How are nurses supported to work in public hospitals until retirement age and beyond in New Zealand?

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ORIGINALITY DECLARATION

I declare that the work presented in this thesis is, to the best of my knowledge and belief, original and my own work, except as acknowledged in the text and reference pages.

Signed: 

Date: 22/5/15
Abstract

How are nurses supported to work in public hospitals until retirement age and beyond in New Zealand?

Introduction

As the population ages, it is imperative that the nursing workforce remain robust and sustainable so the health needs of New Zealanders can be met. Research identifies that 40% of the nursing workforce is over 50 years. In the clinical environment, nurses face challenges with working conditions. The aim of this research was to examine the perceptions of nurses working for District Health Boards (DHBs) to see if they believed they were supported within their workplace to work until retirement age or until they left of their own choice.

Method

An initial literature review was undertaken using the electronic data bases CINAHL, Proquest and Pubmed to identify international and national perspectives of how nurses manage as they age in the workforce. A descriptive survey was undertaken to examine the thoughts and perceptions of nurses to see if they felt supported in preparation for retirement. An online survey was sent to nurses aged over 45 years and working in three DHBs in New Zealand. Data were collected from SurveyMonkey™ and analysed using thematic analysis. Themes emerged from which to identify common perspectives.

Findings

Ninety nine responses were retrieved from approximately 3000 potential participants giving a response rate of approximately 3%. The emerging themes from the responses indicated that participants considered attention to support, education and competency expectations, work-life balance, working conditions and retirement intentions to be critical factors in their work environment.

Conclusions

Over 70% of participants (n=69) have indicated they do not feel supported in their preparation for retirement and it is evident that the workplace culture needs to make change so that all nurses feel supported and able to remain in the workforce as they age. Further research is recommended to identify and implement policies and interventions to address workforce sustainability to ensure nurses are supported until retirement.
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Chapter One: Introduction

As the baby boomer generation born between 1946-1964 (Lavoie-Tremblay et al., 2010) begins to retire the sustainability of the workforce in New Zealand and internationally is threatened. There are increasing concerns that nurses are struggling to carry out their duties in the workplace as they age and that the prospect of continuing in their chosen profession until retirement may be daunting. The research conducted internationally and in New Zealand (NZ) reported that nurses are struggling with shift work and the physical demands of their work (Blakeley & Ribeiro, 2008; Boumans, de Jong & Vanderlinden, 2008; Clendon & Walker, 2013a; Friedrich, Prasun, Henderson & Taft, 2011; McDonald, Mohan, Jackson, Vickers & Wilkes, 2010). Nurses also feel their input is not recognised (Moseley, Jeffers & Paterson, 2008) and some older nurses feel disadvantaged by technological developments (Graham & Duffield, 2010). If the views and needs of older nurses are not examined and considered the retention of older nurses will become an issue and older experienced nurses will be lost to the workforce at a time when it is acknowledged that the population globally is ageing and health needs are higher.

The intention was to explore the perspective of nurses within NZ public hospitals to see if they felt supported to continue working at present and in the future as they approach retirement. The question “how are nurses supported to work in public hospitals until retirement age and beyond in NZ?” was developed to allow nurses to offer their insight into the situation as they see it. It is important to examine what is already known, what is predicted for the future of the New Zealand nursing workforce, how this might impact on the ageing population and what if anything can be done to allow nurses to work for longer if they wish to. With so many clinical areas and such varied job descriptions it is important to identify where nurses work (clinical specialty), hours worked and the nature of their roster as well as their position in the workplace. This research gives an up-to-date snapshot of the situation as it is perceived by participating nurses in three DHBs in NZ at present.

In recent years there has been an increase in research around threats to workforce sustainability and the difficulties of continuing to work as nurses age (Graham & Duffield, 2010. Health Workforce New Zealand (HWNZ), 2012, North, 2010, Nursing Council of New Zealand, 2013c, Walker & Clendon, 2013). This suggests a growing awareness of the issues facing older nurses and the workforce as a whole. According to Statistics New Zealand (n.d.) the post-war baby boom and subsequent decline in fertility have produced a
"demographic bulge" as baby boomers move up the age scale. The oldest baby boomers are beginning to retire and this will impact on sustainability of the workforce in the future (Graham & Duffield, 2010).

Concern about workforce retention and sustainability is not limited to New Zealand. North (2010) found that the nursing workforce in NZ is threatened by other countries recruiting from New Zealand’s supply to reduce their own workforce shortages. This comes at a time when the NZ population is ageing and living with complex co-morbidities (North, 2010). It has also been suggested that nursing workforce studies must be a priority so an understanding can be gained of how the situation looks from the point of view of those delivering patient care and what it would take to retain their skills (North, 2010). If this situation is not explored and potential solutions developed it is known that there will not be enough nurses in NZ and globally to support the health needs of the population (Nursing Council of New Zealand, 2013a). This thesis may be of interest to future workforce employers, nurses working in NZ (and globally) as well as the public who will require the services of public hospitals in future.

Retention of older nurses must be a focus in workforce planning to ensure experience is retained, can be disseminated and there are enough nurses providing patient care as nurses approach retirement. NZ healthcare is constantly changing and developing and public expectations increase as technology advances (The Treasury, 2013). The Health Practitioners Competence Assurance (HPCA) Act 2003 was developed to ensure that registered health professionals maintain and prove competency. It is important that older nurses have an opportunity to speak about and share their experiences in the workforce and explain how the current situation impacts on their retirement intentions. If their experience is not explored changes cannot be made (if that is what is required) to allow them to work for longer thus supporting that workforce requirements can be met in NZ and internationally.

It is apparent that many nurses (of all ages) are struggling with the need to juggle their work/home-life balance. The New Zealand Nurses Organisation [NZNO] (2013c) reported that employers must acknowledge the multi-level family demands that older nurses may be facing, they went on to suggest greater flexibility is required to meet the needs of older workers. Clendon & Walker (2013b) reported a clear relationship between the health of nurses and their intention to retire. Despite initiatives such as the O’Shea No Lift Programme (O’Shea & Associates: Innovative Risk Management, n.d.) workplace injuries
continue to occur. Vecchio, Scuffham, Hilton & Whiteford (2011) report that nurses are at high risk for work-related injuries and it is known that older nurses are more susceptible to injuries (Buerhaus, Staiger & Auerbach, 2000).

For the purposes of this research a descriptive study was chosen to investigate the situation as it is today. The nurses are from three District health Boards (DHBs) within NZ. It is not known if results would be different in other DHBs and this study is limited by the experience of the researcher and resources and time available to carry out the study. Limitations are discussed in more depth in the methodology chapter.

**Thesis structure**

Chapter two provides a comprehensive review of current and recent literature from a national and international perspective in relation to how nurses are supported in their roles. Chapter three examines the research method and design as well as validity, reliability and methods of data collection and analysis. The Treaty of Waitangi and ethical considerations are also discussed. Chapter four presents the findings in meaningful units so that the perception of the participants will become clear. The findings are discussed in relation to previous literature in chapter five and finally chapter six will examine the research, its limitations; and recommendations for further research, education and practice.
Chapter 2: Review of literature

This chapter presents a review of national and international literature regarding the current nursing workforce situation and nurses’ perceptions of support available to them as they approach retirement age. The literature review will examine the average age of the nursing workforce, working conditions and the ability to cope as nurses age, intention to retire and the reasons for this. Furthermore a review of the literature will also examine the consequences of retirement of large numbers of nurses and threats to the sustainability of the workforce when considering the globally ageing population and increasing co-morbidities (United Nations, 2013). By analysing the data from New Zealand nurses it may be possible to identify whether nurses in public hospitals feel supported in their workplace to work until retirement or until they leave by choice rather than necessity. It is also possible that potential strategies to assist workforce sustainability may be identified.

Search strategy

A search of the databases including CINAHL, Proquest and Pubmed was carried out using the same search terms with the focus on the issues of concern to the nursing workforce and in comparison to workforces in other countries.

Keywords included nursing, support, employment and retirement. The Boolean operator AND was used, as using single keywords provided non-specific results or could easily be used in unrelated subject matter. It is impossible to search through thousands of articles, and by using AND it helped to search for more specific information. Wild cards and truncation were not used. The focus was on the situation as it is in NZ however it was also useful to look at what other countries are doing in the face of threats to the sustainability of their workforce.

Although Schneider et al. (2013) suggest research less than five years old, earlier resources were examined as a follow-up to Dodsworth’s (2008) research which explored how nurses could be supported to deliver clinical care until retirement. Dodsworth’s research was from one NZ DHB, this research was undertaken in three DHBs. While the research focussed on nurses working within DHBs in New Zealand, a review of international literature also identified concerns internationally regarding the ageing workforce.
Literature review

In 2008, Dodsworth identified that there was very little academic literature on the situation in New Zealand. Much of what was written related to other countries however it would appear that with the passing of time there has been an increasing awareness of the developing situation and questions have emerged regarding the sustainability of the NZ nursing workforce into the future (HWNZ, 2012; North, 2010; Nursing Council of New Zealand, 2013a; Walker & Clendon, 2013)

Common themes were identified within the literature including the predicted future shortfall of nurses due to pending retirement amongst the large baby boomer generation, the physical and mental demands of shift work (Clendon & Walker, 2013a), intergenerational differences (Lavoie-Tremblay et al. 2010) and health of older nurses (Clendon & Walker, 2013b). Research clearly indicates a pressing need for strategies to avert this predicted shortage (Clendon & Walker, 2013; Moseley, Jeffers & Paterson, 2008; North, 2010; Nursing Council of New Zealand, 2013a). Strategies might include focusing on employment conditions (North, 2010), improved rostering (Clendon & Walker, 2013a), efforts to address the health of nurses (Clendon & Walker, 2013b) and the importance of strong leadership (HWNZ, 2012). A Canadian study examined the workforce from an intergenerational perspective (LaVoie-Tremblay et al. 2010) and found that retention strategies were beneficial across the generations.

HWNZ (2012) is concerned that a large number of nurses are likely to start retiring just as the demand for healthcare increases due to the ageing population and that retirements among the ageing workforce will become a critical factor by 2017 (Ministry of Health, 2014c). Since 1998 the median age of New Zealand nurses has risen from 42.6 years to 46.7 years in 2010 (HWNZ, 2012), and 40% of the total nursing workforce are now over the age of 50 (Clendon & Walker, 2013a), while 59% are over the age of 45 (Nursing Council of New Zealand, 2013). HWNZ (2012) also stated that several international studies accept that retirement rates are key determinants of workforce sustainability. The nursing workforce in New Zealand is 92.8% female, and research shows that in general females retire earlier than males (HWNZ, 2012).

McDonald et al. (2010) recognised that globally the ageing nursing workforce faces significant loss of expertise because of retirements. More junior nurses and those new to
New Zealand (or any other country) may benefit from mentoring from senior nurses. Mentoring nurses also reported the mentoring experience to be rewarding (McDonald et al., 2010). North (2010) examined the impact of health policy and reform on the nursing workforce and suggested that it may have a bearing on the current retention difficulties and future workforce sustainability. At present there is reliance on overseas recruitment to sustain NZ workforce requirements however it is apparent that the nursing shortage is a global problem and international recruitment is no longer an option (North, 2010). Currently the annual output of new nurses is not sufficient to replace retiring nurses or those who choose to emigrate (North, 2010). Distress in the nursing workforce has been linked to ongoing restructuring and reform as well as the loss of nursing leadership structure and career pathways (North, 2010). This could mean that nurses are more interested in a stable work environment rather than one in a state of constant change.

The main threats to workforce sustainability include the large group approaching retirement, large numbers of nurses emigrating and the hours nurses are required to work (North, 2010). The NZNO Employment Survey 2015 sent to 5000 nurses indicates that 16% are considering nursing outside NZ (Walker, 2014). Whilst it is not possible to change the age of the nursing workforce it may be that if conditions were seen to be more flexible nurses might choose to work for longer within the New Zealand health system. The focus may need to be on bringing nurses into the workforce through training as well as providing incentives to retain those approaching retirement.

The literature suggests however that there are global concerns about the ability of countries to sustain their nursing workforce as the population and workforce age and live with more complex co-morbidities (HWNZ, 2012; North, 2010). It would appear therefore that New Zealand cannot rely on recruiting internationally in the long term. More nurses will be needed to maintain the health system and care for the aging population. There does not appear to be a clear solution to workforce sustainability concerns and further research is required nationally and internationally. It would appear that the nursing workforce may be compromised by the looming retirement of large numbers of nurses. North (2010) suggests that the nursing workforce is not growing while demographic-related demand is increasing. Solutions and plans must be put in place to overcome the effects of forecast shortages as nurses approach retirement age. The issues include maintenance of staffing at safe levels, and provision of an enticing and more satisfying work environment for those who choose to pursue nursing as a career in future. Following a mail-out questionnaire sent
to 200 nurses in Canada, Blakeley & Ribeiro (2008) reported that participants identified a number of incentives to postpone retirement including being acknowledged for good work and recognition of seniority.

The purpose of this research was to ascertain how nurses perceived they are supported within their workplace in relation to preparation for retirement. The oldest baby boomers are now 68 years old whilst the youngest are 51 so at present the situation is manageable however the future is unclear when it is known that there is a large group approaching retirement. While there was international research available, Dodsworth (2008) identified a lack of information on the New Zealand experience. There is research from NZ available now, which might suggest an increasing awareness of the national situation, the global situation and its likely impact upon New Zealand. HWNZ (2012) reported there is a risk of a nursing shortage when the demand for healthcare from an ageing population will increase. North (2010) questions New Zealand’s ability to retain nurses in the NZ workforce and Clendon & Walker (2013b) identified concerns about the health of older nurses and their challenges in the shiftwork environment.

North (2010) presented a discursive paper discussing the threats to the sustainability of the NZ nursing workforce. This paper analysed NZ nursing workforce data as part of the international situation and highlighted the global nursing shortages. The aim of a discursive paper is to present a balanced and objective examination of a subject (Pierce, n.d.). North (2010) reported that sustainability of the nursing workforce in NZ is threatened by international competition for nurses and the ageing workforce.

In 2012 an anonymous on-line survey was sent to members of the New Zealand Nurses Organisation (NZNO) who were over 50 years of age to examine their health and experience of shift work as they aged (Clendon & Walker, 2013a). The survey received 3273 responses (a response rate of 57.6%). This survey provided quantitative and qualitative data of the situation at that time. As it was sent to nurses who were members of the NZNO they could have come from DHBs and the private sector.

Clendon & Walker (2013a) reported that approximately 62.2% of nurses in New Zealand work shifts and 57.2% of those work rostered and rotating shifts. Shift work requires changes in the individual’s sleep pattern and restricted sleep can cause cumulative degradation in waking performance and mood (O’Keeffe & Gander, 2012). Clendon & Walker (2013a) found that the impact of shift work is greater in the older person and can
have a negative impact on their health. Working shifts can also lead to increased intention to retire early (Clendon & Walker, 2013a). Strategies to support retention of nurses may include measures such as self-rostering (Clendon & Walker, 2013a), however in order to create a fair and legal roster the needs of all nurses regardless of age must be considered equally. Clendon & Walker (2013a) found that nurses over 50 reported increased fatigue in relation to shift work. The MOH (2014c) stated that while 44% of registered nurses are over 50, 82% of enrolled nurses are aged over 50. It is important to identify age and gender as this might have a bearing on how nurses feel at work, financial plans and intent to retire. Demographic questions can provide a lot of information about the population being studied (Surveymonkey™, 2015a). It may be that nurses in different age groups will respond differently to survey questions. Workplace injuries, levels of sick leave and perception of the physical demands of nursing were included in the survey and literature search to help create a clearer picture of the overall situation. The NZNO (2013) stated it supported development of policy for staged retirement for those in physically demanding occupations such as nursing.

It is important to examine the support of nurses across the age range rather than in separate age brackets. It may be that strategies put in place to support older nurses could also be beneficial for younger staff and that this could then lead to improved retention of staff across the whole workforce. HWNZ (2012) suggests job satisfaction is a key determinant in retention of nurses and goes on to describe factors influencing job satisfaction as “pull factors” whilst “push factors” are described as reasons for considering leaving. Push factors include increased workloads and lack of flexibility in hours and shifts (HWNZ, 2012).

The Royal Australasian College of Physicians (2011) suggested that workplace practices, culture and work-life balance are key determinants of individual health, wellbeing and productivity. The current nursing workforce consists of three main generations: baby boomers (1946-63), generation X (1964-80) and generation Y (1981-2000) (Lavoie-Tremblay et al, 2010). A quantitative study carried out by Lavoie-Tremblay et al (2010) of the three generations looked at their perspective of the work climate, results showed that the main reason Generation X and Y intend to quit their employment is to advance their career whilst among the baby boomers the main reason is retirement. Baby boomers are described as willing to go “the extra mile,” they are hard workers who are sensitive to feedback and can be judgemental of others who may think differently (Lavoie-Tremblay et
al, 2010, p. 415). Generation X workers may be less loyal and more sceptical while Generation Y workers may be considered “high maintenance” but productive staff members (Lavoie-Tremblay et al, 2010, p. 415).

In a Canadian study, a questionnaire was completed by 1376 hospital workers (including but not confined to nurses) (Lavoie-Tremblay et al., 2010). The collected quantitative data highlighted differences in work climate perceptions and intention to quit between the generations. While this study was across three generations it was not confined to nursing. Nurses made up 42.1% of the population (n=579) and the employees all came from a single Canadian hospital.

Current literature identifies many issues in relation to how nurses are managing and problems they report as they age in the workforce, but no clear solution to workforce sustainability concerns. Offering a user friendly roster may seem at first glance to contribute to a resolution of “the problem” of perceived lack of support of nurses. Becker, McCutcheon & Hegney (2010) suggested that enabling staff to work according to their own roster preferences will assist with retention. Lavoie-Tremblay et al (2010) found that retention strategies that focus on improving the workplace could be beneficial for all generations of nurses. HWNZ (2012) described low remuneration as a “push factor” (factors that may lead to staff considering leaving). Clendon & Walker (2013a) also suggested that better pay and rostering have the potential to reduce attrition. While HWNZ (2012) describes low remuneration as a “push factor”, “pull factors” include good morale, teamwork, and being able to have a positive effect on younger staff. HWNZ (2012) also suggested that the choice to retire is more affected by household characteristics than financial reward.

The literature suggests that staffing shortages are a global problem (McDonald et al., 2010) and that there is a need for greater flexibility with rostering and further consideration by management of the physical demands of patient care (McDonald et al, 2010). The literature also acknowledges the contribution that older nurses make to the workforce, providing care and supporting their younger colleagues (McDonald et al, 2010). This Australian research (McDonald et al., 2010) found following a collective case study that a mentoring programme reinforced a positive workplace environment for both the mentors and mentees. The literature explores the need for self-sufficiency in the NZ workforce as the shortages are felt worldwide (Buerhaus et al. 2000; HWNZ, 2012; McDonald et a., 2010; North, 2010;).
There is an expectation that nurses continue education and maintain core competencies. The HPCA Act (2003) was introduced to protect the health and safety of the public by providing mechanisms to ensure health practitioners are competent to practice (New Zealand Parliamentary Counsel Office, n.d.). In 2004, the Nursing Council of NZ began approving PDRPs as recertification programmes under section 41 of the HPCA Act 2003, the aim was to exempt portfolio holders from the recertification audit (Nursing Council, n.d.[a]). The aim of the recertification programme is to ensure continuing competence of the practitioners (New Zealand Parliamentary Counsel Office, n.d.).

Vernon, Chiarella, Papps, & Dignam (2012) surveyed nurses in NZ to determine their satisfaction with the Nursing Council of New Zealand (NCNZ) Continuing Competency Framework (CCF). The Professional Development and Recognition Programme (PDRP) was not the focus of this research and participants reported confusion between the NCNZ requirements and the PDRP (Vernon et al., 2012).

It would appear that there is no simple solution readily available to address workforce concerns and it is apparent that this situation is not confined to New Zealand. New Zealand cannot expect that the nursing resource will continue to be supplemented by international recruiting as other countries face similar problems with the sustainability of their own workforce and therefore it is imperative that research continues in the quest for solutions.

Summary

A review of the literature identified several issues including the burden of shift work (Clendon & Walker, 2013a), the health of nurses aged over 50 years (Clendon & Walker, 2013b), the threat to the sustainability of the NZ nursing workforce (North, 2010) and the looming retirement of baby boomers (HWNZ, 2012).

Themes have emerged from the literature. Nurses report increasing difficulty managing shiftwork as they age (Clendon & Walker, 2013a); nurses working in physical environments have higher pain scores and this can have a bearing on retirement intentions (Clendon & Walker, 2013b); and the nursing workforce is under threat as the population ages and the large baby boomer generation approach retirement (North, 2010). The broader picture indicates concerns nationally and internationally regarding the sustainability of the nursing workforce as the population ages. The threat to workforce sustainability is in part due to the fact that the large baby boomer generation is approaching retirement age. Current research does not appear to address how nurses are supported in their work environment.
If the sustainability of the workforce is under threat this must be addressed, it is only by identifying concerns of nurses that measures can be taken to improve the working environment. The following chapter will discuss the methodology used to conduct this study.
Chapter 3: Methodology

Introduction

This chapter explains the methodology used to conduct this research. The aim of the study was to answer the research question: How are nurses supported to work in Public Hospitals until retirement age and beyond in New Zealand (NZ)? It explains the research process, survey design, steps taken to ensure validity and reliability, ethical and cultural considerations, sample selection, data collection and data analysis.

Methodology

The research design followed a quantitative approach with some open ended questions (qualitative data). According to Whitehead (2013) the positivist approach gives an objective view of the situation and is representative of the quantitative approach. An exploratory descriptive study was used; this approach allows a lot of information to be gained from a large population (Shields & Watson, 2013). Shields & Watson (2013) suggest that surveys measure knowledge and opinions of particular individuals.

SurveyMonkey™ is a provider of web-based survey solutions, it aims to assist researchers to gather information so that they can make informed decisions. The survey was only available to nurses with internet access which limited the potential sample population however it was sent out to nurses via their workplace email address so potentially those without home email access would still have the opportunity to participate should they wish to do so.

Disadvantages of surveys include potentially small response rates, Aitken, Power & Dwyer (2008) conclude that paper questionnaires might still be more effective than the on-line approach when collecting data from health professionals. Hunter (2012) suggests that as nurses become more computer literate this reluctance to participate in on-line surveys may decrease. The cost and extra time necessary for postal surveys were prohibitive and while it may have ensured a wider audience there was no guarantee that that this method would have achieved a higher response rate.

The data were collected via an online survey using the SurveyMonkey™ platform. While it is acknowledged that an online format will exclude those without computer access or skills an online survey provides a quicker return than a postal survey (Resnick, 2012). The online approach also eliminates costs such as printing and postage.
According to McPeake, Bateson & O’Neill (2014) it may be that health professionals are suffering from “survey saturation” and given time constraints they may choose to only answer surveys they believe to be essential. It may be that online surveys result in an unrepresentative picture of a population because only those motivated to participate complete the survey resulting in “self-selection bias” (Tolich & Davidson, 2011). Non-response to single questions may be intentional or accidental, intentional non-response may be because a question is seen as too personal or the answer is not known by the participant (Curtis & Redmond, 2009). In order to improve the response rate questionnaires must be distributed to a group for whom the subject is relevant and interesting (Hunter, 2010).

Pretesting of the survey ensured that it was easy to understand. It may identify ambiguity in questions, unclear instructions and whether participants objected to any questions or found the questionnaire to be too long or complex. The survey was given to colleagues in hard copy as a trial and minor modifications were made as a result. The wording in some questions was altered and after consultation with my Principal Supervisor questions were also added. In order to ensure validity of results it is important to be certain that the questions are clear and convey the intended meaning so that participants understand what is being asked (Sage Publications n.d.). According to SurveyMonkey™ (2015c) it is important to use appropriate language, keep questions simple and take care not to lead participants towards one answer.

Method

Research Question

The aim of this research was to examine the perceptions of nurses to see if they believed they were supported to remain in the nursing workforce until retirement. SurveyMonkey™ (2015b) suggests that before designing a survey it is essential to identify the question for which an answer is sought. According to SurveyMonkey™ (2015d) surveys test hypotheses about attitudes and behaviours while allowing researchers to survey people anywhere in the world.

Sampling

Sample surveys are conducted by selecting units from a population and recording information or data on the units (Fisher and Schneider, 2013). The target population is described as the population that the research aims to represent (Ministry of Health, 2012).
While the survey sought the opinions of nurses working in public hospitals it would be difficult and ineffective to access an entire population (Fisher and Schneider, 2013). For these reasons and perhaps due to time constraints, money and access, the researcher must use sampling strategies (Schneider and Fisher, 2013). The sample should be chosen to ensure that valid generalisations can be made from the sample to the population (Schneider & Fisher, 2013).

According to Parker (2011), sample surveys utilise responses from a cross section of the population and a correctly chosen sample can be generalised to the entire population. The sample population came from three District Health Boards (DHBs) in the North Island, NZ. At present there are 20 DHBs in NZ (Ministry of Health, 2014b). Hospitals in these DHBs provide secondary and tertiary level care.

An invitation to participate in the questionnaire was sent to Directors of Nursing who then made the link available to workplace email addresses via SurveyMonkey™. It was open for one month and was for nurses aged over 45 years working in public hospitals. The sample selection was chosen as it surveyed nurses in different locations in the hope of getting a broad range of opinions. In 2014 there were 51387 nurses who met the criteria to practice in New Zealand, of those 46% were aged 50 or older (Ministry of Health, 2014c).

According to Fisher and Schneider (2013), the key in sampling is to ensure representativeness of the whole group. To generalise from a sample it is critical that the sample is representative of the population therefore it is essential that the researcher identifies their population (Fisher and Schneider, 2013). For the purposes of this research the population was registered and enrolled nurses working in public hospitals within New Zealand, in all specialty areas, male or female, full time or part time, aged over 45 years and regardless of years of experience. Cluster sampling is a good option as it is more economical in terms of time than other types of probability sampling, however the disadvantage is there may be more sampling errors and the statistical analysis is complex (Schneider and Fisher, 2013).

Generally, the larger the sample size the higher the chance of demonstrating an effect (Fisher and Schneider, 2013). The researcher had no control over how many people chose to respond to the survey. As a sample survey was conducted sampling bias had to be considered. Bias is described as any influence that may distort the results of a research study (Schneider et al, 2013). According to Del Mar and Hoffmann (2010) it is a systematic
error in the selection of the participants, the way in which outcomes are measured or data is analysed and may lead to inaccurate results. By surveying in three DHBs it was hoped feedback would be broad and varied, if research had been confined to one DHB results may have been quite different as the workplace culture from one area to another may vary significantly. A larger sample size should result in greater certainty of the findings (Del Mar and Hoffmann 2010).

**The questionnaire**

Osborne and Schneider (2013) describe a questionnaire as a way to gather data from participants in a quantitative study. They also state that questions should be clear, unambiguous and asked one question at a time (Osborne and Schneider, 2013). An advantage of a questionnaire over an interview is that the researcher is absent thus eliminating potential for interviewer bias (Osborne and Schneider, 2013). Questionnaires can also access a larger sample at a lesser cost than interviews (Osborne and Schneider, 2013).

The literature reports that as nurses age many report increasing difficulty managing shift work and the balance of good health and family life (Clendon & Walker, 2013a). Bell (2013) stated that many nurses are motivated by the reward of caring for people, bored or financially challenged. HWNZ (2012) also identified injuries, fatigue and increased workloads as reasons for leaving a position. When considering these factors the questionnaire was developed to examine the current situation from the perspective of nurses working in the DHBs. It was important to identify the clinical environment in the DHB that the nurses worked to see if any specialty area reported a different view to other areas. It was also important to ask about hours worked to see if satisfaction varied according to this and also to see if they were registered or enrolled nurses.

Enrolled nurses must work under the direction and delegation of a registered nurse while registered nurses can work independently (Nursing Council of New Zealand, 2012). This may mean they are more limited in their job opportunities and it may be that they will be working in an area just because they could get a job there rather than it being their area of choice. Questions were asked around the importance of income to see if nurses worked because they wanted to or because of the need to pay a mortgage or meet other financial obligations. Questions were asked about ongoing education and portfolio requirements to see if this had a bearing on intent to retire. The nursing portfolio was designed to
demonstrate competence Vernon et al., (2012). Nurses with current PDRPs are exempt from the nursing council recertification audit (Nursing Council, n.d. [a]). According to Vernon et al. (2012), in a survey of nurses looking at their perceptions of the Continuing Competence Framework a significant proportion of participants indicated that their employers and/or regulatory authority were also responsible for ensuring their continuing competence.

Validity and reliability

A concept can be defined as something that can be measured and can be described as a variable (Gillespie & Chaboyer, 2013). A measuring tool can be a questionnaire and when measuring, two components must be considered—reliability and validity (Gillespie & Chaboyer, 2013). Reliability is described as the consistency with which the instrument measures the question (Gillespie & Chaboyer, 2013). Validity is the degree to which the instrument measures what it is supposed to measure (Gillespie & Chaboyer, 2013) or whether the right questions are being asked to get the answer the researcher is seeking. According to Pearson (2010) validity can be assessed by establishing the extent to which the design of a study addresses potential sources of bias. The researcher must be careful not to lead the participants and must also ensure that the participants are representative of the population they wish to generalise to (Del Mar & Hoffmann, 2010). If reliability and validity cannot be demonstrated it limits the ability to draw conclusions from the findings (Gillespie & Chaboyer, 2013). While the survey was limited to nurses aged over 45 years working within the DHBs there were no restrictions placed on position in the workplace or area of work. The invitation to participate explained the aims of the study but care was taken to present this information without bias.

Data Collection Tool

A questionnaire was selected as the most appropriate method for obtaining the data for this research. It was important that participants were assured that their responses were confidential and their identity could not be known to the researcher.

According to Osborne and Schneider (2013) the quality of data collection methods and integrity of data collected is crucial to the success of a study. Variables of interest can be gathered using one or a combination of five common quantitative data approaches including physiological measurement, observation, interviews and questionnaires, and records or other documents (Osborne and Schneider, 2013). Quantitative data approaches
ask a set of pre-defined questions and may include open or closed questions. A disadvantage may be that not everyone who has an opinion and would like to participate may have the literacy skills to allow their participation.

It is important that a questionnaire is not too long or complicated, as this may discourage some people from participating (Osborne and Schneider, 2013). This means that when designing a questionnaire, a researcher must be clear about exactly what it is that they hope to find out. Larger populations can be accessed with questionnaires than with interviews, this helps to increase generalisation of findings (Osborne and Schneider, 2013). Questionnaires can be in the form of pencil and paper or electronic format (Osborne and Schneider, 2013).

The data were collected from SurveyMonkey™, all responses were anonymous and DHBs could not be identified. The advantages of anonymity meant that respondents would be free to say what they thought rather than what they thought it might be safe to say. Absolute anonymity is difficult to guarantee however as thoughts/opinions may have been voiced in the past and be known to the researcher (Woods and Schneider, 2013).

According to Gillespie and Chaboyer (2013) the quality and rigour of any quantitative study is reliant on ensuring the measuring instruments do actually measure what they were designed for. A measuring instrument is a research tool that enables measurement of study variables which are defined as measurable scientific concepts (Gillespie and Chaboyer, 2013). In this research the variables were described as nurses over 45 years who are working in public hospitals in NZ and the data collected enabled the researcher to use statistics to measure responses and determine meaning.

**Data analysis**

Descriptive statistics allow researchers to describe, organise and summarise raw data so that findings can be better understood and reliability of these findings can be determined (Fisher & Schneider, 2013). There are two main reasons for using descriptive statistics, the first is the organising of data into graphical and numerical terms so that trends and differences may be seen and the second condenses large amounts of information into meaningful units (Fisher & Schneider, 2013).

Measurement is described as the assignment of numbers to objects or events according to certain rules and the level of measurement is determined by the object or event being measured Fisher & Schneider, 2013). The questionnaire elicited nominal and ordinal results
in addition to qualitative data. Survey Monkey™ provides a function that allows data to be presented in this manner. Nominal measurement classifies items into categories for example area of work, age or years of experience while ordinal measurement ranks items in an hierarchical order such as slightly important, mildly important or very important. Open ended questions are an example of qualitative data or information gathered in narrative form rather than numeric (Schneider, et al, 2013).

Qualitative research allows in-depth analysis of how and what people think (McLeod, 2008). Ten open ended questions were asked within the survey; the intention was to allow participants to elaborate on their answers so that further depth of information could be obtained. According to Harding & Whitehead (2013) there is no standard way to analyse qualitative data however it must be systematic while applying abstract and conceptual thinking.

Analysis of the data obtained in the open-ended questions was completed manually. Individual responses were examined then the question summaries were reviewed. All responses to the open ended questions were matched up with demographic information to create an overall picture. This allowed comparison of groups of nurses. The purpose of thematic analysis is to identify patterns of meaning or similarities in responses to questions across a dataset that provide an answer to the research question (Braun & Clarke, 2006). Braun & Clarke developed a six stage process for thematic analysis. The initial phase involves familiarisation with the data followed by coding to identify important features within the data (Braun & Clarke, 2006). The next three steps involve searching for themes, reviewing and naming or defining the themes to determine the ‘story’ (Braun & Clarke, 2006). The final stage of thematic analysis in this process is to weave together the data and analysis then compare with existing literature (Braun & Clarke, 2006). The data were read and re-read to help the researcher to gain an understanding of what participants were saying. Responses from the summary reports such as incidence of workplace injuries were identified and then cross-matched with the individual responses to see what the information meant.

Common themes were highlighted in the raw data to enable quick identification of information on any particular aspect. Once the information had been labelled in this manner the researcher was able to review the data and identify patterns of meaning and common themes. Each theme contributed to the overall picture or perception of how nurses feel that they are supported to continue to work as they approach retirement.
Ethical considerations

Ethical approval was granted from the Eastern Institute of Technology (EIT) Research Ethics and Approvals Committee (REAC) prior to commencing this research and locality approval was obtained from each of the participating DHBs. Consent was explained on the front sheet of the survey and stated that submission of the survey indicated consent to participate. Participants were invited to participate if they wished to but there was no obligation to do so.

Invitation to participate addresses the principle of autonomy as individuals had the right to self-determination. (NZNO, 2010). In order to ensure implied consent it is essential that adequate information about the study is provided (Alessi & Martin, 2010). Raw data were stored electronically in a password protected electronic folder on the EIT electronic platform, this addresses the ethical principle of confidentiality or the right to privacy as well as guardianship of the environment and resources (NZNO, 2010).

Participants were informed that they were not required to answer all questions, and while most completed the questionnaire, some did not. It is not known why they may have chosen not to answer. All responses were anonymous and DHBs could not be identified.

Treaty of Waitangi considerations

The core principles of participation, protection and partnership must be considered when developing health research proposals. As part of locality approval Maori health units were involved. The survey was open to every nurse in the chosen DHBs over 45 years of age. Ethnicity was not questioned or identified.

Limitations

Survey research is increasingly being used in health care research and can determine and measure knowledge, attitudes, behaviours and beliefs (Roberts, 2012). Surveys produce data and opinions at only one time, while a series of repeat surveys can give a picture of change (Tolich & Davidson, 2011). Unless the study was to be carried out regularly, there would be no way to measure change in attitudes or views of the situation as it developed.

According to Tolich & Davidson (2011), surveys collect data at one time and if taken out of context can easily be misunderstood or misinterpreted. As the researcher is not present to correct any misunderstandings it is difficult to be certain that participants have completed the survey independently (Roberts, 2012). Roberts (2012) suggests that questions must be
carefully phrased to assist comprehension by the sample population as incorrect assumptions that the participants will understand the questions may affect their willingness to participate. From the pre-testing performed it appeared that questions were clear and easy to understand. Most staff have work-based email access so should be contactable and able to access the survey however it may be that some staff choose not to use their workplace email. The response rate may also be affected by a lack of trust in the security of transmitting information over the internet (Scott et al., 2011).

By limiting the age group surveyed, the pool of information that could be gained was also reduced. If these questions were to be asked of all nurses regardless of age the information gained would be potentially very large and in this instance the aim was to see how older nurses perceived the situation as they moved into retirement or pre-retirement. According to Cleary, Horsfall & Hayter (2014) participant selection must fulfil a specific purpose related to the research question. Adequacy of participant numbers is also important, as too few may mean the depth of the research is compromised, while too many may yield superficial or unwieldy volumes of data (Cleary, Horsfall & Hayter, 2014). This research was carried out in three DHBs therefore the results are not transferrable as they came from a small population.

The survey was open to all nurses in the DHB setting aged over 45 years in the participating DHBs. It may be that if invitations had only been extended to nurses working in ward areas and provided direct patient care the results could have been different. Limiting the survey to nurses directly involved in patient care would have resulted in a much smaller response rate. It is also possible that these nurses would have greater variance in their work roster and hours as opposed to those that had fixed rosters.

**Summary**

The purpose of the data analysis in this thesis was to provide a descriptive analysis of the findings. The aim was to explore whether nurses felt supported to work until retirement and to determine what might assist them to work for longer in the NZ public health system. Maintaining ethical principles of informed consent and the right to privacy meant that participants were free to say what they thought. It is possible that participants might know the researcher however as the survey was anonymous and accessed through a link from an independent person, participants were unidentifiable. The next chapter will present the findings of the survey.
Chapter Four: Findings

Introduction

The aim of this study was to examine how nurses in clinical practice in public hospitals perceive the current situation regarding levels of support from employers and intentions to retire when considering the demands of their work situation. This study was made available to nurses aged 45 years and over in three NZ DHBs. This chapter presents the findings from the survey.

Response rate

Nursing Council workforce statistics (2013) report that there are approximately 3000 nurses within the DHBs the sample was drawn from who are aged 45 years and over. Ninety nine responses were received from nurses in the survey pool, this gave a response rate of approximately 3%. The survey was open for just over one month. Kalpana (2011) suggests that 100 responses from a population of 3-5,000 will give an error rate of +/- 10%.

While it is acknowledged that the response rate was not high, the information gained is of value because it came from nurses working in this environment. The standard of completion was high with only five incomplete responses, and no questionnaires were excluded from the data analysis. Hunter (2012) suggests that while the internet is likely to become the dominant medium for surveys in future nurses are slow to embrace this technology. There is potential for survey saturation and having the time and energy to participate may remain an issue (McPeake, Bateson, & O’Neil, 2014). Healthcare professionals are regularly asked to complete surveys and this may lead to them only completing those that they deem necessary (McPeake et al., 2014).

Demographic data

Ten demographic questions were asked as part of the survey; collection of this information helped to describe the population. The majority of the participants (95.9%) stated they were registered nurses (n=94). Three enrolled nurses (3.1%) and one nurse practitioner (1%) also responded to the survey. These figures are similar to statistics from the Nursing Council of New Zealand (2013e).

Participants were asked in the survey what year they had registered or enrolled in their current scope of practice. The current scope is important as some of the respondents reported different figures for years in their current scope compared to years working as a
nurse. Participants had over 2000 years of experience between them with the smallest number of years at three and the highest number being 52 years, the average number of years working as a nurse was 29 years.

Participants were asked their age, 94 participants answered with the largest group being in the 50-55 age bracket (34%). Eight nurses identified as being over 65 years of age (8.5%). Participants in each age bracket were represented in the results (figure 1).

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<tr>
<td>61 - 65</td>
<td>18.1%</td>
<td>17</td>
</tr>
<tr>
<td>65+</td>
<td>8.5%</td>
<td>8</td>
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</table>

 responded question 94
 skipped question 5

Figure 1: Age range

The responses to the question of years of experience working as a nurse identified that this ranged from four to 55 years of practice. Of the 96 responses to this question three participants had over 50 years of experience each and only 18 had less than 20 years of experience working as a nurse, of those just three were less than 10 years. This indicates a high level of experience amongst respondents with the average number of years of experience at 28 years. Participants were asked if they were female or male, 90.72% were female with just 9.28% male. Participants were also asked to identify their work area. Responses were varied with the largest group reporting surgical nursing (11) followed by Mental Health (7 in hospitals and 4 in the community). Participants were asked if they worked part-time or full time and results were very close with 50.5% working full-time. Participants were not asked to give reasons for working part-time or full-time.

Participants were also asked for the generic title of their position. This again demonstrated the wide variety of work available within the nursing profession; participants have described their titles rather than the qualification listed on their practising certificates.
Participants were asked when they were considering retirement. This question had a response rate of 100% (figure 2). The largest group (n=45) responded they did not plan to retire until after the age of 65 years with 11% indicating they intended to retire before the age of 65 (n=11).

Figure 2: Retirement intentions

Participants were asked about hours of work and rosters with an option to tick other and specify their response. Half of the responses indicated working on a fixed roster and 28.57% indicated rostered and rotating shifts. Of those (21.43%) who ticked other, responses included comments such as

“full-time and on-call, days and PMs but not nights, hours to do the job, flexible to suit myself and the ward”.

Section two of the survey sought to discover the situation as perceived by the participants in the hospital environment- what nurses thought and their reasoning for these views. The survey gave a range of options as answers and included 10 open ended questions inviting further comments. Participants selected from the options offered such as very important, very demanding, yes or no. Some chose not to comment further, while others took the opportunity to share their views and added richness to the data.

Participants were asked to rate the importance of whether they worked until retirement or not (figure 3). Only 4.1% stated that it was not important that they work until retirement. Of the 37 additional comments, 24 included comments relating to the financial need to continue working. There were also many other comments around the enjoyment of their work and the value nurses placed on their contribution to their patients.
Participants were asked to describe the physical demands of their work (figure 4). More than 80% of nurses who answered this question described their work as demanding, very demanding or extremely demanding. Those that chose to comment further (n=32) reported the physical demands as being on the feet for so long, bending and stretching. They also spoke of long hours, mental demands and the difficulties of shift work.

Question 13 asked about the importance of income and whether that dictated that nurses stay at work (figure 5). Almost 98% of respondents (n=95) indicated that income had a bearing on whether they stayed at work or not. Additional comments were invited and
some participants (n=19) chose to elaborate. They spoke of the desire to maintain their lifestyle and their financial commitments.

Figure 5: the importance of income

Question 14 sought participants’ opinions around ongoing educational requirements and portfolios. More than 90% (n=86) of respondents identified that education was important. Of those that chose to comment further (n=39), 16 voiced concerns about the portfolio requirements.

It was important to examine whether the hours worked impacted on the level of satisfaction of nurses and if self-rostering would help participants to work longer (see figure 6 below). Over 60% reported that this would make a difference to how long they would work. Twenty three participants chose to comment further, with five stating a preference to reduce hours. Participants did not specify an inability to reduce hours because of employer requirements or that they would like to in future but had not yet explored this option. One participant commented

“I aim to drop FTE as I approach retirement- will not be able to do that in current job.”

Another commented

“It is unfortunate that in this position you cannot work part-time, ultimately I would like to work 0.8FTE but make the choice to work full-time as this is the only option for this position.”
Another commented

“I don’t feel I can step aside or down as none of my staff want to step up (most have opted to reduce hours) so I have to leave to get reduced hours or less responsibility. I love my job so this is not an option.”

Figure 6: Rostering options

When asked about their current hours almost 90% indicated they were happy or very happy with their hours (see figure 7). Further comments were invited and of the 26 that elaborated eight voiced a desire to reduce their hours or work part-time rather than full-time. Discussion included comments such as

“it is a requirement of this position to work full time”

Another participant commented

“I work many hours over what I am paid for”

Another participant commented

“there is little recognition of the hours worked”

Another participant commented

“I would prefer to work part time”
How do you feel about your current work hours?

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<tr>
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<td>0</td>
</tr>
<tr>
<td>Please comment</td>
<td></td>
<td>26</td>
</tr>
</tbody>
</table>

Please comment further on anything you would like to share about your response

| answered question   | 97               |
| skipped question    | 2                |

Figure 7: How do you feel about current work hours?

The ability (or inability) to work flexible hours was explored further in question 17. Over 50% of participants indicated they did have the ability for flexibility with 43% (n=42) indicating they did not. Additional comments did not appear to back this up as flexibility was largely based around “the work needs” for example hours could be adjusted as long as it fitted in with the department requirements.

Questions 18 and 19 explored postgraduate education, whether it had been undertaken and if so, what nurses had been studying or whether they were intending to study in future. Almost 80% of respondents indicated they had undertaken postgraduate education (figure 8). Qualifications gained were varied. Of those who chose to comment further (n=93), 55 reported they held either a post-graduate certificate, post-graduate diploma or master of nursing qualification.

Figure 8: Have you undertaken postgraduate education?
The incidence of workplace injuries, whether staff have sick leave available and if regular annual leave was taken, were questions included in the survey. When asked about workplace injuries 28% reported they had sustained an injury (figure 9), further comment was not invited. Almost all (over 90%) had sick leave available (figure 10) and 93% reported that they took regular annual leave (figure 11), further comment was not invited.

### Have you sustained any workplace injuries?

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<td>72.6%</td>
<td>69</td>
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</table>

**answered question** 95
**skipped question** 3

Figure 9: Workplace injuries

### Do you have sick leave available currently?

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<tr>
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<td>8.4%</td>
<td>8</td>
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**answered question** 95
**skipped question** 4

Figure 10: sick leave

### Do you have and take regular annual leave?

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<tr>
<td>No</td>
<td>6.3%</td>
<td>6</td>
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</table>

**answered question** 96
**skipped question** 3

Figure 11: annual leave

Participants were asked for their opinion about how they are supported in preparation for their retirement, see figure 12 below. Almost one third (n=27) indicated they felt they received good or excellent support while two thirds (n=69) indicated that they felt there was little or no support for them as they prepared for their retirement.
Of the 47 participants who chose to elaborate, 21% (n=10) stated it had not been discussed and one participant commented further by saying

“No-one talks about your length of working life and therefore I conclude no-one cares”.

Figure 12: retirement support

The final question invited comments about anything else participants would like to share in relation to this research. Their responses will be discussed further in chapter 5.

**Qualitative data from free text questions**

Themes capture common recurring patterns from within a dataset (Braun & Clarke, 2006)). Thematic analysis can be used to address questions about people’s experiences and perspectives (Braun & Clarke, 2006). According to Braun & Clarke (2006) a detailed analysis of each theme is necessary to determine meaning, it is also recommended that themes are named. After reading through the data an inductive approach was used and colour coding of information allowed common and repetitive comments to become apparent. Five themes have become apparent from within the data and will be explored further in the discussion chapter. These themes were: support, educational and competency expectations, work-life balance, working conditions and retirement intentions.

**Support**

The data suggested that two thirds of participants do not feel supported to continue working and one tenth think support is not even considered by employers. There was also
comparison to other countries where their colleagues describe levels of support that they felt do not exist in New Zealand. One participant commented that

“No one talks about your length of working life and therefore I conclude no one cares.”

Another commented

“Family and friends are good support.”

Another commented

“I have not had any specific support but I was allowed to reduce my hours (with a bit of a fight).”

Another commented

“The organisation is not really that interested. As long as you turn up for your shift there is no distinction between someone aged 20 or 50.”

Another commented

“During recent NPD there was discussion about whether I was going to continue to work the next five years. Suggestions were made about continuing to keep good health to make this happen. Reasonable support given in a supportive way I think.”

It was suggested by some that health insurance subsidised by their DHBs might encourage staff to continue in the workforce. The subject of lack of superannuation was also raised in comparison with New Zealand Police.

One participant commented

“…possibly payments made by the DHB to health insurance. I would certainly stay longer if I had health insurance and dental insurance I could afford with contributions from the DHB… I have a friend in the states who said she would not move to another hospital unless their health and dental was as good or better than where she currently worked.”

Another commented

“Nursing did not prepare individuals well in having superannuation schemes such as provided by the Police.”
The subject of annual leave was also raised with one participant stating they were
discouraged from taking annual leave by the prospect of administrative tasks accumulating
in their absence.

“Support for your job when you take annual leave and not have to come back to chaos on
your return.”

International comparisons were made with one participant stating
“I am aware of a friend who continues to work in the United Kingdom who says they do get
some education and preparation to look at retirement.”

There were comments about older nurses being part of the “sandwich generation”
(American Psychological Association, 2015) with responsibilities for parents and children
and the difficulty this can present.

One participant commented

“Aging nursing workforce brings new challenges- nurses caring not only for children but also
dependent parents.”

Generational differences were also mentioned, one participant commented

“The Y generation of nurses will be expecting greater flexibility in the way they are
employed and if we want them to be available to nurse us when we are older we have to be
more accommodating.”

The subject of bullying was raised more than once. It was suggested that bullying of older
staff is “rife”, that some participants feel unsupported and bullying on top of workplace
stress has also been an issue.

One nurse commented in relation to difficulties with shifts as they age

“I have not asked for this as I do not think it would be accepted and would also lead to
further bullying between staff.”

Another commented

“The older you are the more invisible you seem to become!... Bullying of older nurses is rife.”
Another commented favourably

“There is good support for time off for caring for elderly parents.”

**Education and competency expectations**

When asked for their opinion about ongoing educational requirements and portfolios nine participants felt that a completed portfolio did not always reflect the practice of the portfolio holder. Negative comments seemed to focus more on the portfolio than other educational requirements and the need for maintaining core competencies. Of participants that chose to comment (n=39) about ongoing educational requirements and portfolios, 50% spoke of the importance of keeping up to date and felt that their education was reflected in their practice.

There were comments about the need to attend to education in their own time. One participant commented

“I feel that the demands of nursing are becoming greater and feel that after a hard day's graft I do not have the energy to start thinking about portfolios in my spare time”

Another commented

“Experience is a valuable tool and as us oldies struggle with the academic demands of nursing portfolio requirements there needs to be some recognition of experience.”

Another commented

“I feel a lot of pressure all the time regarding ongoing competencies, I think it is overkill.”

Another commented

“I do not think portfolios prove anyone’s adequacy to do the job at all, having heard of colleagues making up parts of their portfolio to get extra pay. Someone may write academically well but be a poor practitioner.”
Another commented

“They do not reflect the quality of the nurse. Work is so full on I have little mental energy for study.”

Another commented

“Portfolios are a great representation of the body of work you have engaged in. However I do not believe the current system of PDRP is working and puts huge demands on nurses to complete this work in their own time.”

Another commented

“Don’t have time, funding or interest in ongoing education due to the workload- can’t do both.” “I do not believe that the current system of PDRP’s is working and put’s huge demands on nurses to complete this work in their own time”

Another commented:

“Post graduate study done in own time, not supported by hospital. Portfolios are good evidence on the body of work I have undertaken. However, they are completed in my own time”.

Work-life balance

Some participants reported difficulty achieving balance between their work and home lives. One participant commented

“It often affects my days off as there always seems to be some competency expired or due”.

Another commented

“I do not have the energy to start thinking about portfolios in my spare time which is dedicated to my husband and family! It is called work-life balance!”

Another commented

“My work hours allow me additional time for work-life and interests outside work”. 
Some participants identified that flexibility with annual leave might be beneficial.

One nurse commented

“I would like to be able to take flexible annual leave or leave without pay arrangements. This would encourage me to work longer.”

Another commented on annual leave to cover sickness

“I had to use all my annual leave up having surgery, I then had to work a whole year without any leave and yet this is supposed to be the caring profession.”

Working conditions

Additional comments were made around the demands being both physical and mental, the ongoing issues with short-staffing and the incidence of overtime or missed breaks so they could get the job done.

One participant commented that that work was

“physically and mentally exhausting most days, nonstop workload, on feet all day but can usually get meal break”.

Another commented that

“there is no forgiveness with age and shiftwork”.

A further respondent reported:

“I work a 9-10 hour day 5 days a week. I choose to do this so I don’t need to come in during the weekend”.

Another commented

“I don’t feel I can step aside or down, as none of my staff want to step up (most have opted to reduce hours) So, I have to leave to get reduced hours or less responsibility. I love my job so this is not an option”.

Several participants commented on the fact that senior positions often demand full-time work. One commented

“It is a requirement of my role to work full-time”
Another commented

“Very long days due to commitments- expected as part of the position”

Another commented

“The CNS role is full-time. It would be great to job share to allow someone else to learn the role and me to work part-time. ”

Another commented

“It is unfortunate in this position you cannot work part-time…. I make the choice to work full-time as this is the only option for this position.”

Several participants also commented on the increasing demands and the difficulty of working rostered and rotating shifts as they age. One commented

“Find nights very tiring at my age.”

Another commented

“No recognition that night duty is more difficult in relation to adapting to the changing shifts as we get older.”

Another commented

“I find working night shifts exhausting and especially find driving home difficult... I feel this is not safe…”

Another commented

“I think for nurses working in a clinical environment and working rotating shifts it becomes more difficult to continue working even up until they are 65 years.”

Retirement intentions

The findings show that over 70% (n=76) are not planning to retire until the age of 65 or older. Of the additional comments three nurses spoke of the enjoyment of their work and stated that they loved to work with students, felt their work was of high value and that they enjoyed their role. Other described financial goals such as paying off their mortgages or choosing to support their children. One respondent commented that:

“While I still enjoy my work and know I am contribution the outcomes for mothers and babies, I would like to continue”.

35
And another:

“I feel it is really important to have experienced nurses around to teach and support the less experienced nurse”.

Whilst it appears that many participants are not planning early retirement, it is likely that they will retire in the future and it must be remembered that they make up a large portion of the current workforce.

The final question was a free text section inviting comments on anything else participants would like to share in relation to the research question: “how are nurses supported to work in public hospitals until retirement age...” One nurse commented about how difficult it was to return to nursing after a period out of the workforce.

“I was so ill equipped to commence nursing in this environment... very few nurses cut me any slack for having to relearn the system”

There were also comments around the role older nurses could play in mentoring more junior staff, passing on their knowledge and experience. It was suggested that these mentoring roles could be part-time which would support a reduction in hours for older nurses. As well as mentoring junior nurses it was suggested that succession planning was also required.

Participants commented

“Would be nice if part-time nurse consultant roles were established for nurses near retirement, the knowledge and experience these roles could bring to new staff would be very beneficial.”

“Excellent teachers to new and beginning practitioners.”

“I feel that health organisations should be looking at better ways for nurses to pass along knowledge and wisdom and mentor other nurses. I would be happy to reduce hours and mentor at the same time.”

Chapter summary

This chapter has reported the findings which have come from participants in the selected DHBs. They have highlighted concerns and also positive perceptions of their work environment. The following chapter will discuss these findings in depth and compare them with current literature.
Chapter Five: Discussion

Introduction

The aim of this research was to explore the perceptions of nurses to see if they felt supported to work in public hospitals until retirement age and beyond in NZ. Following a search of the literature it became apparent that the sustainability of the NZ workforce as the large baby boomer generation begins to retire is also threatened.

A descriptive study was undertaken to examine the current situation, what nurses are thinking and feeling right now and what this might mean for the future of the nursing workforce in NZ. The survey was made available electronically to nurses aged 45 years or over in three DHBs in NZ and nurses were asked a combination of open and closed questions to obtain both quantitative and qualitative data. Although the response rate was small, the data gathered adds value. Participants have shared their thoughts about levels of support in the workplace, expectations about education and competencies, work-life balance, working conditions and retirement intentions.

This chapter discusses the research findings and themes in relation to current national and international literature to provide current information about the NZ situation as the workforce ages and reaches retirement age. Dodsworth (2008) found very little information relating to the views of NZ nurses. According to the Ministry of Health (2014c) the number of nurses retiring from the workforce will reach critical levels by 2017. With this rising level of awareness, research and published literature in NZ in the field has grown in recent years.

The Research question

The research question (and title of the survey) is, “how are nurses supported to work in public hospitals until retirement age and beyond in New Zealand?” Areas of concern identified within the findings include lack of discussion or lack of awareness from employers about the needs of older workers and the implications of population ageing (Jackson et al, 2013).

The workforce

The current workforce consists of three main generations: baby boomers were born after 1945, generation X after 1963 and generation Y after 1980, (Lavoie-Tremblay et al., 2010). Following a study of 1,376 nurses in Canada, Lavoie-Tremblay et al., (2010) found that
retention strategies that focus on work climate improvements are beneficial to all generations.

Participants were asked for the generic title of their position in the workplace and responses were varied including registered nurses and enrolled nurses and one nurse practitioner. It is important to note that almost half of the participants in this research report that they are in senior nurse roles which suggests they are unlikely to be involved in direct patient care as part of their normal working day. Fifty percent of participants (n=49) also reported they worked fixed rosters. It is possible that if the invitation to participate in the survey had only been for registered nurses and enrolled nurses directly involved in patient care the findings might have been quite different. It is possible that these nurses would report the physical demands as much higher than many senior nurses who tend to work more regular hours with perhaps limited physical patient contact.

North, Leung & Lee (2014) reported that in times of financial crisis, departures from the workforce tended to decline and that more of those that had left the workforce would then re-enter as a result. Skilled migrants contribute to the growth of the New Zealand workforce (Immigration New Zealand, 2013). The reality however is that the number of workers required to meet deficits is too large to be a viable option. The required numbers would result in population growth that would delay the increase in the age dependency ratio but would place excessive pressure on infrastructure and the environment (Oakman & Howie, 2013). Retention of workers is a more sustainable option (Oakman & Howie, 2013). It is therefore essential to examine ways to sustain the nursing workforce from within.

Members of the baby boomer generation are making choices about their employment and if organisations are unwilling to meet their expectations it may be that they choose to leave their employment (Oakman & Howie, 2011). Strategies to support older workers might include flexible schedules, team work, adjustments to reduce the physical demands, ongoing education tailored to the older worker, pre-retirement coaching, health screening and on-site health clinics (Musich, McDonald, & Chapman, 2009). Nursing Council statistics give many different reasons for work status including parental responsibilities, study requirements, travel requirements and the Christchurch earthquake (Nursing Council, 2012-2013d). The current workforce consists of three main generations born between 1946 and 2000 (Lavoie-Tremblay et al., 2010).
Themes

According to Speziale & Carpenter (as cited in Harding & Whitehead, 2013) the goal of data analysis is to illuminate the experiences of those who lived them by sharing the richness of lived experiences and cultures. Harding & Whitehead (2013) suggested that in qualitative descriptive studies lists of concepts are grouped together according to similarities. For the purpose of this research the data was read and reread with similar concepts identified and then grouped together. Five themes emerged from the survey data.

Support: Over 70% of participants in this study believe that they are not supported in their preparation for working until retirement age.

Education and competency expectations: Participants are in favour of education but some do not like the PDRP (n=14) and they are asking for recognition of their skills and experience.

Work-life balance: Participants report difficulty achieving a balance between work hours, educational requirements, time with their families and pursuit of leisure activities.

Working conditions: Participants describe their work as physically and mentally demanding and they also report that they are struggling with either the expectation that they will work full-time or the demands of working rostered and rotating shifts as they grow older.

Retirement intentions: A large group of baby boomers are beginning to retire which threatens the sustainability of the workforce in NZ. Over 70% of participants (n=76) report that they are planning to retire at age 65 or older.

These themes will be discussed further in the next section.

Support

Participants were asked for their opinion about how they are supported in preparation for their retirement, less than 30% (n= 27) reported good or excellent support with over 40% (n= 41) stating they felt there was little support and a further 29% (n= 28) stating there was no support. A study in Australia concluded that employers can retain older workers if support is provided, the work is satisfying and part-time work is available (Oakman & Howie, 2011). It is likely that these strategies would also help to retain staff across the workforce. Furthermore it is suggested that since the global financial crisis sectors such as
health will experience high demand for workers so employers should see older workers as valuable resources rather than expensive commodities (Oakman & Howie, 2011).

If nurses believe they are not supported by their employers, it must be addressed whether it is true or not. Nurses are asking for recognition of their skills and contribution. Manchester (2013) suggested that to alleviate the predicted nursing shortage a culture change is needed so that older nurses feel, valued, consulted and empowered to share their nursing leadership. Bell (2013) suggested strategies including encouraging participatory management which could lead to recognition and respect of older workers, flexible work options and assistance with retirement planning. Furthermore creation of roles focussing on admissions and discharges, clinics and mentoring might also assist with retention (Bell, 2013).

Within this research participants (n=10) have suggested that employers do not discuss support of staff in preparation for retirement. One participant commented

“that no-one talks about it so they conclude that no-one cares.”

In a Canadian survey Blakeley & Ribiero (2008) found the number one incentive to postpone early retirement was being acknowledged for good work. Many respondents reported that the subject was not raised with some commenting that employers just wait for staff to retire and then review. One participant commented

“...everyone is too busy to support those who are going to retire.”

Another participant commented

“Great ideas from Occupational Health in their retirement Seminar but no succession planning from the DHB.”

And another participant commented

“Planning for retirement or future years is not really addressed. It is usually ‘wait and see’ when someone retires then? replace or disestablish their role.”

While it appears that nurses feel there is a culture of avoidance one participant commented that support might be available if it was asked for. Other comments included that it is not a concern as long as staff continue to turn up for work and that employers are only interested if you become physically or mentally incapacitated. Blakeley & Ribeiro (2008) found that one of the top 11 reasons for wanting to retire early was that the
organisation does not offer nurses any incentives to stay for longer and that senior staff are not valued.

Of the participants who commented in relation to support in preparation for retirement (n=47) ten percent (n=5) commented positively reporting good support. Comments included support of sick leave as well as acknowledgement that older nurses may be caring for aged parents. They also talked of support from management with reduction of hours, succession planning and health promotion. One participant noted good ideas from an Occupational Health seminar, but that this was not followed up by the employer. It would appear that support is available but is perhaps not as visible as it could be and that this needs to be addressed by workforce planners and employers.

Several participants referred to the contribution that older nurses make to the workforce and the belief that a mentoring system to pass on knowledge and experience would be valuable. It was suggested that such mentoring roles could be part-time thus allowing older nurses to reduce their hours and also at the same time be beneficial to younger less experienced staff. If older nurses were able to reduce their working hours and work in support/mentor roles, and employers were willing and able to employ them as well as a larger number of new graduate nurses then the workforce would grow and there could be potential for greater retention. McDonald et al. (2010) reported that previous mentoring programmes have been retention strategies for older nurses. While older nurses would be retained, younger nurses would benefit from the experience of their senior colleagues.

According to McDonald et al., (2010) the positive influence of an experienced mentor could assist in developing protective factors against workplace adversity and enhance the ability of the nurse to achieve work-life balance. The presence of mentors and junior nurses would mean a larger workforce and come with a greater cost. In the long term however it could improve nurse to patient ratios and promote a happier more productive and sustainable workforce. The follow-on effect might result in reduced costs in recruitment. McDonald et al. (2010) found that the mentoring programme resulted in significant personal and professional outcomes for mentors and mentees. Perhaps the secondary benefit might be to the older nurse/mentor as effective mentoring can stimulate their own professional development and personal growth (McDonald et al, 2010). It would appear that nurses within this research are already interested in the mentoring role however they are suggesting it in a part-time capacity.
North et al. (2013) noted that the cost of nurse turnover is approximately half of the average salary and that high staff turnover is associated with a decline in mental health and reduced job satisfaction among staff. North et al. (2013) also suggested that acceptance of nurse turnover reflected the view that nurses are replaceable units of labour. This viewpoint conflicts with Willis-Shattuck et al. (2008) who promote the recognition of skills. Participants in this research have commented that they want to be recognised for the skills that they bring to the workplace.

If employers want to convey their support for nurses in retirement planning and other related issues this support needs to be visible. A high number of participants - 70% (n=68) reported that they did not feel supported in preparation for retirement. According to Gambino (2010) it is essential that employers identify and support nurses who are strongly committed to their profession. This may then have an effect on high attrition rates which plague the profession (Gambino, 2010). It is also important that retention strategies are aimed at all nurses within the workforce (Gambino, 2010).

The issue of bullying was raised with reference to bullying of older nurses in particular. Bullying behaviour can be described as persistent misuse of power that is offensive and intimidating (NZNO, 2014b). The case of the nurse who reported that after returning from a period out of the nursing workforce there was no support from colleagues who expected them to be back up to speed as soon as they returned perhaps highlights the stress that nurses are under every day and the perception that everyone must carry a full load whether they are ready and able or not. With reference to hours of work and related fatigue one participant commented

“I would like to work a fixed morning shift regime as I find night shifts exhausting and especially find driving home difficult. I feel this is not safe... I have not asked for this as I do not think it would be accepted and would also lead to further bullying between staff.”

Another commented

“Support for nurses on the floor appears to be non-existent. The older you are the more invisible you seem to become! Your knowledge and ability is disregarded and you are treated as a liability by a lot of the younger staff. Bullying of older nurses is rife.”

While the needs of all generations must be considered it appears that nurses feel they cannot make requests for fear of retribution. If individuals do not feel that they can speak up or that they will not be supported to do so situations will go unresolved and may lead to
nurses making the choice to retire earlier rather than continue to work in the current environment thus they are lost to the workforce. Longo & Lynn (2013) report that the attraction of the work environment is an important component of the decision to remain employed. Workplace bullying impacts the organisation through decreased productivity, increased sick leave and employee attrition (Johnson, 2009). Following on from the comment about lack of recognition and bullying of older nurses, several others also stated they felt that their experience and contributions to the workforce were not acknowledged. One participant stated

“The organisation is not really that interested. As long as you turn up for your shift, there is no distinction between someone aged 20 or 50.”

Issues around roster preferences and resentment of perceived unfair rostering are not about individuals; rather they may be the result of intergenerational differences (NZNO, 2014a). One participant reported that following workplace stress which led to the DHB being investigated they were “malignant and bullied.” Support is available for employees but it may be that after being involved in such an investigation the staff member did not feel confident to take the matter any further. Nurses from the veteran generation (1920-1944) and baby boomers (1949-64) have a strong sense of duty and loyalty to the organisation which might make it more difficult for them to understand how such a situation may have occurred and what if anything they can do about it. Bullying is an issue for all staff and it can affect the culture of the workplace (NZNO, 2014b).

Stewart (2010) reported that bullying is widespread and destructive and furthermore our health facilities have a culture that enables this behaviour. Although bullying is often referred to as “nurses eating their young” nurses of all ages can be affected by this behaviour (Longo & Lynn, 2013). Bentley et al, (2009) also suggest that bullying occurs at all levels and across all parts of the health sector. Johnson (2009) found that bullying will impact on the physical and psychological health of victims and witnesses and that it may impact on work performance resulting in decreased productivity, increased sick leave and employee attrition.

According to Trim (2015) a distinction must be drawn between "what is called bullying and what is a professional critique of practice or raising issues of behaviour”. The short staffing that may result from increased sick leave can also negatively affect the well-being of patients. Of the three nurses who made direct reference to bullying, two were female, and
one did not answer this question; all were part-time registered nurses and they were from different age brackets; they also all worked in different clinical settings.

**Education and competency expectations**

When asked about ongoing education requirements and portfolios, over 90% (n=86) of participants reported this ongoing personal development to be important, just 9% (n=9) reported that it was not important. Thirty nine nurses chose to elaborate and of those 10 reported that the PDRP was not a true reflection of how nurses actually practice. Five participants questioned the validity of portfolios and commented

“I do not think portfolios prove anyone’s adequacy to do the job at all, having heard of colleagues making up parts of their portfolio to get the extra pay.”

Another commented

“I have known people to make up the information for their portfolios…”

Another commented

“portfolios are a waste of time. You can write a good exemplar but that doesn’t mean you are good at what you do.”

Another commented

“If you can write a good exemplar and be an academic you will fly in!!”

Another commented

“It seems to me that if you can write well and talk the talk you can proceed through the levels regardless of how you practice, what I see written and what I see done are often very different.”

A participant stated that nurses who were reluctant to complete portfolios were often those who saw nursing as a job rather than their profession. One participant stated they did not have time, funding or interest in ongoing education because of their workload and could not do both. Participants voiced concern about the number of hours required to complete portfolios in their own time. While participants appear to be in favour of ongoing education, portfolios were not viewed so favourably by 14 participants.
The Health Practitioners Competence Assurance (HPCA) Act 2003 focuses on public safety (Ministry of Health, 2014a). Many countries have developed a Continuing Competence Framework (CCF) and in NZ the framework was implemented following the enactment of the HPCA Act 2003 (Vernon et al., 2012). In a survey of 1157 New Zealand nurses, the majority of participants believed the CCF provided a mechanism to measure competence and ensure safety and most nurses indicated they were responsible for ensuring and demonstrating continuing competence (Vernon et al., 2012). There were however a significant number of nurses who believed that their employer was also responsible (Vernon et al., 2012).

Currently, the CCF requires evidence of ongoing professional practice and professional development as well as evidence that each practitioner meets the relevant competencies (Vernon et al., 2012). Within this research almost 90% (n=78) reported they had undertaken some form of post-graduate education. Actual education varied from post-graduate certificates to Master of Nursing. There was also evidence of other papers and courses. It is encouraging that the majority of participants clearly viewed ongoing education as valuable and important.

When asked about portfolios 39 participants chose to comment further, of those 41% (n=16) suggested that completion of a portfolio takes too long, is “overkill”, doesn’t make any difference to their practice, requires too much evidence and is inconsistent from one area to another. Vernon et al. (2012) also suggest that there is inconsistency from one jurisdiction to another. One participant commented that portfolio requirements put nurses off returning to the workforce. At the very time when workforce sustainability is an issue this should not be ignored. Anastasi et al (2006) believe that competence assessments tend to focus on quantifiable dimensions and ignore the character attributes such as caring, honesty and advocacy and therefore they are not a true test of the significant aspects of nursing. If nurses do not see the PDRP as a reliable tool then it will be difficult to obtain their commitment to the process.

If nurses perceive that their employers have, or share the responsibility, it may be that they also expect them to provide time for this work to be completed. Vernon et al. (2012) suggest that employers and employment settings must ensure that their workforce is, and continues to be competent. The NZNO Multi-Employment Collective Agreement (MECA) 2012-2015 states that staff working on their portfolio are entitled to additional leave to undertake research or study associated with meeting the requirements of the portfolio, the
MECA allows for one to two days depending on the level of the portfolio (NZNO, 2012). In the NZNO Employment Survey (NZNO, 2013a) the biggest barrier to completing professional development requirements was “difficulties attending in worktime.” “Reluctance to complete in one’s own time was also identified as a barrier” (NZNO, 2013a, p53).

While data from some participants appears to see the PDRP in a negative light, positive data also emerged. Comments noted that PDRP encourages nurses to reflect on their practice, is representative of the work in which they engage, provides evidence of safety to practice, helps us to keep up to date and even supports us. One participant reported “It provided a solid foundation when being investigated by the HDC...”

One participant suggested that a supportive return to work programme for nurses after a break from the workplace might be helpful. If the aim is to retain nurses and bring them back into the workforce then the environment must be comfortable and supportive. One participant reported that on return to work they felt prejudged as one who should fit straight back in because of previous experience.

“... I was so ill-equipped to commence nursing in this environment and it was baptism by fire... I was looked upon as an older nurse who should know it all which was far from the case.”

The Nursing Council of New Zealand requires a Competency Assessment Programme (CAP) to be undertaken by nurses who have been away from the workforce for more than five years (Nursing Council of New Zealand, n.d. [b]). Several teaching institutions and some DHBs offer this programme which can be completed over 5-12 weeks. It is not known how long the respondent had been away from the workforce but as this participant suggested a special programme would be helpful this implies they did not participate in a CAP programme.

“If the hospitals want to encourage older nurses back into the workforce to meet demand in the future they need to format a special programme I think similar to the NETP for new grads.”
Work-life balance

The subject of the conflict between balancing work-life and family demands emerged. When asked how they felt about their work hours one participant commented

“But not ideal. Work-life balance is disrupted and there are costs.”

In a female dominated workforce (HWNZ, 2012, Nursing Council, 2013c) it is to be expected that many nurses will take a break in their employment for family and caring responsibilities (HWNZ, 2012). The Nursing Council asks for reasons for part-time work status in practising certificate applications, the highest percentage of responses can be attributed to parental responsibilities (Nursing Council, 2013d). Nursing Council statistics (2012-2013) state 92% female and 8% male. The participants in this survey closely align with national statistics. Although the research examined older nurses there were still some participants who reported they were raising young children.

When asked how important it is that they continue to work until they decide to retire, 37 participants chose to comment further. Of those, nine nurses reported they were sole earners and a further three stated they were the main earner. Another four reported they were raising dependant children or that they chose to support their children. Gendall & Fawthorpe (2006) stated that 25% of children in NZ live in single parent households and only half of those sole parents are in paid work. They also report that a third of women in NZ work part-time but that they tend to increase their hours as the children grow older.

Childcare is a major concern to working parents (Gendall & Fawthorpe, 2006), and for those working shifts over a seven day period this is even more complex. According to Gendall & Fawthorpe (2006) in 2004 the Ministry of Social Development reported a lack of childcare can restrict the ability to work. While the focus of this research is on support of older nurses working until retirement it would appear that the issue of childcare is still relevant and applicable to the whole workforce. If the aim is to retain nurses within the workforce this remains an issue. Further research may be required to look at family support options that support nurses to work. Participants in this research were almost equal in terms of part-time or full-time work with full-time just ahead at 50.51% (n= 50).

Baby boomers are the first generation to be responsible for support of ageing parents and children at the same time and this has the potential to lead to work/family conflict (Kohl & McAllister as cited in Beutell & Wittig-Berman, 2008). Generation X workers also face their own challenges as they are the first generation with large numbers of single-parent families.
(Kohl & McAllister as cited in Beutell & Wittig-Berman, 2008). According to Lavoie-Tremblay et al., (2010) strategies to assist with the sustainability of the workforce and improving working conditions are beneficial to all generations. The Multi-Employer Collective Agreement (MECA) 2012-2015 makes provision for domestic leave when an employee must attend a dependent and may also grant leave without pay if additional time is required to support a seriously ill family member (NZNO, 2012).

It may be that parents or grandparents wish to have particular days off to attend children’s activities or to look after grandchildren. The MECA also identifies the importance of providing a family-friendly environment and works with the union to develop an appropriate environment (NZNO, 2012). While these provisions are in place, data from this research does not identify whether nurses feel this support is evident or not. If nurses face conflict between the needs of their families and the requirements of their employer they may be forced to review their employment. NZNO (2013c) suggested that there is a need for employers to acknowledge multi-level family demands on older nurses and that there is a need for greater flexibility in work arrangements to assist nurses to achieve balance.

Becker et al. (2010) suggested that nurses are choosing to work casually in order to have the level of flexibility that allows them to remain in the workforce. Casualisation was initially intended as a means to increase workplace flexibility however it has become a means to assist with nursing shortages (Becker et al., 2010). If nurses were only to be given these hours in times of shortage it may be that they would decline the work opportunities. The findings suggested that participants would like to work part-time or shorter shifts to assist with mentoring junior staff or for their own benefit as they struggle with full shifts.

One participant commented

“Considering dropping hours to ease into retirement.”

Nurses who can work their preferred hours are likely to demonstrate higher levels of satisfaction. Clendon & Walker (2013a) report that nurses will change their work patterns if they feel they are not coping with fatigue.

According to Garde et al (2012), the ability to influence one’s own working hours will improve the work-life balance, reduce subjective health complaints and medically certified sickness absences as well as reducing staff turn-over. In order to ensure a safe roster it may be that some nurses’ preferences and requests cannot be met. Garde et al (2012) also suggest employees who self-roster do not always make roster choices that favour their
health. It may be that for convenience they work nights or weekends to reduce childcare issues (as an example) or that they work long stretches to get a particular day off. One respondent stated they would like to work less days but the same hours, this would mean longer working days so that there was an extra day off. Another reported working nights due to parental commitments but that adequate sleep was an issue. One participant reported that

“.. do not work shiftwork that has advantages but certainly not financially- positions of responsibility earn less than the shiftworkers.”

Working conditions

Apart from the already discussed strategies of better rostering and flexibility, in the long term access to retirement planning and financial advice would be beneficial and may reduce the stress levels and perhaps reduce the number of older nurses who can no longer work because of ill-health (Walker & Clendon, 2013). This must be balanced with consideration of the needs of younger nurses who are also demanding flexibility and family-friendly options (Walker & Clendon, 2012).

Donovan, Diers, Goodrich, & Carryer (2012) defined succession planning as allowing space for new leadership to emerge and developing or mentoring new talent. Nurses are voicing their inability to step down to part-time hours because of the lack of anyone to step up into the role. Their passion and loyalty to their job requires that they continue in the job for as long as they able in the absence of a successor. It does appear that in some workplaces this is occurring however the majority who commented on this felt that it was not in place. One participant commented

“It would be great to job share to allow someone to learn the role...”

Another commented

“I feel there should be a way of stepping aside and reducing responsibility but there is nothing set up as a plan. Like a tag team. We all get tired and need someone to step up but nothing is done until a vacancy occurs.”

Three participants expressed a desire for employers to offer support or subsidy of healthcare and retirement planning education. Participants suggested this might encourage them to remain in the workforce for longer. Comments noted awareness of colleagues working internationally who report hospitals provide health and dental plans and that they
also provide education in preparation for retirement. The subject of the lack of superannuation for nurses was also raised in comparison with the Police. With a largely female workforce it was suggested that single women are forced to work for longer as a result of this.

Willis-Shattuck et al. (2008) suggested that while financial incentives might help, they needed to be considered as complimentary to recognition of skills and appropriate infrastructure. According to Southern Cross Health Society (n.d.) employers who subsidise health insurance for staff usually enjoy higher levels of employee satisfaction, and they go on to suggest that provision of a subsidised health insurance scheme can lead to a reduction in staff turnover rates of approximately 5 per cent. One participant commented “No healthcare provided, no retirement planning support.”

Another commented “…possible payments made by the DHB to health insurance. I would certainly stay longer…”

NZ superannuation is paid to eligible New Zealanders over the age of 65 (Commission for Financial Literacy and Retirement Income, 2014). It is suggested that workers save over and above what will be received in National Superannuation to meet retirement needs (Commission for Financial Literacy and retirement Income, 2014). NZNO (2013c) report that if government policy increasingly requires retirement funding to be supplemented by savings that women will be disadvantaged as they have often had fewer years in the workplace as a result of caregiver responsibilities for children and parents. Data from Nursing Council statistics (2013d) indicate that nursing remains a female dominated workforce.

One nurse also reported that the employer stops contributing to KiwiSaver once the age of 65 years is reached which was viewed as discriminatory. KiwiSaver (2014) states that employers do not have to contribute after the age of 65 years if members have been in the scheme for more than five years. In order to retain workers after the age of 65 years, ongoing employer contributions might be seen as an incentive.

A Google search for “retirement planning assistance-employers” shows a variety of websites from financial institutions and a brief government site which discusses government superannuation and pensions. There is an absence of information about employer assistance with this planning and support. One participant commented that the
information is probably out there if one is to go looking for it, but that it will not be offered otherwise. This reported lack of information could potentially be perceived as a lack of support whether this is true or not.

In an anonymous survey of 3273 nurses aged over 50 in NZ, quantitative and qualitative analyses found that those working in more physical environments reported higher pain scores and nurses who reported lower levels of health related quality of life were more likely to retire earlier or move to more casual and flexible work as they age (Clendon & Walker, 2013b). It may be that enrolled nurses who must work under the direction and delegation of a registered nurse or nurse practitioner (Nursing Council of New Zealand, n.d. [b]) could have more limited job opportunities. In a competitive job market registered nurses with limited experience (confined to one area) or those without post-graduate qualifications may be disadvantaged when looking for employment with more flexible or part-time hours.

Clendon & Walker (2013a) reported that in a survey of nurses over the age of 50 in New Zealand, most found it more difficult to cope with shift work as they aged. They reported that strategies were required to support ageing nurses to remain in the workforce and that those working part-time hours coped better than those working full-time. In a survey of Canadian nurses carried out by Blakeley & Ribeiro (2008), two of the top 11 reasons for early retirement were that they were “just plain tired” and that the “workload is just too heavy” (p33).

When asked about the physical demands of work over 80% (n=80) of participants reported it was demanding, very demanding or extremely demanding. Of those that chose to elaborate, comments included increased demands because of lack of staff, being on their feet all day and sometimes missing meal breaks. The demands were described as physically and mentally challenging and nurses reported that they found shift work demanding. One nurse also reported that as a senior staff member they felt they carried more responsibility as they sought to ensure standards were maintained and new or junior staff was supported.

In a study of the health of nurses aged over 50 years Clendon & Walker (2013b) found that nurses who work in a more physical environment tend to report higher pain scores, and those that have lower levels of health related quality of life are more likely to retire earlier, or if possible move to casual or more flexible hours as they age. Additional information was
not sought on types of injuries, issues related to sick leave and annual leave- this might be useful in a follow-up study.

Participants were asked if choosing their own roster would help them to work for longer. This was only seen as an incentive for 61% (n= 57) of participants however almost 90% (n= 87) reported they were already at least happy with their current work hours and many were already working regular hours rather than rostered shifts. Workforce planners must consider the need for balance; a roster must be covered safely every day and at all hours. Self-rostering can be problematic as there will always be hours and days that many would prefer not to work.

With finance in mind it may be that nurses opt to work afterhours for financial reasons. A survey undertaken in the United Kingdom (Gould, Drey & Berridge, 2006) reported that those who worked exclusively at night and the weekend experienced difficulties accessing education. When ensuring a roster is balanced factors such as the right number of senior staff and good skill mix must be considered. There will always be unhappy staff and with sick staff not always able to be replaced there are many who will do extra shifts to ensure their patients are safe and receiving optimal care. As a result they may have split days off or work more days in a row before their days off. Clendon and Walker (2013a) surveyed staff over the age of 50 years to look at their experience of shift work and found that the impact is greater in the older person and that shift workers in general have a less healthy lifestyle.

Clendon and Walker (2013a) suggested that as the rotating nature of shift work appears to have the greatest negative effect on health, it might be beneficial to return to more fixed scheduling. Given that many nurses now have some say in their roster and can request particular shifts or days off more fixed scheduling (although supposedly better from a health perspective) might be seen as taking away the nurses choice. Clendon and Walker (2013b) also identified that nurses working in more physical environments reported higher levels of pain and were more likely to retire early as a result.

The findings of this research suggest that less physical work and better rosters or shorter hours would benefit the nurses’ health. At present however, when the health needs of the public are greater as the population lives longer with more co-morbidities and financial constraints do not allow for extra staff to be available to cover all sick gaps and leave requests this cannot be guaranteed. When considering the sustainability of the workforce
as a whole it would be impracticable to roster all ageing staff onto shifts of their choosing (even if they were choosing healthy rosters).

The effect would impact on the safety of patients if all older nurses chose not to work nights or weekends as wards would be running with junior staff at those times. As well, the younger less experienced staff could soon become disenchanted, they would not have the learning opportunities that they get from working with older staff and would be working all the unsociable and more tiring hours that the older nurses were not. If the younger nurses were not looked after and were seen as “roster fillers” the staffing crisis would perhaps be around the loss of the baby boomers and the loss of younger nurses. The situation could turn into a “who will care for the patients” scenario.

The employer has a responsibility to ensure a safe and appropriate skill mix so that the standard of care is not compromised (Nursing Council of New Zealand, 2011). According to Frankel (2008), senior nurses are likely to engage in leadership activities during their daily routine which will allow for positive staff development and enable junior staff to apply theory to practice in a safe and supportive environment. The role modelling behaviour of senior nurses facilitates the transmission of knowledge and values from one generation to another (Frankel, 2008). If junior nurses are not working with senior staff these opportunities for professional growth will not be available. In relation to workplace injuries, 28% (n= 27) reported that they had sustained such an injury. The nature of these injuries and whether they required time off work to recover were not explored within this research therefore it is not known how old they were or where they were working at the time.

Within the survey results the 61-65 age group had the highest incidence of injuries (n= 8). There were also eight injuries in the 50-55 year age bracket however they made up 34% of the total pool compared with the 61-65 age group who made up only 18% of the total pool. Statistics New Zealand (2013) report that in 2012 workers in the 45-54 years age bracket made the most claims for work related injuries however younger and older workers had the highest rate for claims. Workers over 65 years had the second highest rate despite only making up 5% of the total number of claims for that year (Statistics New Zealand, 2013).

Nine of the participants reporting workplace injuries are working in senior roles, the remaining 18 are working in Registered Nurse or Enrolled Nurse roles and are therefore more likely to provide clinical care. Statistics NZ reports those over 65 years report a higher rate of injuries. It may be that by moving out of clinical care these injuries can be minimised. There must always be nurses delivering patient care and ways to deliver safer
care for both patients and staff are always developing. According to Walker (2013) a web-based survey in NZ in 2013 indicated that 11% of nurses surveyed had required time off work for a workplace injury or infection in the last two years. The most common injuries were to the back, knee, wrist or shoulder, mostly related to slips or lifting (Walker, 2013).

The Health and Safety Employment Act (1992) states there is a shared responsibility between employers and employees to ensure workplaces provide a safe work environment through hazard identification and controls (O’Shea & Associates, n.d.). According to ACC (2012) there is evidence that working irregular or long shifts and having inadequate sleep, are associated with musculoskeletal problems including back pain, back injury and sick leave among healthcare staff. One participant reported having had surgery which they attributed to lifting and patient movement over a period of time. This participant felt the surgery was likely to be related to small recurrent injuries in the past. They reported that they did not have ACC cover which would mean time away from work would be deducted from sick leave. Vecchio, Scuffham, Hilton, & Whiteford (2011) concluded that nurses are at high risk of work-related injury due to the physical nature of their work and this can be exacerbated by previous injury, psychological distress and other pre-existing health conditions.

The availability of sick leave was explored. Those without sick leave are either unpaid or can choose to take annual leave when they are unwell. By taking annual leave this denies them opportunity for holiday time to refresh and may then contribute to higher rates of sickness as they have not had a break. Ninety five percent of participants answered this question and of these 91% have sick leave available. Eight nurses reported that they do not have any sick leave available, all were registered nurses and all age groups were represented with the exception of those over 65 years. The nurses without sick leave represented a variety of specialties and were a mixture of part-time and full-time staff, all were female. No questions were asked about the nature of the sick leave, therefore it is not known if it was all for personal sickness or sick family members.

Clendon & Walker (2013a) reported that as nurses are affected by the challenges of their workplace and are unable to manage their current work they appear to be seeking casual or more flexible work opportunities as a means of coping. There is also evidence that those who have a lower self-rated health-related quality of life tend to retire earlier (Clendon & Walker, 2013). If nurses are not supported to manage health issues associated with their work (or personal life) they may be lost to the workforce.
Clendon & Walker (2013b) reported that when asked how the workplace could assist them to work longer, nurses were asked to select from a range of suggestions, the most common was ensuring safe staffing. Other suggestions included implementation of flexible hours, career advice to assist through the transition to retirement, free eye sight tests and provision of mechanical aids (Clendon & Walker, 2013b). According to Lawless (2012) the focus of safe staffing is a combination of factors including applying a method to ensure the best number, mix and schedule of staff to meet patients’ needs; developing a plan to signal whether these needs are being met; and supporting the DHB to effectively respond to any mismatch between needs and resourcing.

The relationship between staffing levels and patient safety cannot be approached solely by increasing staff numbers, skill mix is an essential element that must be considered (Martin, 2012). In a competitive employment environment the reality for many may be that they are unable to achieve the job they might desire with regular or part-time hours in a field of their choice. In an employment survey NZNO (2013) reported that while gaining new skills or a promotion were frequently cited as reasons for the job change, dissatisfaction, stress and workload were also commonly chosen. The 2011 employment survey (NZNO, 2011) reported that many nurses responded to the general employment uncertainty of 2009-2010 by working longer hours.

While equipment is now available to assist with safe manual handling nursing remains a very physical occupation (Clendon & Walker, 2013b). For many, much of the working day is spent on their feet and when combined with rostered shift work the physical demands increase (Clendon & Walker, 2013a). In a survey of 3273 nurses in NZ, Clendon & Walker (2013a) found that nurses report a decreasing tolerance for shift work as they age. Clendon & Walker (2013b) also reported that the health of older nurses has a major impact on intention to retire.

In relation to annual leave 93% (n= 90) indicated they took regular leave. Comments around annual leave were not requested but some comments were made in response to the question around support. Three participants commented that there was difficulty getting leave granted or that it was only encouraged when they had excess leave available. The aim of the Holidays Act 2003 is to promote a healthy work-life balance (Ministry of Business, Innovation & Employment, n.d.). This Act states that annual leave can be taken at any time agreed by the employer and employee and that the employee must be able to
take at least two to four continuous weeks if they wish (Ministry of Business, Innovation & Employment, n.d.).

The reality in any workplace, is that there must always be a safe staffing level. According to the District Health Boards/NZNO Nursing and Midwifery Multi-Employer Collective Agreement (2012-2015) annual leave shall be taken to fit in with service/work requirements as well as the employee’s need for rest and recreation (New Zealand Nurses Organisation, 2012). Furthermore the District Health Boards/NZNO Nursing and Midwifery Multi-Employer Collective Agreement (2012-2015) recognises a mutual interest in ensuring that health services are provided efficiently and effectively, and that each has a contribution to make in this regard (New Zealand Nurses Organisation, 2012). Within the responses, the issue of cover in the nurses’ absence was raised with one participant reporting the need for support while on annual leave. The participant commented “so that you do not return to chaos”.

In a hospital environment patient care is continuous, and while staff are away patient management is uninterrupted. For those in senior roles however the administrative details may be accumulating and awaiting their return.

While employers have a responsibility to employees, nurses also have a duty to the health service in which they are employed. While one participant suggests access to more flexible leave, or leave without pay so that they remain in the workforce for longer, the issue of sustainability of the workforce in the long term must compete with the day to day need to maintain safe staffing levels for optimum patient care. If older nurses were able to take more flexible leave or leave without pay as they wish it would be difficult to ensure a safe roster and for those not able to take leave in these conditions the work load would increase thus putting their commitment to the workforce at risk.

Survey responses suggested that shorter shifts might be more appealing to nurses who can be called in during busy times to assist but not have to work for eight hours. There is evidence that longer shifts increase the risk of errors and resultant harm to patients (Scott, Arslanian-Engoren, & Engoren, 2014). There is also suggestion that nurses working shifts of ten hours or more are more likely to experience “burnout” and intent to leave the job (Stimpfel, Sloane, & Aiken, 2012). A search of the literature regarding shorter shifts tends to refer to the shorter shift being eight hours rather than 12 hours.
Retirement intentions

Participants were asked two questions related to the importance of working until retirement and if income was a factor in their retirement decisions. More than 95% (n=94) reported that it was important that they work until retirement and 37 nurses commented further, of those 12 nurses commented about their enjoyment of their work. They are proud of what they do and feel that as long as they can make a contribution then it is worthwhile. One participant hopes to work until at least 75 years and most hope to retire on their terms having enjoyed good health. Participants commented

“Older registered nurses do contribute to excellent care of patients... excellent teachers/educators new and beginning practitioners.”

Another commented

“I have worked consistently for 45 years...”

Another commented

“When I still enjoy my work and know I am contributing to outcomes... I would like to continue.”

Another commented

“I feel it is really important to have experienced nurses around to teach and support the less experienced nurses.”

The question about income showed that it is important, very important or extremely important for almost 98% (n=95) of participants. Several reported that they were either the only income earner with retired or unwell partners, or that they were single. For many ongoing financial commitments such as mortgages were also an issue.

In the New Zealand Nurses Organisation report to the Retirement Commission (2013b), Clendon reported that in a predominantly female workforce the ability to save for retirement is affected by time taken off for childbearing and often returning to work on a part-time basis. Clendon (2013) also stated that many female nurses would delay retirement due to divorce, loss of income due to the financial crisis or the need to support children and or ageing parents. Clendon (2013) also identified that many nurses retire or
leave the profession early due to the physically demanding nature of their work which they struggle with as they age. Clendon (2013) suggested that if these nurses were able to access superannuation at an earlier age and still work in reduced hours this would allow them to contribute in the workplace for a longer period. According to Jackson, Cochrane & McMillan (2013) baby boomers in NZ and Australia want to work longer than their predecessors but this is dependent on availability of part-time work and flexibility in accommodating the needs of older workers.

Whilst it appears that nurses are planning to work until retirement and beyond there is a need to be mindful of the growing health needs of the ageing population as they live longer with complex conditions (Ministry of Health, 2014b). It is already known that there is insufficient training and retention of NZ graduates to replace retiring and emigrating nurses (North, 2010, Nursing Council, 2013b). According to Alpass & Mortimer (2007) those following on from the baby boomer generation will be insufficient in numbers to meet current health needs. North (2010) described global nursing shortages and this will mean that as the NZ nursing workforce becomes compromised so too will nursing workforces internationally. This will result in strong competition for nurses and if NZ is unable to offer attractive working conditions they may be tempted to look for work internationally thus leaving NZ even more vulnerable (North, 2010).

Nursing Council figures (2013d) indicate that approximately 59% of the current workforce are 45 years or older with six percent of the total workforce over the age of 65 years. Within the DHBs surveyed for this research over eight percent were 65 years or older (n= 8) and the largest group were 50-55 years (22%) (n= 32), this would appear to reflect the general population. In practising certificate applications Nursing Council (2013e) requires age and gender of the total workforce by geographical region and this information is then grouped into 14 regions. Nurses were grouped in ten age brackets, ranging from under 25 to over 65 years (Nursing Council, 2013d). Of those that supplied this data, the largest groups by age were 50-54 years with the smallest groups in all areas being under 25 years of age (Nursing Council, 2013d). Nurses in the 65+ age group tended to be in the next smallest group (Nursing Council, 2013d). The DHBs surveyed for the purposes of this research were similar in age groups to the other DHBs.

Findings from this survey indicated that two thirds (n=69) of participants do not feel supported by their employers to work until they reach retirement. Participants reported concerns about working conditions, 18% reported they were unhappy with education and
competency expectations, yet over 70% of participants in the survey are not intending to retire until they are 65 years or older. Despite these concerns they describe enjoyment in their work however as they age issues may arise around the workload, shift-work, and their physical ability.

Participant comments in relation to this:

“**Shift work is physically demanding on health.**”

Another commented

“I feel that my workloads are increasing as I get older…”

Another commented

“**Physically and mentally exhausting most days, non-stop workload, on feet all day but can usually get meal break.**”

Another commented

“I am noticing arthritis creeping up!”

It is evident that income is important however financial recompense is not the only factor that will have a bearing on how long nurses remain in the workforce. Participants value education and ongoing professional development however they do not view the PDRP so favourably. It is clear that as the baby boomers start to retire workforce planners must consider strategies to make continuing to work a satisfying option for nurses so that healthcare demands can be met. One participant commented

“**Continual restructuring means that change is always occurring and everyone is too busy to support those who are going to retire.**”

Another when asked about how they were supported in preparation for retirement commented

“**Organisationally there is nothing available.**”

North (2010) suggested that a career in nursing that might span 40 years needs to be attractive to recruit and retain nurses. Research into older nurses to understand conditions that will help retain their skills is required (North, 2010).
Participants have identified that they need and appreciate support. They have spoken of the high value of their input and the worthwhile work that they do. Friedrich et al., (2011) also agreed that seasoned nurses enjoy and benefit from continued practice. Participants report that the contributions from older nurses are appreciated and valued, there is no discrimination and they are still being employed into positions of responsibility after the age of 65. Almost one third of participants report receiving good support in their retirement preparation. Intent to retire was investigated with 76% (n=75) indicating they planned to work until at least 65 years.

One participant commented

“I have the oldest workforce in the DHB so rich in skills and experience.”

Another commented

“Although I am 66 years old, I have never experienced any discrimination because of this. I am treated respectfully and the same as other team members.”

Eleven percent of participants (n=11) have indicated they intend to retire before the age of 65 with 31% (n=31) planning to retire at age 65. It is clear that there are issues that need to be addressed in terms of sustainability of the nursing workforce (North, 2010). There has been a perception that the ongoing sustainability is related to the looming retirement of the baby boomer generation (Clendon & Walker, 2013a; HWNZ, 2012; North, 2010). It may be that issues that threaten the ongoing commitment of older nurses to the workplace may also be an issue among younger nurses (Lavoie-Tremblay, 2010). If the workforce is to be maintained moving forward steps must be taken to change the current environment and workplace culture (HWNZ, 2012; North, 2010).

Summary

This chapter has discussed the findings of the survey and compared them with existing literature. Themes that have emerged from the data are support, education and competency expectations, work-life balance, working conditions and retirement intentions. While a perceived lack of support is reported in the findings, 57% of participants have indicated intent to remain at work until retirement or beyond. The following chapter will discuss limitations of this survey and make recommendations for the future.
Chapter 6: Limitations, recommendations and conclusions:

The aim of this research was to examine the perceptions of nurses working in public hospitals to see whether they felt supported within their workplace to work until retirement age. It was important to critically examine data from New Zealand based nurses to see how they perceive the current situation of support in preparation for retirement. Nurses aged 45 years and over in three DHBs in New Zealand were invited to participate in an online survey. The survey results contained qualitative and quantitative data. Analysis of the data demonstrates how the participants view their situation at this time. Twenty four questions were asked to determine how participants perceive the situation and whether they felt supported in the current environment. The data was analysed using thematic analysis and an inductive approach deriving theme development from the content of the data (Braun & Clarke, 2006). The data collected indicated that over 70% of participants (n=69) do not feel supported to continue working in preparation for retirement. Participants also identified concerns regarding current working conditions and expectations for ongoing education and portfolios.

It may be that if the research question- “how are nurses supported to work in public hospitals until retirement age” had been made available to employers rather than employees there might have been different answers. By making the survey available to all nurses in these DHBs who were aged over 45 years opinion has come from all points in the nursing hierarchy.

This research was seen as important due to growing concern for ageing nurses in the wards who appear to be challenged by the physical demands of their work on a daily basis. Clendon & Walker (2013b) reported that nurses who report higher pain scores are more likely to retire sooner or move to casual and flexible work as they age. Initially there was concern for the individual nurse, now however it is evident that the picture is bigger than any single nurse. Dodsworth (2008) found little in the way of information from the New Zealand perspective. Since 2008 research nationally has emerged which appears to show a growing level of awareness of the looming change to the shape of the NZ workforce as baby boomers begin to retire and the resultant threat to workforce sustainability.

The baby boomers are the largest generation in the current workforce. The loss of this generation will mean the loss of a large part of the workforce and importantly the loss of their knowledge and experience. It is therefore imperative that nurses are supported to
work for as long as they can and that they do so in an environment that they believe values and acknowledges their contribution to healthcare in NZ. While retaining older nurses will help in the short term, long term strategies are required to maintain an experienced workforce into the future as the population ages and lives longer with more complex needs (North, 2010).

This looming threat to the NZ workforce as the large baby boomer generation begin to retire cannot be ignored. According to North (2010), analysis of workforce data has highlighted a significant threat to the ongoing sustainability of the nursing workforce both in New Zealand and internationally. If sustainability of the workforce in its current form is threatened when this research indicated that nurses were already reporting their work to be demanding and increasingly difficult as they age then it must also be true that any shrinking of the workforce will have an even greater impact on the nurses who remain. In order to meet the complex health needs of all New Zealanders it is essential that steps are taken to address the identified concerns so that this large generation of older nurses rich in experience is not lost to the workforce at a time when it is known that there are not sufficient younger nurses coming through to manage future health care requirements (North, 2010). This study identified concerns however participants also indicated their intention to continue working until retirement age.

While this research indicates that two thirds of participants do not feel supported by their employers to continue working until retirement, it has also shown that almost one third report good or excellent support. According to Lavoie-Tremblay et al. (2010) retention strategies that support older nurses will also be beneficial to all other generations of workers who will be increasingly required to maintain a sustainable workforce.

It is apparent that the older nurses believe that as well as offering patient care on their duty they can also contribute by working with younger nurses and sharing their experience and role modelling good practice. Nurses in this research spoke of their perceived lack of recognition from their employers of their experience and also lack of support as they approach retirement. Baby boomers (born between 1946 and 1964) are service oriented and seek to please, they are also sensitive to feedback (Lavoie-Tremblay et al., 2010) while generation X nurses (born between 1964-1980) are also motivated by recognition and praise (Lavoie-Tremblay et al., 2010). A change in the workplace culture is required so that all nurses including those starting their nursing careers and those approaching retirement will feel valued and supported. The research indicates that nurses are proud of what they
contribute to healthcare in NZ DHBs. It may be that by making changes nurses will be able to work for longer.

Clendon & Walker, (2013a) suggested that nurses were struggling with the demands of shift work as they aged. Participants also stated that they were struggling with shifts and many stated they would prefer to work part-time which is not always an option especially in senior positions. Over 90% (n=87) of participants reported that they have sick leave available and have and take regular annual leave. Almost 30% (n=27) reported having sustained a workplace injury in the past. All participants were assumed to be aged 45 years or over and within their DHB they make up approximately 60% of the total nursing workforce (Nursing Council of New Zealand, 2013d) which is similar to research from North (2010) who reported nurses over the age of 45 make up 52% of the workforce. Participants also spoke of a feeling that there is a lack of recognition for their skills and years of experience and that the demands of the PDRP programme are excessive and not always a true reflection of the nurse who holds it.

Participants (n=2) believe that their years of experience should validate their competency and that a portfolio is not necessary to prove this. Participants also believe that their skills and practice in the workplace are evidence of competence and are of higher value that a written portfolio. If older nurses do not believe in the credibility of the portfolio programme then their participation will be an issue. Participants were in favour of ongoing education and many (n=78) have participated in some form of post-graduate education.

The impact of the global financial crisis has been discussed by Oakman & Howie (2011), who suggested that in times of crisis the demand for healthcare workers increases. North et al. (2014) contend that nurses are more inclined to remain in the workforce or return to it due to personal financial considerations. While over 90% (n=95) of participants report income is important, it is not the only factor nurses are considering when planning their retirement.

Higher income will not change the physical demands of clinical care or shift work. It is clear then that these physical demands must be addressed. Vecchio et al (2011) recommend that occupational health and safety programmes should concentrate on providing support to nurses to allow them greater opportunity to recover fully from physical and mental illness. Participants asked for respect, a review of working hours and conditions, and assistance
from their employers with retirement planning. It may be that the physical demands of everyday work within the clinical environment need further assessment.

Healthcare needs are not likely to decrease and as ageing nurses retire they too will become part of the New Zealand health consumer group. Participants believe they are making a valuable contribution and while they add value they wish to continue in the workplace for the benefit of the patients and also junior staff. Some participants also indicate their belief that they are unsupported by employers in preparation for retirement. This belief stems from a perceived absence of input from employers.

If part-time mentoring roles were possible this may allow senior nurses the opportunity to pass on their skills and knowledge as well as institutional knowledge. While these part-time roles may create a rostering issue it is preferable to have these nurses available as a resource. Older nurses would have reduced their physical burden and younger nurses benefit from their support and experience. McDonald et al., (2010) also reported potential benefits to inexperienced nurses. Ultimately the patients must also benefit. The cost of staffing wards with older nurses in these part-time supportive roles might be increased but must be considered against the cost of recruitment of new staff members. It is recognised that the nursing workforce is ageing globally (McDonald et al, 2010) and therefore cannot rely on overseas recruitment to sustain the workforce in the long term (North, 2010).

While the data collected for the purposes of this research comes from a small study it provides a summary of how participants feel about the level of support in the workplace. While the data suggests that two thirds of participants do not feel valued and supported in preparation for retirement, one third of participants report good or excellent support. If nurses do not feel supported they may also discourage friends from returning to the workforce based on their experience.

Limitations

A single once only survey collects data at a single point in time and therefore does not allow for ongoing change. The online survey was carried out in only three DHBs in NZ which means the data were collected from a small part of the possible population. The data cannot be generalised to the entire population.

The invitation was to nurses in participating DHBs who were over the age of 45 years, and it is not possible to be certain that participants met this criteria.
The online approach requires internet access and computer knowledge which may have excluded potential participants.

**Personal reflections**

The survey was sent to nurses working for the DHBs with an invitation to nurses aged over 45 years. Participants have come from within the hospital and out in the community in various roles. It was not possible to limit the survey to nurses working in the hospital wards. It might have been useful to ask two separate questions about education and portfolios. As well the question about annual leave was confusing as it asked if participants had and took regular annual leave. It may be that they have leave available but do not take it however space was not provided to comment further. Some did comment in the final question which invited any further comments. Further exploration might have provided useful information around work-place injuries to see when they occurred (age of participant at the time) and the circumstances. Participants were asked for their opinion about how they were supported in preparation for retirement, a direct question asking for examples of support might have encouraged more in depth responses and provided more information in relation to the research question.

**Recommendations for practice, education and future research:**

If supporting the workforce so that it is sustainable is to be a priority then return to work support would need to be studied in greater depth in future.

Consideration should be given to investigating how nurses can be supported to complete portfolios and meet competency requirements during work hours rather than in their own time.

Over 80% of participants reported that the physical demands of their work were at least demanding. Further research is required to address strategies to reduce this physical demand.

Participants have indicated that they have responsibility for children and older family members. Further research may be required to look at options and support for nurses so that they can continue nurses to work.
A follow-up study looking at perceptions of workforce planners might be useful to ascertain what (if anything) they see as the issues threatening the workforce into the future and what can be done to address these concerns.

Review of current rostering practises is required. It may also be that job descriptions need to be examined as some (n=5) of those in senior positions report the need to work overtime to meet expectations.

Consider development of a mentoring programme to allow senior nurses the opportunity to work with more junior staff.

Research is recommended into assistance for employees approaching retirement.

**Summary**

Participants in this survey have portrayed a snapshot of the current situation in the workplace. While some report good support, over two thirds have indicated their perceived lack of support. As the baby boomer generation approaches retirement it may be that the workplace culture needs review so that more `nurses feel supported.
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Appendices:

Appendix 1 Questionnaire:

How are nurses supported to work in public hospitals until retirement age i...

My name is Marie Whitburn, and I am inviting you to participate in an online survey which is research being undertaken as a Master of Nursing thesis at the Eastern Institute of Technology.

Information about the survey

- The survey is anonymous.
- Submission of the survey indicates your consent to participate in it
- You can choose not to answer any question
- For some questions space is provided for you to add comments. This will assist me to gain a clear picture of your experiences and perceptions of support in relation to my research question.

Confidentiality of information in the survey

- Your responses will be entirely confidential and will only be viewed by the researcher and supervisors
- No names, places or mention of specific information that could directly connect the information to any person or organisation will be used in the analysis and writing up of the research.

Rights of participation

- Your participation is entirely voluntary in this survey.
- You do not have to answer all the questions posed to you in the survey.
- Your participation will not jeopardise your employment in any way.

If you have any questions, please contact:

Marie Whitburn, student, Master of Nursing, Faculty of Health Sciences, Eastern Institute of Technology, email: whitbum2@student.eit.ac.nz

Dr Elaine Papps, Senior Lecturer, Faculty of Health Sciences, Eastern Institute of Technology, email epapps@eit.ac.nz (Principal supervisor)

Please proceed to the survey. This survey should take no more than 30 minutes of your time.
Nurses and retirement

1. Demographic questions

Are you a:
- Registered nurse
- Enrolled nurse
- Nurse practitioner

2. What year did you obtain registration or enrolment in your current scope of practice?

3. What is your age?
- 16 - 39
- 40 - 55
- 56 - 70
- 71 - 85
- 85+

4. How many years have you been working as a nurse?

5. Are you female or male?
- Female
- Male

6. What is your work area? (eg Medical, surgical, community, child health etc)
7. Do you work:
- Part-time
- Full-time

8. What is the generic title of your position within your workplace?

9. Are you considering retirement:
- Before the age of 65
- At the age of 65
- After the age of 65
- Haven't thought about it

10. Do you work:
- Rostered and rotating shifts
- A fixed roster
- Other
- Other (please specify)
Section Two

Please answer the following questions by indicating your view on the aspect of the scale provided. There is space for you to add comment if you wish to.

11. How important is it that you continue to work until you decide to retire?
   - Extremely important
   - Very important
   - Important
   - Not very important

Please comment further on anything you would like to share about your response

12. How would you describe the physical demands of your work?
   - Extremely demanding
   - Very demanding
   - Demanding
   - Not at all demanding

Please comment further on anything you would like to share about your response
13. Is income important to whether you stay at work or not?
- Extremely important
- Very important
- Important
- Not important

Please comment further on anything you would like to share about your response

14. What is your opinion about ongoing educational requirements and portfolios?
- Extremely important
- Very important
- Important
- Not important

Please comment further on anything you would like to share about your response

15. If you could choose your own roster would this help you work for longer?
- Yes
- No
- Not sure

Please comment further on anything you would like to share about your response
16. How do you feel about your current work hours?
- Very happy
- Happy
- Unhappy
- Very unhappy

Please comment further or anything you would like to share about your response

17. Do you have the ability to work flexible hours?
- Yes
- No
- Not sure

Please comment further or anything you would like to share about your response

18. Have you undertaken any postgraduate education courses/papers?
- Yes
- No

19. Depending on whether you answered yes or no to the previous questions
- If yes, what courses have you undertaken
- If no, do you plan to undertake any postgraduate education courses

Please comment in relation to your yes or no response
20. Have you sustained any workplace injuries?
   - Yes
   - No

21. Do you have sick leave available currently?
   - Yes
   - No

22. Do you have and take regular annual leave?
   - Yes
   - No

23. What is your opinion about how you are supported in preparation for working until retirement?
   - Excellent support
   - Good support
   - Little support
   - No support

Please comment further on anything you would like to share about your response
24. Please comment below about anything else you would like to share in relation to this research.

☐ Nothing to share

Other (please specify)
Thank you for taking the time to complete this survey
Reference Number 37/14

28 July 2014

Marie Whitburn
Masterate Nursing Student
C/- School of Nursing
EIT

Dear Marie

Thank you providing further clarification to the Committee, as requested. The Committee also notes receipt of approval of your locality assessment, is pending.

I am pleased to inform you that your research project “How are nurses supported to work in public hospitals until retirement age and beyond in New Zealand” was approved by the Research Ethics and Approvals Committee at their meeting held on 25 July 2014.

You are reminded that should the proposal change in any significant way, then you must inform the Committee. Please quote the above reference number on all correspondence to the Committee.

The Committee wish you well for the project and looks forward to receiving a copy of your Locality approval, in due course.

Yours sincerely

[Signature]

Jeannette Fifield
Secretary – Research Ethics & Approvals Committee

cc: Dr. Elaine Papps