response. One respondent commented on the participant information sheet (Appendix 5) that it would be possible to identify the individual (for instance if the nurse is part of a small workforce in a small area of practice); I would argue that individual responses are of no interest to my research. I am identifying themes and phenomenon, looking for trends and commonalities. Any individual judgment or opinion may colour the background picture slightly differently, but will not affect the overall outcome of the project. The fact remains that the nurse was under no obligation to respond, but he or she still chose to do so.

One surprising comment received from a nurse related to the age of the participants. Questionnaires were sent via internal mail to the individual nurse's work place. In areas where several nurses received and opened the questionnaire at the same time, discussions took place regarding the contents of the survey. Nurses who had not received a survey questioned their colleagues, and it became clear that recipients were over the age of 45 years. This shared knowledge of the age of the potential participants appeared to cause offence to a particular nurse; however, this feedback was only received from one participant. The feedback was sent in the form of an e mail and it is unknown if the nurse chose to participate or not. The only way to avoid this perceived breach in confidentiality would have been to send the survey to the home address of each nurse. This would have been difficult due to the cost of

mailing outside the organisation, and due to the inability to guarantee currency of personal information held on Human Resource records. I also feel that response rates would have been negatively affected as receipt of the survey in the workplace encouraged the group synergy discussed previously. The immediacy of returning the completed survey via internal mail also aided the response rate.

Data Analysis Methods

The purpose of data analysis is to impose order on a large body of information so that some general conclusions can be reached and communicated in a report (Polit and Hungler, 1997). Because my research is qualitative and therefore inductive I must be prepared to redirect my research as new insights emerge from the analysis. Field notes and logs, diary entries, demographic data and emerging themes from the open-ended questions in the questionnaire were indexed and categorised. As conceptually meaningful themes developed within the categories of the data they were validated through the use of a framework of questions to direct the focus group discussions. These discussions were transcribed in order to review and use quotes and behaviours to illustrate the world view of the participants.

According to Sandelowski (2000) qualitative content analysis is a dynamic form of analysis of verbal and visual data that is oriented towards summarizing the informational content of that data. There is no mandate to represent the data in any other terms but their own, organized in a way that best contains the data collected and that will be most relevant to the audience

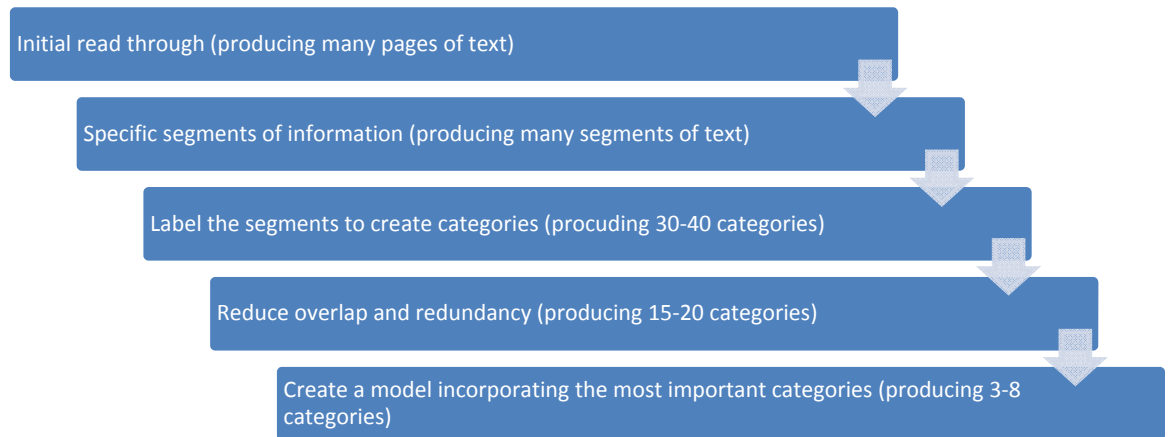
for whom it is written. In this case there will be two separate audiences. Firstly the participants themselves will require feedback on their narratives in language that is meaningful to them. Secondly, the DHB will require a high-level report containing robust data with realistic achievable recommendations. Both representations will be available to the audience who may choose the option that is most meaningful to them.

Gray (2004) explains that data analysis involves the process of breaking data down into smaller units to reveal their characteristic elements and structure. This goes beyond description; it is necessary to interpret, understand and explain. Data can be broken down into their constituent parts and connections made between these concepts providing the basis for new descriptions.

Gray (2004) also discusses three classes of analysis. Firstly the common classes, those categories in everyday thinking i.e. demographics. Secondly, special classes: labels groups or communities use to distinguish things (for instance acronyms or specialist professional terms). Thirdly, theoretical classes: classes that arise in the process of analysing the data providing the key linkages to the patterns. In my research the first level of analysis was the demographic information gained from the questionnaires: age, length of service and area of practice. The second level was analysis of the language used to describe how the nurses feel about work and key phrases about how their employment conditions can be improved i.e. “staff to patient ratios”, “Professional Development Recognition Programme”, and “ shift patterns”.

The third level involved finding themes and phenomena that linked how the nurses feel now to how they want to work in the future.

Thomas (2003) adapts Creswell's (2002) coding process as described below:



In the first instance my data was collected by the note taker documenting key points and statements. In order to check that the note taker was hearing the same meanings as me, I also made notes. I was pleased to find that both sets of notes had identified the same key points and phrases, reassuring me that although I chose not to transcribe the entire discussions I was not missing any key data. I cut up the many key points and phrases and sorted them into high-level sub-categories.

In writing up the research findings, the top level or most important categories can be used as the main headings with specific categories as sub headings (Thomas, 2003). I began to analyse the data by grouping the statements into multiple high-level themes. However, I came to realise that these themes were operational and too broad; I was merely grouping opinions rather than

interpreting the meanings as they relate to the research question. Regrouping and searching for more strategic meanings reduced the categories from thirteen to two. Following guidance from my supervisor it became clear that I had over-simplified the thematic analysis and missed a further three significant categories. I found that I had become so immersed in the data that I had lost sight of the question. By reminding myself of the question I revisited the data and found five themes that link the data with the question. Firstly the nurse participants are struggling to cope with the changing work environment; and secondly they articulate a feeling of hopelessness. The third theme describes the onerous professional life demands that are “the final straw” for many, and in the fourth theme the participants appeal that “I could stay if...” suggesting that life as an older nurse is hard but there are things the organisation could do to make it easier. Finally the participants maintain a passion for nursing despite the overwhelming negative and frustrating aspects of their work life.

Summary

My decisions regarding the epistemology, theoretical perspective, methodology and method utilised in this research were influenced in the first instance by a personal preference for qualitative description. I wanted to understand what it feels like to be an older nurse. The constructionist epistemology describes the theory of knowledge as being created by the subject’s interactions with the world, the understanding being constructed through language. I used the language and interactions of the participants to construct the knowledge.

As an insider researcher with potential power imbalance, I had to attempt not to allow bias and preconceptions to influence the data whilst acknowledging that as an older nurse and a manager I inherently carry these preconceptions. I had to try to replace my view from above with a view from below.

Maintaining the core ethical principles of informed consent, do no harm, anonymity and confidentiality, and avoid deceit ensured that the participants felt safe to take part, and that my experiences and knowledge did not prejudice the data. Utilising the interpretive perspective I therefore suspended my insider position during the focus group discussions by using a passive non-committal stance, not questioning or challenging any ideas. During the data analysis phase I utilised the inductive perspective, acknowledging my own experience and knowledge and using it to critique and explain the themes.

The following chapter discusses the data collected during the first phase of the research process. Questionnaire findings create a background of quantitative demographic data and a high-level qualitative description of how the participants feel at work and what they think the organisation can do to keep them at the patient bedside until they retire.

Chapter 4: Questionnaire Results

Introduction

This chapter describes the findings of the questionnaire, which was the first part of the research project. It paints a picture of the participants and the world in which they live and work. Use of demographic data demonstrates the participant characteristics, while the use of adjectives demonstrates a positive or negative attitude to how work makes them feel. Vitality is briefly explored from the perspective of “how much energy do you have?”, as well as positive and negative factors influencing work. Finally, a free text section asks what the organisation can do to enable the participants to stay at the patient bedside until they retire, setting the scene for the content of the second phase of the research project.

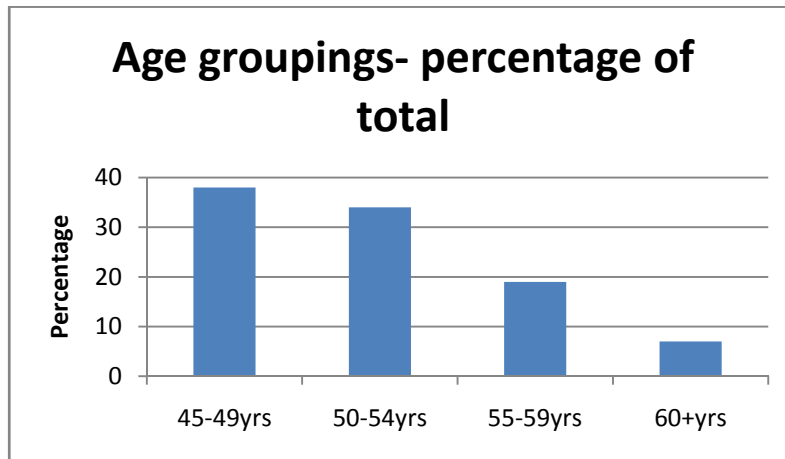
Participant selection and response rate

Surveys were sent to 180 nurses aged 45 years and over working at the patient bedside in the acute inpatient setting (Appendix 1). Completed surveys were received from 68 nurses, a response rate of 37.7%.

Age of participants

The results of the questionnaire (Figure 1) demonstrate that 38% respondents were aged 45-49 years, 34% aged 50-54, 19% aged 55-59, and 7% aged over 60 years. This is proportionately similar to the age split for the total nurse population in the same age groups across the organisation.

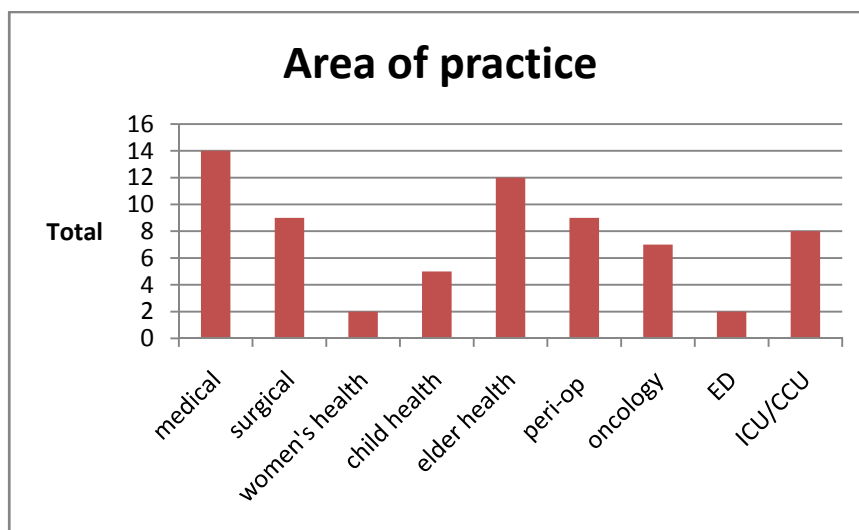
Figure 1: Distribution of sample by age of respondents



Area of practice

As can be seen from the graph below (Figure 2), the majority of respondents work in medical and elder health settings. This is representative of the distribution of older nurses in the organisation.

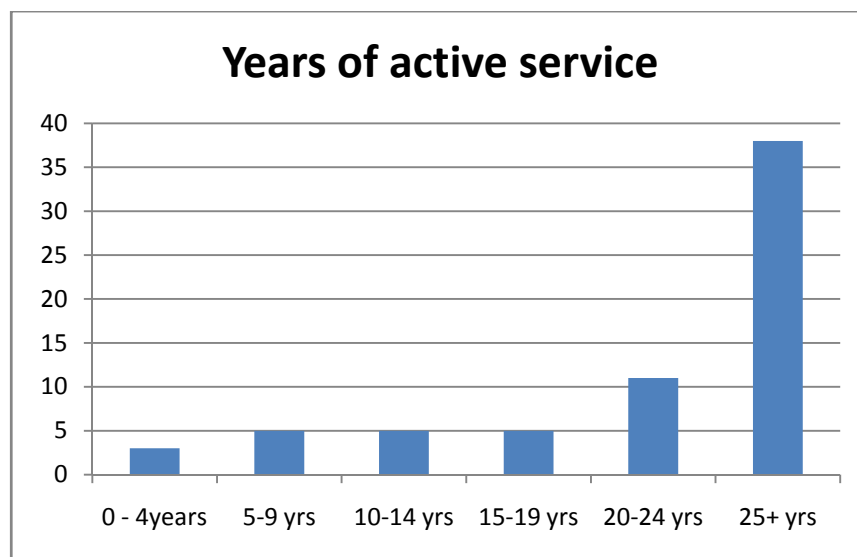
Figure 2: Distribution of sample by area of practice



Years of active service

According to the respondents, 58% have been practicing nursing for more than 25 years, while only 7% have been practicing for less than 4 years (Figure 3). In essence, this meant that my research data came from the perspective of the older, experienced nurse as opposed to the older novice nurse.

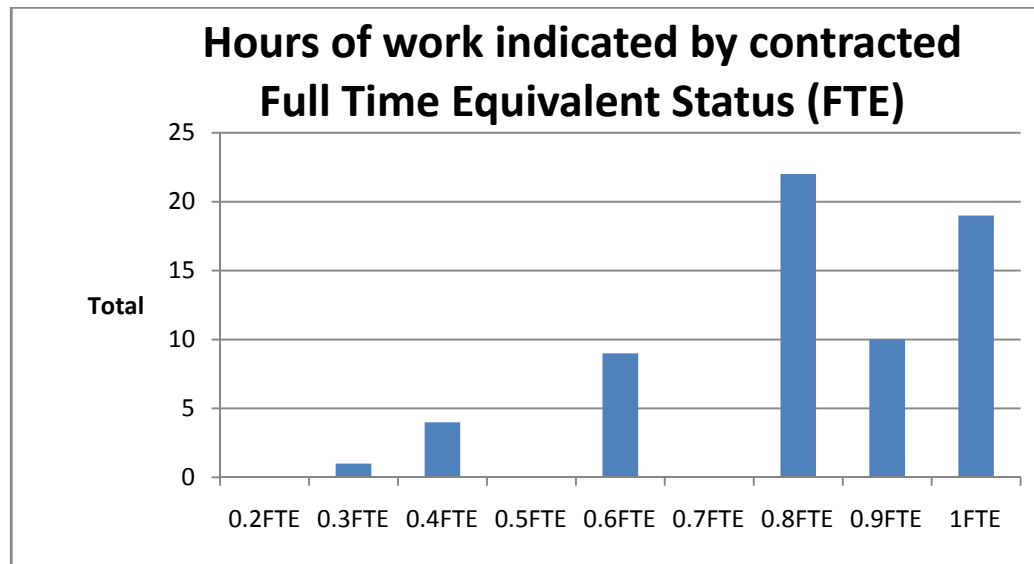
Figure 3: Range of years of active service reported



Contracted hours of work (FTE)

As can be seen in Figure 4, only 29% of respondents are contracted to work 40 hours per week (1.0 Full Time Equivalent). This result supports international literature claiming that older nurses are reducing their hours of work to cope with the physical pressure of nursing (Hasselhorn et al., 2005; Thrall, 2005). However, the pressure to work more than the contracted hours is high and it can be hypothesised that nurses chose to reduce their contracted hours in response to the demand to increase actual hours worked.

Figure 4: Distribution of hours of work (contracted full time equivalent (FTE) status)



Retirement plans

More than a third of nurses surveyed plan to continue working indefinitely, while a further 19% who have no plans to retire or have not thought about it yet. In comparison, only 24% plan to retire before they reach 65 years of age. It is reassuring to realise that over half of nurses currently practicing intend to continue to be active members of the workforce, despite international data suggesting that nurses intend to leave the workforce imminently (Aitken et al., 2001).

How does work make you feel?

The participants were given a list of 22 adjectives selected from relevant nursing literature, half with positive associations (Figure 5) and half with negative associations (Figure 6), and asked to choose as many words as they wished that identified how work made them feel. The results demonstrated a ratio of 3:2 in favour of positive feelings. Although the choice of words used in this section was entirely random, the outcome provided key words for the development of themes to explore in more depth at a later stage in the research process.

Figure 5: Number of nurses selecting positive adjectives

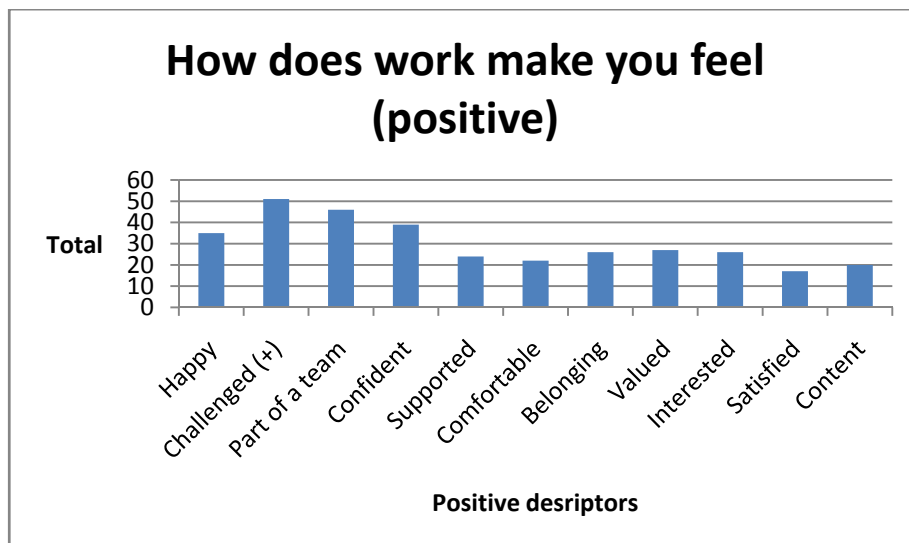
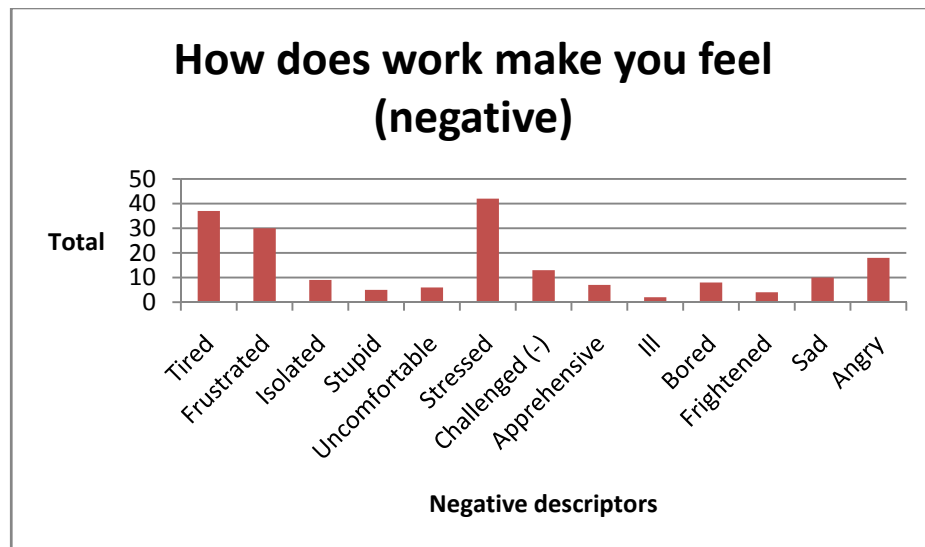


Figure 6: Number of nurses selecting negative adjectives



The use of the word “stressed” was questioned by the Human Resources Manager of the organisation, as a term over-used in the literature and with possibly litigious overtones. The notion of stress or anxiety was analysed by Evans, Pereira and Parker (2008); they found that work based stress suggests the presence of “stressors”, while the presence of anxiety is suggestive of occupational distress. Although the terms “stress” and “anxiety” are often used interchangeably in nursing literature, the concept of “stress” dominates. Evans et al. found in a literature search of 420 papers that 92% used the term stress in the title. Nurse authors in relation to patients or carers used the term “anxiety” more often, but “stress” remained the dominant theme.

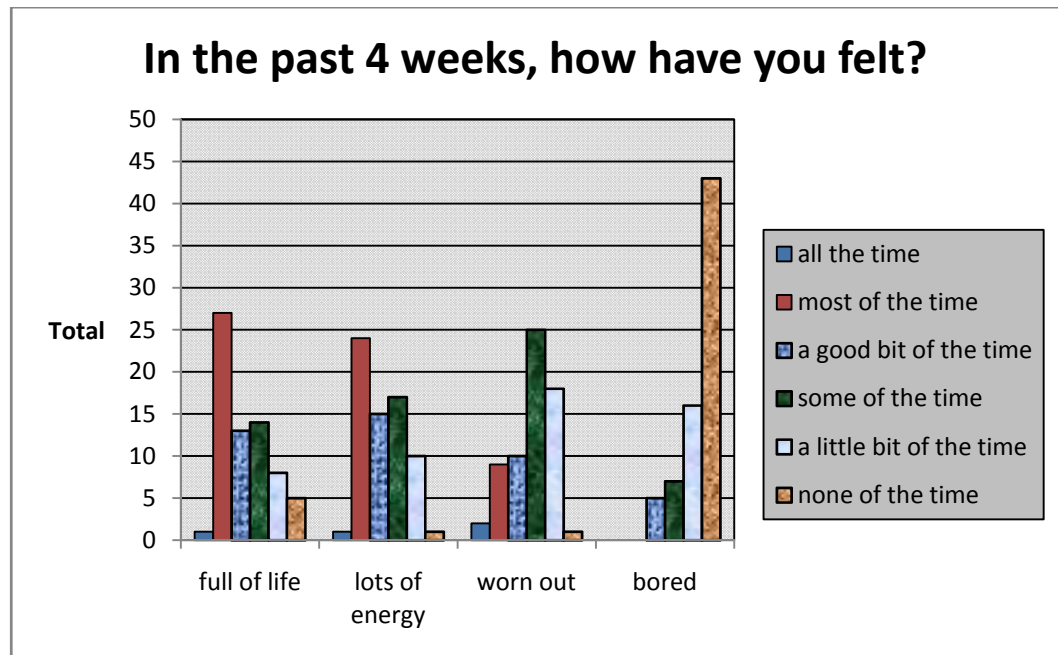
For two reasons I chose to use the term “stressed”; firstly because it is a dominant term in nursing literature with which my research participants are familiar. The second reason was because if the nurses identified with “stressed” this would give me the opportunity to explore the causative “stressors”, and to seek opportunities to reduce these stressors.

Vitality

The questions in this section are based on the vitality component of the Medical Outcome Short Form (SF 36) Health Survey (Ware, 1993) measuring energy levels. Options range from feeling tired and worn out all of the time, through to feeling full of energy all of the time. Respondents were asked to rate how they felt in four areas on a Likert scale of frequency. The results (Figure 7) were weighted towards positive vitality most often and negative vitality least often. The majority of respondents felt full of life and had lots of energy most of the time, worn out some of the time, and bored none of the time.

This differs from the research carried out by Budge, Carryer and Wood (2003) who found that their nurse participant’s vitality was low. Budge et al. did not control for age; further study is required to discover if the high vitality of this group of nurses is attributable to age or if the vitality of the whole nurse population has improved.

Figure 7: Distribution of range of response to vitality component of SF36



Positive and negative impact

Respondents were invited to self-select three things that had a positive impact, and three things that had a negative impact on their work. This required a free text response with no leading prompts.

Positive impact:

- Relationships with colleagues
- Support from management
- Opportunity for continuing professional development
- Part of a team
- Good outcomes for patients

Negative impact:

- Shift work (particularly nights)
- Staff: patient ratio
- The Professional Development Recognition Programme (PDRP)
- Excessive paperwork

All of these themes were visited in more detail during the focus group discussions in the second part of this project

What can the organisation do?

The final part of the questionnaire asked respondents to self-select what they thought the organisation could do to enable older nurses to remain at the bedside until they retire.

The initial responses included

- Access to a gym
- No more night shifts
- Shorter shifts
- Reduced staff: patient ratios
- Recognition of the experience and knowledge of older nurses
- Improved access to annual leave
- Dislike of the PDRP

These themes reflect the positive and negative categories of the previous question and were explored in more depth during the focus group discussions.

The results are described in the next chapter.

Conclusion

The results of my questionnaire described a workforce of older nurses who are tired and stressed, but happy, confident, challenged in a good way, and energised. They enjoy being part of a team, they want to be appreciated by supportive management, and they want more flexible rosters. They want the organisation to recognise their experience but they do not like the PDRP. The majority have part time employment contracts but frequently work extra shifts, and they have no intention of retiring in the near future.

These nurses do not fit the description of the nursing workforce in crisis depicted in international literature. They may be in crisis numerically; however although they are tired they are satisfied with their jobs and have no intent to leave. In order to explore this phenomenon in more depth, focussed discussion groups were required. The results of the focus group discussions are explored in the following chapter.

Chapter 5: Focus Group Findings

Introduction

Phase two of my research involved semi-structured focus group discussions with 18 participants who had volunteered during the initial questionnaire phase. The purpose of the discussions was to explore and explain the questionnaire results and to give a more in-depth picture of the emerging themes. The results will present the facts in everyday language, providing a comprehensive summary of the voice of the participants (Sandelowski, 2000). The participants were not individually identified in excerpts of their conversation; rather I have used key quotes and phrases to illustrate the themes. Quotes and phrases are identified in italics, with a new line for each different participant's voice. Identification of response to each group has been omitted to maintain confidentiality, and also because all four groups produced very similar data.

Themes

Five themes emerged from the data analysis. The first theme is the “struggle to cope” with the work environment, and the second an overwhelming “feeling of hopelessness”. The third theme relates to a sense of onerous professional life demands or “the final straw”, and the fourth suggests that “I could stay if...”. The final theme is a “passion for nursing”. Each of these themes will be explored in more detail in this chapter.

It is interesting to note that the themes extracted from the questionnaire phase painted a picture of a satisfied and happy workforce, but the themes extracted from the focus groups suggest an unhappy, frustrated and disillusioned workforce. This confusion of conflicting data reflects the contradictory nature of current literature available on the subject of the ageing nursing workforce and current nursing shortages. It may be that only the disillusioned participants chose to take part in the focus groups, or it may be that the satisfaction expressed in the questionnaires is a veneer covering a more dissatisfied workforce. As discussed previously, this research does not set out to demonstrate generalisability therefore I will not attempt to suggest ways to validate the focus group data with the questionnaire data, nor to extrapolate the data out to a wider cohort of nurses.

Struggle to cope

The first theme describes the participants' perceived struggle to cope. The work environment has changed significantly since the participants entered the workforce. The frustrations of working in a multigenerational workforce cause anxiety and distress for older nurses. Social times such as patient handover have been lost, and they perceive that teamwork has broken down. Patient acuity and workload have increased, and patient expectations have also increased. Having too many patients to look after as well as the extra responsibility of supervising less experienced and less qualified nurses is compounded by the fact that the participants have no professional voice to raise their concerns.

The frustration created by working with a generation of nurses with different characteristics and work ethics became apparent when the participants discussed the attitudes of what they described as “younger nurses”.

“Generation Y generational attitudes are very frustrating. Nursing is a 24/7 service. New nurses need a realistic view of what nursing is in reality before they commit to the profession.”

“Sick leave- older nurses come to work sick, young nurses have no obligation to come to work.”

“Newer, younger nurses don’t seem to appreciate (or cope with, or accept) shifts and holidays. Get over it- this is nursing!”

The subject of management of generational differences in all areas of employment is very well researched and documented internationally (Arsenault, 2004; Christmas, 2008; Hu, Herrick & Hodgins, 2004). According to Melik (2007) the “veteran” or “mature” (those born before 1946) generation characteristics developed from experiences in the Great Depression; responsibility and quality are key expectations, as well as structure and respect. Organisational loyalty is important, they are respectful of authority, supportive of hierarchy and disciplined in their work habits. The “baby boomer” generation (born between 1946 and 1964) experienced an era of growth and prosperity; they require praise and recognition, putting company needs before personal needs while juggling multiple responsibilities with competence. They have a strong work ethic, and work has been a defining part of their self worth and their evaluation of others. “Boomers” are also known as the “sandwich generation”, caring for older adults and younger children while

holding down a job as well (Kovner, Brewer, Cheng & Djukic, 2007).

Sherman (2006) indicates that the “veteran” and “boomer” generations have worked comfortably together with only minor communication issues. The research participants fall into both the “veteran” and “boomer” groups and clearly demonstrate these characteristics through their language and stories.

However, “generation X” (those born from 1965 to 1978) was the first generation with more expectations for themselves, valuing self-reliance and work life balance, less loyal to the corporate culture. “Generation Xers” initially turned away from nursing as a career, preferring the opportunities offered in other jobs; however many have since entered nursing as a second career choice. “Generation Y”, “millenials” or “nexters”, (born between 1979 and 2002) possess traits such as lack of trust in corporations, a focus on personal success, and short-term career perspectives. They are often compared to the “veterans” in their values and a higher interest in nursing in this generation has been noted; applications to nursing programmes increased significantly when this cohort entered tertiary education age (Melik, 2007; Sherman, 2006).

“Veterans” and the “boomers” have struggled to come to terms with the different work philosophies, seemingly unable to deal with the team dynamics created by generational differences. In order to work together as a multigenerational workforce nurses need to reframe perceptions about generational differences and to view these differences in attitudes and behaviours as potential strengths (Sherman, 2006).

“We should work as a team but younger nurses don’t seem to be able to do that. Their time management is bad; they can’t anticipate patient needs or manage patient flow.”

“Young nurses are quick but not better. They don’t look at patients; they look at machines, they are taught to “measure”. Older nurses are more intuitive, holistic, have better assessment skills”.

Although the participants associate these dilemmas with generational differences, Orsolini-Haine and Malone (2007) suggest the differences described by the participants are in fact a gap in clinical nursing expertise; they are the difference between the novice and the expert nurse. Novice nurses rely on technology, engage in concrete thinking, and have difficulty setting priorities when confronted with multiple demands. Expert nurses grasp “the big picture”; demonstrating clinical forethought or intuition leading to early interventions in patient care (Benner, Hooper-Kyriakidis & Stannard, 1999; Benner, 2001).

Christmas (2008) explains how the attributes of the “millennial” generation make them ideal candidates for nursing careers. Optimism, the quest for fulfilling work, collaboration and respect for authority are positive attributes, but their affinity for technology in a profession that remains relatively untechnical, the need for structure in a chaotic environment, and the need for positive feedback in a workforce of disapproving older nurses may be detrimental to their success in their chosen career.

The older nursing workforce appears to be struggling with the concept of differences, whether the differences are related to generational attributes or clinical expertise. This contradiction does not enable them to see the importance of their role in supporting novice nurses. It appears to embed the passive-aggressive nature of the participants' tendency to blame someone else for their situation. *"It's not our fault they [younger nurses] don't hit the floor running, it's the way they're trained or something. They need our help but we haven't got time"*. The research participants feel that the differences are generational, but they do not demonstrate any desire to break down the generational barriers. There is an expectation that the "younger" nurses should change their behaviour to meet the needs of the "older" nurses. And yet in almost direct contradiction, supporting each other was discussed by all focus groups participants, all mourning the loss of the "social" aspect of work. *"We've lost the old social hand over time because of the rush- the time when you debriefed, socialised, bonded and problem solved"*. *"Nobody wants to listen"*. Older nurses remember a time when the pressure of work was less intense and the shift changeover, or patient "hand-over" time, was a social occasion as well as an important communication forum. In the current work structure nurses have 30 minutes to discuss the clinical plan of care for up to 32 patients and this leaves no time for socialising or debriefing. The stress or distress experienced by nurses working in the acute setting can be detrimental to their emotional and physical health if they are not given the opportunity to debrief, reducing their ability to cope with the pressure of work.

According to Hanna and Romana (2007) moral distress surfaces in high-stakes, high-stress healthcare settings. Nurses who experience moral distress in their work setting without receiving situational support are unable to easily process the experience; those who eventually resolve their moral distress alone may take longer than a year to do so. Whereas dramatic, “newsworthy” events trigger an outpouring of support for workgroups, the daily, less dramatic but morally draining events that nurses face often remain unacknowledged. Employees may benefit from brief interventions, called debriefing or critical incident stress debriefing, when exposed to a traumatic event. Leadership initiative is needed to bring together staff members to acknowledge shared distress, to accept responses to that distress, to affirm the group's human suffering, and to help the group cope (Hanna & Romana). Patient handover time is recognised by the participants in this research as the ideal opportunity to provide this debriefing but they appear unable to “make” the time, or to utilise the available time effectively.

The participants also articulated a perceived inability to provide collegial support to each other. When they talked about nurses working together, or nursing and medical staff having a collegial relationship, the participants believe times have changed. They remember working together as a team, but feel this no longer happens. They did not articulate any reason for this breakdown in teamwork, but mourn the loss of it.

“Working together doesn't seem to happen any more”

“Team work- bring it back! Buddy nursing, 2 nurses :11 patients. It works in other DHBs, it's a breeze. Nurses have to get back to supporting each other

and working together; they shouldn't be sitting on the computer playing cards instead of offering help to their colleagues."

"No one works as a team anymore; working together is not part of the culture. In 10 years time those of us who role model team work won't be here anymore and "they" [the next generation] will become completely fragmented".

This feeling is inconsistent with the generational attributes of the "millennial" cohort of nursers. They have been guided into working in teams all of their lives, they want to collaborate not compete. Although their idea of how a team works may be different from that of their older colleagues, they function well as part of a team (Christmas, 2008). It is the strong and independent "generation X" cohort who need to learn to participate in a team culture, working together to optimize patient care.

Working with groups of patients in four or five bedded rooms, the nurses in this study predominantly practice in a hybrid of primary and team nursing, described by Makinen, Kivimaki, Elovainio and Virtanen (2003) as modular nursing. Makinen et al. describe modular nursing as a patient-focussed nursing care mode. They found that patient-focussed care models seemed to reduce the likelihood of interpersonal problems among staff. This did not appear to be the case for the participants in this study. Further research on the reasons for this disparity is required before any explanation can be put forward.

Nurses accept that their workload is increasing as patients become more acutely sick, more chronically sick and more obese, and as the length of stay

decreases and patient turnover increases. *“Acuity and technology has increased so much, but it’s harder at the bedside when your body is older”*
“I don’t think general wear and tear is recognised. Because of age, when you hurt yourself it will hurt more”.

“It seems like nurses are getting older and patients are getting more obese and demented with more co-morbidities. It seems like older nurses are given heavier patients (both in acuity and weight); not because of acknowledging experience but because no one wants to look after them”

“I’m not tired- I’m stuffed!”

What the participants appear to be saying is that the changes in working patterns are especially hard on them as older nurses. The constant pressure to maintain patient flow and meet workload demands creates unrealistic expectations of each other.

“There’s no one to pick up the slack”

“Picking up work from the previous shift before starting your own shift.

Backlog of work- always starting on the back foot”

“Other staff make stress in your life i.e. patient transfers at handover time, no one wants to do it. Puts you on a guilt trip. Nurses do it to each other, they don’t support each other, they’re worn out.”

The frustration caused by the untenable workload and the participant’s ability to do the job well was evident. *“I’m stressed by unrealistic expectations of my own ability to do a good job”.* *“Not being able to complete anything- being*

interrupted constantly. Not able to get notes read, verbal handover is brief.

You're reading notes hours into the shift, looking after ill patients and unable to read the notes because the previous shift is still writing in them"

"Making sure that the millions of short cuts I take aren't affecting the safety of patients, myself or the organisation".

The participants felt powerless to meet patient satisfaction. There is an apparent divide between the care the patient and relatives expect to receive and the care that nurses are able to provide.

"Verbally aggressive patients are difficult to accept.....people have high expectations"

"Relatives can cause a lot of stress- pressure from family when the nurse is unable to move the patient up the bed by herself- the nurse might be pregnant or colleagues away at tea break"

"Patients waiting for attention- you're tied up in a side room and the four-bedder patients don't see you; they can ring the bell for 20 minutes sometimes"

"I look forward to going to work, enjoy patient contact, some are rude and demanding, some have needs that can't be met by the public system despite being informed, other people are very grateful."

Public expectations have changed during the span of older nurse's careers, from grateful passivity to consumerism; this can manifest itself as questioning, challenging and demanding behaviour. According to Baggot (1998) the consequence of the expectation that consumers voice their concerns about

health services and articulate their demands or complaints is that nurses struggle to manage verbally aggressive patients in a busy and frenetic ward environment.

Consumerism in health care, or the concept of patient satisfaction, has its roots in the consumer movement of the 1960s (Williams, 1994). Klein (1995) describes it as a redistribution of power from professionals to the consumers, while Neave (1994) suggests that the aims of consumerism are to create a better balance of power between consumers and providers, indicating a move towards less paternalism and more democratic relationships between consumers and professionals.

Almond (2001) defines consumerism as

“...a belief and attitude, which regards patients as powerful, active and sentient participants in structuring and developing health services. Their opinions and involvement to assess the quality and provision of services are sought and valued, and form a pivotal role in providing optimum levels of care for all. Consequently health services meet the needs of the consumer and not those of the professionals” (Almond, 2001, p. 896).

In the quest for a compromise between what the patient wants versus what the patient needs, and what the patient thinks they want versus what the health professional thinks they need (Appleton & Cowley, 2000) nurses strive to

provide optimum care, to be the patient advocate, and to meet the needs of an ever more demanding public.

However, patient satisfaction is a concept driven by consumer demands and based on the assumption that if the patient is satisfied then they have received good care. Turriss (2005) argues that in the case of quality of nurse-patient relationships that are thought to be a reliable predictor of patient satisfaction, nurses may be told that these need improvement. This feedback focuses on individual behaviour and may ignore systemic constraints on nursing practice such as workloads that do not allow sufficient time to develop relationships. Energy is then put into fixing the symptom rather than the source of the problem (Turriss).

The participants in this research were very aware of the effect that managing a heavy workload has on their ability to provide quality patient care. Having to manage their own workload as well as that of the junior staff they are supervising also adds to their burden. In response to this shift in workload, the participants seek what they see as reasonable staff to patient ratios. Nurses referred often to the “1 in 4” ratio, seeing it as a panacea for their excessive workload. However, they were also realistic that a reduced nurse to patient ratio is difficult in the current environment of nursing shortages. *“Even if we were funded for a 1:4 ratio we would never have it because there aren’t enough nurses”*.

“Everyone would be happy with 1:4 or even 1:5, but when you have that they take the nurse away. There is no allowance for down time. We need more bureau staff”.

“It isn’t our problem there are no nurses coming through”

Too many patients and not enough nurses made the participants feel unsafe.

“There’s lots of talk about safe staffing and improved staff: patient ratios but nothing happens”.

“We are short staffed, the bureau can’t help. What is the point of safe staffing – is it about the actual number of staff or the skill mix? It’s protection for yourself in case things go wrong”.

“Not enough staff feels unsafe”.

The extra workload created by supervising less experienced and unqualified staff was discussed widely by the participants.

“New Grads need more clinical experience before they qualify- they are “paper nurses” [registered nurses but unable to practice independently].

Christmas (2008) suggests that this problem is attributable to the way we currently provide nursing education. Students do not receive robust clinical experiences that are similar to the working conditions they will encounter; this means that they will need more assistance and mentoring to acclimatise to their new role.

Experienced RNs are looking after new RNs as well as the patients”.

“Supervision of students- there’s no incentive- why are we doing it? Having a student is harder, everything takes twice as long.”

“Older nurses are often carrying huge responsibilities working with inexperienced nursing or medical staff whose practice is often compromising the well being of patients and/or families.”

Millennial RNs have demonstrated that they are able to successfully complete assigned tasks but they do not naturally develop critical thinking skills. They are compliant rule followers, but are used to having a choice (a “drop-down box”) to help make their decisions. In a chaotic health care environment that requires nurses to think on their feet and make critical decisions on the run, experienced nurses are vital to mentoring and teaching new nurses how to develop these critical thinking skills (Christmas, 2008)

I find it concerning to hear that experienced nurses no longer consider mentoring and education of less experienced staff to be a core responsibility of their role. Gabrielle and Jackson (2007) reported the same comments from their research of Australian older nurses, suggesting that the pressure of overseeing junior staff contributed to stress and burnout in a busy environment. It appears that the perpetual cycle of a constantly heavy workload, inadequate staffing and skill mix, supervision responsibilities, and the physical strain on an ageing body has caused the loss of the desire to nurture our young.

From a management perspective, recruiting and retaining sufficient numbers of skilled nurses depends on having an adequate core of experienced nurses to provide supervision and education to the less experienced and less qualified

nurses. As the number of older experienced nurses reduces, the pressure on the remaining group increases. This is further exacerbated by the fact that alternative career options for enrolled nurses are limited (Iley, 2004) and they tend to stay in the workforce longer than registered nurses who have more options. Reinstatement of the second level nurse training may be seen to be a short term fix to the nursing shortage, but in the long term it will create a much worse situation of burn-out and dissatisfaction for the first level nurses who are required to supervise them (College of Nursing Aotearoa NZ, 2000).

Enrolled nurses in the inpatient setting provoked mixed feelings for the participants. Within the focus groups both registered and enrolled nurses spoke together without animosity about the problems associated with limited scopes of practice in an increasingly acute inpatient setting.

“ENs are very experienced but they are treated like New Grads”.

“ENs are glorified care assistants – their scope of practice is too narrow”.

“ENs feel they are putting too much pressure on RNs”.

According to Dearnley (2005) enrolled nurses have a clearly defined role to assist registered nurses. However while ENs retain a lower status in the nursing profession they are often delegated duties and responsibilities similar to those of RNs. While the role of EN has been eroded by discontinuation of the two year training programme, and by more highly qualified registered nurses above them and less qualified health care assistants below them, they remain a significant presence in the cohort of older nurses. These ENs have had the opportunity to convert to first level registration but have chosen to

retain their second level registration. Dearnley refers to these nurses as hesitant or silent practitioners, characterised by passivity and dependency.

Dearnley (2005) suggests that hesitant practitioners consider themselves to be good nurses because they are assessing their practice against the criteria by which they were trained. They are consumed with the survival of their professional status within a changing professional climate, and therefore have no professional voice. By relying on the opinions of others, hesitant practitioners run no risks of making wrong decisions of their own. Re-instatement of the second level nurse training programme (College of Nursing Aotearoa NZ, 2000) in response to the nursing workforce crisis could also amplify the problem of the silent practitioner.

As hesitant or silent practitioners, enrolled nurses may be less likely to take active part in finding a voice for nursing, or to participate in any process designed to improve nurse satisfaction and intent to stay. As a significant proportion of the ageing nursing workforce (23%) in this organisation, ENs should not be a forgotten group, but should be empowered to have a professional voice in the same way as their registered nurse colleagues.

In order to find a professional voice (Dearnley, 2005) it is important for these nurses to move from being hesitant and silent practitioners to being liberated and dynamic practitioners, to become visible in their ward or department. This can be achieved through postgraduate education during which the nurse progresses from “knowing nursing in a silence characterised by fear and

apathy, to knowing nursing from a variety of dimensions which increased their professional confidence, autonomy and motivation for professional practice” (Dearnley, 2005, p. 219). Creating an innovative education process that supports Enrolled Nurses to consider converting to first level registration may facilitate this process.

A feeling of hopelessness

Although the research participants were all experienced autonomous professionals, they appeared to be stuck in a vicious cycle of disillusionment, unable to have a say in their work life, or to influence change. In the participant’s stories, there is an overwhelming sense of being “done to”. In their world view PDRP, No Lift, rosters, workload and management decisions are all “done to” them with no apparent collaboration or recognition of a job well done. Is this because top-down consultation has not worked, or because bottom-up participation does not happen? Is this behaviour entrenched, or can moving from silent practitioner to participative practitioner change the “done to” by management to “done with” management, or even “done for” themselves?

Nurses are aware of their responsibility to “speak out”, to have a voice. *“Advanced nurses are relied upon to voice concerns; junior nurses are too scared to do it. Some people aren’t willing to stick their chin out- they might get burned.”*

“Everybody is frightened to say anything, scared of offending someone or putting their jobs on the line. Positive (constructive) criticism is not good anymore.”

“We need to take the power back- to be in control. This is nursing governance but why can’t we make it work?”

“It’s our responsibility to let management know when the tank is low.”

The persistent myth that came through the research findings is the fear that the participants will lose their job if they speak out. This is incongruent with an environment of nursing shortages; having and voicing an opinion is not a reason to sack an employee. It is also indicative of a culture of “victim” mentality (Kitson, 2004; Neubauer, 2008).

According to Hess (2004), in nursing the primary resources for practice are the providers themselves. Thus to control practice, nurses must have influence over themselves as a professional group. By giving clinical nurses equal footing with nurse managers to allow them to participate in the decision making processes that affect their practice, nursing leadership can more easily affect change in practice. This can only occur when nurses report directly to nurses.

The participants obviously do not consider that they have equal footing with their managers. Through their conversations, they disclose frustration and disillusionment with nursing leadership. I personally struggled with this area of conversation, worried that the participants may confuse my “outsider” role as researcher with my “insider” role as manager. My fears were unfounded

and the participants happily discussed their opinions and feelings about “management”. This was not through naivety of my position; rather the nurses appeared to classify me in a different category, comfortable with the knowledge that I was both an insider and an outsider.

The nurse participants see the Charge Nurse as visible and in touch with their own world. *“Charge Nurses are management but they understand the pressures”*. However, above Charge Nurse level the situation becomes one of “us (nurses) versus them (management)”. Management was described by the participants as *“the ones who impact on your day- nurse manager, DON (Director of Nursing), duty managers”*. The nurses were unable to articulate who “management” is. *“Don’t know who the DON or Group Manager is”*. However, they have firm ideas on what management should do. *“Management should meet regularly with staff, be more visible and accessible for ward meetings. Then more information sharing would take place”*

It is interesting to note that nurses focus their concern about “management” on one position- that of the Director of Nursing (DON). Their worldview extends to the limit of the most senior nursing position; other management positions do not exist for them. In one respect, it is good that nurses see the strong link with nursing management in their world, even if they feel that nursing leaders have lost touch with clinical reality. However, the naivety created by the silo effect of the nursing profession working in isolation may prevent nurses at ward level from developing a “helicopter view” of how the organisation works.

“We never see management. No one knows who they are. Nurses live in a silo with no concept of what happens outside their own area. It’s easy to blame them (management) but we don’t know what they do”.

The nurse participants consistently demonstrate no insight into their own passivity. Their language is that of being “done to” by “management” and they make no effort to challenge the “us versus them” culture. Being able to see beyond the four walls of their own ward or unit, and understanding how political decisions are translated into clinical decisions is the measure of a dynamic practitioner (Dearnley, 2005). Clinical nurses having equal footing with managers (Hess, 2004) is the ideal step to achieving this improved understanding. This group of participants appear to perpetuate the “them and us” anti-management culture; their language demonstrates no desire to understand or collaborate with management, but they want management to understand them.

“You never see the DON unless there’s a complaint”.

“The DON is not visible- she talks down to us”.

“How quickly people like the DON forget what it’s like on the shop floor”.

“The DON is “way up there”, not accessible, we get dictated to by her”.

“If you had a room full of New Grads and experienced nurses, very few would be able to pick out the DON”

The powerful myths and assumptions about the role of the Director of Nursing continue to demonstrate the victim “them and us” culture; the participants presume that the DON has no insight into the day-to-day work of the wards

even though she is a registered nurse with many years of clinical experience. It is difficult to understand why such mature experienced women have such a naive view of the role of management.

According to Laschinger and Havens (1996), visibility of nurse managers at all levels of the clinical setting is an important indicator of support and gives clinical nurses the opportunity to demonstrate their clinical expertise and be recognised for their skills. By talking to nurses, asking questions, and listening to staff nurses' perspectives of the work setting, nurse executives can gain valuable insight into the current reality of nursing practice environments. This assumes that the nurse executive (or DON in this instance) does not already have current insight, and also assumes that the clinical nurses are not too busy (or too disinterested) to share their experiences with nurse executives.

In order to address this split between nursing and management, one of the participants suggested that there should be "*better communication and visibility above Charge Nurses (i.e. DON, CEO). Nurses don't know how they fit into the organisation.*"

The participants wanted management to understand when they feel unsafe; to recognize their ability to assess an unsafe situation, to listen and respect their ability to put their hand up and ask for help. "*Instead they just ignore your assessment and still admit patients*".

"Coordinators often don't even come to the ward to see how you are coping. They don't value your ability to assess the situation, particularly after hours

and weekends. They manipulate Trendcare (patient acuity measurement system) to make it look better.”

Unfortunately, this sentiment is often true. Despite ongoing education and coaching, the Duty Nurse Managers (DNMs) often manipulate the nurses’ clinical assessment of patient acuity in order to address staffing shortfalls and justify internal movement of nurses. While the DNMs are frequently put in untenable situations with no staffing resources to make up the deficit, it is unjustifiable to challenge the clinical judgement of experienced nurses in order to validate their decision. The DNMs argue that they discuss their decisions with the nurses before they make the changes; however this exploits the power relationship they hold over the nurses and further exacerbates the “them and us” situation.

Just one nurse advocated for management: *“Management know exactly what’s going on but their hands are tied”*. This particular nurse comes from a background of working in a different organisation and country, and therefore may have been exposed to a more horizontal nursing management structure where managers are more visible and their management style more inclusive. She demonstrates a different level of insight into the role of management and does not display the same victim mentality.

It is difficult for ward based nurses to have any appreciation of the workload of their managers; however it is clearly important to them that their managers understand the pressure of the workload on the “shop floor”.

“Nurses who become managers lose their understanding and empathy”.

“Lack of presence (visibility) of top management means they don’t care, not willing to understand the stress and workloads”.

“They [management] are full of ideas but bugger off, never put on a uniform and get in to help”.

The perception that nurse executives do not understand or care about the stress levels experienced by nurses on the clinical floor is an indication that the participants do not feel valued or supported to be able to continue working as they grow older. The participants referred to the core principles of Magnet status as a solution to improving this culture in the context of the organisation treating nurses with respect and nurses wanting to work in the organisation.

The participants felt that if the organisation achieves Magnet status then nurses would treat each other better, recruitment would improve and their workload would reduce, and therefore their satisfaction would increase.

“We can’t all be bitchy, we need to treat each individual differently. We should care for each other, emotionally and physically, and look after the ward environment. We can be Magnet ward and Magnet people”.

In the 1980s, because of the severe nursing shortage in the USA, the American Academy of Nursing commissioned a study to investigate and identify hospitals that were able to successfully attract and retain nursing staff (McClure, Poulin, Sovie & Wandelt, 1983). These hospitals were referred to as ‘magnet hospitals’. The commissioned study approached 165 hospitals that had the features that could have identified them as possible ‘magnet hospitals’. Of these hospitals, 155 voluntarily participated in the study. After the

examination of nursing structure and managerial leadership qualities, 41 hospitals were awarded 'magnet status'. Fourteen 'forces of magnetism' subsequently were identified as crucial foundations of 'magnet hospitals' (McClure et al.).

In 1994, the American Nurses Credentialing Centre developed the Magnet Recognition Program (MRP) to recognize health-care institutions where nurses report high job satisfaction and patients receive high-quality care. This programme, still current today, has voluntary participation open to all health-care facilities who wish to apply for recognition of their quality patient care and professional nursing services. Recognition as a 'magnet' provider is a rigorous, lengthy and costly process involving lodging of the application, submission of written documentation, evaluation and a site visit by appraisers, with all costs borne by the health-care facility. Magnet status recognition is valid for a period of four years (Middleton, Griffiths, Fernandez & Smith, 2008).

According to Ulrich, Buerhaus, Donelan, Norman and Dittus (2007) Magnet status is associated with many positive outcomes for nurses, patients, and organizations. They argue that both nurses and patients have better outcomes in Magnet-designated hospitals. For example, nurses working in Magnet hospitals report higher levels of job satisfaction, fewer needle stick injuries, less burnout, and more autonomy and control over practice. Being a patient in a Magnet hospital is associated with lower morbidity and mortality and higher overall patient satisfaction. Magnet-designated organizations have also

reported decreased nursing turnover, resulting in significant cost savings. In 2002, the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) recommended the adoption of characteristics of Magnet hospitals that "foster a workplace that empowers and is respectful of nurses".

Ulrich et al. (2007) suggest that support from front-line management was rated more strongly in both Magnet organizations and those in the process of achieving Magnet than in non-Magnet organizations. Front-line management recognizing the importance of nurses' personal and family life is seen as an important indicator of Magnet status. It is concerning that the participants in this study do not feel supported by management as this may impact on the ability of the organisation to achieve Magnet status.

Although this organisation does not yet have Magnet status, experienced nurses are familiar with the philosophies of the accreditation standards and can articulate the intent. However they have become disillusioned with the lack of progress towards accreditation, anticipating that their work life will improve as a result. The participants did not demonstrate any understanding of the reasons why Magnet status has not yet been achieved; they do not see it as their responsibility to actively seek out any accountability for accreditation, appearing content to wait for it to be delivered to them. Therefore while one of the answers to the research question may be that gaining Magnet status will support midlife nurses to deliver bedside care in the acute clinical setting until

they retire, I could argue that empowering nurses to actively participate in the accreditation process will give them a feeling of ownership of their professional life and motivate them to continue working in a more meaningful role.

The theme of disempowerment, of having no control over their work life, of avoiding responsibility, is also evident in the conversations regarding shifts and rostering. Providing a 24 hour per day, seven days per week service is part of their life, but it is becoming onerous for the participants.

Shifts and rostering have been an integral part of older nurses' lives for their entire career. While the participants have no illusions regarding the importance of covering the roster, they are beginning to feel the physical strain on their bodies. *"Night shifts are getting more difficult. You have to do your share, but it takes longer to recover. I feel impaired."*

They are also beginning to feel that the organisation relies too heavily on their good will and willingness to work extra shifts. *"I want to be able to work part time. It seems like the less hours you do the more you are asked to do extras."*

"I gave up working extra shifts because I am the most important person- I can't keep "plugging the holes."

"What would happen if you don't do extra? We do it out of a sense of loyalty to the patients and who I am as a nurse. I am supposed to be 0.3FTE but I

work full time- I don't feel valued by management, I feel like I have to work extra for the good of the unit."

Nurses who choose to work part time are finding the pressure to work extra shifts hard to cope with. There is no mandatory overtime in the New Zealand public health service, but nursing bank resources are limited and there is no access to private agency workforce in this area. The only option for managers to cover planned or unplanned shortages is to ask part-timers to work extra.

More creative and flexible shift scheduling is frequently cited in the literature as a means of retaining the older nurse (Andrews, 2005; Hatcher et al., 2006; Rosenfeld, 2007). It is also frequently cited as a means to encouraging non-practicing nurses to return to the workforce (Barriball et al., 2007; Burns & Smylie, 1993; Myers & Bushnell, 2007). However none of these authors offer any advice on how to cover a 24/7 roster if all the flexible shift needs are to be met.

The roster has to be covered and covered adequately, but equity causes concern and flexibility is seen to be important *"in order to recruit staff we need to be more flexible"*.

"Some nurses have set shifts or maybe seem to be given preferential treatment and this causes flack"

Rostering appears to be a deep-seated frustration for all nurses, causing anxiety and friction in all areas of practice providing 24 hour care.

“If rostering was open and “round the table” there would be less back stabbing and griping about other people’s rosters”

The participants appeared to have a number of ideas on how to improve rostering and therefore reduce this particular stressor in their life, but they appear to expect someone else to make the changes. They speak in a passive way as if the roster is “done” to them; they make no reference to self-rostering which would give them the opportunity to make improvements. If they can be empowered to take responsibility for rostering, taking into account the requirements of the Nurses and Midwives Collective Employment Agreement (2007) and those of the organisation, they may develop more understanding of the difficulties of providing safe 24/7 staff cover and they may come up with new, innovative and sustainable rostering practices.

While nurses accept that shift work is a part of their working life, balancing the responsibilities of work with the responsibilities of home is as hard, if not harder, as nurses become older. Many older nurses juggle work with significant responsibilities at home, described by Kovner, Brewer, Cheng and Djukic (2007) as a characteristic of the “baby boomer” generation or the “sandwich generation”.

In order to address the problem of wear and tear, musculoskeletal injury in the ageing workforce and to reduce the cost of workplace injury, the organisation in this study implemented the “O’Shea” No Lift process in 2006, with significant and demonstrable improvement in staff accident and injury.

However judging by the unanimous opinion of all the focus group representatives, nursing staff remain philosophically in opposition to the process.

“No Lift doesn’t work in practice because of the time it takes to set up the equipment.”

“No Lift is a great concept but it doesn’t work - manual handling remains a continual strain. It’s used as a blaming tool if you haven’t been able to comply”

“You get “slapped cross the face” for manually pulling a patient out of the wet shower room when she collapsed and arrested”

Although the participants were concerned about wear and tear on their bodies, they had very strong negative feelings about the “No Lift” policy adopted by the organisation to address occupational risk. This may be because the change management process utilised to implement the process did not reach the end users. The majority of the participants had seen multiple moving and handling methods come and go during their career and there may be a certain amount of cynicism regarding yet another “fad”. However, the extent of the lack of buy-in to the process is concerning for management, creating a significant risk for nurses who choose to ignore advice and take short cuts.

Excessive back and shoulder loading due to lifting heavy loads during manual patient handling, applying excessive forces during pushing and/or pulling of objects, required use of awkward postures during patient care, and working long hours and/or working shiftwork are all associated with musculoskeletal

disorders. Injury caused by manual handling incurs high cost to the organisation and to the nurse. When the appropriate patient handling equipment is used, the risk of musculoskeletal disorders is significantly reduced (Waters, Collins, Galinsky & Caruso, 2006; O'Malley et al., 2006). Mechanical equipment, training and education on the proper use of equipment, a safe lifting policy, and implementation of lifting teams have demonstrated positive results such as a reduction in injury by 70% leading to payback of the cost of the equipment in three years (Waters et al., 2006; O'Malley et al., 2006).

The organisational Occupational Health Department who were responsible for implementation of the process are perceived to be both the problem and the answer. *““No Lift” people have been off the floor for too long - it's not realistic”*

“Occ[upational] Health could do more - they could come to the ward to demonstrate appropriate cares for large patients”

The concept of “No Lift” requires nurses to work together as a team. As previously discussed, the lack of working together and supporting each other was a theme explored with sadness and a sense of loss. This may be one of the reasons why the process has encountered lack of buy-in; if a nurse is unable to find a “buddy” to help her to move a patient, there is a perception that it is quicker and easier to do it herself.

O'Malley et al. (2006) discuss barriers that discourage or prevent organisations from protecting their staff. Mechanical lifts can reduce risk, but they do not eliminate it; the nurse must still move the patient to apply the sling. There is also the dilemma that nurses might not use the equipment because of personal choice, lack of time, difficulty of use, space constraints around the bed, or patient preference.

At no time did the participants refer to the evidence that injuries caused by manual handling have decreased significantly since implementation of the "No Lift" system. Learning to utilise evidence-based practice through postgraduate education may also help to improve buy-in for the "No Lift" process in the long term.

The theme of "a feeling of hopelessness" is characterised by the passive-aggressive tendencies of learned helplessness, procrastination, stubbornness, resentment and sullenness. Roberts (1999) refers to Freire's (1996) theory of oppression when she suggests that nurses have internalised the values of physicians and the medical model, leading to low self-esteem and passive-aggressiveness. Low self-esteem leads to further dependence, passive aggressiveness and to further dominance in a cycle of oppression; hopelessness leads to dissatisfaction and intent to leave.

The final straw

The third theme extrapolated from the data related to what the participants saw as "the final straw" of onerous professional demands. They work hard but the

profession still wants them to demonstrate ongoing professional development, to supervise and educate junior and less qualified staff, to work extra shifts and overtime, to comply with manual handling policies, to meet increasingly higher patient satisfaction requirements, and to undertake postgraduate education. These demands seem irrelevant to them and for some it is the final straw.

Continuing professional development for nurses is actively encouraged and financially supported in this organisation as in many others, with strong professional and academic links to the local university. Although uptake is generally good, this group of participants did not consider postgraduate education a priority in their work life. A common feeling was that further education required more energy than the nurses have to give.

“I’m on the “looking after number one” slope now- not interested in post grad study.”

“I want to go home to my family at the end of the day, not get books out and study. I’m just too tired”.

“Older nurses have other caring responsibilities, young children, older children who won’t leave home, elderly parents. It’s a huge amount of work- when do you have time to study?”

The effect on the “sandwich generation” (Kovner, Brewer, Cheng & Djukic, 2007) of coping with an ageing body in a physically demanding job, meeting caring responsibilities for both younger children and ageing relatives, and then being required to study as well, is more than they are willing or able to give.

The professional expectation to pursue lifelong learning has increased significantly during the working life of older nurses and they are not accepting of the change.

Continuing education is recognised as essential element of professional development (Whyte, Lugton & Tonks, 2000). Employers, peers, and patients have expectations from nurses in relation to their level and currency of knowledge, putting them under some pressure to continue learning (Bahn, 2006). According to Bahn, although traditionally trained nurses continue to work and function at first and second levels, since the commencement of graduate and postgraduate level training in the 1990s these nurses has felt that their qualification has been devalued. Nostalgia and a sense of protectiveness towards their traditional basic training can be a source of resentment against academic training, engendering a sense of solidarity between traditionally trained nurses. I certainly felt this sentiment in my participants, and as a traditionally trained nurse, I can also empathise with them. However, as a researcher, I have learned the value of academic training and I can now role model the benefits of continuing professional education and development to my nursing workforce.

According to the participants, having the organisation recognise their seniority and experience appears to be more important than demonstrating ongoing competence and professional development. They do not appear to make any connection between recognition of service and professional development recognition. *“Why should I justify what I have learned?”*

“It’s a two way thing- life experience and clinical skills experience. History of life is not recognised”. The participants do not seem to understand that unless they can provide evidence of their learning and how it has improved professional practice or patient outcomes, it is meaningless.

The PDRP was clearly identified in both the questionnaire and focus group discussions as a major stressor in the work life of nurses. The subject of competence requirements led to lengthy discussions on the subject of the ongoing requirement to demonstrate competence.

It is a legal requirement of the Health Practitioners Competence Assurance Act 2003 that nurses are able to demonstrate current competence. This can be achieved through a certified employer based programme or through the New Zealand Nursing Council auditing process. This organisation was the first in New Zealand to develop and implement a New Zealand Nursing Council accredited programme requiring three yearly recertification. However, judging by the unanimous and intense feedback from the focus group participants, this section of the nursing workforce have not bought in to the process. This data complements the findings of Carryer, Russell and Budge (2007) who found that the greatest resistance to PDRP came from older and hospital trained nurses who expressed resentment towards demonstration of competence, feeling that their years of practice should be enough to demonstrate competence.

The nurse participants demonstrated the tendency of traditionally trained silent practitioners (Bahn, 2006; Dearnley, 2005) in their persistent belief that they are doing a good job, but measured against the way they were trained, not the profession of today. *“Nursing never changes, why do we have to update- I don’t see the need”*. This comment encapsulates some of the challenges inherent in responding to the current practice environment.

“I’ve been nursing since I was 17 and I’m in my 50s now, why should I have to prove I can do the job? Nurses have to prove competence, why don’t teachers? Doesn’t make you a better nurse- you could write anything on that piece of paper.” The law, and the ability of the government to be able to regulate the profession and maintain patient safety, obviously do not have any impact on the world view of these participants, entrenched in their hospital training ethos.

“PDRP is boring, stressful, time consuming, prescriptive, not user friendly, it doesn’t reflect practice, has no credibility, is impractical to reality and I refuse to do it”.

“My most precious thing is when a patient says “Thank you”. That’s more important than any piece of paper” [referring to PDRP].

The participants suggested making the task less onerous by making it quicker and easier, making it a peer review system, reducing the amount of evidence required, and being given time and support at work to do PDRP. *“I shouldn’t have to use annual leave to do it”*.

The effects of onerous professional responsibilities are also being felt at home:

“give, give, give- it never stops at work. I give at work all day and I go home and have nothing left to give at home.”

“I want to enjoy nursing, then go home to my family or do the gardening. I don’t want to do homework or sit in front of a computer.”

The challenge for nurse managers is to enable their nursing staff to meet regulatory and professional development requirements whilst working in a physically and emotionally demanding environment and juggling extensive family commitments is considerable.

The effects of juggling a physically and emotionally challenging career with family responsibilities have been identified as having negative effects on nurses health, as well as their intention to leave the profession (Rosenfeld, 2007; Walters et al., 1996). The ageing process adds wear and tear to the list of negative effects on health.

“My thought processes are affected, my eye sight worse, that “eyes in the back of your head” ability reduced”.

The conflict created by juggling the onerous professional demands of a physically challenging environment with the burden of family caring responsibilities, whilst coping with the effects of an ageing body, are too much for some nurses. Stuck in the traditionally trained culture of the silent practitioner they are unable to see the benefit of continuing professional development, preferring to rely on previous experience to demonstrate competence.

“I could stay if.....”

To help them to remain active in the workforce older nurses want more staff and a lighter patient load; they want their experience and contribution to be recognised; and they want help to be able to look after their ageing bodies in order to remain fit and well.

The participants talked about the difference a 1:4 ratio would make to their lives. *“If we had 1:4 or 1:5 it would be easier, you could give better care, have time for your patients. 1:6 is too many”*. Aitken et al. (2002) found that each additional patient in excess of a patient/nurse ratio of 4:1 was associated with a 7 % increase in the chance of failure to rescue, as well as a 7 % increase in the likelihood of the patient dying within 30 days of admission. The study found that a 6:1 ration increased the chance of death by 2.3 per 1,000, and an 8:1 ratio increased the chance of death by an additional 8.7 per 1,000. For each patient over a 4:1 ratio, the odds of nurse burnout increased by 23 %, and job dissatisfaction increased by 15 %. Although this study related specifically to a surgical unit, the nurse participants in this research routinely work with a 5:1 or 6:1 ratio, often providing indirect supervision to novice nurses, and evidence suggests that they have every right to feel unsafe.

Buchan (2005) examined the policy implications of mandatory minimum staffing ratios in nursing. He proposed that the arguments that ratios reduce nurse turnover and absenteeism and improve patient outcomes do not actually support ratios; they support improved staffing. Higher staffing levels make the profession more attractive to new entrants; ratios mean more nurses which in

turn means improved patient outcomes. Ratios are a “blunt instrument” (Buchan, p244) for achieving safe staffing levels, and they rely heavily on satisfactory calibration of the definition of safe staffing in different patient areas.

According to Wieck (2006), nurse: patient ratios is an indication of the “baby boomer” management strategy based on the premise that the shortage can be fixed by getting more nurses. They grew up in a time when labour was plentiful and their policies do not take into account that there simply are not enough nurses to recruit. When the “millennials” or “Y generation” become managers they will look at the problem as one of supply and solve the problems within the nurse education sector, or one of demand and reduce the number of activities that impede nurses’ ability to provide hands-on care (Wieck).

The participants felt strongly that the answer to the current nursing shortage was to recruit more nurses. *“There’s plenty of nurses out there, we just need to make it easier to come back”*. To some extent this is true; in the year 2000 6943 nurses and midwives were registered by the Nursing Council of New Zealand as “non-practising” (NZHIS, 2000). The perception that there is an abundant supply of nurses “out there” is peculiar to the “baby boomer” generation (Wieck, 2006) who grew up in a time when labour was plentiful. In the participants’ opinion, there are plenty of nurses “out there” and the organisation is not doing enough to recruit them. Possible solutions suggested

by the focus groups include increasing care assistant resources, and improving recruitment of overseas nurses or those returning to practice.

North (2007) criticises international recruitment as a short-term response to underinvestment by destination countries and suggests that it is arguably a cheaper and more attractive strategy for destination countries than making the improvements necessary to attract and retain nurses to the workforce.

However overseas trained nurses continue to provide replacement for the outflow of New Zealand trained nurses. This causes financial problems as overseas-trained nurses are expensive to train on the job until full productivity is achieved. There is also no guarantee that these nurses will remain in the same hospital, or even in the same country (Zurn & Dumont, 2008).

While reducing their workload is seen as an important strategy to encourage retention, the participants also need the organisation to recognise their experience and the contribution they make.

Older nurses want their length of service to be recognised and acknowledged. They perceive that there is currently no recognition or encouragement of seniority or experience, no career progression. Older nurses are “*not considered better than anyone else*”.

“The organisation should show nurses they are valued. Flowers, dinner, travel vouchers on certain anniversaries (10th, 20th, 30th years of service). Even a letter of acknowledgement of service would be nice”.

This need for praise and recognition is identified by Melik (2007) as a generational trait of “baby boomers”. Tang (2003) suggested that expressions of recognition and respect, either written or verbal, can boost job satisfaction and therefore retention. According to Laschinger and Havens (1996), although the work of staff nurses is fundamental to the provision of patient care, neither the position of staff nurse nor staff nurses themselves have received the visibility or recognition commensurate with the centrality of their role in achieving organisational goals. Recognition to reward and celebrate achievements can be through such mechanisms as organisational newsletters or award ceremonies. Regular, specific, and timely positive feedback is also a simple and effective way of recognising contributions.

The participants gave examples of positive feedback that made them feel good. *“It’s nice when the Charge Nurse says “thank you””*
“On my 70th Birthday I was overwhelmed by the love I was shown by my colleagues”. According to a survey conducted by Ulrich et al. (2007) recognition of accomplishments and work well done was rated excellent or very good by Magnet organisations and those in the process of achieving Magnet status. The nurses who took part in the survey saw recognition and reward for excellence as an important factor in these organisations.

Demonstration of current competence is also linked to the area of nurses returning to practice following a career or family break. It is a Nursing Council requirement that nurses are able to demonstrate a minimum number of clinical practice and professional development hours in order to hold an

Annual Practising Certificate (Nursing Council of New Zealand, 2005/06). It is also a requirement of the organisation that nurses returning to practice complete a Clinical Practice Development Programme (CPDP) relevant to their area of practice. The return to practice process caused some anxiety for the participants.

“We’re short staffed but young married women with kids won’t come back because of competence requirements and book work”.

“Returners struggle with the paperwork/ competences etc. The requirements prevent nurses coming back after they’ve had their families”.

“It’s too hard to return to practice after a break, the process puts people off.”

The research participants demonstrated concern regarding the competence requirements of return to practice; however, literature on the subject discusses the concerns of the “returners” themselves from a different perspective. The nurses wishing to return to the workforce are not concerned about the competence requirements; their main concern is the availability of “family friendly” or flexible shifts (Barriball, Coopamah, Roberts & Watts, 2007; Burns & Smyllie, 1993; Myers & Bushnell, 2007; NZHIS, 2000).

It has certainly been my personal experience that a significant proportion of nurses approaching the organisation to return to practice are seeking very part time, fixed hours or “school hours” and are not available to work rostered rotating shifts. Working part time for the nursing bank is seen as useful for returnees as it offers maximum flexibility over working hours; however the

quality of, and access to supervision for newly returned nurses raises concern for patient safety (Barriball et al., 2007; Myers and Bushnell, 2007). It also increases the stress for senior nurses who feel responsible for supervising the returnees.

None of the research participants had personal experience of return to practice; therefore, their comments were based on opinion. *“RNs don’t return to practice [after a break in service] because the hours don’t suit family life”* These perceptions could potentially have a negative effect on nurses in the community who may be considering returning to the workforce. If increasing recruitment directly improves nurse satisfaction by reducing workload, the organisation needs to find a way to make return to nursing an achievable goal. However the resolution to the problem of flexible rostering to meet the needs of the current and future workforce may not be so attainable.

While flexible rostering may be a requirement of nurses returning to the work place, the current workforce also struggle with caring responsibilities and shiftwork. *“Women are having children older. Older nurses still have significant child care issues as well as elderly parents”*. Younger nurses want child friendly shifts to suit child care, but older nurses are saying *“pay for it like everyone else!”* Generation Xers seek work/life balance and refute the “work is all” attitude of previous generations; they know they are needed and are prepared to move on if they do not get the balance they are looking for. Veterans and boomers have worked hard and paid their dues and they find it hard to accept that younger generations do not have the same philosophy

(Christmas, 2008). The inconsistency between older nurses wanting to socialise and work together as a team, but at the same time ungraciously demanding equal rights and demonstrating almost a sibling rivalry between themselves and their younger colleagues is again indicative of the resentment and the passive-aggressive behaviour caused by low self-esteem and oppression (Roberts, 1999)

“We have other caring responsibilities- older kids, grand kids. A lot of nurses are leaving because of their responsibilities, or they go casual.”

The effect of this constant juggle becomes apparent. *“So much is happening in your life, sometimes it tips you over and you take it out on your colleagues - use black humour and then upset them. Or you are unable to support your colleagues when they are struggling”.*

The participants are feeling the effects of ageing, but they are not ready to surrender to it.

“My body isn’t going to be able to maintain the workload but I still have a brain and skills.”

“I have thought about transferring to a lighter area, but I like the adrenalin-I’d be bored”. Suggestions for ways that the organisation could help focused on physical fitness and wellbeing, as well as emotional and psychological wellness; *“Listen to us when we say we’re tired”*

Developing a buddy or mentor role for older nurses who are no longer able to cope with the physical pressure was discussed. This suggestion to redesign

current roles for older nurses, removing them from the physically demanding bedside role to that of mentor, was been put forward by Hatcher et al. (2006). Christmas (2008) concurs with this opinion, seeing it as a way of meeting the needs of both the ageing nursing workforce and the needs of the millennium cohort who require a higher level of support and supervision when they enter the profession.

A support group was also a popular idea- *“I enjoyed this focus group - it feels better to know that other nurses feel the same. Should have a “silver fox’s” group every quarter to celebrate older nurses”*

Nurses are very aware of the need to maintain fitness and health. Going to the gym, walking, and taking regular holidays were all discussed by the participants as necessary for healthy ageing.

“We need a gym, maybe access to the rehab pool to de-stress, access to physio without feeling guilty about taking up public resources.”

“We are going to get more injuries as we age. A health service dedicated to staff would be great” (remembering the staff GP service available many years ago; they also thought that this may prevent unnecessary sick leave- the service used to check up on you if you phoned in sick!). *“Health benefits would be good- subsidised health insurance, or queue jumping to see specialists”*, *“access to private health systems may enable nurses to give back more (i.e. surgery without waiting on public waiting lists would enable the nurse to get back to work sooner)”*.

Thompson (2002) describes the physical effects of ageing on the older nursing workforce. These include musculoskeletal wear and tear, as well as visual and cognitive deterioration; Gabrielle and Jackson (2007) report that nurses commonly retire around age 55 or move to less demanding jobs due to work injuries or health related problems. The participants in this research are feeling these physical effects, but they do not demonstrate any intention to retire or leave the acute setting. This may be because by the time nurses reach the age of 45 the individuals who are not able or willing to remain in the physically demanding and stressful environment have already left.

Gabrielle, Jackson and Mannix (2007) studied the health, ageing concerns and self-care strategies of older women nurses working in a physically, emotionally and mentally challenging profession. High workloads and challenging work environments increase nurses' risk of stress, ill health and injury; shift work (especially night shift) also increases excessive tiredness and susceptibility to burnout. Chronic pain, family obligations and work demands are a disincentive to exercising as a self-care strategy. Working mothers are "time-poor", putting family needs first (Currie, 2004). Gabrielle et al. advise flexible rostering, managerial support and promotion of healthy exercise programmes during work hours as policies to prevent excessive tiredness and early retirement.

Passion for nursing

Despite the considerable negative impacts of being an older nurse working in a physically challenging environment, without exception all the participants

spoke animatedly and with enthusiasm about their role and their love of providing “hands-on” nursing care. With no prompting from the researcher, and with a free choice of the order in which they wished to discuss the topics, all four groups chose this topic as the first part of their conversation. From this I can only surmise that the passion and satisfaction they gain from their profession is the easiest thing to talk about, a common bond that they all share. Perhaps it is a form of protection that they wear at work every day to help them through each shift, convincing themselves that they are doing this because they love it. Perhaps they felt that by articulating their passion it gives some legitimacy for being a nurse, convincing themselves and their colleagues that despite all the bad experiences and negative feelings they will inevitably discuss, they are still a good nurse because they care deeply and passionately about their patients.

The focus group participants talked openly about the reasons why being an older nurse is so hard, yet all the participants talked about a love of nursing and could clearly articulate the motivation for coming to work every day.

“If I didn’t have nursing where would I fill that gap in my life?”

“We are there to give the best possible care. We love nursing- that’s why we’re here (and the money’s useful as well!)”

“I come to work because it’s fun, challenging, satisfying.”

“It’s the pride and joy of working with patients”

The participants enjoy the respect that knowledge and experience engender.

“I feel respected by medical staff- they appreciate a mature knowledge base. Medical staff have trust in older nurses.”

“It’s about the ability to make a decision while you’re running. That’s what older nurses are good at!”

For some of the participants nursing is their work and their social life, but as they get older it becomes harder to cope. *“You come to work and give all of yourself during your hours of work- work is almost my recreation. I can socialise, I know I’m doing a good job. But it’s getting so crappy I don’t get that feeling any more- I’m really struggling.”*

The passion for nursing appeared to be the main reason for the participants to continue to work at the patient bedside. The passion compensated for the workload, disempowerment and frustration. In its most simple form, the answer to the question “How can midlife nurses be supported to deliver bedside care in the acute clinical services until retirement?” is to give them the ability to maintain the passion. Nurses who are satisfied with their job maintain their passion; when they lose the passion, they become dissatisfied and move on to other roles, or stay out of habit and become miserable, complaining and less effective.

The satisfaction expressed by the participants is reflected in the pilot study conducted by Hatcher et al. (2006) who found that 99% of their respondents were satisfied or very satisfied with their job. Gabrielle and Jackson (2007) also found that their participants loved nursing and wanted to stay. However,

these voices are very at odds with professional literature citing intent to leave due to dissatisfaction as the main cause of the current and future nursing workforce shortage (Aitken, 2001; Coffey-Love, 2001; Heinz, 2004; Orsolini-Hain & Malone, 2007).

Conclusion

This chapter has critically examined the themes extracted from the focus group discussions. The five main themes that emerged were “the struggle to cope” with the frustrations of a changing work environment, an overwhelming “feeling of hopelessness”, a feeling that the excessive and onerous professional expectations are “the final straw”, negotiating improved working conditions through “I could stay if...”, and a passion for nursing.

The nurses feel immense pressure from the increased patient acuity and they mourn the loss of the social time that has been lost as workload has increased. They have struggled to come to terms with the generational differences created by working with younger nurses, and while they anticipate that achieving Magnet status will make things better they demonstrate no real understanding of, or desire to be part of, the process. They want to be able to spend more time with their patients and see improved nurse: patient ratios as the answer, but they are unwilling to provide the supervision of junior staff this would require. They actively avoid postgraduate education, and have no appreciation of the benefits it would bring. They want to work shifts that are more flexible and have fair and equitable rostering, but do not have any idea

how to achieve this. They want to have a voice in their work environment but do not know how to be heard.

The participants struggle to manage the conflict between what the patient wants, what the patient needs, and what the nurse is able to provide. They are worn down by the pressure of work and the responsibilities of home, and the effects of a physically demanding job on an ageing body. They have not accepted the No Lift policy of the organisation even though it is specifically designed to prevent injury. They want management to be more visible and understanding, they want their experience and contributions to be recognised, but they do not want to participate in a formal professional development recognition programme.

The themes of failure to cope with the changing work environment, of overwhelming onerous professional expectations and of disillusionment and disempowerment point to a dissatisfied workforce. As dissatisfaction is an indicator of nurses' intent to leave, it is important that the organisation look for ways to empower older nurses to regain control of their work life. The following chapter will review the research findings and discuss how this can be achieved.

Chapter 6 Discussion and Summary

Through the use of questionnaires and focus groups I asked nurses aged 45 years and over what the employer can do to ensure that they are able to continue to work at the patient bedside until they reach the age of retirement. A qualitative descriptive method was used to provide the data for a qualitative study. The analysis reveals how the participants understand their current situation, and constructionism underpins how these understandings can be interpreted.

Gray (2004) explains that data analysis involves the process of breaking data down into smaller units to reveal their characteristic elements and structure. In my research the first level of analysis was the demographic information gained from the questionnaires: age, length of service and area of practice. The second level was analysis of the language used to describe how the nurses feel about work and key phrases about how their employment conditions can be improved i.e. “staff to patient ratios”, “Professional Development Recognition Programme”, and “ shift patterns”. The third level involved finding themes and phenomena that linked how the nurses feel now to how they want to work in the future, and therefore how the organisation can encourage them to remain at the patient bedside until they retire.

There is currently almost no information relating to the views of New Zealand midlife nurses who might wish to remain in clinical practice until retirement. As this is currently the largest cohort of the nursing workforce, every effort should be made to address the needs of these nurses in order to retain the

expert knowledge and experience that they bring to their profession. The perspective of the midlife nurse in New Zealand will add to the body of knowledge from Europe, Australia and America to identify the specific needs of this valuable resource.

The results of this research demonstrate a workforce of nurses who are passionate and committed to their profession, but feeling disillusioned and disempowered. The nursing environment has changed over the span of their career and they find the increased workload, together with increasing professional demands, too hard to cope with. They feel they have no control over their workload, their shift patterns, or the expectations of their patients and colleagues. They want their experience to be recognized but they do not want to have to prove competency; they want to have a voice but they are unwilling to pursue postgraduate education to learn how to become visible and emancipated.

The participants clearly exhibited the characteristics of the “baby boomer” generation (born between 1946 and 1964); they require praise and recognition, putting company needs before personal needs while juggling multiple responsibilities with competence. They have a strong work ethic, and work has been a defining part of their self worth and their evaluation of others. Boomers are also known as the “sandwich generation”, caring for older adults and younger children while holding down a job as well (Kovner, Brewer, Cheng & Djukic, 2007). They struggle to come to terms with the generation attributes of

their younger colleagues who seek work/life balance and have a different work ethic (Christmas, 2008).

The participants spoke at great length about their desire to have their experience and service recognised by the organisation, but they did not view the Professional Development Recognition Programme as a medium for this even though there is financial reward attached. They seek a more personal approach, initiated by the organisation, as opposed to a self assessment process which they see as laborious and pointless. They cannot see that postgraduate education may give them an emancipated professional voice and they feel unable to commit to the demands of academic training. In order to persuade these nurses to gain valuable research skills and to be able to utilise evidence based practice and therefore positively influence patient outcomes, the profession needs to consider repackaging post-registration education.

A generation of new nurses have learned how to practice as an individual, focussing on a group of patients rather than a group of tasks. The shift from working together as a team to working in isolation may have come about because of implementation of the Primary Nursing model of care. This appropriately changed the focus away from the functional model or task oriented nursing care towards a more holistic individualised or primary care model. Instead of a team of nurses providing care for multiple patients and dividing the tasks up between themselves, each nurse became responsible for providing the total care to a small group of patients in order to provide more individual care (Kron & Gray, 1987). However this theory, whilst plausible,

remains unsubstantiated as I have been unable to find any evidence in the literature to demonstrate a link between change in care processes and a breakdown in teamwork.

Unit managers now have to find a way to help their team focus on groups of patients as well as helping each other with tasks. As an example, changing a care process such as drug administration is having this effect on one of the wards for which I am responsible. In the past, drug administration time has meant each nurse walking backwards and forwards between the drug room and her own group of patients. It also involves answering buzzers and telephone calls, taking observations, supervising care assistants and enrolled nurses, teaching students, expending a lot of energy and time in the process, and increasing the risk of drug administration error because of the constant interruptions. By splitting the ward into two teams of nurses and giving each team a drug trolley, each nurse can still administer drugs to her own patients but the team provide support and supervision to each other in the process. The drug trolley makes its way from room to room, and with no prompting or encouragement the team automatically work together. Patient safety is improved and the increased efficiency of the process ensures extra time to focus on care of the patient.

The nurses in this study mourn the loss of the social links they used to have; they are disillusioned by the increasing workload, shift work and staffing shortages. The pressures and stressors on themselves, the patients, and on their family lives make them feel hopeless. They want to have a voice and some

control over their work lives but their sense of hopelessness prevents them from pursuing this. They express a sense of powerlessness, of “being done-to”, of having no control. This was described overtly particularly through descriptions of the prescriptive PDRP, and the “No Lift” process in the workplace, not being able to work the hours and shifts they chose, and the perceived invisibility of management.

The physical hospital environment may well contribute to the feeling of excessive workload. The majority of participants work in bay wards that have been found to increase workload and reduce patient satisfaction due to reduced ability to monitor patients and increased travel time sourcing equipment (Hurst, 2008). Although nurses cannot easily change the current ward layout, they can influence improved work practices through processes such as the NHS “Releasing Time to Care: The Productive Ward” system (NHS, 2007). This process focuses on improving ward processes and environments to help nurses and therapists spend more time on patient care thereby improving safety and efficiency.

Nurses’ knowledge, skills and social relations are essential to productivity. Fewer managers with wider spans of control risks dismantling the professional infrastructure for nurses. In the healthcare restructuring of the 1990s the termination of Charge Nurse level positions deprived hospitals of professional nursing leadership, disempowering nursing and adversely affecting patient outcomes (Carryer, 2001; McCloskey & Diers, 2005). Nurse managers represent the professional interests of nurses to management and are

instrumental in reducing nurse turnover and improving morale (Baumann & Blythe, 2003). A governance structure, shared information and shared leadership empower nurses and encourage autonomy, responsibility and accountability.

The nurse participants appeared to understand the language of this theory, but do not feel empowered to apply the theory into practice. In my personal experience of trying to implement a nursing governance structure within the organization, it is very difficult to release ward based nurses to take part in quality improvement processes. The over-representation of nurses who do not have a patient load at nursing forums can lead to a breakdown in the vertical governance structure leaving ward based nurses feeling that their voice is not heard.

Being able to demonstrate a robust governance structure, strong working relationships with medical colleagues, a focus on continuous quality improvement and clinical excellence are all areas in which nurses can be involved on a daily basis. This may seem huge and overwhelming to nurses working on the wards; but making it part of normal conversation, making it real and achievable in the ward or unit setting is a positive step towards being a Magnet organisation. Demonstrating how each nurse can make a difference to patient outcomes will give the power back to nurses, inevitably improve their ownership of nursing care, and give them back the power to make a difference. If they feel they can make a difference then they will stay at the patient bedside.

The underlying message in the feelings of disempowerment and disillusionment, the sense of being “done to” and having no say in the professional expectations of the organisation, is that nurses feel oppressed and do not use their professional voice. In order to find a professional voice (Dearnley, 2005) it is important for these nurses to move from being hesitant and silent practitioners to being liberated and dynamic practitioners, to become visible in their ward or department and perhaps take pride in their seniority. This can be achieved through postgraduate education during which the nurse progresses from “knowing nursing in a silence characterised by fear and apathy, to knowing nursing from a variety of dimensions which increased their professional confidence, autonomy and motivation for professional practice” (Dearnley, 2005, p. 219).

The dilemma is that while postgraduate education can be a means to achieving a professional voice through increasing a nurse’s sense of personal efficacy, nurses cannot be compelled to undertake academic study. They can be encouraged and supported but the commitment required to juggle work and family obligations is, for many, too much.

According to Lachinger (2000) disempowerment becomes apparent when individuals are deprived of opportunities for growth and development. They are excluded from decision making processes and frequently lack resources to perform their job effectively whilst still being held accountable and

responsible for their actions. Nurses in this study feel frustrated; they think people think they are incompetent, and they have little loyalty to their organisation, manifesting itself in disinterest and apathy that subsequently affects patient care. Unrelenting attempts to deliver a quality service under enormous pressures and stressors contribute to emotional exhaustion and fatigue (Clegg, 2001). It is understandable that exhausted, disempowered, dissatisfied nurses will seek alternative employment, moving away from the patient bedside and depriving the acute environment of their vital experience and skills. But if they actually stay, as these nurse participants are keen to do, they potentially perpetuate the cycle of oppression, infecting the workforce with their low self-esteem and self-worth.

These findings are of concern because it is forecast that the demand on the health service will outstrip the supply of qualified workforce in New Zealand by between 28% and 42% by 2011 (NZIER, 2004). However there is little evidence to demonstrate what will happen if the current ageing nursing workforce retires prematurely due to burn out or ill health. Nurses born in the 1950s comprise 50% of the nursing workforce (Beurhaus, Steiger & Auerbeck, 2000; Cooper, 2003). This is partly due to the baby boom bulge, and partly because nursing was seen as a popular choice of vocation for school leavers with few options available for women at that time (Aitken, 2004; Bednash, 2000; Benjamin, 2000). These women are now in their later 40s and 50s and contemplating retirement within the next 15 years (Cooper). It is clear from the NZIER research that the employer needs to keep older nurses, but if they stay in the workforce feeling sad and disillusioned they are kept at a cost.

Workforce issues

Nursing shortages, the ageing nursing workforce, the increasing demands of an ageing population with multiple and complex co-morbidities, and the effects of working as well as caring for children and/ or older family members are affecting the ability of health care organisations to provide sufficient experienced nurses to meet the demand (Hatcher et al., 2006). A decrease in supply of new nurses, an increase in demand from an ageing population bulge requiring intensive health care, and an ageing nursing workforce on the brink of retirement come together to cause a potential crisis (Hader, 2005)

This cannot be ignored as also noted in the literature review, inadequate hospital staffing is a factor in poor patient outcomes, adverse patient occurrences, increased hospital errors and increased patient mortality (Aitken et al. 2001). Staffing shortages have already led to a decrease in quality of care as well as an increase in errors as heavier workloads and longer hours fall on an already stressed staff (Aitken, 2001; McCloskey & Diers, 2005).

The OECD report of 2008 provides an interesting insight into nursing workforce characteristics in New Zealand. The percentage of foreign trained nurses has nearly doubled since 1994. The number of nurses leaving New Zealand also doubled from 1992 until 2006. The nurse training rate of 32.8 graduates per 100,000 population is slightly below the OECD rate and this figure is worsened by out migration to Australia. The high number of foreign

trained nurses in New Zealand and the high number of New Zealand trained nurses working outside New Zealand raises unique challenges for workforce planning. The OECD report concludes that there is better need for collaboration and co-ordination between the Department of Labour, the Ministry of Health and the District Health Boards (OECD, 2008).

A review of current health policy directives suggests little concrete, focussed attention to building and sustaining a registered nurse workforce. Nor can it be guaranteed that the change of Government will not signal a return to neo liberal policies of the 1990s thus creating even further vulnerability for nursing which would further jeopardise patient safety (Carryer, 2008).

Nursing schools are not graduating enough baccalaureate and graduate nurse levels to stabilise the workforce (AACN, 2004). Although enrolments in nurse education programmes has increased, the number of expert nurses available to orientate and mentor students, new employees and new graduates is shrinking and creating a situation where more nurses are competing for preceptors time. This inevitably leads to burnout and dissatisfaction. Although increasing nurse recruitment and reducing nurse: patient ratios may appear to be a short-term solution to improve job satisfaction and therefore retention of experienced nurses, it does not address the problem or maintain a work environment that sustains the expert nurse (Orsolini-Hain & Malone, 2007).

With the reality of an ageing nurse workforce, nurse administrators would be wise to develop interventions that address the needs of these nurses.

Participating in action research that further determines the needs of older nurses and develops shared solutions would be a good first step (Hatcher et al., 2006). Letvak (2002, 2005) looked at retaining the older nurse, specifically focussing on the health care industry's response to the ageing nursing crisis, reporting that few institutions had policies in place to directly address the needs of the older nurse.

The way forward

It is likely that a combination of transformational and servant leadership, dependent upon the circumstance and environment, will enable older nurses to become empowered, to feel valued, to find their self-worth and to continue to deliver bedside care in the acute clinical services until retirement. Jackson (2007) suggests that there are similarities between servant and transformational leadership, particularly in relation to valuing people. However the focus of the transformational leader is on the needs and objectives of the organisation, while the focus of the servant leader is on the needs of the individual.

In the opinion of Murphy (2005) the development of transformational leadership through professional education and intellectual stimulation achieves a chain reaction that empowers nursing staff and enhances patient care. Emotional burnout and exhaustion are less prevalent among empowered nurses (Clegg, 2001). Empowering staff and developing a climate of mutual

trust increases job satisfaction and fosters commitment to the organisation, culminating in the delivery of high quality care (Sheldon & Parker, 1997).

The philosophy of servant leadership may meet the needs of both the older and younger nursing workforce. This involves helping nurses to become freer, more autonomous, more capable and more effective through the principles of listening, empathy, healing, awareness, persuasion, conceptualisation, foresight, stewardship, commitment to the growth of people, and building the community (Howatson-Jones, 2004; Neill & Saunders, 2008; Swearingen & Liberman, 2004). The servant-led organisation emphasises mentoring and role modelling, is focussed on customer satisfaction, hires people who will be flexible, listen to their staff, and consider training important. The servant leader focuses on teamwork, seeks to involve the team in decision making, enhances the growth of the team, and improves caring and quality. This philosophy appears to align with the expressed needs of the older nurses who desire their leadership to possess the qualities of valuing and human connectedness, respectful collegiality and trust. It also meets the needs of young nurses who crave mentoring, nurturing and support.

This study has revealed a culture of disempowered, passive nurses embedded in a victim mentality. Both charge nurses and nurse managers need to develop leadership skills in order to enable a cascade of empowerment that will change the culture and enable older nurses to remain at the patient bedside until they retire. This requires the organisation to invest in appropriate leadership

training and education for middle managers. Therefore my recommendation to the organisation to improve retention of older nurses is to invest in leadership training in order to enable nurse leaders to utilise the skills of transformational and servant leadership to empower their team to achieve both organisational and individual goals.

In addition to their skills and expertise, older nurses can also help to meet the need, as previously discussed, for guidance and teaching of novice nurses entering the profession. In order to enable these older nurses to remain in the clinical setting, the organisation should also consider development of supernumerary support roles to enable them to mentor and role model their experience, at the same time as reducing wear and tear on their ageing bodies.

Having taken part in this research, it will be a useful step for the participants to be given the opportunity to critically review the results and to be encouraged to take part in influencing change. To have a voice in how rosters are planned, review of the PDRP process, improving buy-in of the No Lift process, taking an active part in nursing governance, or advising future Workforce Development Policies. As a leader, not as a researcher, I will be in a position to enable this process, to challenge ideas and encourage change. The expected outcome will be for older nurses to find their professional confidence, autonomy and motivation, and to remain active participants in the nursing workforce until they retire.

Limitations of the study.

The major limitation of this study was the power relationship that prevented me from challenging or questioning the views of the participants. As Sandelowski (2000) asserts, the description in qualitative descriptive studies involves the presentation of the facts of the case in everyday language, not delving into or beyond the data. The researcher does not need to feel obliged to defend their efforts as something more than mere description; it is purely a comprehensive summary of the voice of the participants. If I, as the researcher, had approached the topic as a true outsider I could have conducted the research from a critical enquiry or perhaps action research perspective; however the themes elicited from the data created by the qualitative descriptive process provide me with the foundations on which to inform change.

Because the history, culture and traditions of every organisation are different, this research is neither generalisable nor transferable. However I did not set out to inform the Workforce Development Policies of other organisations, only my own. In order for this to happen, the research would have to be conducted on a larger cohort across a range of DHBs.

Concluding statement

The most recent literature relating to nursing workforce planning suggests that due to the down turn in the global economy and the unexpectedly high number of young people choosing nursing as a career, the anticipated workforce crisis

may not be as severe as predicted. The fact remains that by 2012 there will be a 24% increase in the amount of workers aged 55 or older, and only a 2.5% increase in 25-40 year old workers in New Zealand (Koubaridis, 2008). The effects on ageing nurses of continuing to provide bedside care in a physically and emotionally demanding environment on ageing nurses remain unchanged. Additionally, although young people are choosing nursing as a career, if their need for structure and mentorship is not met they will leave and seek employment in a more nurturing environment. The needs of both the older experienced nurse and the young novice can be met through development of a mentor nurse role, thus ensuring that the organisation retains the knowledge and experience of the older nurse and the future resource of the new graduate. However this requires older nurses to appreciate the importance of mentorship, to embrace the benefits of research and evidence based practice and to model the compassion required to address the development needs of nurses with different skill levels (Jackson, 2007). This concept is central to the philosophy of servant leadership.

The culture of the workplace with its relentless demands to perform has contributed to a climate of individualism leading to a breakdown in collegiality (Jackson, 2007). The overwhelming clinical and professional demands, as well as the energy required for caring responsibilities at home, leave older nurses unable to contemplate the extra requirements of post graduate education. Options for non-academic training are limited in the current environment, but the nursing profession must look at “repackaging” education to meet the needs of those nurses who possess years of clinical

experience but are afraid of the commitment to university papers. Perhaps by developing vocational training packages that act as a bridge between the current fundamental clinical practice development programmes and the Bachelor or Masters programmes, older hospital trained nurses will be able to gain confidence in their own ability and learn some academic skills. By gaining confidence they will find a professional voice and role model excellent clinical practice to novice nurses entering the profession.

New nursing roles over and above current staffing resources, and development and implementation of leadership training programmes have significant financial implications. Arguing for the increased financial investment which will be necessary to meet the demands of this policy is the responsibility of current nursing leadership. An evidence based understanding of the current international workforce situation, a clear vision of the requirements of the future, and a strong professional voice will be required to influence change in a fiscally constrained health care sector. However if older nurses are not encouraged to stay in the acute setting and novice nurses leave because they have no support structures, the alternative may be to redesign the way nursing care is delivered to patients because there are simply not enough qualified nurses to do the job. The benefits of the first option far outweigh the costs of the second option. The security of creating an empowering and rewarding opportunity for older nurses, and the profession of nursing as a whole, is unquestionably important to the health care consumer in an unpredictable future.

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Appendices

Appendix 1 Questionnaire

“How can midlife nurses be supported to deliver bedside care in the acute clinical services until retirement?”

Questionnaire

You are an **essential** resource to this organization. By taking part in this survey you can have a say in how the organization looks after you and how it can plan to provide a supportive work environment into the future.

I want to ask midlife nurses (that’s 45+ for the purposes of this study!) **“How are you?”** I want to know what motivates you to continue working in a **busy, stressful, physically demanding** job; and what would enable you to **continue** in this role until you reach retirement.

This questionnaire includes a mixture of closed and open ended questions. Please feel free to use extra paper if your answer is too long for the space provided. Although all the questions are relevant and useful to the research you may choose not to answer any particular question. The first few questions will help me paint a picture of the research participants, and provide a framework on which to build your stories. The rest of the questions will ask about your wellbeing, and what you think the organization can do to enable you to continue working in your current role.

1) Year of birth:

2) Year of first registration:

3) I am currently employed as (please circle):

Registered Nurse Enrolled Nurse

4) Number of years of active service in nursing:

5) FTE (number of hours per fortnight):

6) Current area of practice (please circle):

Medical Surgical Women’s Health Child Health
Elder Health/Rehab Peri-operative services ICU/CCU Oncology

7) Current shift Pattern (please circle):

Rostered rotating shifts Permanent night shift Permanent day shift
Other (please state)

8) At what age do you plan to retire from nursing?

9) How does being at work make you feel? Please circle any combination of the following words or phrases that relate to you.

Happy Tired Challenged (in a good way)

Frustrated Part of a team Isolated Confident Stupid

Supported Comfortable Belonging Uncomfortable

Stressed Valued Challenged (in a bad way)

Apprehensive Ill Interested Bored Satisfied Frightened

Sad Content Angry

10) These questions are about how you feel and how things have been with you during the **past 4 weeks**. Please tick the relevant boxes.

How much of the time during the **past 4 weeks**.....

	All of the time	Most of the time	A good bit of the time	Some of the time	A little bit of the time	None of the time
Did you feel full of life?						
Did you have a lot of energy?						
Did you feel worn out?						
Did you feel bored?						

Vitality is described as physical or mental vigor or energy; or the power or ability to continue in existence, live or grow.

11a) Can you identify up to three things about your work which have a **positive** impact on your vitality?

- 1.
- 2.
- 3.

11b) Can you identify up to three things about your work which have a **negative** impact on your vitality?

- 1.
- 2.
- 3.

12) What could this organization do to enable you to continue working at the patient bedside until you retire if that was your choice?

Thank you for taking the time to complete this questionnaire. Your response is anonymous and your confidentiality will be maintained. Please place the completed questionnaire in the envelope provided and return via internal mail to:

Caroline Dodsworth
C/o Human Resources Department

“How can midlife nurses be supported to deliver bedside care in the acute clinical services until retirement?”

Focus Group Volunteer

The second phase of the research project will be focus group discussions exploring the themes revealed in the questionnaire responses. If you feel strongly about this subject and you would be interested in taking part in a focus group, please indicate below.

This volunteer consent form will be separated from the questionnaire response in order to maintain the confidentiality of the participant.

- Yes, I would like to participate in a focus group discussion
- I would like to find out more about this project before I commit to participating

Please complete the information below so that I can contact you to arrange a meeting:

Name (please print):

Ward:

Appendix 2 Information Sheet for Focus group Discussions

“How can midlife nurses be supported to deliver bedside care in the acute clinical services until retirement?”

Information Sheet for Focus Group Discussion

Introduction

My name is Caroline Dodsworth and I am currently studying towards a Masters in Nursing at Massey University. I am employed as Nurse Leader, Internal Medicine Inpatients at *****. My supervisor is Jenny Carryer, Professor of Nursing.

My area of interest is the ageing nursing workforce, and the title of my thesis is **“How can midlife nurses be supported to deliver bedside care in the acute clinical services until retirement?”**

As the nursing population ages and the demand for health care professionals grows faster than the supply it becomes more and more essential that the employer provides a working environment that supports the physical and emotional needs of the ageing nursing workforce. Phase one of this two part study gathered data through questionnaire response relating to what the employer can do to ensure that you are able to continue to work at the patient bedside until you reach the age of retirement. Phase two of the project is intended to expand on the themes that became apparent through data analysis of the questionnaire responses. Through focus group discussions we will explore in more detail the preliminary findings in order to develop strategies which will inform the DHBs policies on supporting the ageing nursing workforce.

Participant Recruitment

You have been identified by self-nomination of interest to take part in this focus group discussion after completing the questionnaire section of the project.

Project Procedures

Prior to the group discussion I will supply you with an outline of the preliminary findings of the questionnaires. This will enable you to prepare to take part in the discussions. The discussions will be noted in short hand by an expert note taker who has signed a confidentiality agreement. The completed notes will be used to inform the research findings.

No participants will be identifiable through the research findings; confidentiality will be maintained at all times. To this end you will be asked to complete a confidentiality agreement. Completed consent forms will be stored securely by the Human Resources Department for 5 years; all other research data will be stored securely in the School of Health Sciences, Massey University, for 5 years. After 5 years all data will be destroyed. The research findings may be used to inform a larger study across a greater cross section of DHBs for PhD thesis. If this is the case the data will be kept securely up until and including the duration of the PhD study period and subsequently destroyed.

Participant Involvement

The focus group will consist of up to 8 nurses, plus myself and a note taker. It is anticipated that the discussion will take 1-2 hours. Permission has been sought and granted from the General Manger of ***** to conduct this discussion during work time.

Participant Rights

You are under no obligation to accept this invitation. If you decide to accept you have the right to:

- Decline to answer any particular question
- Withdraw from the study at any time
- Ask any questions about the study at any time during participation
- Provide information on the understanding that your name will not be used unless you give permission to the researcher
- Be given access to a summary of the project findings when it is concluded by email or hard copy.

Non-participation or withdrawal from the research will not affect your employment in any way.

Project Contacts

If you have any questions about the project please do not hesitate to contact the researcher or the supervisor at any time. Contact details are as follows:

Researcher

Caroline Dodsworth

Nurse Leader

Internal Medicine Inpatients

Ruahine Street

Palmerston North

09 3569169 pager 012

caroline.dodsworth@*****.co.nz

Supervisor

Professor Jenny Carryer

Department of Nursing Massey University

Phone 0274 491 302

J.B.Carryer@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 06/60. If you have any concerns about the conduct of this research, please contact Professor John O'Neill, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 350 5799 ext 8635, email humanethicssoutha@massey.ac.nz

Appendix 3 Focus Group Participant Consent Form

“How can midlife nurses be supported to deliver bedside care in the acute clinical services until retirement?”

Focus Group Participant Consent Form

This consent form will be held for a period of 5 years

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.

- I agree to the interview being transcribed
- I agree to not disclose anything discussed in the Focus Group
- I agree to participate in this study under the conditions set out in the information sheet

I agree to the information collected possibly being used for further study across a greater cross section of DHBs for a PhD thesis. Yes No

Signature: _____ **Date:** _____

Full Name (printed): _____

Appendix 4 Note Takers Confidentiality Agreement

“How can midlife nurses be supported to deliver bedside care in the acute clinical services until retirement?”

Note Taker’s Confidentiality Agreement

I _____ (full name, printed) agree to transcribe the discussions for the above study, and to keep the information I hear confidential.

I will not make copies of the transcripts or keep any record of them, either on disc or on my hard drive, other than those required for the project.

Signature: _____ **Date:** _____

Appendix 5 Information Sheet for Questionnaire

“How can midlife nurses be supported to deliver bedside care in the acute clinical services until retirement?”

Information Sheet for Questionnaire

Introduction

My name is Caroline Dodsworth and I am currently studying towards a Masters in Nursing at Massey University. I am employed as Nurse Leader, Internal Medicine Inpatients at *****. My supervisor is Jenny Carryer, Professor of Nursing.

My area of interest is the ageing nursing workforce, and the title of my thesis is **“How can midlife nurses be supported to deliver bedside care in the acute clinical services until retirement?”**

As the nursing population ages and the demand for health care professionals grows faster than the supply it becomes more and more essential that the employer provides a working environment that supports the physical and emotional needs of the ageing nursing workforce.

The enclosed questionnaire is the first part of a two part study in which I will ask nurses aged 45 and over “How does working in a profession that requires constant physical activity and high stress levels affect your health and wellbeing?” I want you to tell me what the employer can do to ensure that you are able to continue to work at the patient bedside until you reach the age of retirement.

Participant Recruitment

As the participants of my research you will be a registered or enrolled nurse aged 45 and over, currently working at the bedside in the acute clinical services at *****. A total of 416 nurses have been sent a questionnaire. This process has been conducted by the Human Resource Department to protect your privacy and to remove selection bias. No individual nurse will be identifiable through the questionnaire response.

Project Procedures

Data will be in the form of completed questionnaires. The data will be stored securely in the School of Health Sciences, Massey University, for 5 years. A summary of the research findings will be made available on request on completion of the project.

The results of the research will be published as a Masters thesis and published in a health service journal. The results will also be made available to the Human Resource Department, in order to inform the long term strategies of workforce planning policies of the DHB. The results may also form the framework for future national research on the ageing nursing workforce in New Zealand. If this is the case the data will be kept securely up until and including the duration of the PhD study period and subsequently destroyed.

Participant Involvement

The enclosed questionnaire includes questions relating to your age, area of work, and length of service; how work makes you feel; and what the DHB can do to ensure you are able to continue working. It should take a maximum of 10-15 minutes to complete; permission has been sought and granted from the General Manager, *****, to undertake this research during work time. The completed questionnaire should be returned to the Human Resources Department in the envelope provided.

Participant's Rights

Completion and return of the questionnaire implies consent. You have the right to decline to answer any particular question, and you have the right to withdraw from the research at any time. Non-participation or withdrawal from the research will not affect your employment in any way.

Project Contacts

If you have any questions about the project please do not hesitate to contact the researcher or the supervisor at any time. Contact details are as follows:

Researcher

Caroline Dodsworth

Nurse Leader

Internal Medicine Inpatients

Ruahine Street

Palmerston North

09 3569169 pager 012

caroline.dodsworth@*****.co.nz

Supervisor

Professor Jenny Carryer

Department of Nursing Massey University

Phone 0274 491 302

J.B.Carryer@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 06/60. If you have any concerns about the conduct of this research, please contact Professor John O'Neill, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 350 5799 ext 8635, email humanethicssoutha@massey.ac.nz

Appendix 6 Outcome of Ethics Application

From: alan [acanc@xtra.co.nz]
Sent: Friday, 20 October 2006 8:00 a.m.
To: Caroline Dodsworth
Subject: Fw: Southern A Application 06/60 - Outcome

Importance: High

----- Original Message -----

From: [Broad, Patsy](#)
To: acanc@xtra.co.nz
Cc: [Carryer, Jenny](#) ; [Benn, Cheryl](#)
Sent: Thursday, October 19, 2006 4:40 PM
Subject: HEC: Southern A Application 06/60 - Outcome

06/60 How can midlife nurses be supported to deliver bedside care in the acute clinical services until retirement?

Caroline Dodsworth (HEC: Southern A Application 06/60)
Department: School of Health Sciences
Supervisor: Professor Jenny Carryer

The Massey University Human Ethics Committee: Southern A considered the above application at their meeting held on Tuesday 10 October 2006.

It was noted that the ethics application was originally sent to the Central HDEC, who subsequently stated ethical approval was not required by a Health and Disability Ethics Committee (refer letter dated 20 September attached to application).

However, given that the Screening Questionnaire indicated a conflict of interest (refer Q19), review was required by a MUHEC. Prof Rumball and Prof O'Neill agreed that review of the application on the HDEC form would take place so that the applicant would not experience further delays to research.

The application was provisionally approved, subject to the fulfilment of the conditions below to the satisfaction of Professor John O'Neill (Chair).

Please note that the Committee is always willing to enter into dialogue with applicants over the points made. There may be information that has not been made available to the Committee, or aspects of the research may not have been fully understood.

PART 2

SECTION A, Q3.1

- Clarify who the note taker will be.

SECTION E, Q7

- Clarify whether the data will be required for possible future use in a PhD study. If so, it should be made clear in the Information Sheets that the data will need to be kept. This would also need to be covered in an explicit yes/no option on the Consent Form.

PART 3

GENERAL

- This section should include discussion of the ethical implications of being in a line management role with some of the participants. Please comment.
- Given the acknowledged conflict of interest, clarify how any power relationship will be mitigated in the focus groups.

QUESTIONNAIRE

- Given the extensive demographic information requested, would it not be possible for the researcher to identify individuals? If such a possibility exists, clarify how this will be mitigated, e.g. by having someone else input the data into the software analysis programme. Include detail in the Information Sheet.
- Final version of the questionnaire should be lodged with the Research Ethics Office and be checked by the supervisor to ensure that questions can legitimately be answered by participants, e.g. 11a could read “Please identify up to 3 things ...”

1ST INFORMATION SHEET

- Refer Section E, Q7 above – ensure detail is included in the Information Sheet, if applicable.
- Ensure inclusion of all relevant participant’s rights (refer template on the MUHEC website).
- Refer Questionnaire query (above) in regard to identifiable information and include detail, if necessary.
- Clarify how participants will receive a summary of the research findings.
- **Delete** reference to ethical approval from an HDEC and **include** the following statement: “This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 06/60. If you have any concerns about the conduct of this research, please contact Professor John O’Neill, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 350 5799 x 8635, email humanethicssoutha@massey.ac.nz”.
- Provide a copy of the revised Information Sheet.

INFORMATION SHEET FOR FOCUS GROUP PARTICIPANTS

- Refer Section E, Q7 above – ensure detail is included in the Information Sheet, if applicable.
- Refer Part 3, General (above) – include details of how the conflict of interest will be mitigated.
- Project Procedures – offering of transcripts - suggest this could create problems. Typically focus group participants are not given the right of editing as this could alter the sense of the transcript as a whole and, in any case, participants may only edit their own contribution. Please reconsider.
- Participant Recruitment – Rephrase this section to indicate that participants have been identified by self-nominating their interest.
- Clarify how participants will receive a summary of the research findings.
- **Delete** reference to ethical approval from an HDEC and **include** the following statement: “This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 06/60. If you have any concerns about the conduct of this research, please contact Professor John O’Neill, Chair,

Massey University Human Ethics Committee: Southern A, telephone 06 350 5799 x 8635, email humanethicssoutha@massey.ac.nz".

- Provide a copy of the revised Information Sheet.

LETTER

- Provide a copy of the letter to Mid Central Health outlining the research project and what is expected of potential participants.

Please supply to the Secretary, one (1) copy of this email with the reply inserted under each point, plus any amended documents which should clearly identify changes made, e.g. using track changes, italics or bold font. Please ensure that your Supervisor has checked your response before you submit your reply. Do not begin your research until you receive your final letter of approval.

Yours sincerely

Professor John O'Neill, Chair

Massey University Campus Human Ethics Committee: Southern A

*Patsy Broad
Ethics Administrator
Office of the Assistant to the VC (Ethics and Equity)
Old Main Building, Turitea PN221
Massey University/Te Kunenga ki Purehuroa
Private Bag 11222, Palmerston North
New Zealand*

*Phone 06 350 5573
Email: p.l.broad@massey.ac.nz
Fax 06 350 5622*

Appendix 7 Response to Human Ethics Committee

26 October 2006

Professor John O'Neill

Chairman

Massey University Campus Human Ethics Committee: Southern A

Old Main Building

Turitea PN221

Massey University

Application Number 06/60: How can midlife nurses be supported to deliver bedside care in the acute clinical services until retirement?

Dear Professor O'Neill

Thank you for considering the above ethics application and for agreeing to review the application on the HDEC form. I appreciate the timeliness with which the application was processed.

Please find enclosed my response to the conditions of the provisional approval, with amended documents attached.

Following discussion with my supervisor Jenny Carryer, there are three points that I would like to clarify further before final approval is sought.

- Firstly, the committee expressed concern that it may be possible to identify individual participants from the demographic information provided. I would argue that with over 400 potential participants from multiple practice areas it will be impossible to identify any individual. Although it would be feasible to have a third party input demographic data, I feel that the cost of this process does not warrant the extremely minimal risk.
- Secondly, the committee required that all relevant participant rights be included in the questionnaire information sheet. I understand this to mean inclusion of a statement relating to withdrawal or non-participation not affecting the participant's employment in any way. I have included this statement; however I do not feel comfortable with the decision. In my opinion (and my experience of ***** nursing staff) the idea that non-participation in research may affect their employment would not have occurred to the participants. They frequently choose to participate or not participate in a multitude of research throughout their clinical practice, and I feel that just the suggestion that this may affect their employment would make them feel uncomfortable, and potentially put them off participating.

- Thirdly, although I now realise that I should have made a written approach to senior management to apply for permission to carry out this research, unfortunately this was not the case. I made appointments to see each individual to discuss the research face to face. I also provided copies of the ethics application to present further information relating to the research process. I am therefore unable to provide a copy of a letter to *****.

I appreciate your consideration of these points and look forward to your response.

Yours sincerely

Caroline Dodsworth

Appendix 8 Final ethics approval



Massey University

5 December 2006

Ms Caroline Dodsworth
185 Moonshine Valley Road
PALMERSTON NORTH

**COPY FOR YOUR
INFORMATION**

OFFICE OF THE ASSISTANT
TO THE VICE-CHANCELLOR
(Ethics & Equity)
Private Bag 11 222
Palmerston North
New Zealand
T 64 6 350 5573/350 5575
F 64 6 350 5622
humanethics@massey.ac.nz
animalethics@massey.ac.nz
gto@massey.ac.nz
www.massey.ac.nz

Dear Caroline

Re: HEC: Southern A Application – 06/60
How can midlife nurses be supported to deliver bedside care in the acute clinical services until retirement?

Thank you for your letter dated 27 November 2006.

On behalf of the Massey University Human Ethics Committee: Southern A, I am pleased to advise you that the ethics of your application are now approved. Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Professor John O'Neill, Chair
Massey University Human Ethics Committee: Southern A

cc Professor Jenny Carryer
School of Health Sciences
PN351

Professor Carol McVeigh, HoS
School of Health Sciences
WELLINGTON