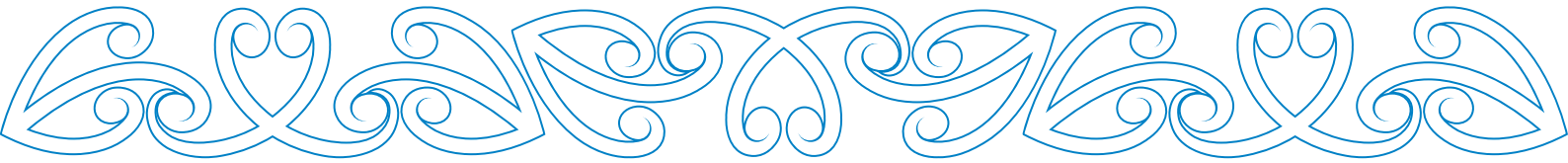
RESEARCH

EMPLOYMENT

Vital Signs

THE NZNO EMPLOYMENT SURVEY 2011



NEW ZEALAND
NURSES
ORGANISATION

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Written by Dr Léonie Walker Researcher

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Summary

This survey was based on the UK Royal College of Nurses Employment Survey, which has taken place every year for the last 21 years. The questionnaire was first modified (with the RCN's consent) to address the differences in terminology and structures required for use in New Zealand in December 2008, and has been incrementally refined and adapted to reflect ongoing changes and events for web-based data capture for use in the second biennial survey. An invitation to take part in the survey was sent to the e-mail addresses of a computer generated random sample (of 10% of the members of the New Zealand Nurses Organisation over the age of 30. Nurses under the age of 30 were surveyed at the same time but separately using a similar format. Most of the questions were identical, and a separate report will highlight similarities and differences. Where comparisons of morale with the previous survey are made, (to correct for age-related effects), a random sample of the responses to that survey were added back to the full employment survey data. The Younger Nurse Survey (YNS) was a full-cohort survey, and the approach outlined above for the Employment survey was taken to avoid over-surveying of this group. The YNS is reported in full elsewhere.

NZNO represents 46,000 members (nurses, care givers and midwives). Questionnaires were not sent to midwives who were not dual registered as nurses, as they had recently been separately surveyed. The membership of NZNO is broadly representative of the nursing workforce in New Zealand, covering nurses and care givers working in all employment sectors and roles.

Profile of the Nursing Workforce

The nursing workforce, in common with the workforce as a whole appears to have responded to uncertainty in general employment, and to unemployment by working longer hours and changing employment less than was seen two years ago. There are also ongoing changes to the regulatory structures, roles and scopes of practice, and to the education of nurses. While other data about age, ethnicity, gender and qualifications exist, this survey also documents the proportions of such nurses, their employers and job titles. This allows comparisons with other items in the survey, such as pay, working patterns, second jobs, career plans and perceptions of nursing roles and careers. 2009-2010 was also a period following national and international recession and a change of government in New Zealand. Evidence of substantial structural and organisational change in the New Zealand Health system has been captured

Pay

Across all sectors and roles nurses agree or strongly agree that they are poorly paid. There are continuing disparities in pay between sectors, and also perceived gaps between nurses and other comparable professionals. For those working in other sectors (Primary Care, Maori & Iwi employers) the pay gaps with DHB nurses

are perceived as unfair. While a modest pay settlement was secured in 2010, other settlements in the public sector, tax changes and continuing inflation in all areas, combined with a perception of having to "work harder for less" meant pay was a significant area of discontent for very many.

Working Hours

While nurses are mostly satisfied with their hours, large numbers work part time or casual hours. This is particularly associated with the need for work life balance, child care responsibilities and a desire not to work rostered and rotating shifts. (Younger nurses are much less content to work shift patterns that conflict with family or other social demands. This is explored more fully in the YNS.) There is evidence that the pool of part time workers prepared to regularly work additional shifts have found it increasingly hard to get the extra hours they would like to work. This is a significant change from two years ago, and has implications for staffing levels and also for enabling employers to manage their nursing workforce with higher patient contact time than previously. While there has been a reported easing of the difficulties seen over the last few years in recruitment of nurses, ongoing re-structuring and financial difficulties in the DHB sector mean that fewer casual nurses are employed, and that some posts are either frozen or disestablished. At present, nurses are continuing to work part time long past usual retirement age. If the longer term workforce planning is to be adequate, the assumptions that there will continue to be a pool of experienced semi-retired nurses prepared to work small numbers of shifts may need to be robustly tested. More flexibility regarding hours and choice of shifts will be important to retain these workers.

Workloads and Staffing

While in New Zealand specific staff to patient ratios are not mandated or expected, it is clear that many nurses feel the workload and pressure caused by increasing numbers and higher acuity of patients, combined with a perceived lack of experienced staff, high staff turnover, freezing of posts, and the inability to cover vacancies, holidays and sickness and education leave is contributing significantly to reduction in job satisfaction, and to increased stress. This is a trend that has increased since 2009. Loss of senior positions has a dual effect of reducing skilled mentorship, and of further limiting opportunities for career progression. Continued reduction in satisfaction with the quality of care given, and the knock-on effect on ability to take leave or attend training will also have long term implications.

Job Change

There continues to be a relatively high level of staff turnover, with stress and lack of prospects being key drivers for job change. Choice of hours, dissatisfaction with workload, and bullying also all contributed to nurses changing jobs. 7.5% respondents, representing the whole nursing workforce would like to work overseas. This is an increase compared to 2009.

The aging profile of the workforce also means many will be coming up to retirement within the next ten years.

Enrolled Nurses

278 Enrolled Nurses completed the survey, There is a broad spectrum of views about the recent changes to the scope of practice for Enrolled Nurses, and a range of experiences and perceptions of the role and the esteem in which the role is held. There is apprehension about future employability, as Enrolled Nurses, and resentment and resignation for some for the need to undertake more training and accreditation; for some, in the last years of their employment before retirement, this requirement may prove a hurdle too high.

Restructuring

There is considerable evidence of ongoing and widespread organisational change throughout the health sector. Claims that "back office" functions only are being lost are challenged, with reports of job losses, support staff reductions, poorer staff to patient ratios, and in particular a loss of clinical nursing leadership. Uncertainty and loss of expertise are adding to pressure at work, and any productivity gains risk being lost due to burnout, loss of goodwill, and dysfunction caused by removal of experience and safety structures.

Continuing Professional Development

There is considerable variation by employer and by role between the amounts of paid time spent on Professional Development for nurses working for different employers – from none to months. There are also different rates of access to mandatory training on topics such as infection control or cultural safety. Patterns of access to paid Professional Development related to role and employer were discernable, and while nurses have always put their own time into their development, those with children clearly find the competing calls on their time stressful. Equally, access to regular appraisals was very patchy, with many answering "never" to the question related to their last appraisal.

Morale

Nurses are a resourceful, resilient and committed group of workers who know their value and have often lived through similar cycles of disruption. Some younger nurses (particularly new graduates) are finding it hard to get a start in their chosen profession.

While older nurses may have the experience and confidence to ride out the storms, younger nurses are largely more positive, optimistic and secure in their feelings about the future than older nurses. More research is needed to explore whether this is a function of age itself, or an effect of the pressures of long term work as nurses.

Despite considerable and ongoing change, reorganisation, restructuring, budgetary constraints and financial insecurity, nurses and care givers remain largely positive about their chosen career. While job security, financial pressure and increased workloads all scored as more evident than two years ago, satisfaction with providing high quality care, and of providing a compassionate and professional service remains high.

Limitations

Only surveying those with valid email addresses excludes those who do not use email. Currently 60% of the membership does have an e-mail address, and there are no patterns by age or membership category for those who do not. The demographics of respondents to this survey are comparable to the total NZNO membership. All surveys are subject to potential respondent bias, with those with strong views being more likely to respond.

Introduction

1.1 The 2010/11 NZNO Employment Survey

The New Zealand Nurses Organisation (NZNO) is the leading professional and industrial organisation of nurses in Aotearoa New Zealand, representing over 46,000 nurses, midwives, students, kaimahi hauora and health workers on a range of employment-related and professional issues. NZNO has a commitment to the Treaty of Waitangi (te Tiriti o Waitangi) as the founding document of Aotearoa New Zealand and articulates their partnership with te Tiriti through Te Runanga o Aotearoa. NZNO provides leadership, research and support for professional excellence in nursing, negotiates collective employment agreements on behalf of its members and collaborates with government and other agencies throughout the health sector. This report documents the results of a survey of a random sample of NZNO members. A 10% sample was drawn by computer from the 46,000 membership, representing nurses and care givers from across Aotearoa New Zealand. Midwives were excluded from the sample on this occasion.

The questionnaire was adapted for use in Aotearoa New Zealand from the UK RCN 2008/09 employment survey (parts of which have been standardised since 1992) allowing for international comparisons to be made. Incremental changes have been made to the survey following experience from the 2008/09 survey, and taking account of known changes since then. NZNO membership is largely representative of the New Zealand nursing workforce as a whole, and it is hoped that the results will provide a useful picture of the employment and morale of nurses.

1.2 Context

This is the second biennial employment survey of NZNO nurse and care giver membership, and was undertaken in December of 2010, some six months after a one year Multi Employer Collective Agreement was reached with DHB employers, and 2 years into a major recession, and increasing health service reform and budget constraint initiated by the incoming National party government.

The RCN 2009 survey reported on the effects of recession and reorganisation over a similar time period. The UK represents a significant source and destination country for nurse migration to and from New Zealand, so comparisons with the RCN survey are therefore timely.

The structure of this report heavily and intentionally follows the format of the RCN report "Past imperfect, future tense, Nurses' employment and morale in 2009" by Jane Ball and Geoff Pike, published by the RCN, and "Holding Up: the NZNO Employment Survey, 2009.

1.3 Method

A web-based survey of NZNO members was undertaken in December 2009. Midwives were excluded from the 10% random sample on this occasion. Invitations to participate in the web-based survey were sent by e-mail link, along with a covering letter. Participants were also offered a reward for their time spent participating with (voluntary) entry into a pre-Christmas ballot, with a chance of winning $50. Contact details for the entry into the drawer were separated at source from all answers, and participation was kept anonymous.

Questionnaire Design

NZNO wishes to thank the RCN, and Jane Ball / Geoff Pike from Employment Research Ltd for their permission to use and adapt the questionnaire. The RCN survey was extensively and iteratively adapted for use in New Zealand in consultation with the NZNO Professional Nursing Advisory team, and cognitive testing and piloting was also undertaken at the NZNO annual conference. The questionnaire covers core employment issues (contracts, hours, pay, job change) along with demographic details, and items related to plans for, and perceptions of, working life. The attitudinal rating scales were identical to those used in 2008/9, allowing change over time to be tracked, and kept as similar as possible to the standardised RCN set to allow international comparisons.

Sample and Response Rate

4790 invitations were sent out, 31 were returned as not known at the address available. 1076 responses were returned, giving a response rate of 23%. This is considered a good response rate for a detailed web-based questionnaire where no reminder is sent out.

1.4 Report Structure

The results are given for all respondents. Individual analyses exclude missing data, and this is indicated where applicable.

Chapter 2	details the demographic and employment profiles of the respondents
Chapter 3	examines pay
Chapter 4	describes working and shift patterns
Chapter 5	captures workload issues, and the effects of restructuring and reorganisation
Chapter 6	summarises the changes in employment, and plans for future changes
Chapter 7	summarises the evidence of restructuring and organisational change
Chapter 8	explores patterns of training and development
Chapter 9	utilises a combination of the attitudinal scales and the qualitative comments to present a picture of the morale of the workforce

Respondent Profiles

Not all the respondents are currently working as nurses. However, given the fluidity of the workforce, the moves in and out of retirement, and the small numbers involved, no respondent was excluded from the analysis, except that in many items, "blank" , "missing" or "Not Applicable" were accounted for statistically.

2.1 Employment Situation

The numbers and percentages of respondents in each category are shown below.

Table 2.1 Respondent Profile by Employment Status

	Number	Percentage
Employed, working	825	76.7
Employed, maternity leave	15	1.4
Employed, sick	5	0.7
Student	126	11.7
Semi-retired	7	0.7
Not employed (unemployed, career break, retired)	38	3.5
Not in nursing employment / other	60	5.6
Total respondents	1076	100

2.2 Age profiles

The ages, percentages and comparative figures for the Nursing Council of New Zealand are shown in the tables below. (Nurses under the age of 30 surveyed separately)

Table 2.2 Respondent Gender, Role and Age Profile

				Age group						
Role	Total	Female	Male	31-35	36-40	41-50	51-60	61-65	66-70	70+
EN	278	275	3	4	4	71	140	42	7	1
NA	30	28	2	3	3	11	9	4	-	-
RN	412	369	43	13	31	111	201	43	9	2
HCA / CG	255	233	22	30	32	95	68	21	-	-
Other	101	84	12	7	9	39	36	8	1	1
Total %	1076	989 92	82 8	57 5.2	79 7.3	327 30.3	454 42	118 11	17 1.5	4 0.37

(EN = Enrolled Nurse NA = Nurse assistant RN= Registered Nurse
HCA / CG = health Care assistant / Care Giver)
Compared to Nursing Council registration (see below) this survey record the views of fewer Enrolled Nurses in the 61+ age group, otherwise, demographics are comparable. This may be explained by the survey method; e-mail invitation to web survey

Practising	T	Female	Male	16-25	26-35	36-45	46-55	56-65	66+
Enrolled Nurses	3,385	3,276	109	0	20	201	1,615	1,392	157
Nurse Assistants	254	238	16	3 30	50	62	80	32	0
Nurse Practitioners	71	65	6	00	0	11	48	11	1
Registered Nurses	48,052	44359	3,693	1,863	8,278	12,568	14,925	8,483	1935
TOTALS	51,762	47,389	3,824	8,348	8,348	12,842	16,668	9,918	2093

(Nursing Council of NZ 2009)

2.3 Caring Responsibilities

Responsibilities	Female (number)	Female %	Mean age of nurse
Dependent Children	430	27	42.4
Adults with care needs	168	10.5	53.1
Both responsibilities	71	4.4	
	Male (number)	Male %	Mean age of nurse
Dependent Children	29	22.4	38
Adults with care needs	11	8.5	45.5
Both responsibilities	6	4.6	

There continues to be a significant part of the nursing workforce with responsibility for children, adults or both. The smaller percentage of men with responsibility for adults with care needs may also reflect their slightly lower age profile. These numbers have implications as the workforce demographics show increasing age (& consequent responsibilities) that might affect the labour supply.

2.4 Gender

The gender of respondents compared to the Nursing council data is shown below in table 2.4

Table 2.4: Gender of respondents compared to Nursing Council data (Nov 2010)

Gender	Respondents (%)	Regulated Workforce (%)
Female	91.9	93
Male	8	7

2.5 Chosen Ethnicity

Table 2.5 Chosen Identity (note multiple identities could be chosen)

Response	Number	percentage
NZ Maori	128	12.0
NZ European	784	73.7
Other European	74	7.0
Samoan	31	2.9
Cook Island Maori	9	0.8
Tongan	12	1.1
Fijian	19	1.8
South East Asian	32	3.0
Chinese	11	1.0
Indian	28	2.6
African	8	0.8
Australian	7	0.7
New Zealander	8	0.8
Other	69	6.5

This question, though standard in many situations, proved contentious for some. In addition to missing data, questions were written as to why the question was relevant, and many chose to identify as other, often citing "New Zealander". Many who had initially trained overseas now identify as New Zealander or NZ European, though others retained another identity (particularly constituent countries from the UK such as Scottish or Welsh) where people had identified more than one identity, the least commonly reported identity was recorded. Two frequent double identities were Maori + NZ European and Fijian + Indian. While this is less accurate, and important to capture, this was done in this case to allow comparisons with other data sets. The original data remains available.

The identity of members of NZNO has changed considerably over the last few years, as the proportion of overseas trained nurses has increased. The biggest increases have come from Asia (particularly from the Philippines) and from Europe (particularly the UK). See Nursing Council data below, 2010

	Registered Nurses			Nurse Assistants			
	NZ	O/Seas	Total	NZ	O/seas	Total	Total
2010	1231	1270	2501	106	25	131	2632
2009	1268	1363	2631	52	24	76	2707
2008	1224	1172	2396	19	35	54	2450
2007	1999	1285	2484	16	42	58	2542

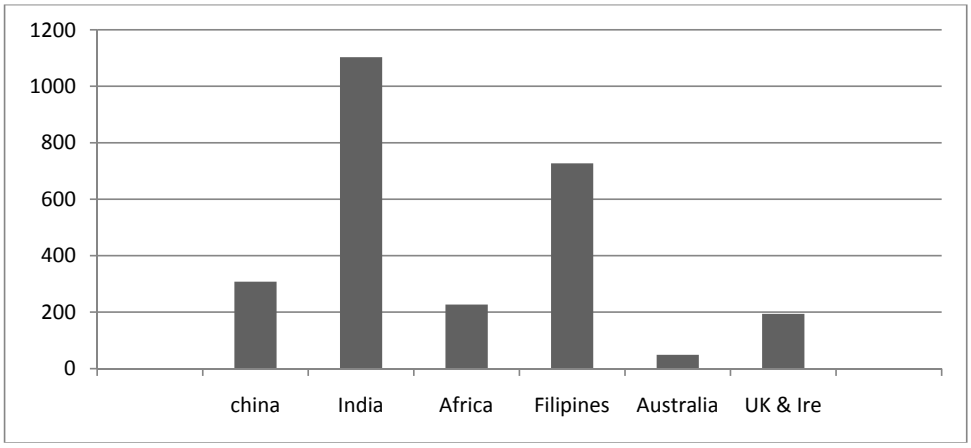
* Nurse assistant data includes Enrolled Nurses in the table above

With the percentage of overseas trained nurses having increased from around 22% to 50% in the space of 5 years, the experience, views and plans of this group are particularly important to understand – particularly their longer term plans.

The percentage of the 50 % of new members of NZNO not from NZ coming from main source countries in 2008 – 2010 is shown below. This pattern reflects Nursing Council registrations by country.

2.6 New Migrants

Graph 2.6 Origin of New Migrant Members



2.7 Overseas Trained Nurses (OTN)

The results of the three questions specifically asked of OTN are shown in table 2.7 below. The implications of newer migrants being unsure of their employment plans, or not confidently deciding they might stay till they retire, has implications for the workforce longer term, given the reliance on OTN and the migration of New Zealand trained nurses, particularly to Australia. The main groupings of OTN were (in order) UK/Ireland, Philippines, India and the Pacific Islands.

Table 2.7 Overseas Trained Nurse Questions

	Number	% total OTN Responding to Q
Trained Overseas	298	27.6
Undertook further training	54	18
Undertook English Language test	44	21.4
Feel unable to use OSN experience fully	92	49.2
Plan to work in NZ till retirement	85	55
Unsure of plans	34	22
Expectations of nursing in NZ met	76	43

(Responses from this cohort are analysed further in later sections)

There were many comments related to feeling unable to fully use overseas training or experience in NZ. These could be divided into those unable to gain registration here: "*I have to go through the English test, competency then get my Registration here in New Zealand".*

and those for whom the differences between health systems proved a barrier: "*An enrolled Nurse in Sweden, I had more responsibility, staff supervision of Nurse Aids, catheterised both male/female patient, taking bloods, able to work in community. I have a post graduate certificate and worked as a Health Visitor in the UK. This is not recognised in NZ".*

"No recognition for UK/ Paediatric training; recognised in Australia but not NZ".

2.8 Qualifications

A variety of different qualifications are held by nurses and carers in New Zealand. Broadly, they can be divided into Diploma/ Certificate level (including hospital training in the past), Degree level, and post graduate level (including post graduate certificates through to masters and PhD. Very many respondents had multiple qualifications. There were many missing fields for this question, and blank was recorded only if none was selected, or the qualification was unrelated to nursing.) Broad categories are shown in Table 2.8 below.

Table 2.8 Qualifications

Qualification	Count
Enrolled Nursing	335
Bachelor nursing / other nursing degree	165
RGON (hospital trained)	121
Diploma Nursing	76
Post graduate Certificate	72
Masters (nursing related)	57
Graduate Certificate	16
Plunket Certificate	15
Advanced Diploma in nursing studies	12
Registered psychiatric nurse	10
PhD	7
Registered Midwife	5
Care giving Qualification	222
Student	5
Other / blank	85

Amongst nurses, the qualifications related to age profiles are of particular interest. Designations are as for the previous table. Very many held a number of different qualifications, where ascertainable, the highest qualifications as judged by academic hierarchy have been selected. This reflects researcher bias.

Table 2.9 **Highest Qualifications by age for nurses (RN + EN) , as percentage of respondents to this question by age group (rounded to whole numbers).**

Age group	Number	Missing Q	Diploma	Degree	Post Graduate	Masters/ PhD
31-40	82		14	150	11	7
41-50	99		26	46	43	13
51-60	109		34	35	21	29
61-70	25		15	4	2	9
Missing age	35					
Total	530	13%	89	235	77	58
%	100		17%	44%	14%	11%

For Registered Nurses only, 43.4% have PG qualifications (PG cert / PG Dip / Masters / or PhD) 39% of female RNs have PG qualifications, and 47% of male RNs.

It can be seen that the Degree has replaced the Diploma / Certificate / Hospital training as the main qualification in the younger age groups. A very large number of postgraduate degrees did not follow Bachelor of Nursing degrees (EN training, RGON and Nursing Diplomas), suggesting that many have upgraded their initial training after experience as nurses, perhaps in response to a requirement for a degree or post graduate qualification in the job market. There may also be a bias amongst postgraduates to return surveys, perhaps appreciating the need for research!

By role, the 58 respondents with masters and PhDs were disproportionately employed outside direct clinical nursing: as educators, researchers, managers, and in government advisory roles. 12 were employed as RNs, Public Health or Community nurses.

Of the 4 respondents who identified as Service Managers, 1 had a degree, 2 had RGON and 1 an Enrolled nursing qualification. Qualifications were broadly correlated with wages: as seen in table 2.10 below.

Table 2.10 Wages by Qualification

Highest Qualification	(Valid) Number	Mean Hourly Wage ($)
Masters / PhD	42	$37.18
Post Graduate (not M /PhD)	32	$29.19
Degree	78	$25.22
Care giving, qualified	72	$17.53
Care giving, unqualified	29	$14.86

Wages are also correlated with role, and this may be independent of qualifications. Increasingly, formal qualifications rather than experience in the absence of formal qualifications are required for more senior and higher paid jobs. Many respondents withheld their salary details. Pay is analysed in far more detail in chapter 3. By comparison with the RCN survey, New Zealand nurses report a higher proportion holding post graduate qualifications, though similar percentage have masters or PhD. This might reflect differences in definitions, opportunity for further study, value placed on further study, or a combination of all factors.

2.11 Current Job and Employer

The main descriptors of the employment of the respondents are shown below. All categories with fewer than 1% of respondents are not shown separately.

Respondents (light bar) compared to DHB area (dark bar) are shown on the graph below. Note log scale. No respondents were found from Lakes, Tairawhiti, Whanganui, West coast or Otago.

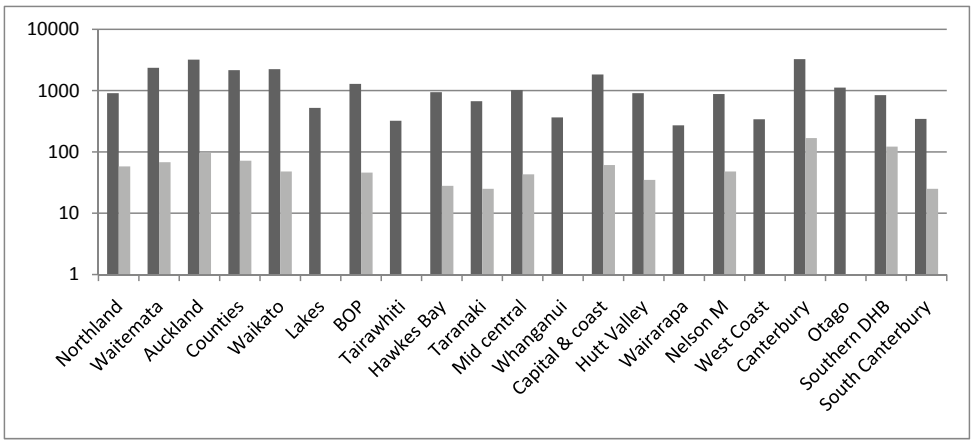


Table 2.12 Main Employers and Hours of Work

Employers	Count	Employers	Count
Accident and Medical centre	6	**DHB - Community**	98
Casual / various hours	1	Casual / various hours	4
Full time	4	Full time	64
Part time	1	Part time	30
Aged care provider	222	**DHB - In patient**	318
Casual / various hours	29	Casual / various hours	41
Full time	111	Full time	139
Job share	2	Job share	1
Part time	80	Part time	133
Community Hospital (rural)	11	**Educational institution**	57
Casual / various hours	1	Casual / various hours	2
Full time	2	Full time	35
Job share	2	Job share	3
Part time	6	Part time	12
		Private surgical hospital	37
		Casual / various hours	5
General Practitioner	24	Full time	16
		Part time	16
Casual / various hours	2	**PHO provider**	15
Full time	7	Casual / various hours	1
Job share	0	Full time	8
Part time	14	Part time	6
Government agency (MOH, ACC, prisons etc.)	20	**Self-employed**	12
		Casual / various hours	4
Casual / various hours	1	Full time	6
Full time	11	Part time	2
Part time	7		
Maori and Iwi health provider	14	**Other/ missing**	185
Full time	12		
Part time	2		
NGO provider	23		
Casual / various hours	1		
Full time	12		
Part time	10		
Nursing agency	17		
Casual / various hours	7		
Full time	4		
Part time	5	**Total**	**1080**

"Full time" was self defined, and this varies between employers. As will be presented later, many who do not work "full time" in their main contract often do other shifts (either for the same or different employers) on a regular/casual basis. The existence of a pool of part time nurses allows flexible deployment of positions, as employers are more likely to be able to cover holiday, sickness and training time without employing cover nurses themselves, or paying the higher costs associated with employing agency nurses. Such cover is often paid at the same rate as the normal salary. (More detail is given in chapter 3.) The ease of finding appropriate cover is likely to vary geographically and by specialisation. There was some evidence from free text comments that casual overtime is much less available than two years ago, and that particularly in Aged Care, there were many who would choose to work more hours if these were available. Professional concerns exist about too high a deployment of nurses temporarily in areas and wards, as team cohesion and specialist knowledge can be lost, and time continually helping these nurses familiarise themselves with resources, relationships and nursing specialism can detract from available nursing time.

2.13 Job Title:

The number and range of job titles of the respondents are shown below.

Table 2.13 Job Titles

Title	Count	Title	Count
Allied health professional	11	Nurse assistant	31
Care Giver	99	Pacific Island nurse	1
Charge nurse / manager	15	Practice nurse	16
Clinical nurse specialist	8	Public health nurse	31
Community nurse	14	Registered nurse /staff nurse	97
Director of Nursing	2	Service manager	2
District nurse	5	blank	30
Duly authorised officer	1	Other	230
Educator / researcher / lecturer / tutor	46		
Enrolled nurse	278		
Health Care Assistant	156		
Maori and Iwi nurse	2		
Mental health nurse	13	Total	1080

2.14 Turnover

Questions related to the length of time nurses had been employed by their current employer, and in their current roles were examined by main employers. This revealed considerable job change, both to different jobs with the same employers, and to different employers. Nicola North also identified "churn" within DHBs. While this is not necessarily a negative phenomenon (representing career advancement and acquisition of new skills and experience) it does come at the cost of vacancies, increased workload, lack of speciality skills and continuity for both patients and colleagues, particularly in the more senior roles. The figures are shown in table 2.14 below. Those with higher turn over are highlighted.

Staff working for provincial DHBs had the most stable employment history, while those working for agencies, were (not surprisingly) the most flexible. All categories however had huge variation, the ranges were from weeks in post through to 45 years, so other than to say nurses change their employers and posts more frequently than many other professions, conclusions are difficult to draw. Data from DHB HR departments on turn over, rates of vacancy and numbers of applicants per job advert may illuminate this. The costs of job change to employers (of induction, training, and the cost of recruitment) are sometimes hidden by the savings made by having empty positions on the books.

Table 2.14 Turn Over by Employer

	Time with employer	Time in Current post
Accident and Medical centre	6	
between 1 and 2 years	2	2
between 2 and 5 years	1	1
between 5 and 10 years	1	1
more than 10 years	1	1
Under 1 year	1	1
Aged care provider	222	222
between 1 and 2 years	43	36
between 2 and 5 years	63	75
between 5 and 10 years	39	38
more than 10 years	22	28
Under 1 year	53	42
Community Hospital (provincial)	11	11
between 1 and 2 years	3	2
between 2 and 5 years	0	0
between 5 and 10 years	1	0
more than 10 years	6	8
Under 1 year	1	1
DHB - Community	98	98
between 1 and 2 years	21	16

between 2 and 5 years	25	19
between 5 and 10 years	17	13
more than 10 years	24	42
Under 1 year	10	7
DHB - In patient	318	318
between 1 and 2 years	30	18
between 2 and 5 years	70	51
between 5 and 10 years	60	54
more than 10 years	116	157
Under 1 year	40	31
Educational institution	57	57
between 1 and 2 years	7	4
between 2 and 5 years	15	12
between 5 and 10 years	10	8
more than 10 years	9	15
Under 1 year	11	11
General Practitioner	24	24
between 1 and 2 years	4	2
between 2 and 5 years	6	4
between 5 and 10 years	5	6
more than 10 years	3	9
Under 1 year	2	3
Government agency (MOH, ACC, prisons etc.)	20	20
between 1 and 2 years	4	1
between 2 and 5 years	5	4
between 5 and 10 years	2	7
more than 10 years	1	7
Under 1 year	2	1
Maori and Iwi health provider	14	14
between 1 and 2 years	3	2
between 2 and 5 years	9	3
between 5 and 10 years	3	6
more than 10 years	1	1
Under 1 year	6	2
NGO provider	23	23
between 1 and 2 years	3	1
between 2 and 5 years	9	9
between 5 and 10 years	3	3
more than 10 years	1	4
Under 1 year	6	5

Nursing agency	17	17
between 1 and 2 years	5	4
between 2 and 5 years	4	5
between 5 and 10 years	2	1
Under 1 year	6	5
PHO provider	15	15
between 1 and 2 years	6	4
between 2 and 5 years	1	1
between 5 and 10 years	1	2
more than 10 years	2	3
Under 1 year	5	5
Private surgical hospital	37	37
between 1 and 2 years	3	1
between 2 and 5 years	10	10
between 5 and 10 years	13	14
more than 10 years	7	8
Under 1 year	3	3
Self-employed	12	12
between 1 and 2 years	1	0
between 2 and 5 years	0	1
between 5 and 10 years	2	2
more than 10 years	2	1
Under 1 year	3	3
Total	**1080**	**1080**

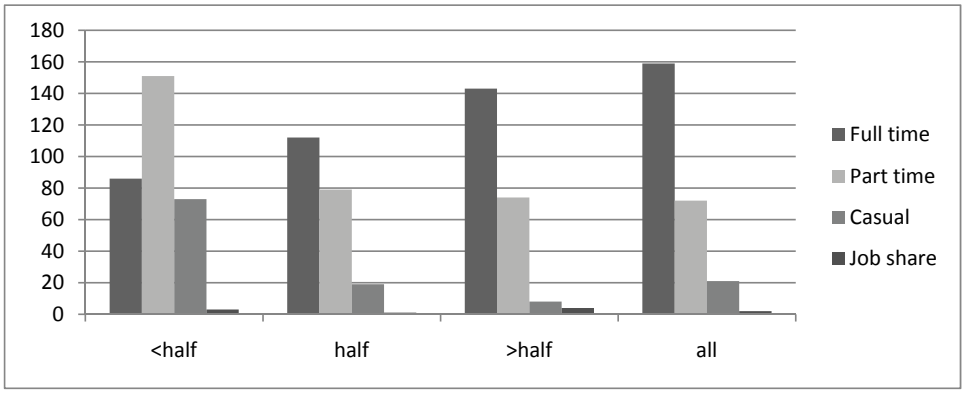
2.15 Household Income

Table 2.15 below, shows the proportion of household income that nurses contribute, separated into those who work full time, part time (including job share) and casual. As would be expected, there is an inverse correlation between the hours worked, and the proportion of the total household income that the nurse's salary makes up.

Table 2.15 Proportion of household income

Job Type	Total (n)	Missing	<Half	Half	>Half	All
Full time	500		86	112	143	159
Part time	376		151	79	74	72
Casual	121		73	19	8	21
Job share	10		3	1	4	2
Total	1080	73	318	215	230	256

Graph 2.15 Below shows contribution to household income by hours



As might be expected where salaries provide half to all of a household income, work is more likely to be full time.

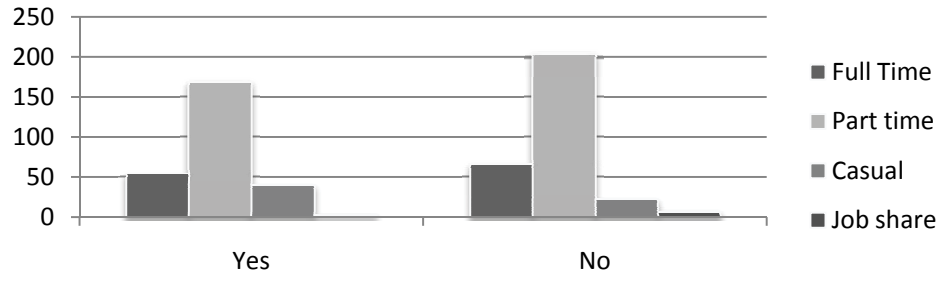
When these are given as percentages, irrespective of hours, the figures are similar for nurses working in the UK. This is shown in the table below. These figures are very similar to 2009.

Table 2.16 New Zealand / UK Comparison

Proportion of household income	Percentage (NZ)	Percentage (UK)
less than half	29.4	27
half	19.9	25
more than half	21.2	25
all	23.7	23

There was less of a link between part time working and the reporting of dependent children living at home, compared to the same question in 2009. This is shown in the graph below.

Graph 2.17



The patterns of working are explored in more detail in chapter 3.

Key Points: Chapter 2

The age profile of nurses in New Zealand (as in other OECD countries) has profound work force planning implications. This relates both to the desire of older nurses not to work full time, to those nearing retirement, and to those with caring responsibilities for parents.

27% of respondents first trained overseas. This proportion is likely to continue to grow unless other wider global events change the trends seen over the last few years. OTN have exceeded NZ new registrations with NCNZ for 3 out of the last 4 years. There is a risk to the health service if NZ were no longer able to compete for OTN in future.

There is considerable change both within and between employers in the nursing workforce in New Zealand.

Of the established main employer groups, residential care homes show the greatest turn-over of staff, and the fewest highly qualified staff.

The nursing workforce in New Zealand is more highly qualified than that in the UK (especially considering the UK survey was of registered nurses only)

Nearly half of respondents have caring responsibilities for children or for elderly relatives or other adults.

Pay and employment Agreements

The impact on pay and labour market behaviour of the 2004 MECA for nurses, hospital midwives and healthcare assistants employed by District Health Boards was reported by Buchan and North in 2008. This employment survey provides additional information about the salaries, working patterns, contracts and awareness of the MECA among NZNO membership. It also allows detailed comparisons of nurses employed in different sectors, and the relative wages of care givers and nurses other than registered nurses. The 2004 MECA was re-negotiated in 2010, a Primary Health Care MECA was also ratified and a Māori and Iwi Provider MECA is still under negotiation. The global recession, a change of government and tough communications about public sector wages and fiscal responsibility were experienced late 2008-2010, along with inflation, GST increases and other fiscal shocks.

3.1 Contracts and Employment Agreements

Table 3.1 Employment contract status

Contract Type	% ES 2011	% ES 2009
Casual	11%	4.9%
Other	2.7%	1.4%
Permanent	81%	88.7%
Temporary or fixed term	5.3%	2.8%

The majority of respondents hold permanent contracts. Those on temporary contracts had often been employed on particular projects. There is a real and observable increase in the change of permanent contracts to temporary, fixed term or casual contracts.

There was no particular type of employer for whom temporary or casual contracts predominated, though there was a slight over-representation of those employed in the education sector compared to the total. Respondents employed by nursing agencies cited flexibility and home / life balance as being their prime reason for choosing agency work.

3.2 Employment Agreements

Table 3.2

Knowledge of Employment Agreement	Number	Percentage
Yes	858	82.3%
No	103	9.9%
Uncertain	81	7.7%
Total	1042	

This table illustrates that most were aware of whether they were employed under an agreement, and if so, what sort of agreement they are employed under. Most DHB employed staff were aware of the DHB MECA.

3.3 Rates of Pay

Tables in this section examine the rates of pay in relation to agreement type, nursing registration, job title, and perceptions of satisfaction with pay.

Because of the very small numbers, those who stated they were not employed under an agreement were excluded from the analysis. The number of valid cases refers to those who gave details of their hourly rate of pay.

Table 3.3 Rates of Pay by Agreement Type

Agreement type	Valid n	Mean hourly rate ($)	Standard deviation	95% CI
MECA	246	$23.88	4.34	$28.22 - $19.54
SEA	45	$23.0	5.14	$28.41 - $17.86
IA	75	$19.9	6.38	$26.28 - $13.52
Unsure	72	$20.53	4.49	$25.02 - $16.04
Total	438	$22.56	8.97	$$31.53 - $13.59

(MECA = Multi Employer Collective Agreement, SEA = Single Employer Agreement, IA = Individual Agreement)

This demonstrates the wide variation in rates of pay, with the widest variation being amongst those on individual agreements.

Separating out the hourly rate by whether nurses were registered with the Nursing Council (i.e. regulated nurses versus others) Registered Nurses were less likely to answer this question than other respondents.

The table below shows mean rates of pay by title, also giving the variability:

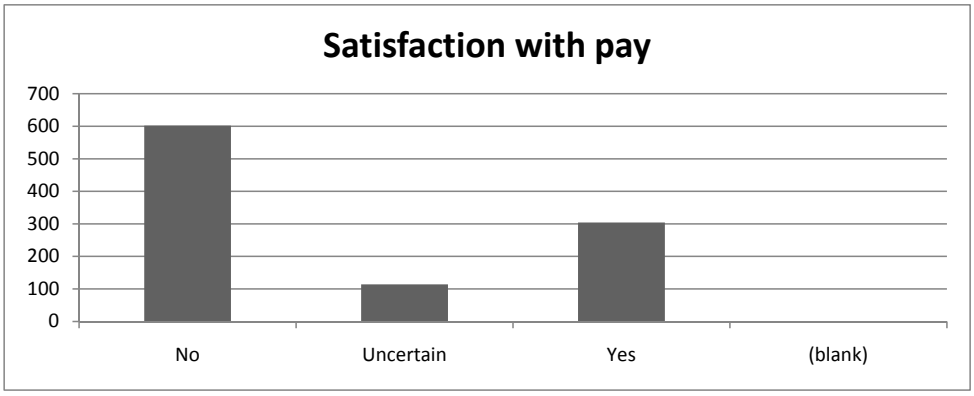
Table 3.4 Pay by Job Title

Title	Valid (n)	Mean hourly rate ($)	Standard-deviation	95%CI
Registered Nurse	165	$30.99	7.68	$38.67-23.31
ENs and N Assistants	198	$20.98	2.9	$23.88 – 18.08
HCA / Care Givers	175	$16.22	1.98	$18.2 - 14.22

(Enrolled nurses and Nurse Assistants combined as regulated 2nd level nurses.)

Question B5 asked whether respondents thought their current pay was appropriate given the role and responsibilities. The response is shown below, with fewer than 32% thinking their pay was appropriate.

Graph 3.1 Satisfaction with Pay



There was only a very loose connection between feeling paid adequately for role, and actual mean rates of pay, with those paid more being slightly more likely to be satisfied with pay as shown below.

Table 3.6 Satisfaction with Pay

Feelings about appropriateness of pay	Mean hourly rate ($)
Yes	25.42
No	21.52

To explore this a little further, 10 discrete roles were selected and examined for mean hourly pay, and percentage who feel they are adequately rewarded.

Table 3.7 Satisfaction by Title and Pay

Title	Valid number	Mean hourly rate	% agree paid adequately
Director of nursing	2	$48	100% (both)
Clinical nurse specialist	8	$35.25	37.5%
Charge nurse	15	$39.14	46.6%
District nurse	5	$21.02	40%
Manager / service manager	2	$25.30	0 (neither)
Mental health nurse	13	$30.01	38%
Practice nurse	16	$27.24	37.5%
Community nurse	14	$23.25	21.4%
Registered Nurse*	165	$27.84	29.8%
Enrolled nurse	198	$20.98	44%
CG / HCA	175	$16.22	28%

(* where people recorded their job title as registered nurse, not by whether they were registered with the nursing council)

More research is required to determine if these perceptions reflect difficulties employers face in filling these roles at the pay rates available, or if they influence career choices. Individual variations and small numbers mean caution should be taken in the interpretation however. Chapter 8 will compare overall satisfaction ratings with the different roles, as pay may be only one of many factors.

Three additional statements were included in the attitudinal series, which reflect opinion on pay. These are:

I could be paid more for less effort if I left nursing

Considering the work I do I am well paid

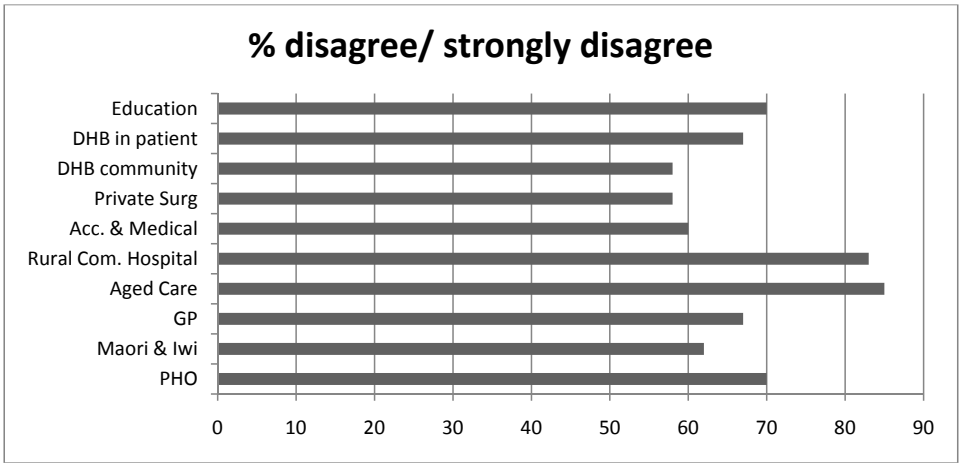
Nurses are paid well compared to other professions

(The scoring for the first statement options were reversed for analytical purposes)

These are more fully explored in a later chapter, but broadly, more New Zealand nurses in 2010 STRONGLY felt undervalued compared to two years ago (19.3% sum all items, versus 13.5% sum all items) 68 % felt or strongly felt financially undervalued. This was particularly striking for the statement related to pay relative to other professions, where 76.4% felt undervalued. By employer type, the figure below shows the percentages of respondents who disagreed or strongly disagreed with the statement “Considering the work I do I am well paid”

These are shown in graph 3.8

Graph 3.8 Response to Statement "Considering the work I do I am well paid"



3.9 Additional Employment

A lower proportion of New Zealand nurses versus nurses working in the UK have additional employment – around 16.5% compared to 23%. However, this should be interpreted with caution as 47% of NZ nurses worked additional hours (paid and unpaid) for their main employer. Mean number of hours per week was 14, range 1-60 hours. In the UK, additional employment was more commonly found in migrant nurses, who are often the main wage earners for the family. This was tested in the New Zealand survey, and no real differences between NZ and overseas trained nurses holding of additional employment was seen. See table below.

Table 3.9 Those with Additional Paid Employment

Where initially trained	Where working	% with additional jobs	% of these citing income as a key reason
New Zealand	New Zealand	16.5%	45.4%
Overseas (to NZ)	New Zealand	18%	66.6%

The nature of additional employment varied widely. 14% of the 156 respondents who reported additional employment had full time contracts with their main employer, compared to 21% who had part time or job share contracts, and 6% who had casual contracts. These figures are smaller than two years ago. The percentages and broad categories are shown in the table below. A large number of different jobs were described under the category "other", some of which were health care related, some not.

Table 3.10 Additional Employment Types Chosen

Additional employment	Percentage 2010	Percentage 2008
Aged Care	9.5	6
Casual other employer	14.9	1
Casual with same employer	7.1	10
Nursing agency	6.5	9
Self -employed	11.9	11
Non-nursing	15.5	4
Other nursing	45.8	45
Other / Blank	38	14

In addition to a reduction in casual / additional work overall, there appear to be significant changes in the patterns of additional work undertaken, with other non-nursing work rising and other nursing work, and agency and casual work with the same employer reducing.

A rise in non-nursing related additional work may herald increasing movement out of the nursing workforce altogether, and is a trend that must be watched carefully if workforce planning assumptions are to be accurate.

Working hours and patterns are examined in more detail in chapter 4

Key Points: Chapter 3

There is clear dissatisfaction with the rates of pay, at all levels.

While there is wide variation in rates of hourly pay, related to role, title, registration and employment agreement, most nurses are paid within quite narrow pay bands ($16-$38 per hour).

Approximately 16.5% have other paid work, (including nearly one in seven full time workers) with more than half of those citing the need for additional income as the main reason for taking additional work.

Working patterns

This chapter describes the working patterns of respondents: contract hours, excess hours, shift patterns and total reported working hours.

Nurses with family care-giving responsibilities and those nearing retirement particularly benefit from a choice of more flexible working hours. For employers, access to a willing pool of casual trained staff is of benefit, particularly to cover sickness, training leave and holidays.

The qualitative data (see chapter provide evidence of nurses using part time hours to cope with less tolerable working conditions, along with strong desire to maintain both work-life balance and work-family balance. However, proportionately, having a large number of part time staff can increase the time required for induction, training, supervision, appraisal, hand over and team meetings compared to direct patient care hours available per staff member. This is balanced against the risk of long vacancies requiring cover, and can allow for mentoring, and continuity.

Table 4.1 Type of Contracts

Contract	Number	Percentage 2010	Percentage 2008
Full time	504	49.7	41.6
Part time	379	37.3	48.6
Casual	122	12.0	4.7
Job Share	10	0.9	1.98
Blank / missing	12	1.0	3.1

49.7% Hold designated full time contracts. This is a much lower overall percentage than in the UK, where nearer 60% work full time.

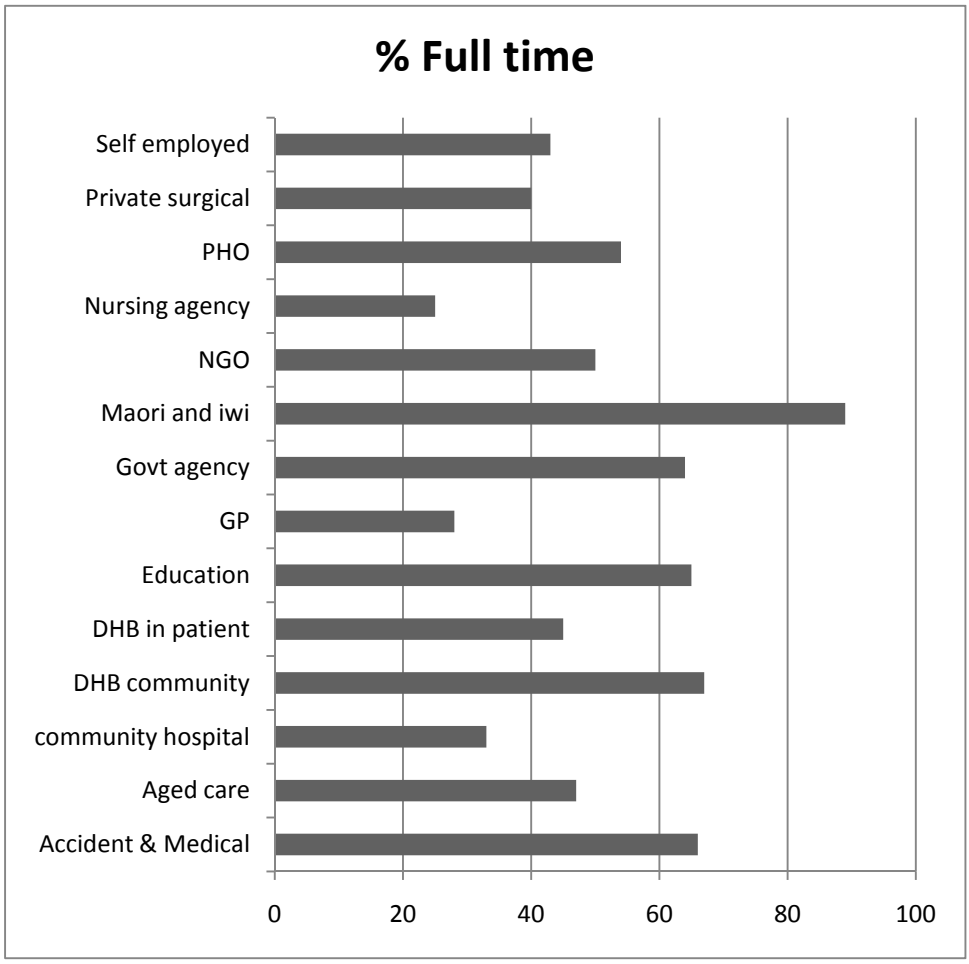
When asked how many actual hours they worked each week, slightly different pictures emerge.(Full time hours are defined differently by different employers).

Table 4.2

Hours	Count	Percent
More than 38	311	30.9
33-38	178	17.7
25-32	203	20.1
13-24	212	21
12	20	2
8	40	4
<8	44	4.4

There were large differences in the proportion of nurses employed in the different sectors who hold full time contracts. This is shown in the following graph.

Graph 4.1 Full time contract by employer



Seeking to find patterns of working linked to other caring responsibilities, the average ages and contract hours were analysed and are shown below.

Table 4.3 Additional Caring Responsibilities

Part time workers n=248	% 2008	% 2010
Responsibility for dependent children	44	44
Responsibility for adults with care needs	14	17.7
Full time workers n=327	%	%
Responsibility for dependent children	39	44
Responsibility for adults with care needs	14	17
Casual workers n=82	%	%
Responsibility for dependent children	-	50
Responsibility for adults with care needs	-	18

Table 4.4 Actual Hours Worked

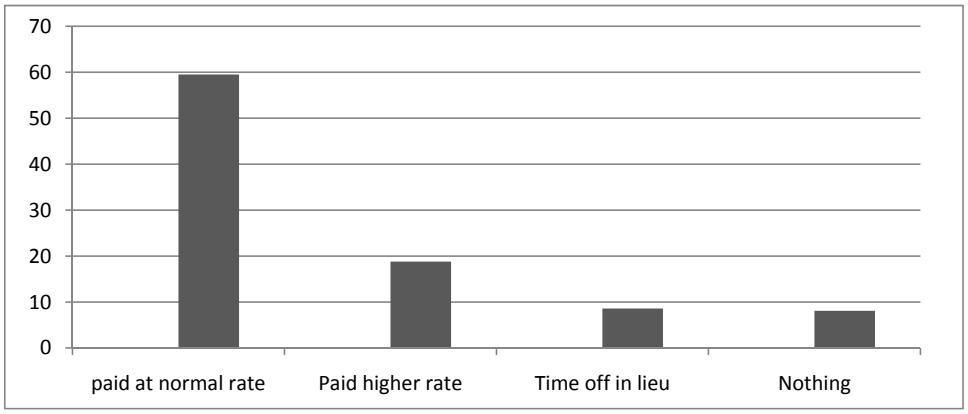
Contract type	Number	% working extra hours 2008	% working extra hours 2010	Mean weekly extra hours	Mean weekly total hours
Full time	335	47%	57%	8	48
Part time	391	49%	69%	8	36

There was a large range of extra hours worked by both full and part time workers, from 1-60 hours. The mean and mode of extra hours indicate that in the majority of cases it is mostly whole extra eight hour shifts that are worked. There has been a significant increase in the numbers working extra shifts. Qualitative evidence that still more part timers (particularly in aged care) would like extra shifts, but find these harder to come by than they have previously found. Part time nurses in New Zealand work longer hours (32 per week) than their counterparts in the UK, where 29.1 hours per week is the average, once excess hours and additional jobs are added.

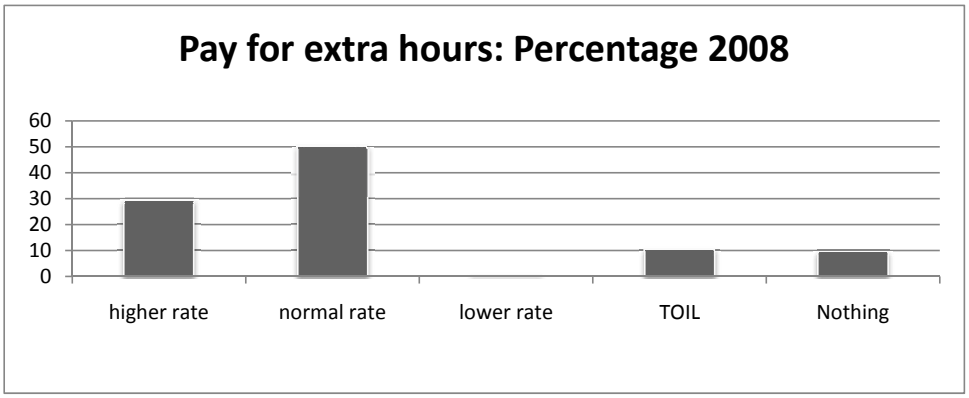
4.5 Additional Hours

The remuneration offered for working extra hours is shown in the graphs below. Many were only offered any recompense if they worked full shifts in addition to their usual hours. Many of the 191 nurses who worked an average of 3 hours extra per week received no pay. This included working over meal breaks and at the ends of their official shifts.

Graph 4.5.1 Payment for Extra Hours



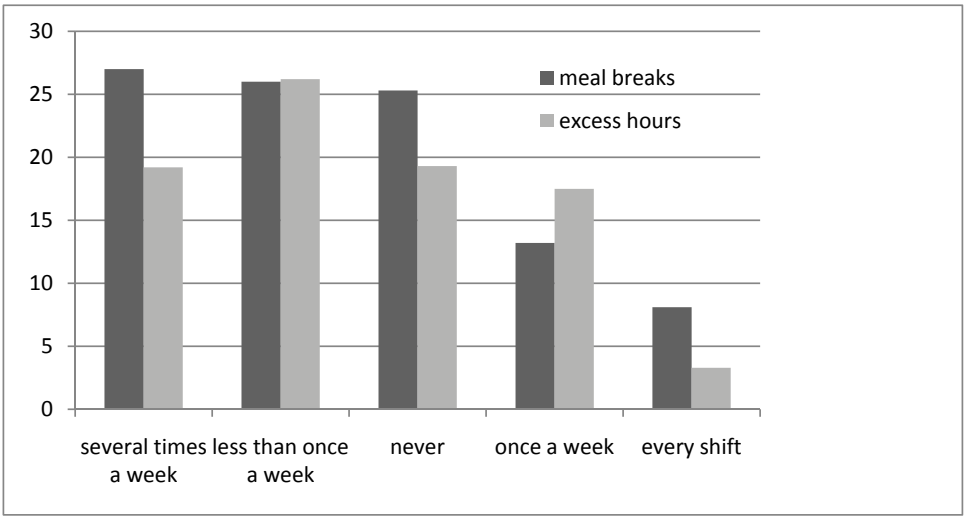
Graph 4.5.2 Pay for extra hours in previous employment survey



There appears to have been a real shift to being paid at normal rate rather than higher rate. Some of the difference may be made up by the changes in working extra shifts for other employer, rather than for the same employer.

In addition, the frequency of working excess hours was explored. The results are shown in the graph below.

Graph 4.5.3 Percentage and Frequency of Excess Hours



4.6 Working Hours and Shift Patterns were also explored

Table 4.6.1 Work Patterns

Work pattern	Valid number	Percentage
Office hours	327	32.3
Shifts	521	51.5
Flexi / irregular	74	7.3
Casual	89	8.8

Table 4.6.2 Shift Length

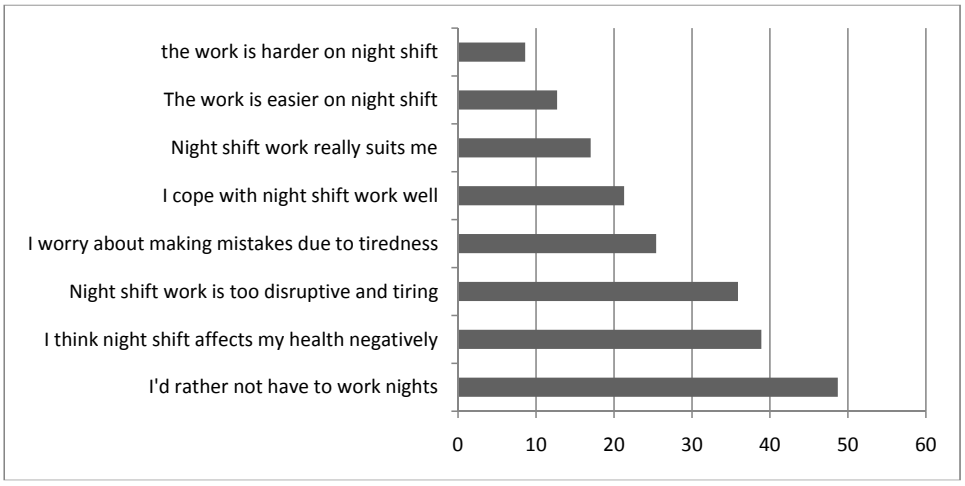
Shift length	Valid number	Percentage
<8 hour	82	15.8
8 hour	324	62.4
8-12 hour	78	15
>12 hour	15	2.9
Total		

Table 4.6.3 Shift Type

Shift type	Valid number	Percentage
Days only	181	35.1
Nights only	67	13
Mix day and night	267	51.8

Where nurses work shifts rather than office hours, the commonest pattern by far is still the 8 hour shift, with rotating mix of day and night shifts. Those working day shift only were more likely to work for private surgical hospitals, GPs and aged care than for DHBs.

Graph 4.6.1 Feelings about working night shift



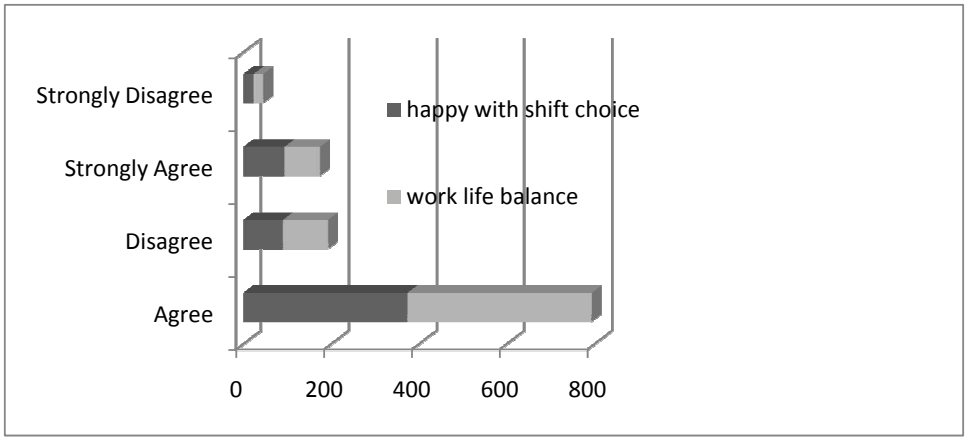
4.7 Working Hours Satisfaction

Most respondents, in common with their UK counterparts, were positive about their working hours. Two items from the array of statements related to working hours:

80.4% agreed or strongly agreed that they were "Happy with their choice of shifts"

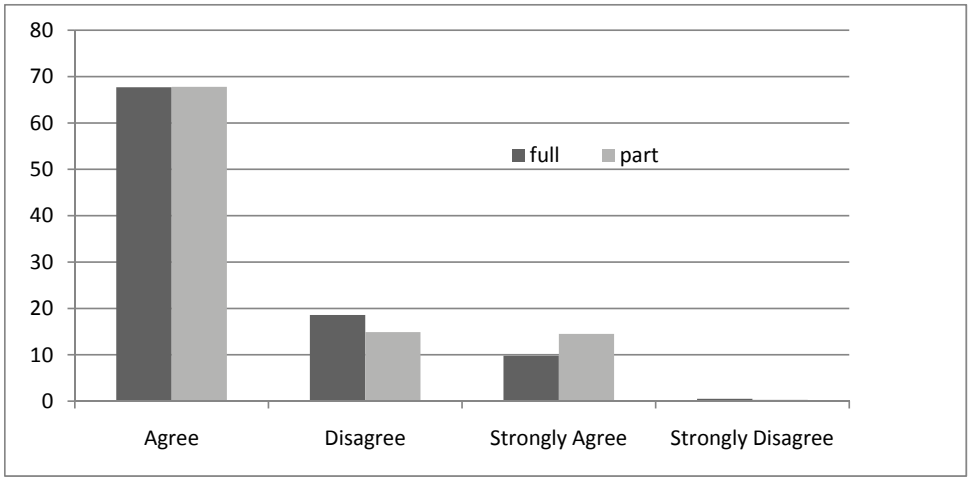
80.1% agreed or strongly agreed that they were "able to balance home and work lives" These figures are almost identical to results in 2008.

Graph 4.7.1 Views of Working Hours (percentages)

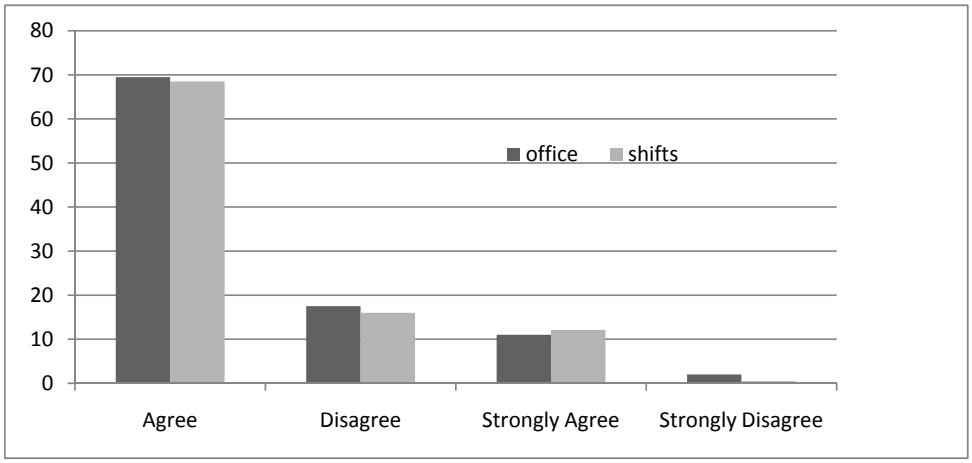


There was only a very slight difference between the views of full time and part time worker, it was interesting to note that part time workers were marginally more satisfied with their working hours than full time worker. This is shown below.

Graph 4.7.2 Composite % satisfaction (agreement with the two statements above) by contract type.



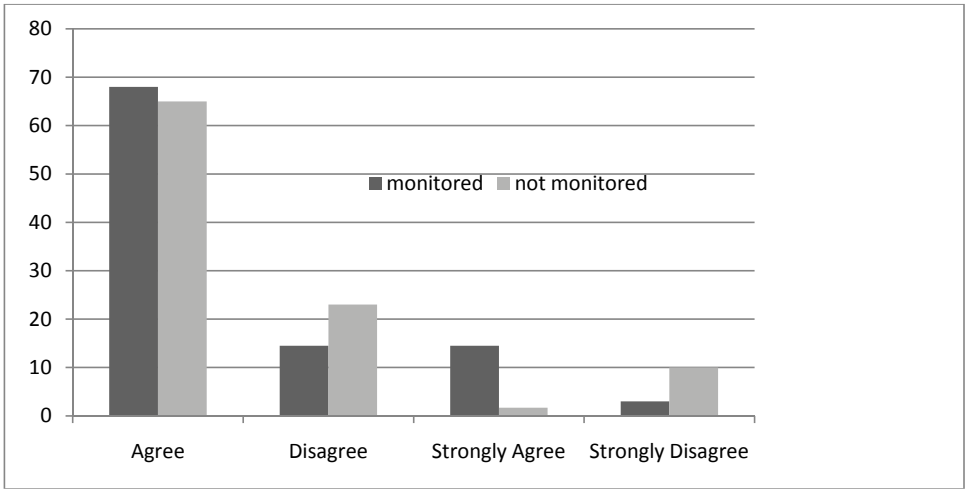
Graph 4.7.3 Composite Percentage Satisfaction with Hours by Work Pattern



Workers who work office hours are marginally more satisfied with their working hours than those who work shifts. The necessity to do night shifts was frequently cited in the comments sections as a cause of stress and interference with family / work life balance. More detail is required to examine if particular rosters are more damaging or disrupting than others – for example, regular weeks on and off nights, compared to rolling programmes where night shifts were on different nights of the week. Those who work permanent nights were more likely to be very satisfied with their hours than those who worked mixed shifts. Satisfaction with shift patterns is compared more fully between those under 30 and this sample in another report.

4.7.4 Control of Total Hours Worked

Where worker's total number of hours were monitored and regulated by their employers, there was marginally higher satisfaction with shifts and work life balance. This is shown below.



Key Points: Chapter 4

Considerable numbers of nurses work extra hours, and through breaks / meals without extra pay.

Where extra hours are worked, this is usually for normal pay

Mostly, New Zealand nurses are happy with their choice of work patterns.

The majority of shifts are 8 hour shifts

A large number choose to work "office hours", and day only shifts to find jobs that meet their needs.

A smaller number find permanent night shifts best suit their needs. Later questions related to access to education found that night shift workers found it more difficult to access training in their work time – an area of dissatisfaction with their chosen work pattern.

Workload and staffing

The questions about how nurses' time is spent were analysed using a median weighting system to give approximate percentages of what respondents felt their work lives consisted of. The results for selected groupings are shown. The results should be interpreted with some caution, as it is likely the terms were interpreted differently and the percentages were guessed at rather than captured using time diaries or other more precise methodologies. Overall, responses often added up to considerably more than 100%, and there were also large numbers of missing variables.

Table 5.1 Percentage of time spent on various activities, by title

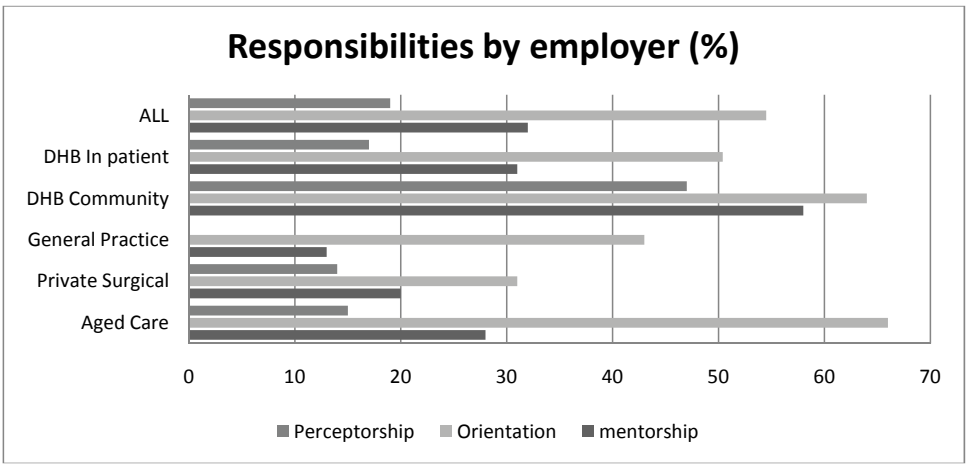
Roles	Clinical	Management	Patient education	Cleaning	Admin	Research	P D
Registered nurse	70.5	9.8	9.7	7.6	15	4.3	6
Enrolled Nurse	70.6	4.7	5.5	9.7	12.8	2	5
Charge nurse	31.3	42.8	9.5	2	24.3	6	7.3
Practice Nurse	71	2	7	7	16.3	2.4	6.7
Health care worker	79	3	2	14	8	0.2	4
All respondents	62	11	8	8	17.4	3.2	8.5

(PD = Professional Development)

5.1 Additional Responsibilities

The graph below shows the percentage mentoring, orientating new staff and providing preceptorship. This is broken down by some of the larger employment groupings. A majority of staff in all roles and settings were responsible for orientating new staff, this is a requirement for RNs under Nursing Council Competencies.

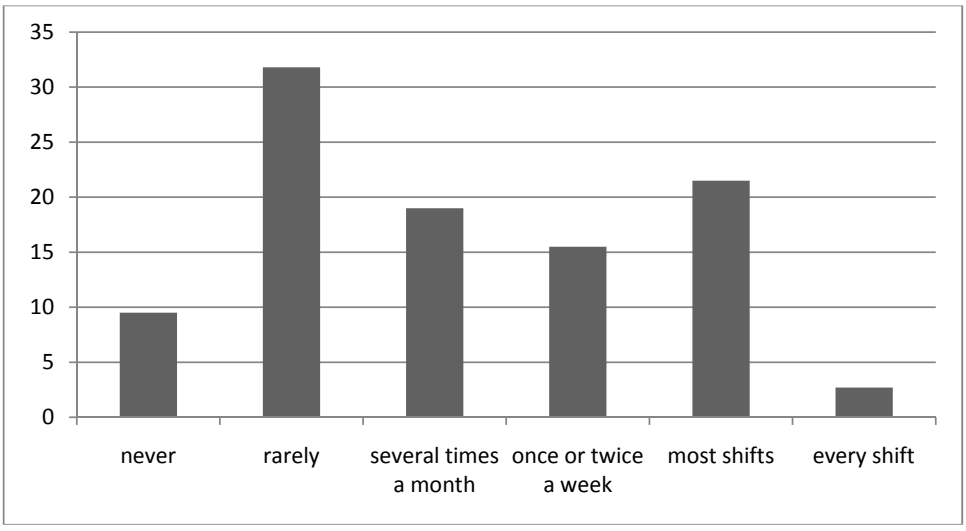
Graph 5.1 Additional Responsibilities, By Employer



5.2 Views of Workload and Staffing

Questions in section E specifically addressed issues to do with staffing levels. The first found that 44.2% felt there were enough nurses where they worked to meet patient needs. This is a slight improvement compared to 2 years ago. Despite this, around one in five nurses felt care was compromised on most shifts. This varied by employer, with 25.6 % and 26.9 % respectively respondents from Aged Care and DHB in patient feeling care was compromised most shifts, compared to no respondents from private surgical hospitals feeling this. The graph below shows how often respondents felt patient care was compromised where they work. (percentages)

Graph 5.2 Views of patient care compromise, percentage



Causes of Compromised Patient Care

The highest risks were perceived to be associated with shortages of (especially experienced) staff, levels of dependency, and communication difficulties. The factors contributing least to compromised care was re-use of disposable single use equipment.

Specific questions examining awareness of, and agreement with the NZNO safe staffing campaign were also asked. The results are shown in table 5.4 below. More people agreed with the campaign process than answered that they were aware of NZNO campaign. This might just indicate that they knew about the campaign but did not associate it with NZNO. It is pleasing to see that agreement with safe staffing and willingness to report unsafe staffing levels have both risen over the last 2 years.

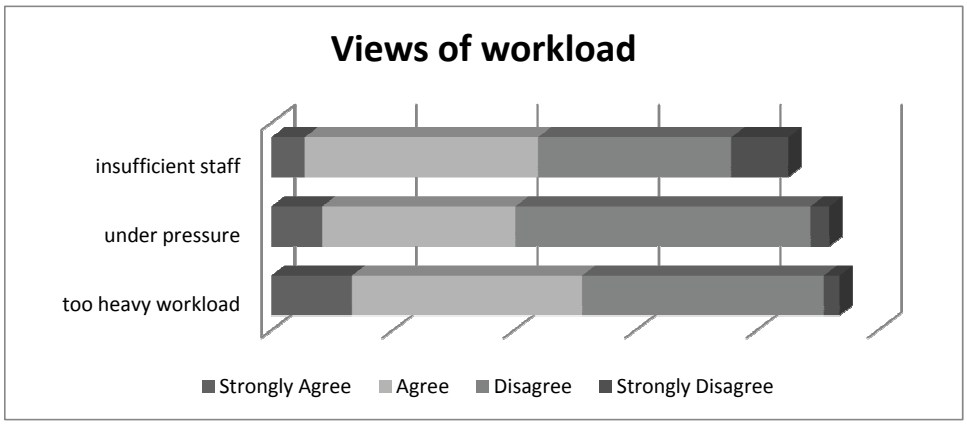
Table 5.3 Safe Staffing

Question	% Yes 2010	% Yes 2008
Are you aware of the NZNO Safe Staffing campaign?	58.3	65.5
Do you agree with the Safe Staffing campaign?	97.5	71.5
Do you feel comfortable reporting unsafe levels of staffing?	81.6	72

The survey also indicates that 18.4 % of respondents still express discomfort with the reporting of unsafe staffing levels.

The figure below is a summary of the responses to 3 items in the views section related to workload and pressure at work. There is a fairly even split, with slightly more respondents feeling strongly that workload was too heavy or feeling under pressure than disagreed strongly that the work load was too heavy

Graph 5.4 Views of Workload



However, there was significant variation between employers and roles. 88% of those working in private surgical hospitals agreed with the statement "there are sufficient staff to provide good care" This compared with 41% of those working in aged care, and 46% of those working in DHB hospitals agreed with the statement. By role, Practice Nurses were most comfortable with staffing levels, with 90% agreeing with the statement, compared to only 36% of RNs, and 30% of Health Care Workers, Health Care Assistants and Nurse Assistants combined.

Key Points: Chapter 5

Nurses and care givers are engaged in a wide range of activities, with the majority of time still spent on direct clinical work.

Administrative tasks were the next most time consuming for regulated nurses in clinical posts.

Those employed in DHBs (both community and in patient) were most likely to have additional responsibility for others – mentoring colleagues, students, or orientating new staff. Aged care staff of all designations had responsibility for orientation of new staff.

Although 42% felt patient care was rarely or never compromised, a range of issues was identified which regularly or always led to compromised care.

The most worrying issues for respondents were too few staff, and too highly dependent patients. The least reported issue was the re-use of single use equipment

More than half felt there were insufficient staff where they work, and that workloads were too heavy.

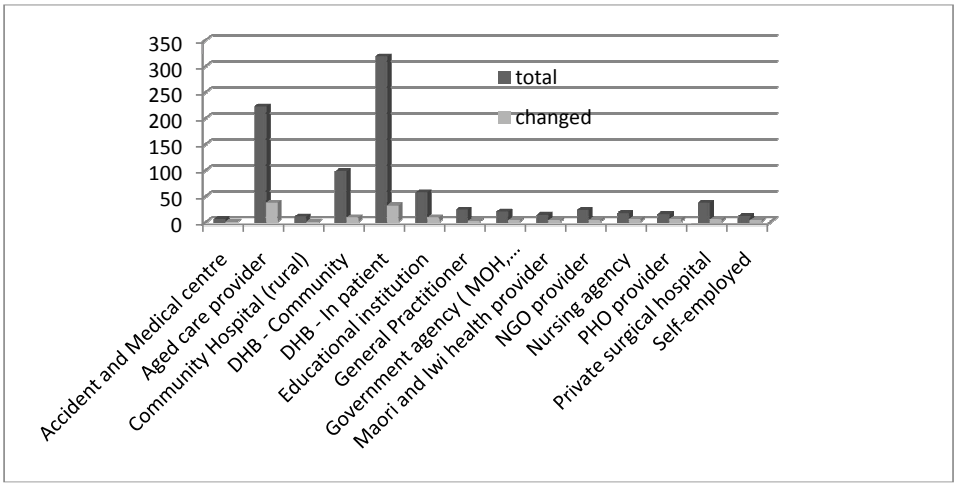
While knowledge of the NZNO Safe Staffing Campaign had dropped over the last two years, agreement with the safe staffing message, and agreement with reporting had increased amongst respondents.

Job Change and Career Progression

As shown in chapter one, there have long been changes in positions with the same employer, with many respondents changing jobs frequently. Question G 3 asked "Have you changed jobs in the last 12 months?" 155 (14.6%) answered yes. This is very comparable with turnover in the UK. The mean age of those answering yes was 47, not significantly different from the sample as a whole.

Change was not disproportionally attributed by employer type

Graph 6.1 Job change for employer types



The following table details the reasons selected for changing jobs. The rank order importance of each reason is also shown. This was determined by counting the number of times each was selected as first or second most important reason. Comparisons are shown between teh total sample and the YNS sample.

Table 6.1 Reasons for Last Change of Job

Reason for job change	times mentioned	Importance to NZ sample overall	Importance to YNS sample
Gain different skills	65	4	1
Change in hours	42	5=	8
Stress / workload of previous job	51	1	4=
Better pay	52	2	2
Better prospects	44	3	3
Dissatisfied with previous job	42	5=	9
Bullying / harassment	31	7=	10
Better terms and conditions	28	7=	4=
Distance home to work	20	9	11
Personal / moving area	24	11=	7
Family reasons	23	11=	12
Educational opportunities	20	11=	6
Health problems	12	15	15
Promotion	10	14	13
Child care	-	-	14

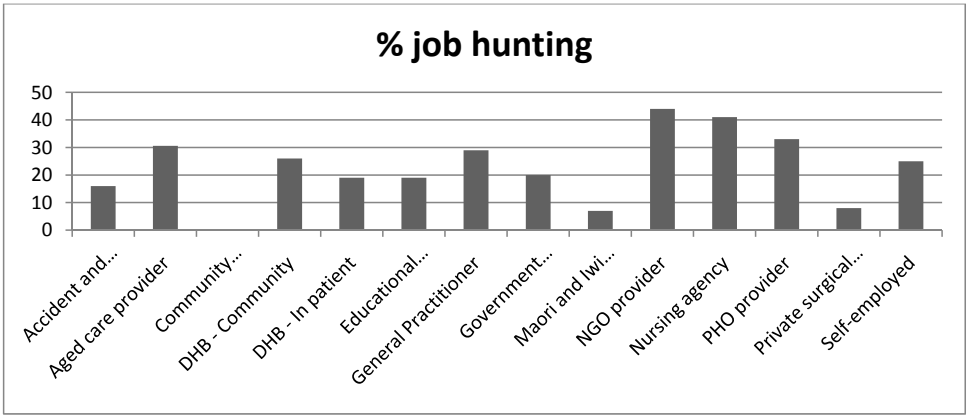
There were three distinct patterns –

- Those who changed primarily for career reasons (skills, education, promotion, pay and prospects) These reasons were particularly important to the younger nurses.
- Those who changed because they didn't like their previous jobs (dissatisfaction, workload /stress, bullying)
- Those who changed for personal reasons (hours, family, distance, health)

The importance of dissatisfaction with jobs, stress and bullying appears to be more prominent as a reason to change jobs, and these have increased in prominence since 2008. What is clear is that retention could be improved by accommodating flexible working patterns better, by reducing bullying and stress, and by improving educational opportunities and opportunities for career progression. A smaller number than the last survey changed jobs as a result of promotion. 25.2% (up from 9.4% last time) are currently seeking work or a change of job, 7.5% (down from 20% last time) selected nursing outside New Zealand as one of their preferred options. The comparable figure from the 2009 RCN survey was 25% who were actively seeking a new job.

In Graph 6.2 below, those actively job hunting as a percentage of those employed in each employer type are shown.

Graph 6.2 Those Seeking New Jobs



Those who work for agencies, by definition need flexibility, or may be between ideal jobs. Proportionately, a high number NGO provider staff seem to be actively job hunting, and private surgical community and Māori and Iwi providers not job hunting.

Of those who are looking to change, DHB nursing remains the commonest choice, though nearly 22% want to leave nursing, and 7.5 % to work overseas. This is an increase from 2% recorded in 2008.

New graduates reported looking for jobs – including places on the NEtP programme. I have included the following representative comments, as they raise real issues for workforce planning, nurse education, and our membership.

"I am a new graduate nurse with good grades, great comments from preceptors from all my clinical placements, impressed in my only interview (feedback from Capital & Coast) but unable to find a job in the current economic climate. "

"I have been and continue to apply for every nursing job in the Wellington area with not even an interview due to being a new graduate. It is extremely demoralising and distressing to have spent all this time and effort on gaining my nursing qualification only to find no-one willing to give a new graduate a chance. "

"I know many of my classmates do not have jobs and some are heading overseas for employment. Moving is not an option for me as my husband has a good job and I have four children, three who are at school."

"It is frustrating trying to find a new graduate position. We are told there is a shortage of nurses but employers are not offering enough placements for first year nurses. Some DHB's closed applications for NEtP programmes early in the year - before we (as third year students) were aware of the need to apply. "

"The economy effects on all nursing settings and as I am a new graduate student. I could not find a job where DHB used to employ a large number of nurse but not in this time."

"There are not enough new graduate positions for the number of new graduates. I was the top student for 2010 to graduate from *** and yet have not managed to gain a NEtP position for 2011."

Key Points: Chapter Six

There is considerable movement in the nursing workforce, between and within employers. Compared to two years ago, there appears to be a large increase in those looking for a change in employment, especially in the numbers who may be lost altogether from the NZ nursing workforce.

New graduates are finding it hard to get nursing jobs and NEt-P places

Those working for nursing agencies are more likely to be seeking a new job – perhaps working for agencies while looking for their preferred options.

7.5% of the total nursing workforce would like to work overseas.

Stress and lack of prospects are key drivers for job change

Choice of hours and dissatisfaction with pay, workload, and bullying all contribute to nurses changing jobs.

Restructuring and Organisational Change

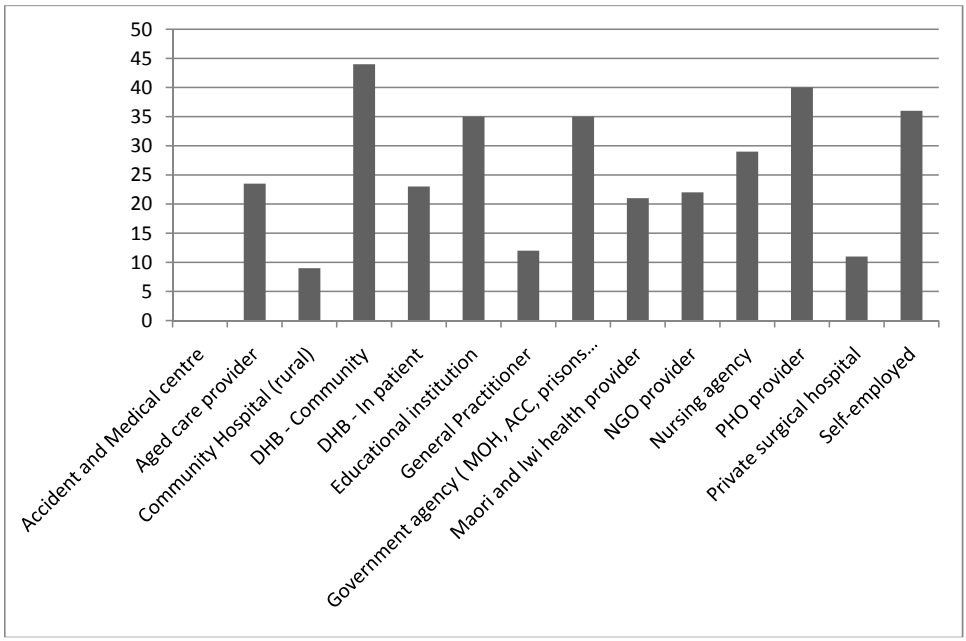
The organisation and provision of Health Services (nationally and internationally) has always been the focus of considerable scrutiny and change geared to getting the best possible patient outcomes at the best price. Health is also a key political issue, and waves of successive changes have been experienced by staff for years. The last really fundamental restructuring happened in the 1990's under the last National government, so there was considerable disquiet and concern in the health sector regarding the change of government that happened in late 2008.

For the 2010 Employment survey, we sought to capture the experiences of members related to job restructuring and organisational change.

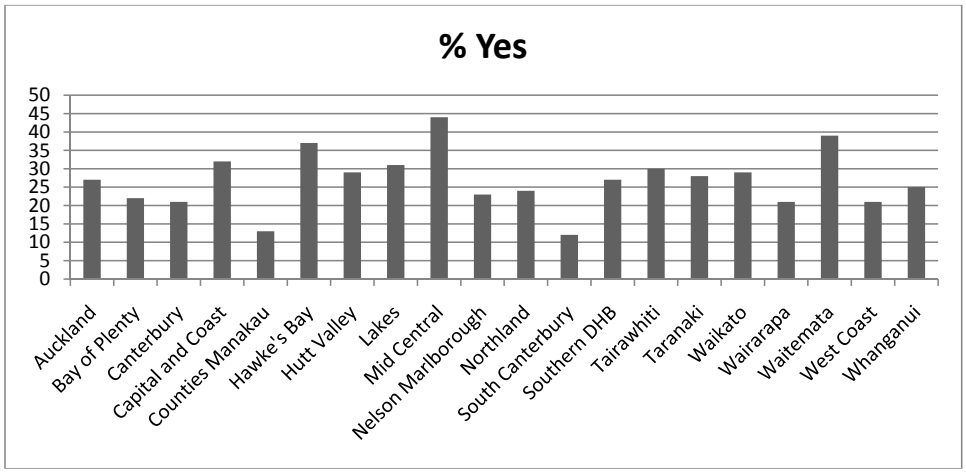
26.1% of respondents reported being affected by significant restructuring by their main employers within the last 18 months.

By employer, there were considerable differences in responses:

Graph 7.1.1 % of respondents from each employer experiencing restructuring



7.1.2 % by DHB area, experiencing restructuring.



Themes from the comments related to being affected by restructuring:

There were several key themes that emerged from the free text answers related to the effects of restructuring and reorganisation. Indicative quotes are presented below. The commonest answers related to loss of availability of extra hours and shifts, (particularly casual shifts) or of hours being cut.

"I'm not getting as many casual hours as I did 12 months ago".

"Casual work less available, due to roster restrictions due to trend care and budgets"

"Other major issues include the impact of loss of support services and essential equipment that effectively either increase the nurse's workload or impact negatively on working conditions"

"Administration staff were made redundant, so now have to do these tasks myself"

"Review process led to redundancies, more work expected of fewer staff, less clerical support, less reimbursement of work related costs incurred personally"

"They removed the work car from the community. I now have to use my own car for work. I am a community worker".

"Also frequently mentioned was the emotional impact of constant restructuring and organisational uncertainty, particularly at senior clinical leadership level".

"Contractual changes have seen an upheaval of pressure on my colleagues as well as myself and others in the role I work in".

"The service has been very disrupted by senior management losing their jobs and there is a current "freeze "on all clinical positions".

"Undergoing a Senior Nursing Workforce review whereby the DHB proposed to reduce the number of CNSs (Clinical Nurse Specialists) to be employed within the Service".

"There is a general air of tension in the work place. One is very aware of other staff having a difficult time resolving redundancy issues & for those who remain managing extra work loads".

Changes to funding for home based care, and changes brought about by the Enrolled Nurse scope of practice were also frequently mentioned:-

"Funding cuts by the DHB for the provision of home support has reduced the number of clients I have in my care by almost 100. This may have an effect on the hours I work per week".

"Where I worked they decided to make me redundant as they say for the past 6 years I had been working outside my scope of practise and hadn't realized it".

Key Points: Chapter 7

Funding cuts and budget constraints are impacting on front line nursing staff. These are far from isolated incidents

Extra workload and emotional pressures are commonly experienced

The changes to the Enrolled Nurse scope have impacted on their employment in some instances

Disruption and uncertainty in senior roles impacts at all levels, with the long term effects of loss of clinical nursing leadership in particular to be hugely of concern

Continuing Professional Development (CPD)

The questions in this section relate to the amount of time spent on continuing professional development, how this varies between nurses and employment groupings, and the extent to which nurses are supported in their professional development. Where answers were given in hours, these were rounded to half days.

Table 8.1.1 Time Spent on CPD

	Days spent on CPD last year	Days employer paid for
Mean days	10.9	4.1
mode	3	2
Standard Deviation	31.15	9.7
Valid number	951	950

The high standard deviation is a measure of the large variation between respondents.

Once all readings 2 standard deviations or more were excluded (as being outside the 95% confidence intervals) a total of 60 respondents (or 6.3%) had all time paid for by their employer. This was ten-fold lower than 2009. Two hundred and nine recorded that they spent no time on CPD last year. 17 of these were registered, employed nurses (2 retired but working) – a further 12 were sick, studying, or on parental leave. The rest were Care Givers, Health Care Workers, or other workers. Of the 11 respondents who recorded greater than 70 days spent on CPD (more than 2 SD of the mean) 6 were employed by DHBs. Paid for training time by job title is shown below

The mean number of days spent on CPD by nurses who originally trained as nurses overseas was 6. The difference is not significant.

Table 8.1.2 Paid Time Spent on CPD by Job Title

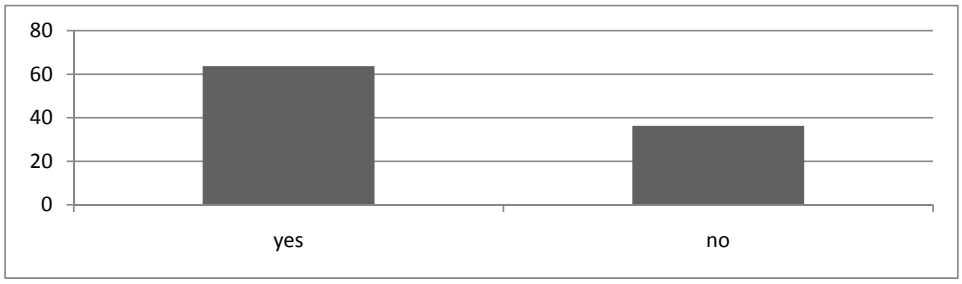
Job title	Valid number	Mean paid for days
Clinical N Specialists & Charge nurses	23	3.16
Registered nurses	43	2.39
Practice Nurses	16	2.56
Mental health nurses	16	2.1
Enrolled nurses & Nurse Assistants	277	6.6
HC workers & H C Assistants	255	1.28
TOTAL	759	4.1

* Two MHN who had 30 & 70 days paid for last year were excluded from mean as complete outliers.

There appears to be an effect of the changes to Enrolled Nurse scope of practice leading to a large increase compared to 2 years ago of paid training for Enrolled Nurses. Changes to make CPD requirements more proportional to risk and work patterns may have the effect of encouraging trained nurses to return to work, even part time, and would have a large potential for reducing critical shortages. Of the 129 who had no professional development time funded by their employers, 37 worked in aged care, 31 for a DHB, 11 for a GP and the rest for the whole range of employers. There were several comments in the qualitative answers related to a perception that access to training opportunities was seen as unfairly distributed.

8.3 Development Reviews / Appraisal and Training Plans

Graph 8.3.1 Respondents who had development reviews / Appraisals in last 12 months



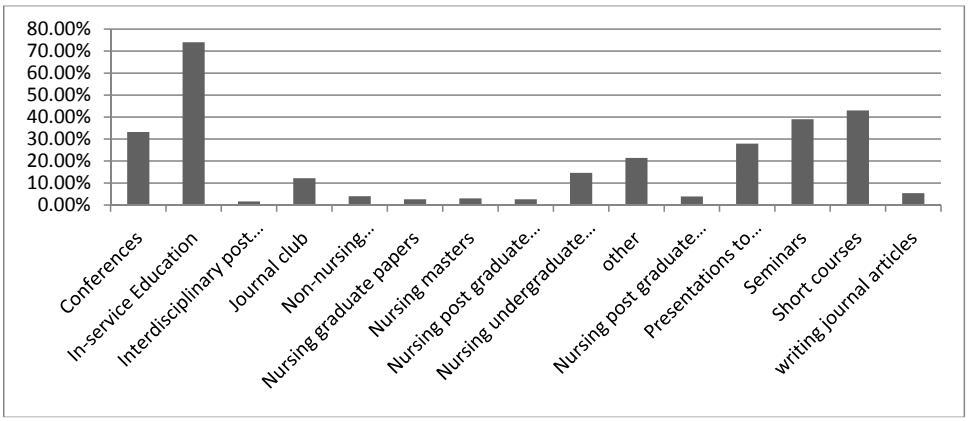
64% percent of respondents have had an appraisal / development review in the last 12 months. This was a large increase compared to results in 2008. By DHB, the percentages who had had an appraisal within the last 12 months ranged from 43% to 84%, and by employer type, from 43% (NGO provider) to 80% (Government agency).

Those who had not had a review in the last 12 months were asked when their last one had been. The 46 RN's who had never had a review, were found among all employer types and all staff groups.

Just less than half respondents had personal development plans, and fewer of these

reported their managers being involved in drawing up their plan, though there was a high number of missing responses.

Graph 8.3.2 Educational Opportunities



Considerable professional education is undertaken by New Zealand nursing workforce, despite several barriers which were identified. Of the barriers, the costs in terms of own time, family commitments, fees, and travel were important – but more so was the difficulties attending in own time or being able to take time off to attend in own time. Shift workers reported difficulties finding in-service training available when they were working, and large numbers reported finding the paperwork and increasingly, costs to employer in terms of time and fees, and lack of support from employer issues. Full detail can be provided by role and employer type. Many reported the difficulties of juggling full time work, family commitments and exhaustion, when contemplating further study.

8.3 Mandatory Training

88 respondents had attended all seven of the listed recommended update training updates within the last year. Percentages were calculated only on the 722 respondents who answered this question.(88 answers of "all" were added to each of the separate item counts) Non-responders primarily were in non clinical roles.

Table 8.3 Mandatory Training

Training	Number	Percentage
Occupational health and safety	512	54.8%
Fire safety	660	65.5%
Lifting and handling	570	61%
Infection control	592	63.4%
Cultural safety	509	54.5%
CPR	613	65.5%
IV competency certification	105	11.2%

For some of the elements, annual updates are not required. For example, IV competency certification is required 3 yearly, so about one third of respondents per year would be appropriate. Many also do not require IV certification in their role.

Key Points: Chapter 8

Considerable variation exists between employers and roles as to how much time for training and development is paid for.

Variation also exists in the number of appraisals and personal training plans carried out in the different employment.

Even recommended updtate training (which is by definition usually delivered in-house, in very short sessions, and at the work site) is patchily delivered

Given the high priority placed by nurses on the development of new skills, haphazard access to training planning, and to time for training may contribute to high staff turnover in particular settings.

Further study is required to discover whether perceptions of fairness related to access to training is a significant source of dissatisfaction.

Morale in 2008

This chapter describes the views of nurses, and is based on the analysis of the set of 30 Likert scales of questions related to careers, workload, pay, and nursing as a profession, and on the additional comments supplied at the end of the questionnaire.

The majority are identical to those used in the RCN survey, a few are changed slightly on advice following piloting (but are essentially the same in meaning). The percentage shown are the sum of those agreeing or strongly agreeing with the statement. The percentage agreeing with statements in each theme block are reported in reverse to allow easy comparison. (For example, the % disagreeing with "I would leave nursing if I could" are shown instead as % agreeing with "I would NOT leave nursing if I could, to allow comparison with "I would recommend nursing as a career") results from 2008 are shown for comparison.

The summary of the themes reveals that New Zealand's nurses are positive about the quality of care they deliver, nursing as a career, job security and job satisfaction. They are less positive about access to training, career progression, choice of hours and the extent of bullying. They are least positive about workload and pay, especially in comparison with other professionals.

Compared to the responses from 2009, New Zealand nurses' morale with most aspects of nursing as a career are very similar. Slight falls in confidence about career progression and job security are seen, and a worsening of perception of bullying. It will be interesting to plot changes in these parameters as the survey is repeated in years to come. It would also be interesting to compare NZ nurses with other NZ workers, as there may be wider differences in outlook, related to the profession. There were a few big differences associated with either employer type or roles:

Table 9.1.1

Theme	% strongly agreeing	Employer
PAY is poor	37	Aged care
	11	DHB in-patient
	8	Education
Access to training is poor	7	Aged care
	8	DHB in-patient
	1.5	GP
Bullying is a problem	12	Aged Care
	7	DHB in-patient
	16	Education

Table 9.1.2 Positivity Scores

The percentage agreeing and strongly agreeing with each statement is shown. The scores for the same set of questions in the 2008 NZ Employment survey, and for the 2010 YNS (younger nurse survey) are shown for comparison. The 2010 Employment survey results are shown with a random 11 % sample from the YNS added back to correct for age differences that were apparent compared to the 2008 (whole age sample)

Themes / Statements	Percentage Agreeing ES 2008	Percentage Agreeing YNS 2010	Percentage Agreeing ES 2010
1. **Nursing as a career**			
I would recommend nursing as a career	81.4	91.6	84.4
I would (NOT) leave nursing if I could	70.44	93.5	75.4
I am (NOT) in a dead end job	86.24	86.24	76.9
Mean "positivity" score	**79.4**	**90.5**	**79**
2. **Career progression**			
It will (NOT) be difficult to progress from my current salary	29.9	47.1	28.6
Career prospects are (NOT) becoming less attractive	60.6	69.3	55.1
Mean "positivity" score	**45.25**	**58.2**	**42**
3. **Bullying / Harassment**			
Bullying & harassment is not a problem where I work	62.15	61.0	50.3
I'd be treated fairly if I reported being harassed	60.12	78.4	62.6
Mean "positivity" score	**61.1**	**69.7**	**56**
4. **Working hours**			
I am happy with my choice of shifts	74.75	61.7	80.2
I feel able to balance home and work lives	77.4	71.8	79.3
Mean "positivity" score	**76**	**66.7**	**79.5**
5. **Job satisfaction**			
Most days I am enthusiastic about my job	87.7	87.7	90.3
I feel satisfied with my present job	77.07	83	76.4
I feel my work is valued	75.91	78.9	72.7
I feel part of a team	87.38	94.4	84.6
I am able to practice autonomously	82.03	89.1	79.2
My opinions about nursing are valued by my manager	71.83	83.9	69.2
Mean "positivity" score	**80.2**	**86.1**	**79**

6. **Pay**			
(NOT) paid more for less effort if I left nursing	23.81	33.4	37.9
I am well paid considering the work I do	36.55	39.2	33.7
Nurses are paid well compared to other professionals	17.57	25.1	23.9
Mean "positivity" score	**25.9**	**32.5**	**32**
7. **Quality of Care**			
The quality of care provided where I work is good	**87.77**	**93.1**	**87.4**
8. **Job security**			
Nursing will continue to offer me a secure future	87.0	94.2	82.8
I am (NOT) worried I may be made redundant	84.7	90.5	71.5
I would find it easy to get another job with my skills	73.48	76.6	60.5
Mean "positivity" score	**82**	**87**	**72**
9. **Training**			
I am (ABLE) to take time off for training	71.58	75.2	65.4
I am able to keep up with developments to do with my job	75.48	83.6	77.9
I have regular dialogue about my work with my manager	62.03	58.4	62.8
Mean "positivity" score	**69.7**	**72.4**	**68.7**
10. **Workload**			
My workload is (NOT) too heavy	44.94	52.4	47.3
I am (NOT) under too much pressure at work	51.7	58.1	56.3
(NOT) too much time is spent on non-nursing duties	56.28	54.1	51.6
There are sufficient staff to provide good care	55.15	57.1	49.4
Nurse staffing levels have improved over the last year	35.6	48.9	40.1
Mean "positivity" score	**48.7**	**54**	**49**

"Positivity" scores were mostly higher for younger nurses than for the sample as a whole. Statistically, this was tested using a T test on the data from the two sets of raw data: (YNS and ES 2010) Mean "positivity score" for YNS was 73.38%, and for ES was 67.32%. The difference was however not significant, with a P value of 0.257.

The only area where younger nurses were less positive was working hours. This is explored more fully in the YNS. The big difference in agreement by younger nurses to "it will not be difficult to progress from my current salary" is likely to be because younger nurses are at the lower end of salary scales, whereas many nurses who have been working for a long time are on the top of capped salary progression scales. There has been a marked decrease in perception of job security.

The score for the two questions related to bullying and harassment showed higher awareness of bullying compared to 2008. There was slightly greater confidence in being treated fairly if they reported bullying. Although 56% felt bullying was not a problem where they work, 44% did think it was a problem. Bullying also featured in the reasons many had changed jobs in the past, and many of the qualitative statements indicated that previous places of employment had been badly affected by a culture of bullying. It could be that raised awareness has in fact been caused by an improvement in openness about the issue, rather than an increase, or it also could reflect extra stress and poorer nurse leadership / management partly due to restructurings and productivity drive. By contrast, there has been a steady improvement in the RCN scores for bullying since a zero tolerance and mandatory staff training / harassment policy was introduced across the NHS. All other items are remarkably consistent with results from 2008.

Qualitative Comments

A final section invited free text comments related to any aspects of working as nurses and care giving, and about nursing as a career. 30.5 % of respondents added comments, and these were read and classified into broad themes. The most commonly represented themes are shown, in order of frequency. All comments are available in the appendix (identifiers removed)

Table 9.1.3 Qualitative themes

Themes	Number
Enrolled Nursing	
Both positive and negative reactions to recent changes, retraining, lack of jobs, poor pay	123
Positive comments	
General: love the job, great team,	72
Pressure	
Pressure, workload, stress, patient ratios, high staff turnover , sick leave	65
Pay	
Salary, especially compared to others or overseas, lack of reward for training	63
Hours	
Largely concerned with shift working and lack of flexibility /job share, difficulties around child care, compulsory night shifts, and lack of available cover. Work life / family balance	29
Poor management and bullying	
Too many managers, too poorly trained, bullying managers, too many changes in managers, bullying by colleagues un-tackled	24
PDRP	
Bureaucracy, difficulties fitting in hours, return to work after child-care, costs, dual midwifery / nursing registration	15
Roles	
Too much paperwork, cleaning & admin ,	14
Overseas trained (OTN) nurses	
Nursing experience in NZ, registration difficulties, qualifications & skills not recognised or used, discrimination,	9
Quality of care	
Concern about not being able to deliver quality care, unsafe working	9
New Graduate related	
Need for support, lack of jobs, NEtP	6

In terms of important implications for the sector, there is concern still about pay rates, particularly for care givers relative to minimum wage and unqualified CG, and for Enrolled nurses relative to HCAs. Comments also lend support to anecdotal evidence that nurses choose casual and reduced hours as alternatives to having to do shift work, particularly night shifts which are difficult for those with children, but that reliance on income from casual shifts is becoming riskier for some. The onerous nature of PDRP, particularly for those returning to work, who have been ill or have been having parental breaks, together with dissatisfaction about the Nursing Council's processes was also frequently mentioned.

Exemplar Quotes:

Each heading is briefly summarised, followed by two or three quotes from different individuals related to the theme and covering the spectrum of views.

Enrolled Nursing

There is a variety of views about the recent changes for Enrolled Nurses, and a range of experiences and perceptions of the role and the esteem in which the role is held.

"I have enjoyed all my years practising as an Enrolled Nurse. I have not lost my love of nursing although at times it has been very challenging".

"When I trained in 68 as an EN we were a respected, desirable bunch to have on the team, having gone through the changing times I am happy to see once again we are appreciated and training is being reinstated in some places".

"Enrolled nurses are highly regarded in my workplace, by management and other nurses. I am very pleased enrolled nurses will continue to be trained adequately for the future, but I do think we are underpaid for the work we do".

"I feel as a Enrolled Nurse we have no future. This has been further demonstrated by allowing Nurse Assistants to be called Enrolled Nurses, and now Real Enrolled Nurses have to prove themselves due to a decision made by others outside of our control. This devalues Enrolled Nurses".

Pressure

"The pressure of working (whether related to patient burden or system failings / relationships) help explain the difficulties retaining nurses in the profession and the choices nurses make about their employment".

"I love nursing in itself - however in the last year the DHB I worked for constantly left the nurses on the floor understaffed and stressed. Senior staff nurses resigned for better working conditions, which had a negative impact on staff in regards to guidance, support and a questionably safe work environment".

"I love the work with service users, however, burn out - related to extreme case load, and personal ethics of completing work - make the 'job' tiring, personal life suffers".

"There are too few experienced nurses and too many junior nurses who are exploited for budgetary reasons and not given good enough hospital training. Mistakes and near misses are a daily occurrence. Overtime isn't given and it is expected that nurses will cover breaks and go home late, this is part of looking after the team by management. It's rubbish and leads to sickness and exhaustion".

Pay

Pay relative to minimum wage and other jobs was a common theme, as was lack of increased pay related to experience, qualifications or responsibility. Care Givers were, understandably, most vocal about deserving better pay.

"I could work at the freezing works with no training and earn more than I do now. My husband's work pay their PA's more than we get as nurses - this is wrong. When we got married I earned more than my husband but he now earns three times my salary".

"I completed level 4 health care assistant last year, and they only increased my rate by 41cents to $13.82".

"How many people would work with psycho geriatrics and incorporate being pooed on, peed on, hit, spat at, punched, kicked, including heavy lifting and cleaning for min wage or just slightly more than $12.50 - not too many!".

Hours

Both shift work and choice of work patterns and hours figured significantly as one of the least favourable aspects of the profession.

"I feel as a nurse you give up so much with shift work, I have missed out on my children's sports days, school events, weekends with the family to name but a few. I am either at work, tired from work, doing study for work, or recovering from night shift".

"I am unable to do shift work in particular night shifts for health reasons, so am seeking employment that has regular hours and lighter duties. These types are positions are difficult to obtain even though I am an experienced, skilled and qualified health professional".

"Casual shifts suit my family as my husband travels with his work, so I can be unavailable for work at times".

"Night shifts suit my family routine although I do feel it has a detrimental effect on my health".

"When I first started no-one was ever allowed to "double shift". This is now standard practice and The RN's do it too! This is unfair and unsafe for the residents and their co-workers. The workers involved burn out and/or end up sick".

Bullying

Bullying (and the lack of appropriate managerial response to it) was cited as a major reason for job change and dissatisfaction at work.

"Bullying and harassment, as well as appalling communication and leadership skills, have pretty much trashed the environment for a great many staff (and patients)".

*"Lots of Bullying at ***, Have not returned to work in certain areas because of it".*

"I am quite appalled by the amount of work related bullying going on, staff to staff and management to staff".

PDRP

All comments about PDRP related to perceptions of over frequent and over bureaucratic requirements. Other issues related to dual requirement for our Nurse/Midwife members, and the difficulties in demonstrating competence for those who had been on parental or sick leave.

"It is very difficult to be able to complete PDRP education hours requirements. This is due to not enough cover for study days, employer reluctance to pay for courses".

"The PDRP is a farce, there is no client feedback and a lot of crony-ism and pseudo-intellectual jargon, masquerading as performance management".

"What I find hard about nursing is not the hours, or the patient loads, but the massive amount of competencies, workbooks and general paperwork that we have to do to prove we are competent".

OTN

Most quotes related to being trained overseas related to difficulties gaining NZ NC registration, or to overseas competencies not being recognised. There were a few comments from NZ trained workers who felt having OTN caused problems in the workplace.

"By the time I completed all my documents and thinking positively that they are going to approve my papers, they just sent me an email that I have to submit again all my documents because it lapsed already and I had to start again from the very beginning..For the second time, I paid the $485 processing fee".

Quality of Care

Concerns related to unsafe staffing levels, inadequate skill mix, or pressure compromised patient care.

"Care is compromised by budgetary constraints - too few dressings, inappropriate dressings, too few doctor visits - all very stressful for RNs who are solely responsible for resident care with no immediate medical backup, and are also responsible for supervising and orientating caregivers".

"I really enjoyed my career as a Nurse but i feel that present nursing conditions do not allow for adequately taking proper care of patients. With present workloads and the increasing severity of patient illnesses the safety margins for "proper" nursing care of all patients cannot be maintained with present staffing levels".

Restructuring

There was a whole section of responses to a question about the effects of restructuring. While restructuring and organisational change has always been a feature of health care, the current changes are undeniably unsettling and may have longer term consequences for succession planning, management development and staff retention, once the economic climate improves more generally.

"It is hard for employees to be able to work effectively in this sector when you have the upheaval of a management restructure and building renovations happening. It is unsettling for both staff and residents".

"I have worked as a Healthcare Assistant in a job where the business has changed hands twice and I have worked under six different managers in about 5years".

*"I found that when I worked for *** as a nurse educator there was a lot of uncertainty about job tenure because of constant restructuring".*

New Graduates

There were many comments from third year nursing students, or from very recent graduates that indicated problems finding work and places on the NETP programme.

"It is frustrating trying to find a new graduate position. We are told there is a shortage of nurses but employers are not offering enough placements for first year nurses. Some DHB's closed applications for NETP programmes early in the year - before we (as third year students) were aware of the need to apply".

"Tough times for inexperienced nurses to find suitable jobs".

"My observations are that we are not nurturing our new graduates. In our DHB some are given the opportunity to be in new grad program for 1 year but no guarantee of a job at the end".

"On the nursing vacancy websites, there are no new grad positions available, every nursing vacancy asks for experience, how do you get experience in the first place if there are not many new grad positions? A new grad nurse must start from somewhere".

*"I am a new graduate nurse with good grades, great comments from preceptors from all my clinical placements, impressed in my only interview (feedback from ***) but unable to find a job in the current economic climate".*

Positive About Nursing

Overall comments about nursing as a career echoed the positivity scores from the morale question set, with very many offering positive comments in answer to the free text question.

"Nursing has been a very rewarding career that has taken me to other countries and other places in NZ. It has been the right choice for me"

"I love my job and feel I can make a positive difference to peoples wellbeing everyday".

"Nursing is much better paid in relation to other professions than it used to be and it is still a fairly secure job prospect once you have some experience. Good career for travelling and working".

Finally, an inspiring and insightful quote representing the long view, reproduced in full:

"When I die, I won't regret I did Nursing but when I have my low moments, I do wonder what Life may have been like if I had never started, or dropped out of it early some point along the way. I have considered calling it quits...yet I always seem to come back. It's a subconscious thing about the skills & knowledge I have built up, and that feeling you have when you know you are not ready to let go. And yet, there will come a time shortly when it is time to go. I hope I know when that is, and when I do, I will go happily - knowing that I gave it my all, did a good job, and that now is the time to rest. Re Nursing as a Career - there will always be a need for good nursing i.e. for nurses with excellent clinical competency & Nursing knowledge. I am in heart on that - Nursing will survive. Those decision-makers & gatekeepers who pay us will need Nurses at some point in their lives (or their Families' lives). They may try to put in cheaper options but the proof is in the pudding - if they are the recipients of poor nursing then they will re-think those cheaper options. Us Baby-boomers have a voice, and are in good voice. There is one thing my colleagues & I have noticed over the years - those in power go after a while, and we stay on doing the work we do. Nursing is not going to die, it is going to live on. But, NB! Nurses need help to keep up (don't I know it with new technologies, etc - and evidence-based learning). But Nurses must always remain at the bedside, or within the clinical presence of the patient/client - that is where we belong. Anyone who can support us in that role (researchers, Tutors, managers, policymakers & the like) is a vital part of our survival - and it is vital that we all work together on this one".

Key Issues: Chapter 9

Comparative pay remains the biggest source of dissatisfaction for nurses and for care givers

Workload, stress, bullying and lack of job satisfaction also contribute to job change, and to lower morale

Confidence in job security and abilities to get other jobs is less than two years ago, linked in part to uncertainty in the wider economy

The issues of employment for new graduates, their support when entering the workplace, and their negative feelings about shift working are important for long-term workforce planning.

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NEW ZEALAND
NURSES
ORGANISATION

Level 3, Willbank Court, 57 Willis Street, Wellington 6011
PO Box 2128, Wellington 6140
Phone 0800 28 38 48

www.**nzno**.org.nz

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