RESEARCH

EMPLOYMENT SURVEY

NZNO Employment Survey 2015

Our Nursing Workforce: Condition Deteriorating

Dr Léonie Walker
NZNO Principal Researcher

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Acknowledgements

The New Zealand Nurses Organisation, and the authors, would like to ***fully*** acknowledge the Royal College of Nursing for its support and permission to replicate the RCN 2008 Employment Survey here in New Zealand.

We would also like to thank all the members of NZNO who gave their time to answer this questionnaire, and for the insights they have provided.

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Executive summary

This is the fourth biennial employment survey of the New Zealand Nurses Organisation (NZNO) nurse membership. The web-based survey of members was undertaken in December 2014. Midwives were excluded from the 10 per cent random sample on this occasion, though dual registered nurse/midwife members could have been selected.

The questionnaire covered 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 since 2008/9, allowing change over time to be tracked, and kept as similar as possible to the standardised Royal College of Nursing set to allow international comparisons. New questions for 2015 included more detailed exploration of occupational health and safety, employment law changes and progress with the introduction of Care Capacity Demand Management (a joint project being rolled out in district health boards designed to better match nursing resource with patient requirements).

Of the 5000 invitations sent out, 52 were returned as not known at the address available. Invitations to take part were also sent to recipients of the NZNO e-newsletter. 1175 responses were returned. It is not possible to calculate a response rate, though the timing of responses relative to the e-mail invitation and the news letter indicate the e-mail was the main prompter to complete. Respondent profiles by age, gender, district health board (DHB) area, health sector and fields of practice showed good concordance with both NZNO regulated nurse membership, and Nursing Council.

New Zealand's nurses show resilience and commitment to their profession in the face of continuing restructuring and resource restraint. The ageing profile of the workforce brings more urgency for changes to aid retention.This survey corroborates previous NZNO research (on late career nurses and flexible working practices) related to factors influencing nurses' retirement intentions. For many older nurses, increases in workload and patient acuity, the challenges of night-shift work, and the pain and discomfort associated with the more physically demanding aspects of nursing were considerable. There is growing disenchantment with workload and pay, and a loss of confidence in health sector leadership, compounding a continued decline in morale that has the potential to become entrenched if not addressed.

Significant and emerging themes

Profile of the nursing workforce

The Aotearoa New Zealand nursing workforce appears to have experienced some uncertainty in general employment, and increasing unemployment (especially for newly graduating nurses) compared to two years ago. 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, morale and perceptions of nursing roles and careers. The period from 2013 to 2015 was one of continued substantial structural and organisational change in the health system. Changes over the previous two years have been captured, and are reported where significant.

Restructuring

Over a quarter (27.46 per cent) of the respondents had experienced significant restructuring in their main employment. This related to reorganisation within work sites and across the wider employer; particularly DHBs. Close to 25 per cent (24.63 per cent) reported reductions of more senior nursing positions, and 23 per cent, changes to skill mix. Regionalisation and privatisation of specialist services, and merger / acquisitions in the aged- care sector were also recorded. The processes used have affected morale, damaging feelings about employers, and leading to 45 per cent of those affected (vs 24 per cent of those not affected) questioning their nursing future.

Workplace-acquired infections and injury

Twenty per cent had required time off work in the previous two years with workplace-acquired infections and injury (10 per cent increase on two years ago). Of these, 12 per cent were referred to the Accident Compensation Corporation (ACC). The commonest causes were back, knee, wrist and shoulder injuries relating mostly to slips and lifting, and flu or norovirus infections. There were some very disturbing accounts of violence towards nurses, especially in the fields of mental health and aged care. A worrying forty six reported assaults, fifteen reported injuries caused by these assaults by patients, and one reported a needle-stick injury.

Nurses' own health

The internationally validated EQ5D health tool was used. Nineteen per cent reported having some problems with performing their usual work, study, housework, family or leisure activities, and 34.9 per cent reported moderate pain or discomfort. Both of these figures are higher than 2013.

Morale

The morale of nurses (particularly those employed in aged care and DHBs), has continued to decline. Heavier workloads, higher patient acuity, restructuring and the financial climate were cited frequently in the recent survey, both in the answers given to questions about workload and restructuring, and in the free text general comments. While many love nursing, many also expressed perceptions that increasingly unsafe practice environments, leadership unresponsive to nursing concerns and rigid management were causing them to reflect on their future.

Access to, and use of, NZNO 2015 employment survey data

This reports details very many broad themes and specific areas of relevance to nursing workforce planners, policy makers, managers and the work of NZNO itself to support and advocate for the professional and industrial aspirations of our members.

Requests for sub-set analyses for example by sector, field, DHB area or issue can be addressed to the principal author: leoniew@nzno.org.nz

Chapter 1: Introduction

1.1 The 2015 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 commitment to te Tiriti o Waitangi is embedded in its constitution, and articulated through its partnership withTe Rūnanga o Aotearoa.
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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 comprising around 5000 drawn by computer from across New Zealand.

The questionnaire was adapted for use in New Zealand from the United Kingdom 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 the results will provide a useful picture of the employment and morale of nurses.

1.2 Context

This is the fourth biennial employment survey of NZNO nurse membership, and was undertaken in December 2014, following a prolonged period of DHB restructuring and some amalgamations, set against a background of increasing health service reform and budget constraint.

1.3 Method

A web-based survey of regulated nurse NZNO members was undertaken in December 2014. Invitations to participate in the web-based survey were sent by e-mail link, along with a covering letter. A link was also inserted into the e-newsletter. Participants were also offered a reward for their time spent participating, with (voluntary) entry into a ballot for a chance of winning $50. Contact details for the entry into the draw were separated at source from all answers, and participation was kept anonymous.

1.3.1 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 has been extensively and iteratively adapted for use in New Zealand. 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 since 2008/9, allowing change over time to be tracked, and kept as similar as possible to the standardised RCN set to allow international comparisons. Questions for 2015 included more detailed questions on health and safety, employment law changes and progress with the introduction of care capacity demand management (CCDM) (a joint project being rolled out in DHBs designed to better match nursing resource with patient requirements).

1.3.2 Sample and response rate

Of the 5000 invitations sent out, 52 were returned as not known at the address available. Invitations to take part were also sent to recipients of the NZNO e-newsletter. 1175 responses were returned. It is not possible to calculate an exact response rate, though the timing of responses relative to the e-mail invitation and the newsletter indicate the e-mail was the main prompter to complete. An approximate response rate from the random sample was 20 per cent.

1.4 Report structure

The results are given for all respondents, except where indicated. Numbers and percentages are shown to allow comparisons. Individual analyses exclude missing data, and this is indicated where applicable.

Chapter 1	Introduces the context and methodology of the 2015 employment survey.
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 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	Examines perceptions of health, and incidents of occupationally-acquired infections or injury.
Chapter 10	Reports on use of social media.
Chapter 11	Utilises a combination of the attitudinal scales and qualitative comments to present a picture of the morale of the workforce.

Chapter 2: 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.

Ninety five per cent held annual practising certificates, with nearly 0.4 per cent awaiting registration with the Nursing Council, and a further 3.8 per cent not seeking registration.

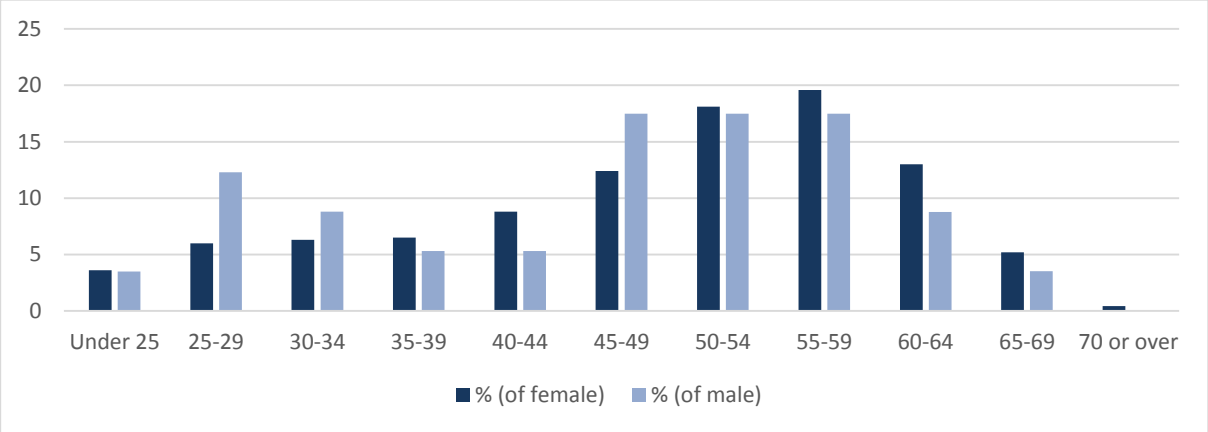
2.1 Age and gender profiles

The ages, percentages and comparative figures for the Nursing Council are shown in the tables below.

Table 1. Respondent gender and age profile

Age	female	% (female)	% female NC	Male	% (male)	% Male NC
Under 25	34	3.6	3.2	2	3.5	1.8
25-29	57	6	8	7	12.3	14.4
30-34	60	6.3	7.9	5	8.8	10
35-39	62	6.5	8.7	3	5.3	9.5
40-44	84	8.8	12.3	3	5.3	13.2
45-49	118	12.4	13.1	10	17.5	13
50-54	172	18.1	16.2	10	17.5	14.4
55-59	186	19.6	14.6	10	17.5	13.7
60-64	124	13	9.6	5	8.77	6.8
65-69	49	5.2	6.4*	2	3.51	3.1
Over 70	4	0.42	-	0	0	-
total	956	**94.4%**	92.3	57	**5.6%**	**7.7**

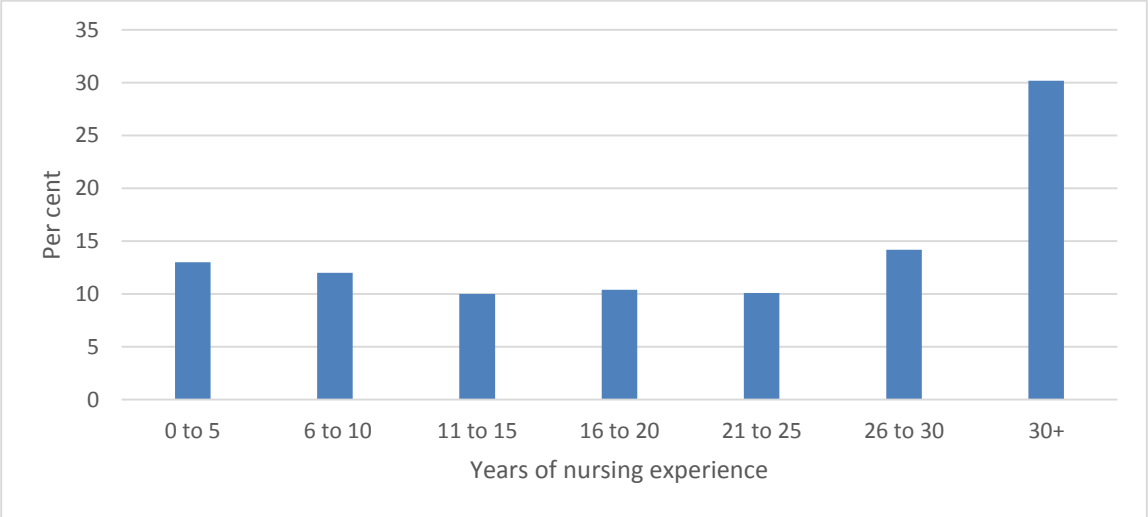
Figure 1. Age and gender profiles of respondents



NB. At the request of the gender equality group at the Council of Trade Unions (CTU), a question regarding gender identity “other“ than male or female was added. No “other” responses were recorded.

The nursing workforce, in addition to ageing, has accumulated many years' experience as a nurse:

Figure 2. Percentage of respondents with numbers of years of experience



2.2 Ethnicity

Table 2. Ethnicity

Ethnicity	Number	%	NC %	Ethnicity	Number	%	NC %
NZ European	767	75.34	67.02	**Samoan**	7	0.7	1
NZ Māori	66	6.48	6.86	**Cook Island Māori**	3	0.3	0.3
Other European	105	10.31	15.6	**Tongan**	1	0.1	0.05
South East Asian	23	2.26	6	**Niuean**	0	0	0.001
Other Asian	21	2.06	0.09	**Tokelauan**	1	0.1	0.001
Chinese	12	1.8	2	**Other Pacific**	3	0.3	0.003
Indian	22	2.0	5.5	**Other**	77	7.56	3.8
African	3	0.3	1.3	**New Zealander**	7	0.7	-

Of all the respondents, 20.65 per cent FIRST trained as nurses outside New Zealand. They will be referred to in this report as internationally qualified nurses (IQNs). This also accords well with Nursing Council workforce statistics the NZNO membership database (23.9 per cent first qualified internationally).

Table 3. Country of first training as a nurse for those first training outside New Zealand

Country of first training	Number	%	% Nursing Council
Australia	12	5.7	6.2
Pacific	4	1.9	5.1
Philippines	32	15.2	19.5
China	2	0.95	1
India and Sri Lanka	14	6.64	13.3
Other Asia	2	0.95	1.6
Middle East	0	0	0.02
South Africa	11	5.21	6.2
Zimbabwe	2	0.95	1.9
Other Africa	1	0.47	0.08
United Kingdom	91	43.13	36.6
Other Western Europe	5	2.4	3.9
Central Eastern Europe	2	0.29	0.05
North America	4	1.9	2.4
Central / South America	0	0	0.008
other	29	13.74	-

2.3 Scope of Practice

Table 4. Scopes of practice

Scope	Number	%
RN	877	88
EN	50	5
NP	6	0.6
Midwife	14	1.4
Unregulated	48	4.8

2.4 Employment situation

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

Table 5. Respondent profile by employment status

Employment status	Number	%
Employed, working	1075	93
Employed, parental leave	13	1.13
Employed, long-term sick leave	0	0
Retired, still in paid employment	17	1.47
Fully retired	2	0.17
Unemployed, looking for work	13	1.13
Unemployed, on a career break	3	0.26
Student	8	0.69
Other	24	2.08
Total respondents	1155	100

2.5 Job title

Table 6. Job title

Title	Number	Title	Number
Caregiver	15	Midwife	14
Charge nurse / manager	59	Nurse practitioner	6
Clinical nurse specialist	78	Other	150
Community nurse	28	Pacific Island nurse	1
Director of nursing	0	Practice nurse	88
District nurse	25	Public health nurse	8
Educator / researcher / lecturer / tutor	40	Registered nurse /staff nurse	494
Enrolled nurse	50	School nurse	10
Māori and Iwi nurse	5	Service manager	4
Mental health nurse	26	Nurse Assistant	9
Duly Authorised Officer	2	Kaimahi Hauora	0
HCA / Care giver	34	Medical receptionist	3
Professional nurse adviser / consultant	8	Allied health professional	3

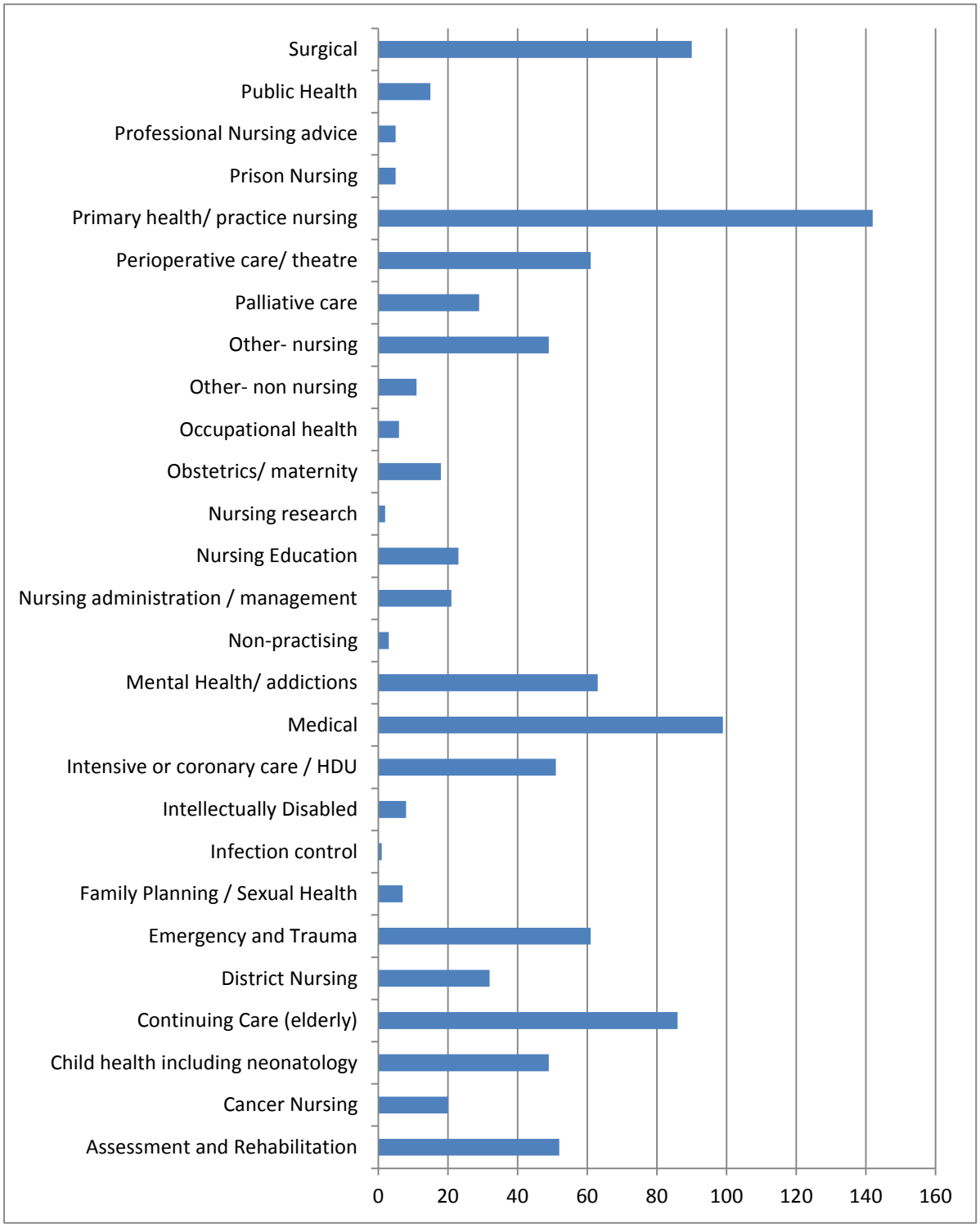
2.6 Nursing field

Table 7. Field of practice

Field	Number	Field	number
Continuing care / elderly	86	Nursing administration	21
Assessment and rehabilitation	52	Nursing professional advice	5
Cancer nursing	20	Nursing research	2
Child health	49	Obstetrics / maternal health	18
District nursing	32	Occupational health	6
Education, including clinical	23	Other - nursing	49
Emergency and trauma	61	Palliative care	29
Family planning / Sexual health	7	Perioperative care / theatre nursing	61
Infection control	1	Primary health / practice nursing	142
Intellectually disabled	8	Prison nursing	5
Intensive or coronary care / HDU	51	Public health	15
Medical including educating patients	99	Surgical	90
Mental health / addictions	63	Non-practising	3

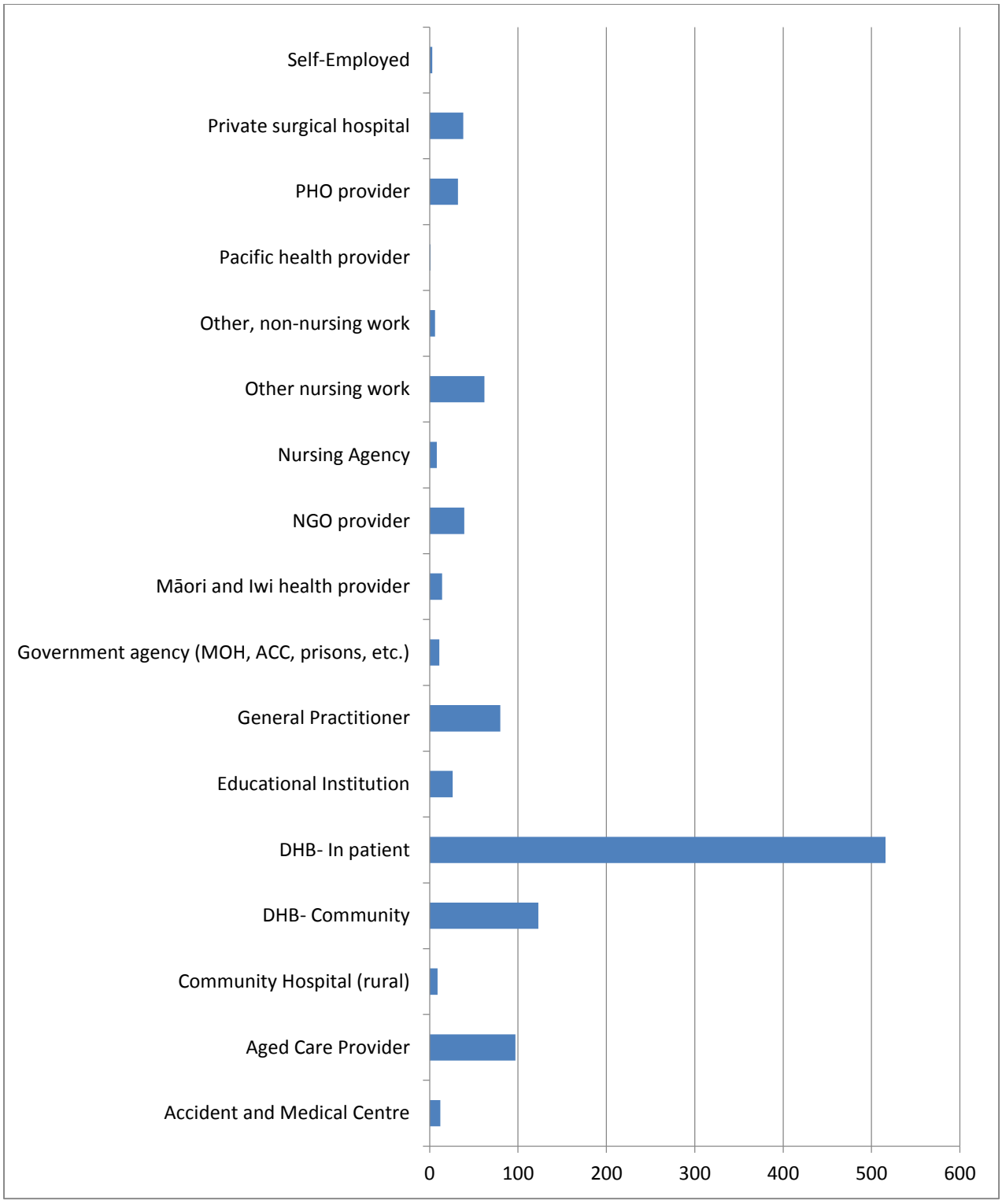
Total 1009

Figure 3. Field of practice



2.7 Employer

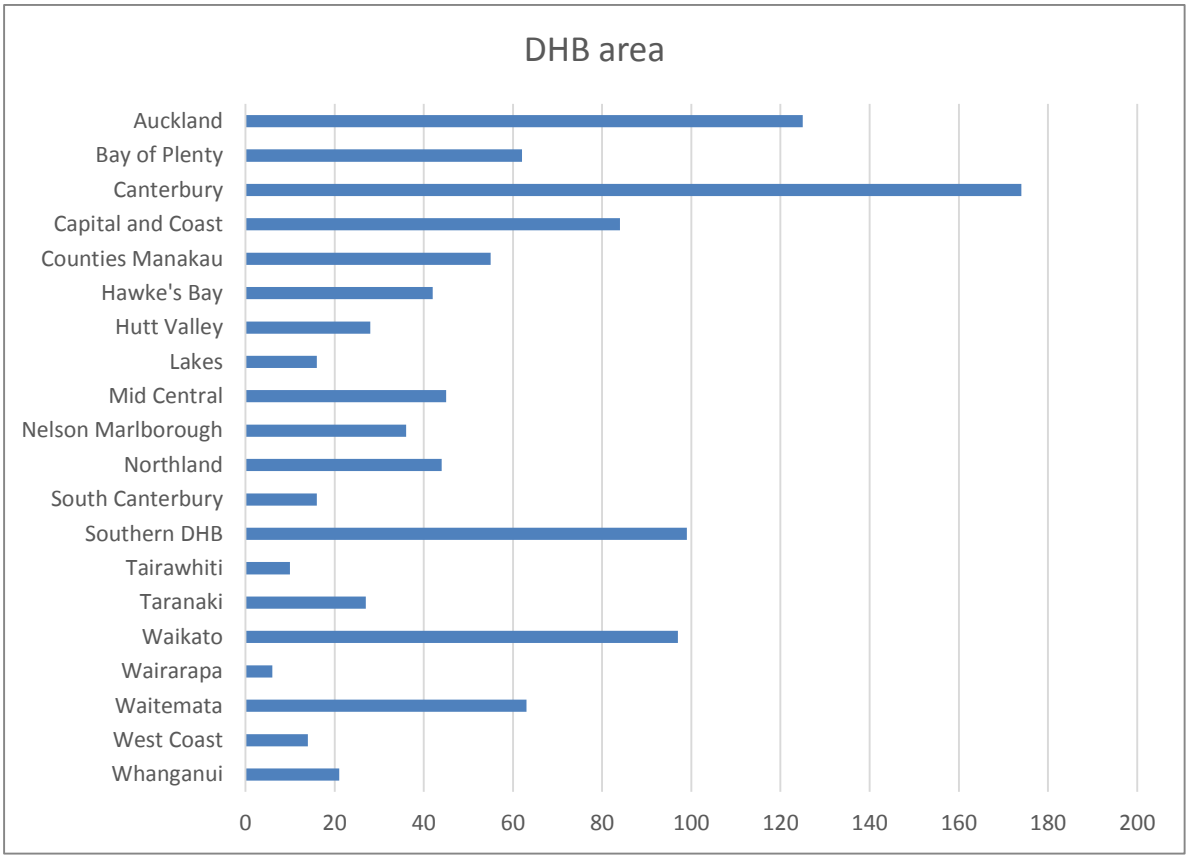
Figure 4. Employer



2.8 DHB area

A representative sample by DHB area was achieved.

Figure 5. DHB area



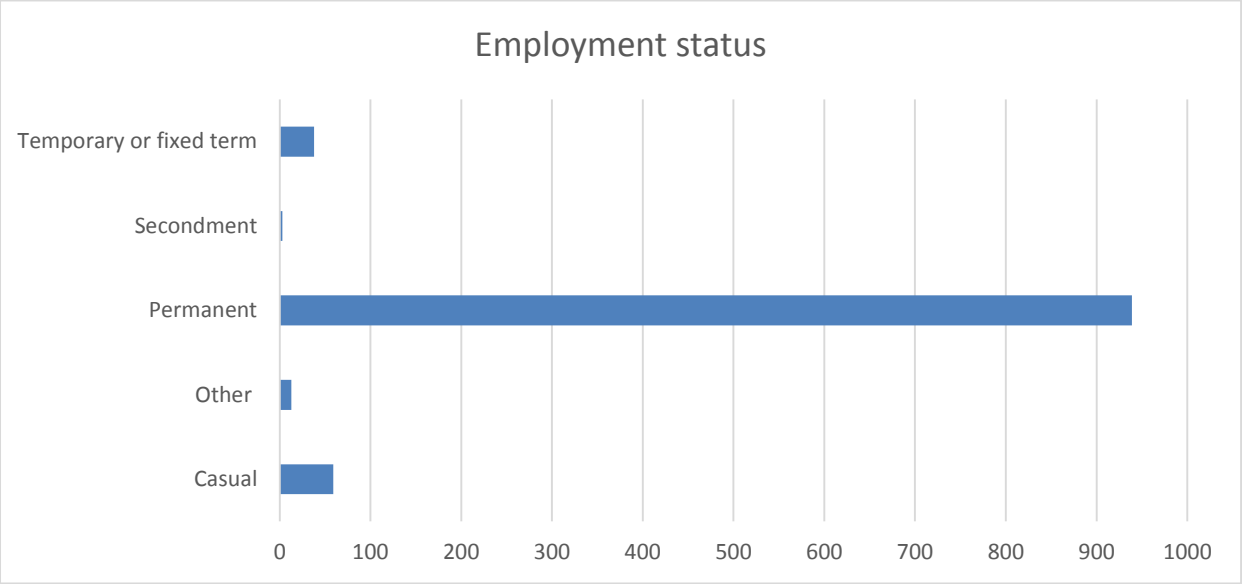
2.9 Employment contract status

This is shown in the table and graph below.

Table 8. Employment agreement status

Employment agreement	number	% ES 2015	% ES 2013	% ES 2011	% ES 2009
Permanent	939	89.3	89.1	81	88.7
Secondment	3	0.29	0.4	-	-
Temporary or fixed term	38	3.61	4.4	5.3	2.8
Casual	59	5.61	4.5	11	4.9
Other	13	1.24	0.6	1.4	2.7

Figure 6. Agreement status



There has been a slight increase in casualisation and use of temporary agreements since 2013, though not to the levels seen in 2011.

2.10 Summary

> A representative sample of the regulated New Zealand nursing workforce responded to the survey.

> The ethnicity, age and gender profiles approximately match available nursing council data

> All regulated nursing scopes were represented in the appropriate proportions.

> DHB area, employer sector, nursing field and job titles cover the full nursing employment context.

> The permanent employment agreement status has slightly increased in comparison to 2013.

> There has been a small increase in casualisation and a small decrease use of temporary agreements

> A third of the nursing workforce has more than 30 years' accumulated experience as nurses. The loss of this experience when this significant cohort retires ***must*** be factored into workforce sustainability.

Chapter 3: Pay and employment agreements

3.1 Pay

(This section must be interpreted with some caution, as it was clear people **variably** factored in part time status and its effect on earnings)

Figure 7. Salary band

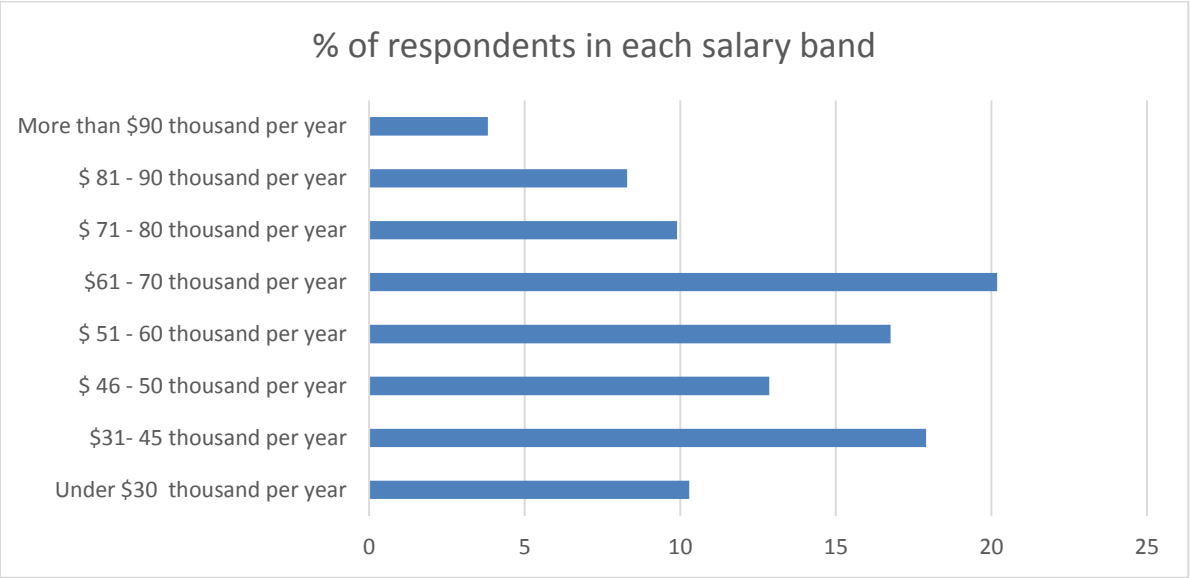


Table 9. Pay rates by employer (Number in each pay band, thousand dollars per year)

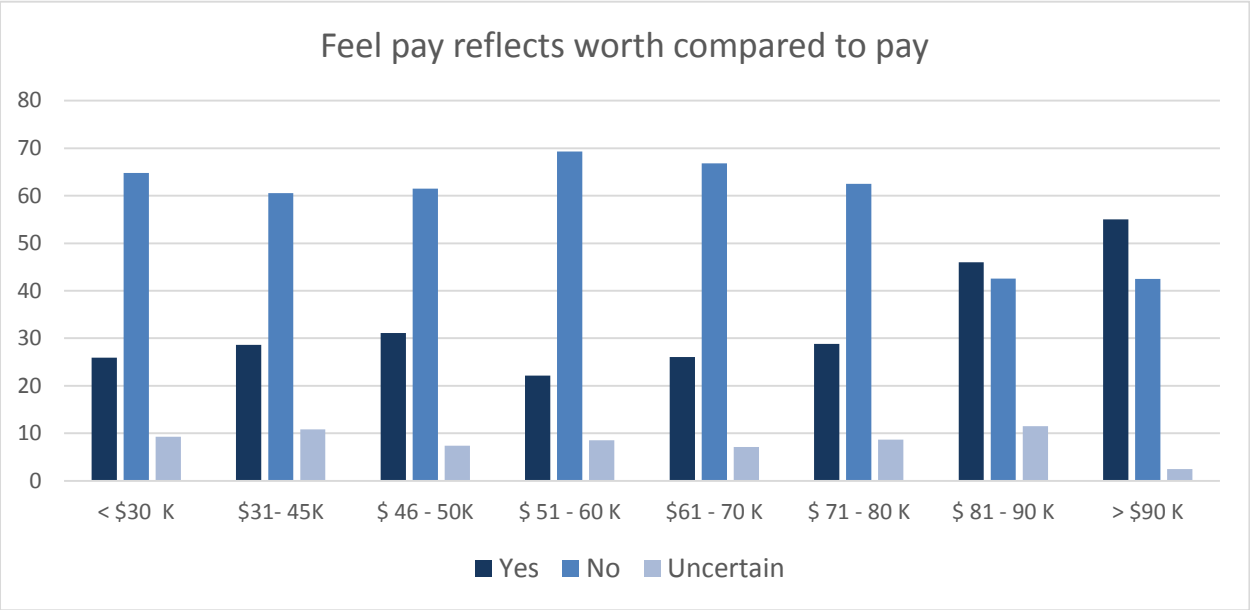
Employer	< $30K	$31-45 K	$ 46-50 K	$ 51 - 60 K	$61 - 70 K	$ 71 - 80 K	$ 81 - 90 K	> $90K
DHB- In patient	31	76	58	105	116	47	51	24
DHB- Community	9	14	7	11	32	27	14	5
Private surgical hospital	4	6	5	6	7	4	3	2
Accident and Medical Centre	1	5	2	0	3	0	0	1
Community Hospital (rural)	1	2	2	2	2	0	0	0
General Practitioner	12	21	14	12	13	3	2	1
Aged-Care Provider	29	27	15	9	5	1	3	0
Nursing Agency	2	2	1	3	0	0	0	0
Self-Employed	0	1	0	0	1	0	0	1
Māori and Iwi health provider	2	3	4	2	2	1	0	0
Pacific health provider	1	0	0	0	0	0	0	0
Educational Institution	1	6	1	5	6	3	2	2
Government agency (MOH, ACC, prisons, etc.)	0	1	1	1	4	0	3	0
PHO provider	2	3	5	7	5	4	3	1
NGO provider	2	9	7	7	4	5	4	1
Other, non-nursing work	0	0	1	0	0	2	1	0
Other nursing work	10	11	12	6	11	6	1	2

Table 10. Pay rate by job title (Number in each pay band, thousand dollars per year)

Job Title	< $30	$31-45	$ 46 - 50	$ 51 - 60	$61 – 70	$ 71 – 80	$ 81 – 90	>$90
Charge nurse/ manager	2	1	3	1	8	9	20	14
Community nurse	1	4	4	4	10	3	1	1
Enrolled nurse	16	17	8	7	1	0	0	0
Nurse assistant	1	5	0	0	1	0	0	0
Service manager	0	0	1	1	0	0	1	1
Director of nursing	0	0	0	0	0	0	0	0
Clinical nurse specialist	1	2	4	8	14	21	23	3
Nurse practitioner	1	0	0	0	1	0	1	3
District nurse	4	4	1	3	7	6	0	0
Duly authorised officer	0	0	0	0	2	0	0	0
Public health nurse	1	0	1	1	2	3	0	0
Mental health nurse	0	3	4	4	5	7	1	2
Registered nurse/ staff nurse	42	92	76	119	114	28	13	4
Midwife	0	1	3	4	2	3	1	0
Pacific Island nurse	1	0	0	0	0	0	0	0
Māori and Iwi nurse	1	2	0	0	2	0	0	0
Kaimahi hauora	0	0	0	0	0	0	0	0
Pacific Island or Māori and Iwi care giver	0	0	0	0	0	0	0	0
School nurse	1	7	0	2	0	0	0	0
Practice nurse	13	24	16	16	16	3	0	0
Educator/ researcher/ lecturer/ tutor	0	5	4	3	9	5	11	3
Health care assistant	3	10	2	0	0	0	0	0
Caregiver	11	2	1	0	0	0	0	0
Allied health professional	0	0	0	0	0	0	0	0
Phlebotomist	0	0	0	0	0	0	0	0
Social worker	0	0	0	0	0	0	0	0
Medical receptionist	0	0	0	0	0	0	0	0
Professional nurse adviser/consultant	0	0	0	1	2	2	2	1

There was little discernible pattern of pay satisfaction by job title, though those in the top two bands were more satisfied than the middle bands.

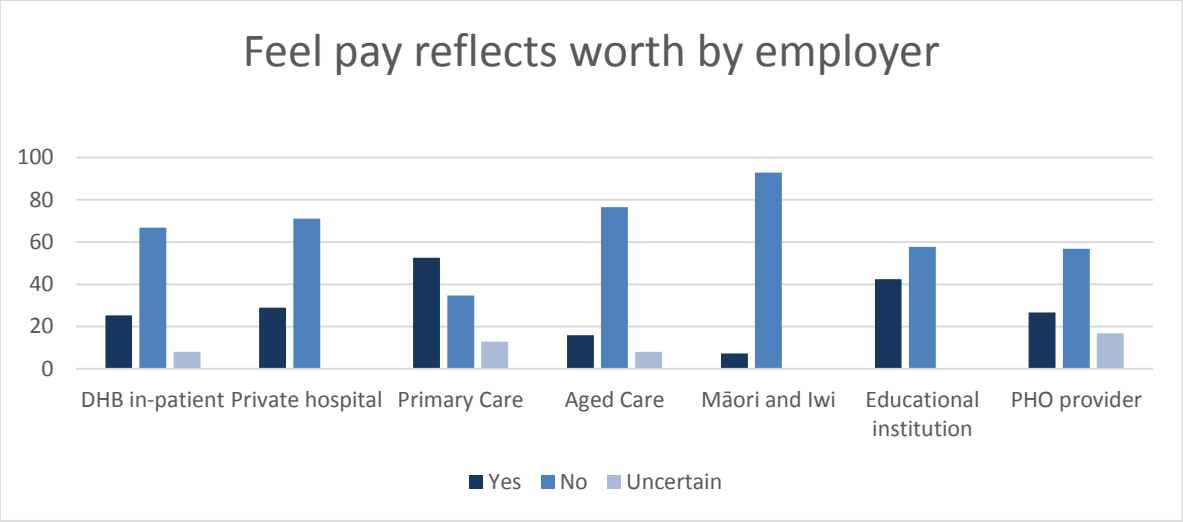
Figure 8. Opinion on whether pay rate appropriate (per cent)



The mean pay per hour of those feeling they were paid appropriately was higher than those who did not feel they were paid appropriately. There were differences in perception by employer type also.

Figure 9. Perception of pay by employer (%).

Yes = paid appropriately, No = not paid appropriately and Uncertain = not sure if paid appropriately



Other data from the survey ascribes the apparent higher satisfaction of (lower paid) practice nurses in primary care with their pay to greater job satisfaction, choice of hours and flexible working.

3.2 Income and families

The following figure indicates that the perception held by some outside the sector that nurses' salaries are "nice to have, extra pin money" for households is *absolutely* not the case. Not only do salaries contribute significantly to households, but nearly half of all respondents had significant responsibilities for children, adults or both.

Figure 10. Proportion of income that contributes to household income

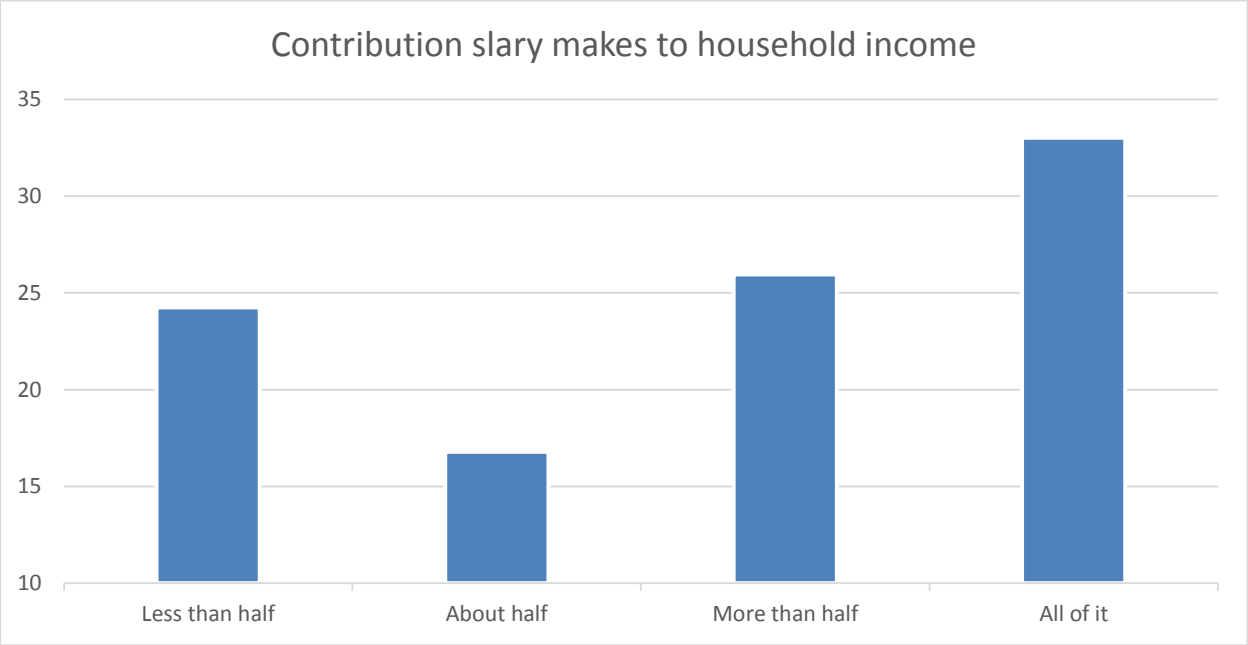
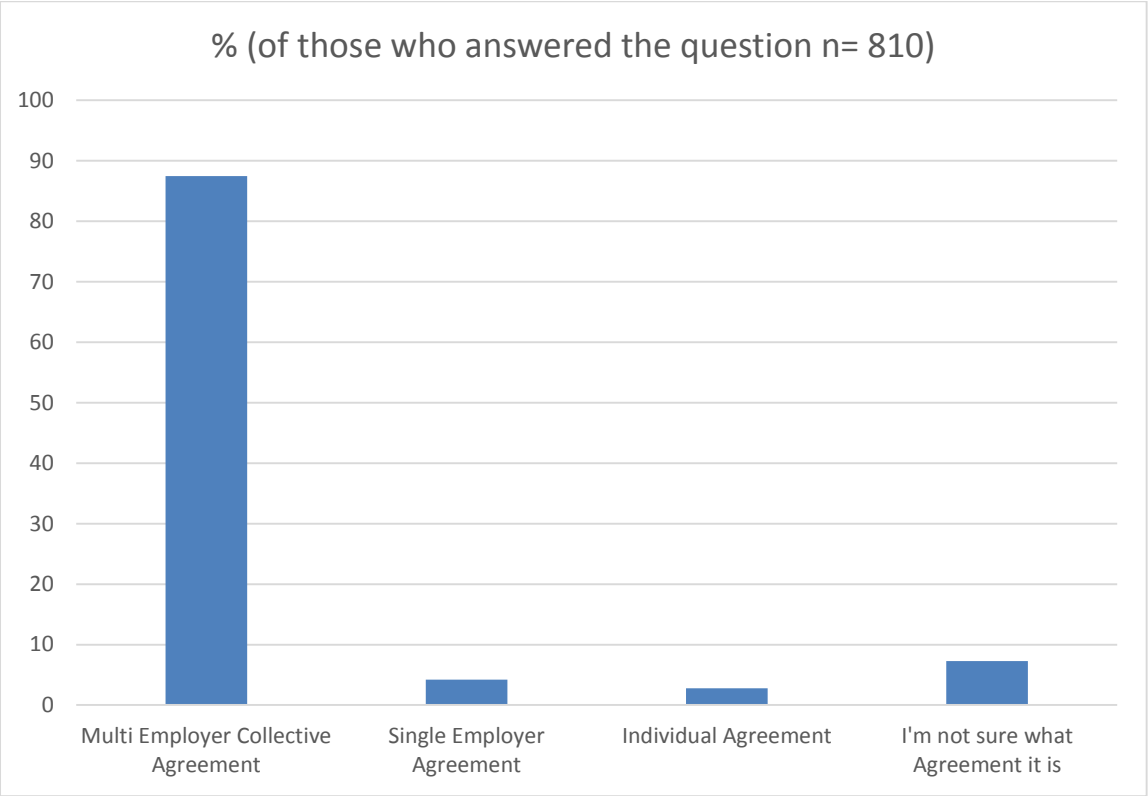


Table 11. Responsibility for dependent children or adults

Responsibilities	Number	%
Responsibility for children	372	35.6
Responsibility for adults	120	11.5
Responsibility for both children and adults	42	4.0
Responsibility for neither	553	52.9

3.3 Employment agreements

Figure 11. Percentage of respondents and type of employment agreement



The proportions of each type of agreement, and knowledge about agreements vary by employer.

3.4 SUMMARY

> Over half of all respondents were dissatisfied with their pay rates.

> The highest rates of pay were seen for nurse practitioners and nurse lecturers.

> The lowest rates of pay were for enrolled nurses, Māori and Iwi nurses and unregulated caregivers.

> Perceptions of the appropriateness of pay rates were, understandably, correlated with actual pay rates.

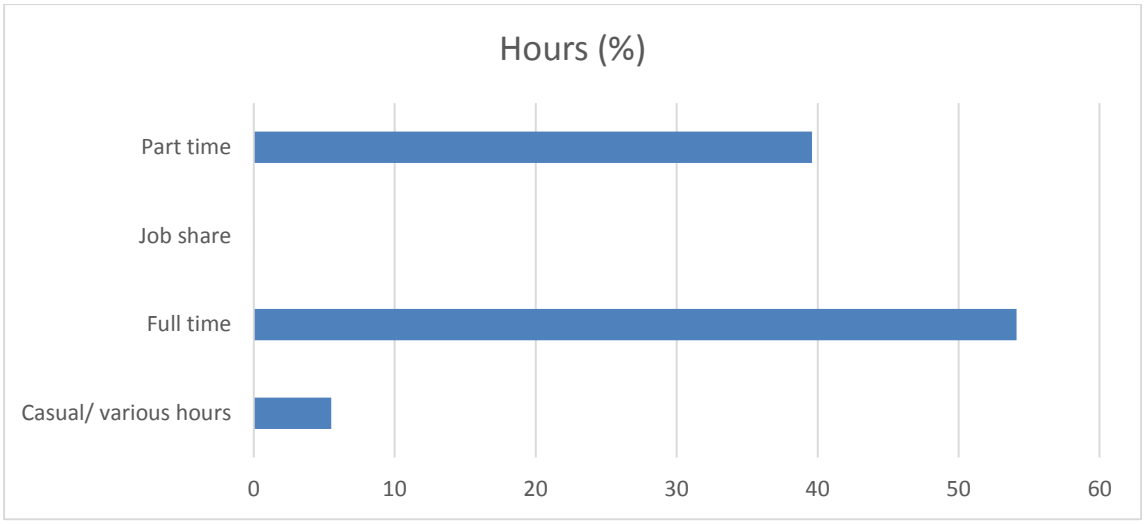
> Nurses' salaries make a significant contribution to the household budget, with around three quarters contributing half or more than half of all income to families (a rise since 2013).

> The majority of nurses are employed on multi-employer collective agreements.

Chapter 4: Working patterns

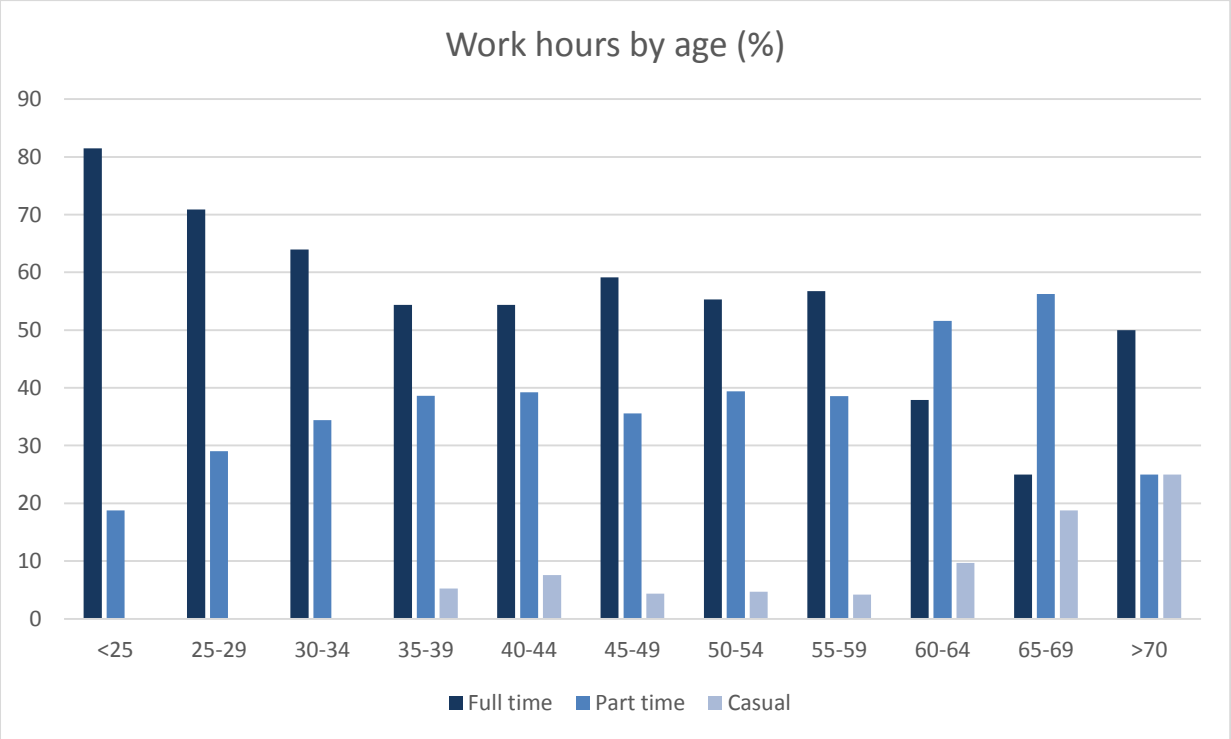
4.1 Contracts

Figure 12. Type of contract



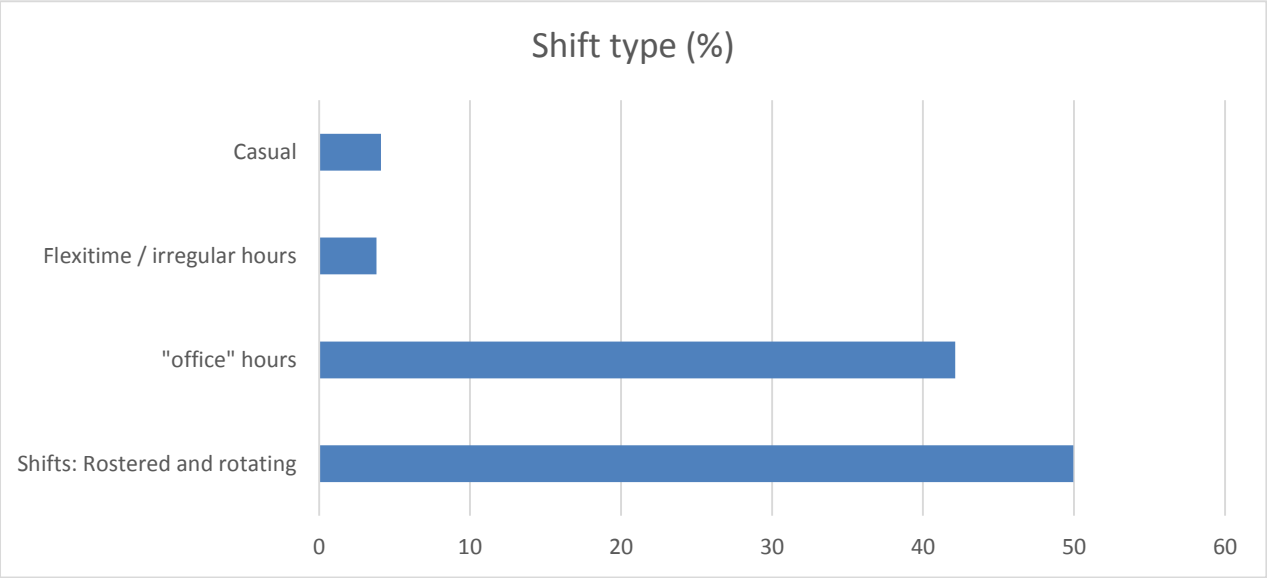
There has been a slight increase in the proportion of nurses working full time compared to 2013 (54% vs 50.5%). There were differences in the types of contracts in the various age groups, as shown in figure 13:

Figure 13. Types of work contract by age



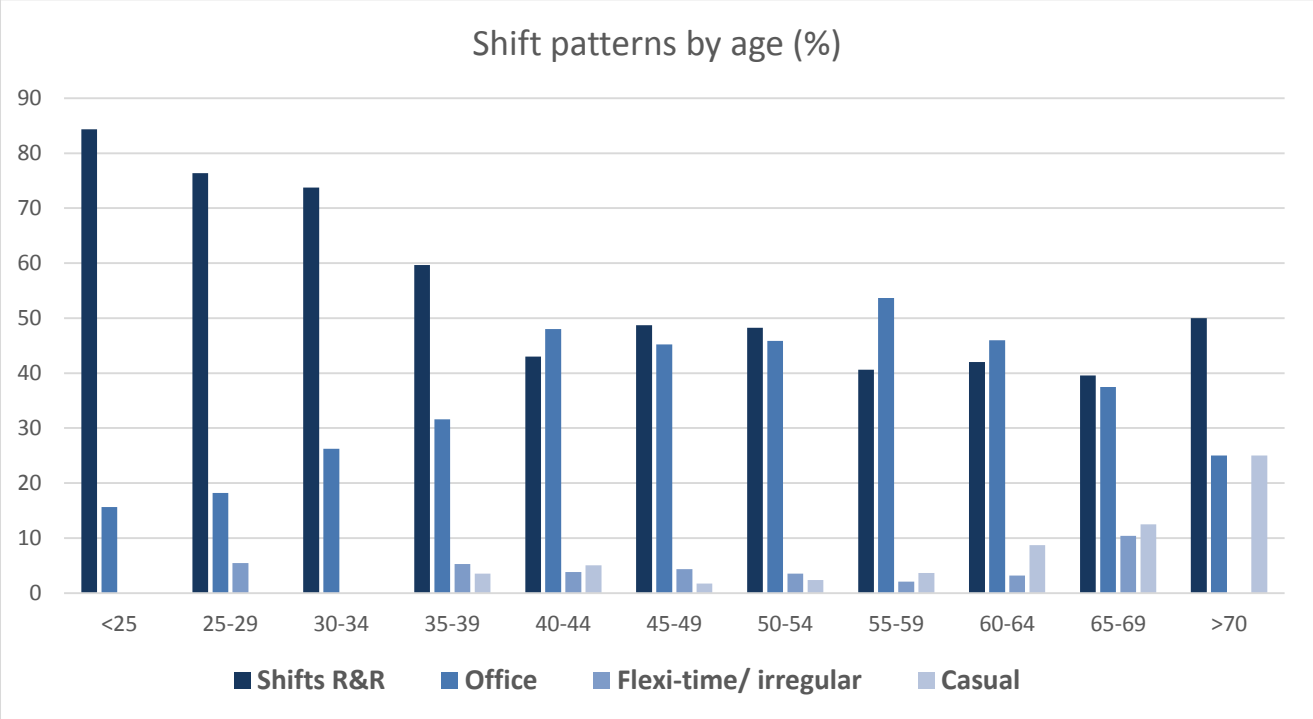
4.2 Work pattern

Figure 14. Work pattern



Work pattern also varied by age: with evidence of a preference to work office hours for those between 51 and 60 year olds, while more 21-30 year olds work rostered and rotating (R&R) shift patterns.

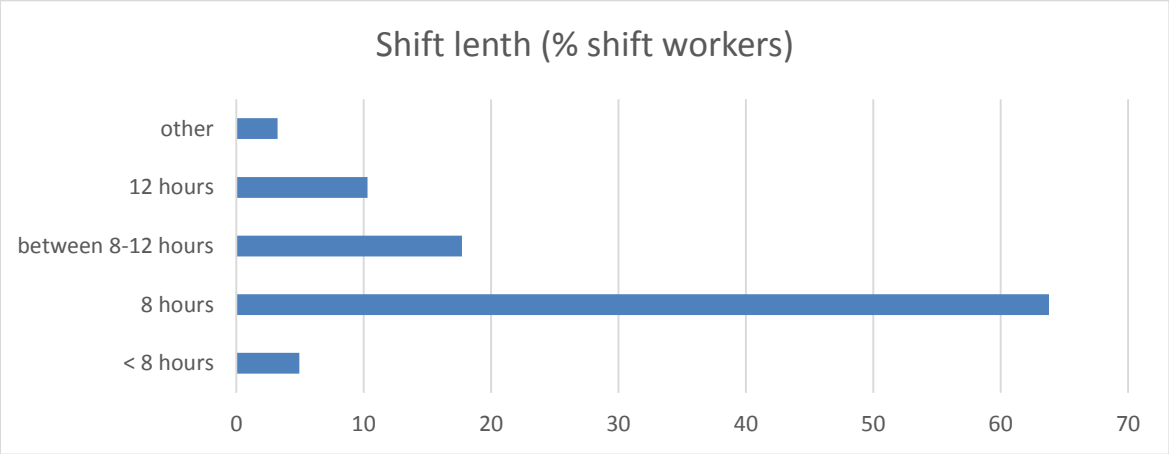
Figure 15. Percent of nurses in each age group working particular shifts



4.3 Shifts

The commonest shift length was eight hours.

Figure 16. Shift length



Of the 12 per cent who worked 12-hour shifts, the vast majority worked for a DHB, and the largest field of practice with 12-hour shifts was HDU/ICU, followed by neonatology and surgical. The three DHBs with significant 12-hour shift options were Auckland, Capital and Coast and Counties Manukau.

Figure 17. Shift lengths by DHB area

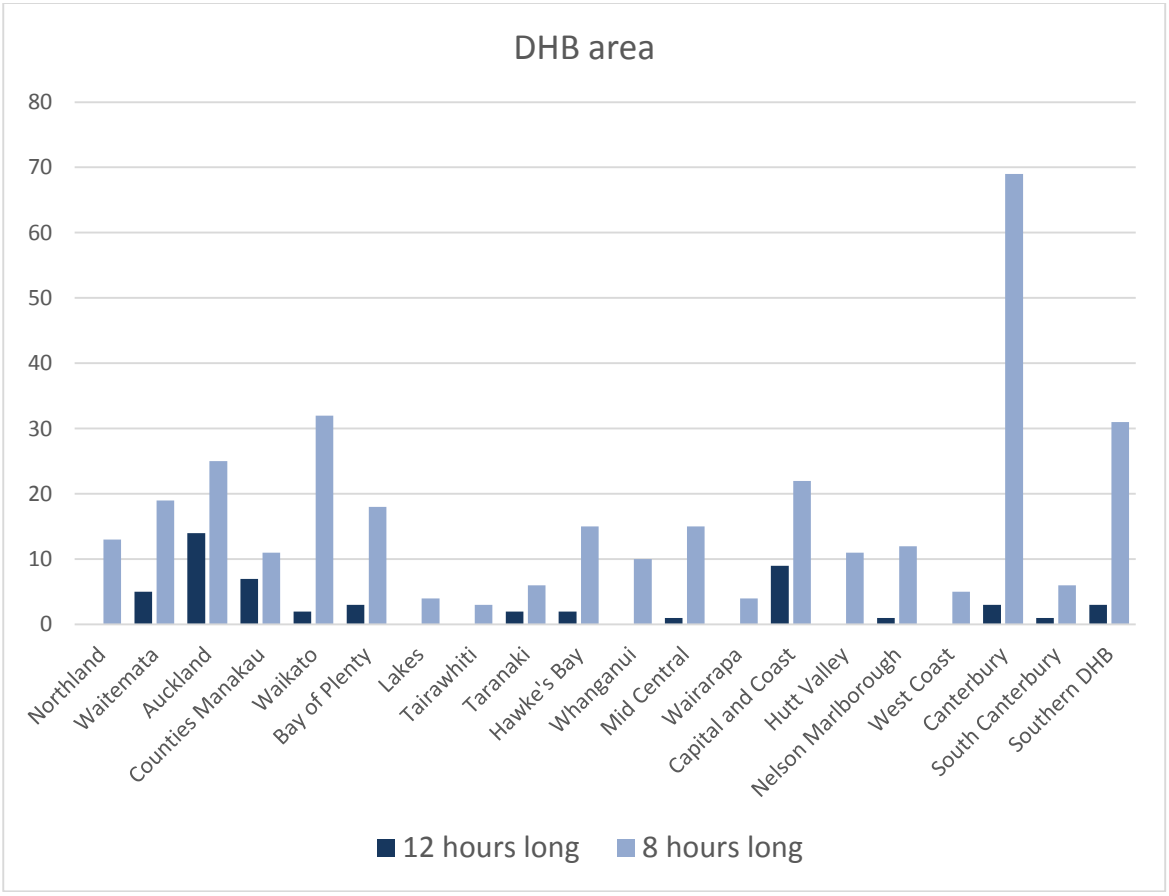


Figure 18. Shift length by field

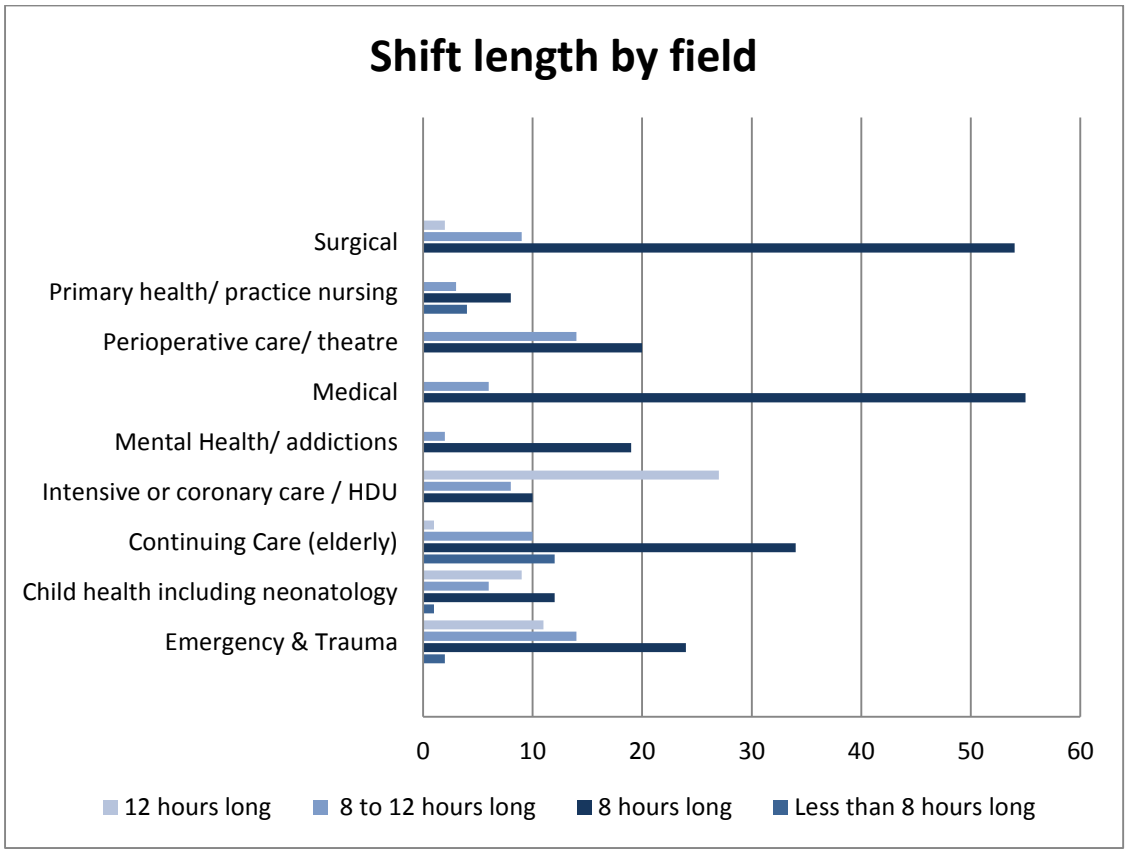
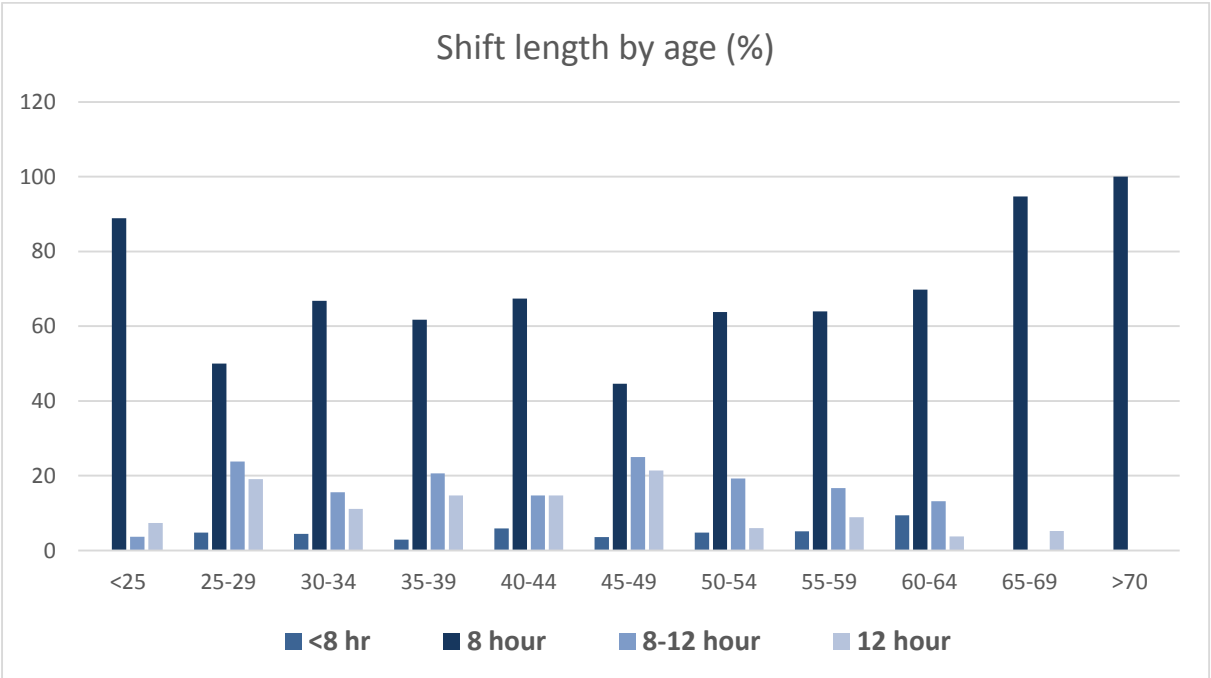


Figure 19. Shift length by age

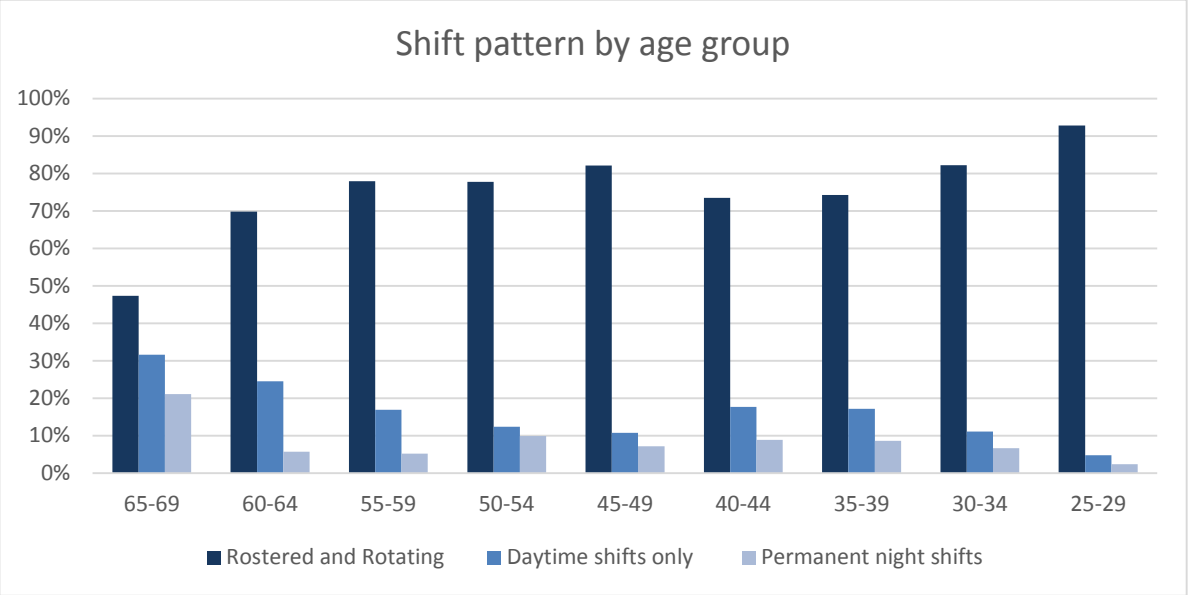


Of those (523) who worked shifts, 77 per cent worked (R&R)shifts. This is 20 per cent higher than for the 2013 survey, and corroborates other evidence of a move by many employers to compel all staff to do R&R shifts. This is particularly unpopular with older nurses, and with those previously happy with permanent shift work e.g permanent nights.

Shift types by age

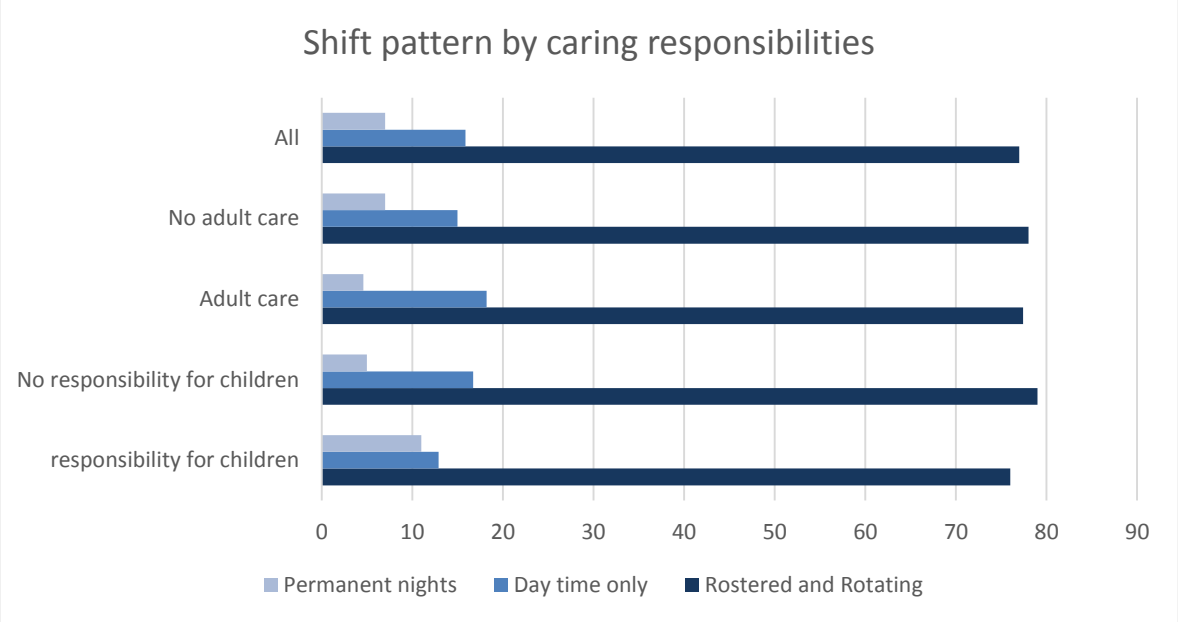
Comparing the age profiles of the shift workers, those who work permanent nights, many were in the older age groups. Very few under 40-year-olds worked day shifts only. Older workers most commonly worked eight-hour day shifts.

Figure 20. Shift pattern by age



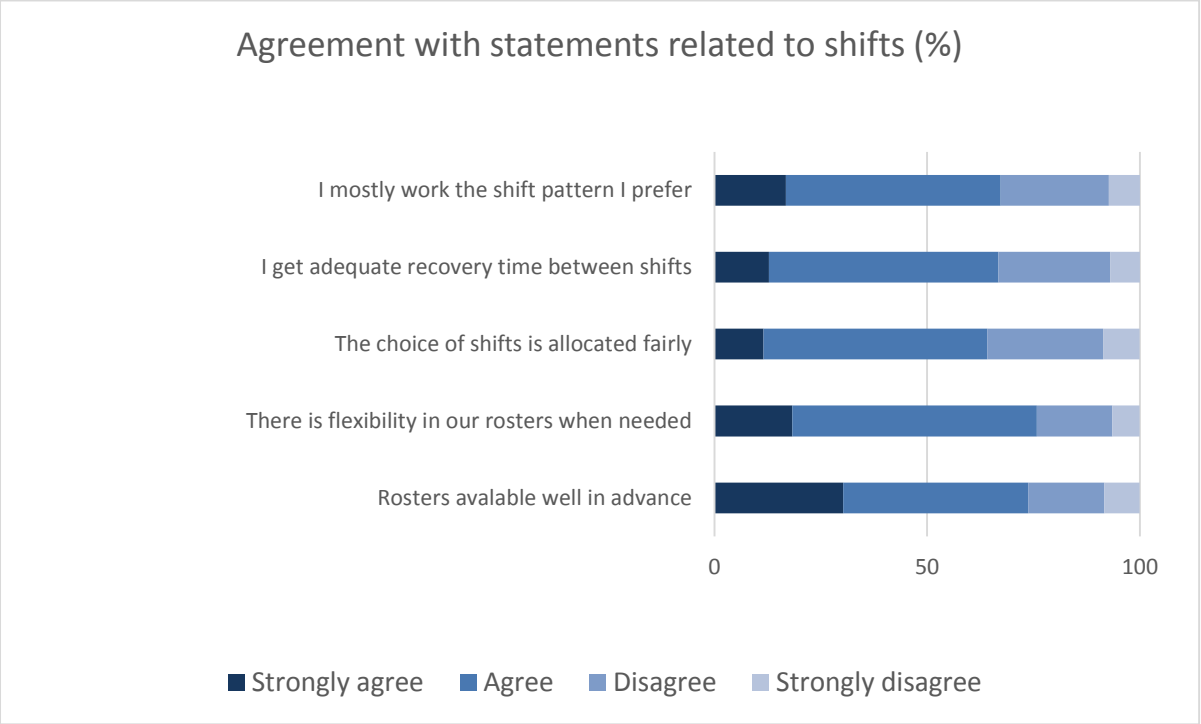
Having dependent children was not associated with particular shift patterns.

Figure 21. Shift pattern and caring responsibilities for children and adults



Those who worked shifts (n=523) were asked their agreement/disagreement with a series of five *statements* about shift preferences and management.

Figure 22. Degree of agreement or disagreement with statements related to shifts



4.3 Qualitative data related to shift work (nights)

(Representative quotes from each category.)

Negative effects

It affects everything. Most nurses I know are exhausted all of the time. Relentless!

Night shift is very difficult particularly when you are older, affects my well-being as you feel exhausted and nauseated for a couple of days after.

Often feel fatigued. Disrupted circadian rhythm due to working mix of am, pm and night shifts. Sleep problems.

I find rotating through the shifts especially nights plays havoc on my health and energy levels, my family have to miss out on school and social events because I am working. It's impossible to get a decent sleep as have to take kids to and from school (a 1 hr round trip).

Nurses who prefer to work night shifts are being made to work day shifts while the nurses who struggle at night are made to work night shifts, leading to unsafe situations.

Driving home after a night shift is totally unsafe

More positive comments

As I work permanent nights, I feel that it is better than doing rostered shifts. I have one pattern to stick to, and that is good for me.

I have worked rostered shifts for over 40 years...because of this, it is not problematic for me. However, I notice that with younger nurses they do struggle to work the night shifts, especially if it is only for one or two nights a week. It totally disrupts their sleep pattern.

Shift work and rostering effects

Split days off following night shifts are unhealthy & I have an issue with it happening.
Not uncommon to work all three shifts in a week, often only one day off after last sleep day, have gone from rarely doing nights to at least three per month.

Very tiring when switching days to nights and vice versa - difficult to recover from, depressing, they reduce the amount of time and interaction with loved ones resulting in relationship issues.

I seem to have lot more illness due to all the night duty we are compelled to undertake some weeks I am rostered morning afternoon and night duty all within one week this is never requested but frequently given.

Management keep trying to get rid of permanent night staff. Doing all 3 shifts is more tiring it kills me. There is enough people wanting to do nights but they insist on mucking it around. For me if I misbehave they give me day shift as punishment.

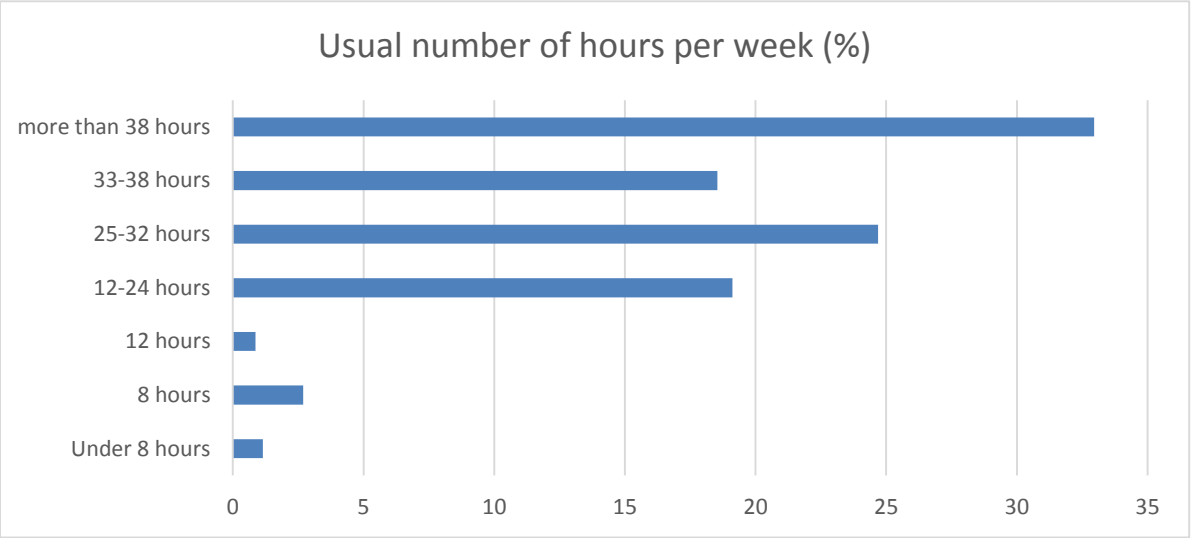
Don't like to have one day off before night shift & sometimes can end up to have 7-8 days (with 3 different shifts on) in a row, extremely tired.

Being rostered on 3 different shifts in 1 week is hard to physically cope with.

4.4 Hours worked

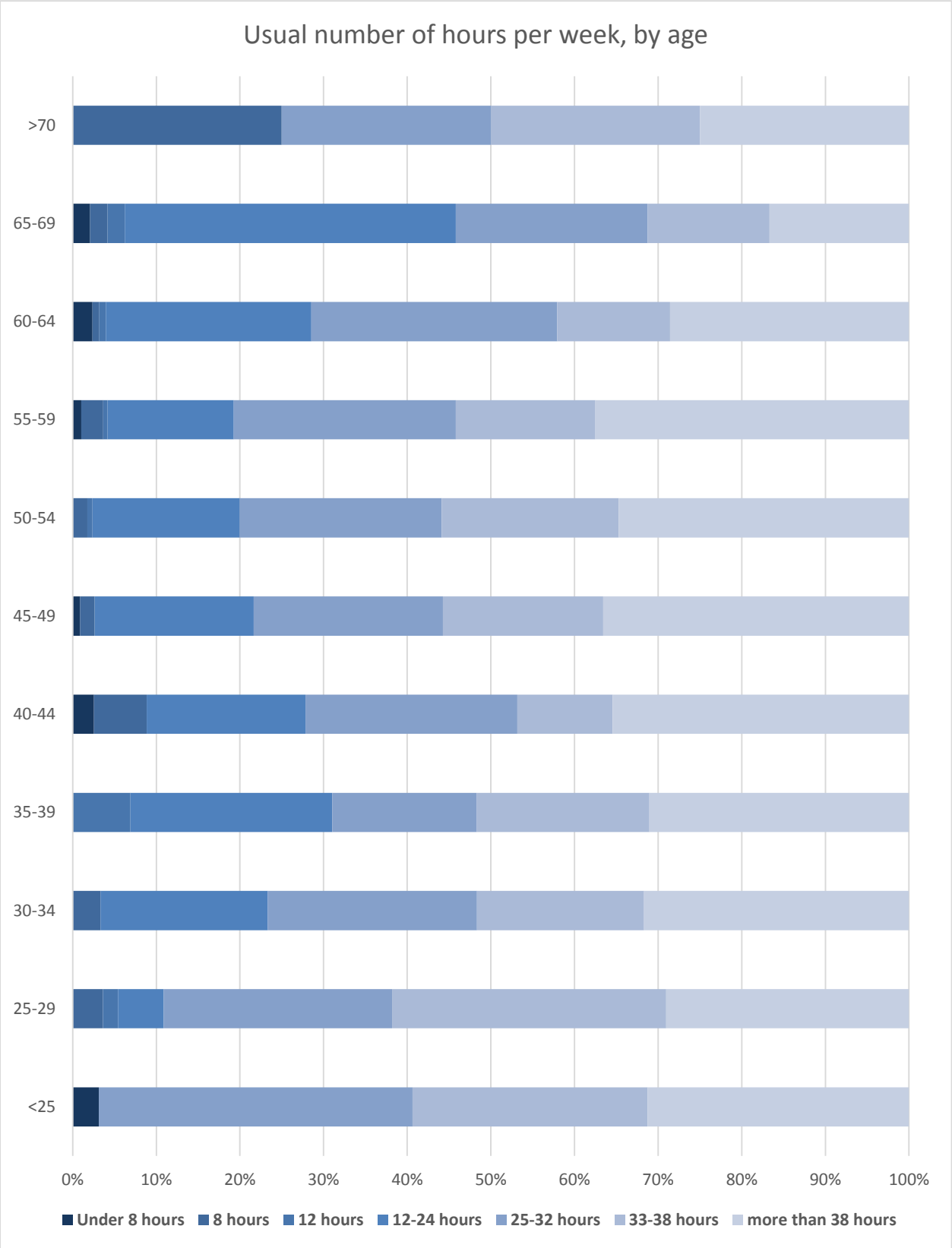
Only around a third of nurses are contracted to work more than 38 hours per week in their main job, with just under five per cent working the equivalent of one eight- or 12-hour shift per week. This has not changed significantly since 2011.

Figure 23. Percentage working different hours per week



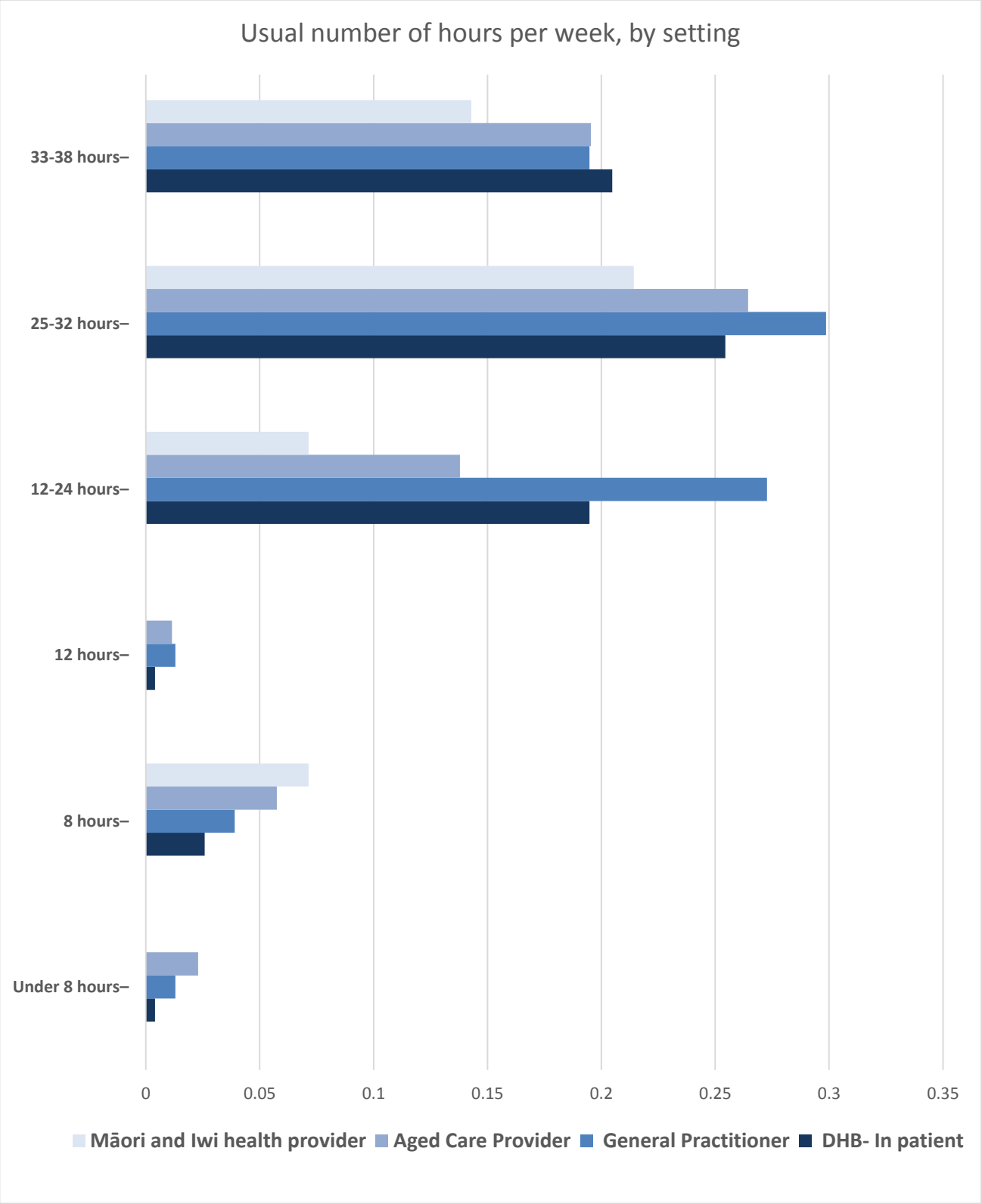
For those working 12 hours per week or less, this is seen at all age groups, though the over 65 year olds are over represented.

Figure 24. Usual number of hours per week by age



Comparing DHB, Māori and Iwi providers, general practice and aged-care (AC) employers, the hours worked (as a percentage of all DHB or AC staff) can be seen in figure 27.

Figure 25. Usual number of hours worked per week by setting



Sixty five per cent (up from 47 per cent in 2013) of nurses reported regularly working extra hours to provide cover, 54 per cent were paid at the normal pay rate,17 per cent at a higher rate; nine per cent had time off in lieu, and 12 per cent (up from five per cent in 2013) received ***no*** financial reward for working extra to provide cover.

4.6 Extra hours

Asked specifically about the previous week, 47.3 per cent (490 nurses) had worked extra hours the previous week.

Figure 26. Frequency of missed meals or excess hours

For illustration, differences can be further analysed by field. The percentage of those who worked excess hours in aged care, primary health / practice nursing and surgical (who each had similar numbers of respondents) are shown in figure 27.

Figure 27. Percentage of those who worked excess hours by work setting – surgical, primary health/practice nursing, aged care / gerontology

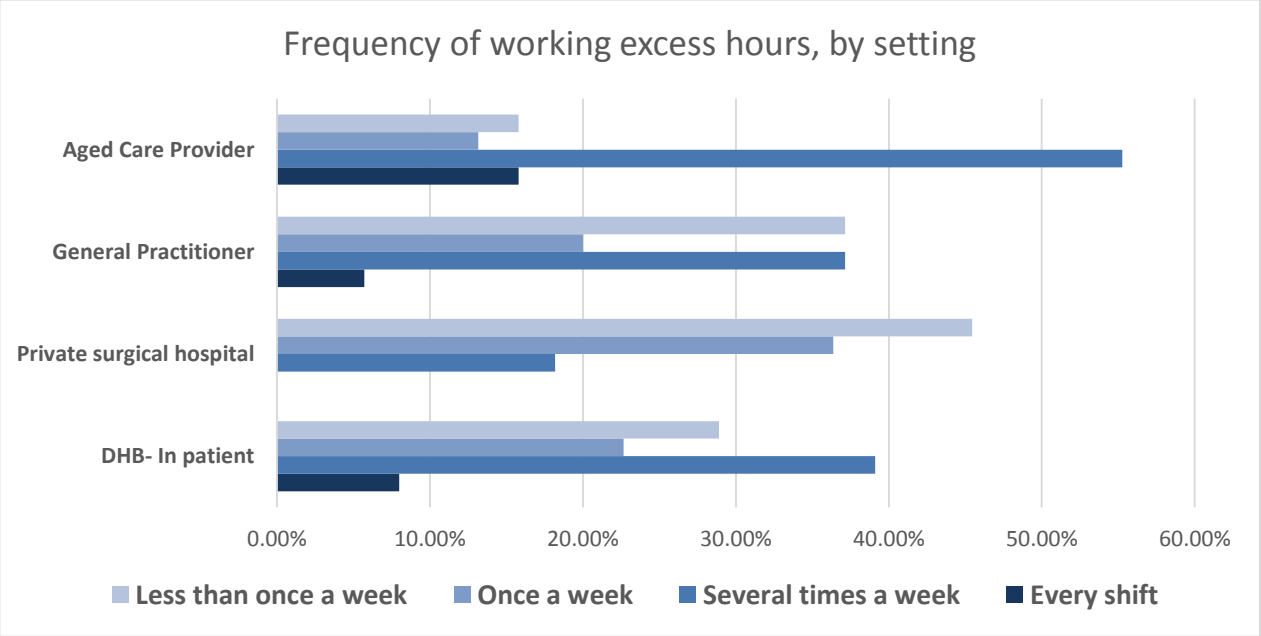
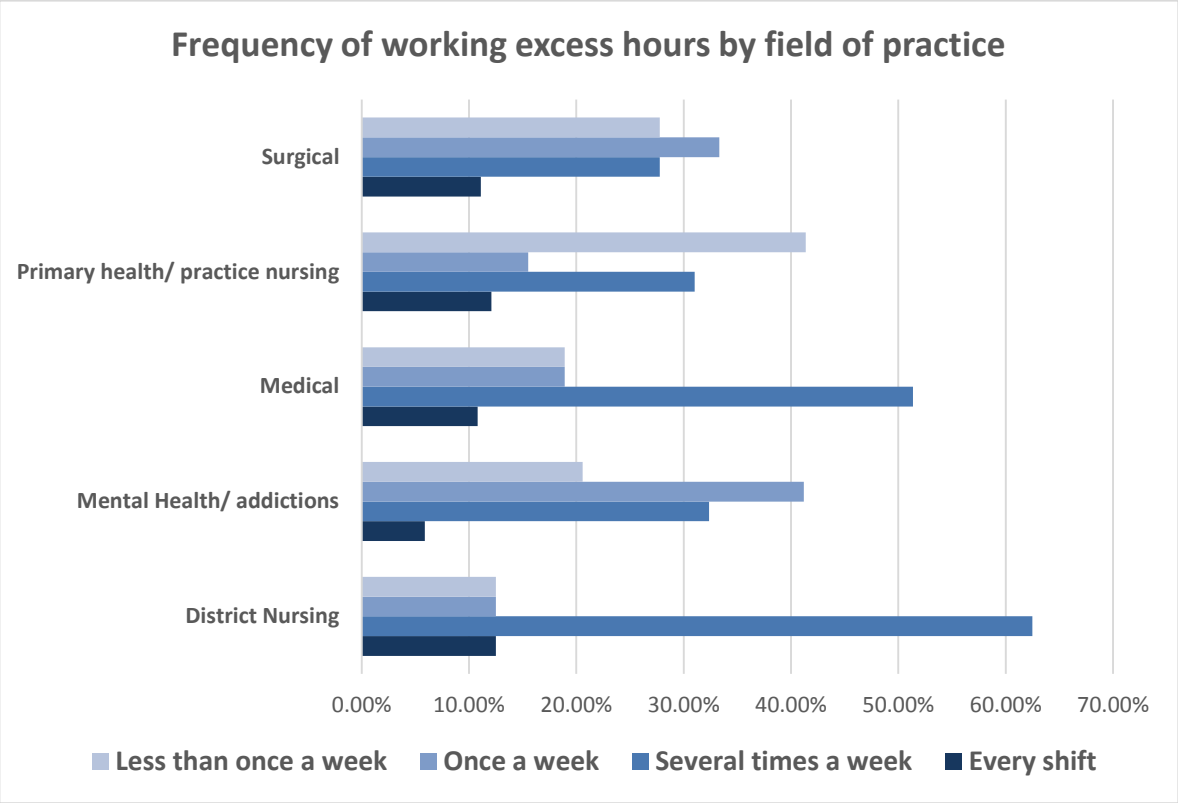


Figure 28. Percentage of those who worked excess hours by field of practice – surgical, primary health, medical, mental health and district nursing



Other analyses of excess hours by field, DHB area or sector are available on request.

4.7 Nursing tasks

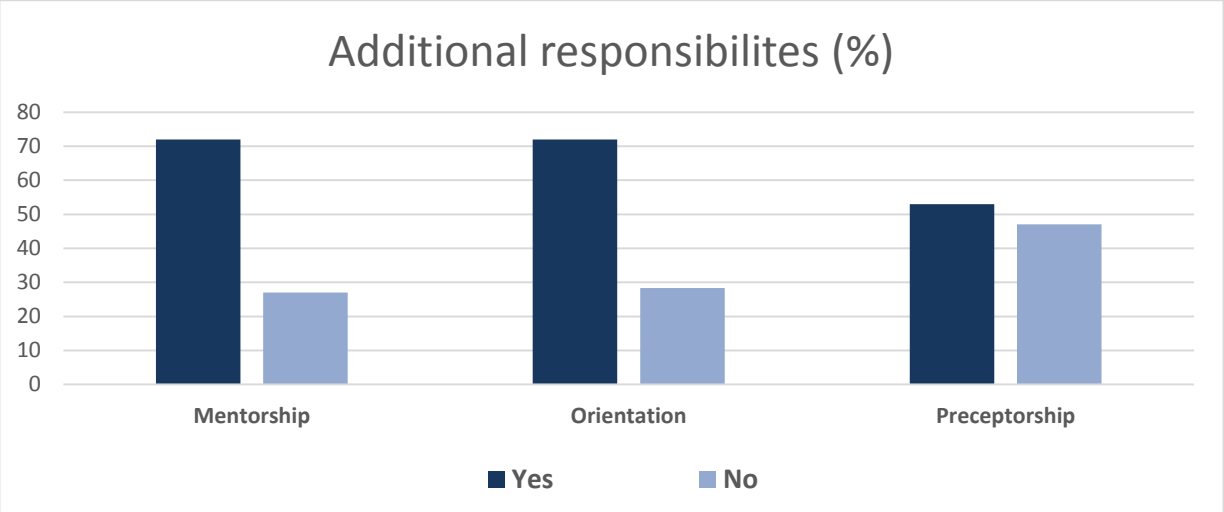
The approximate percentage of time spent on a variety of nursing tasks was also recorded. Table 11 shows a variety of tasks listed in reverse order of the highest proportion of time allocated to each item. The figures are virtually identical to those in 2013. (The sum of 129 per cent of time spent on all activities may reflect the excess time, multitasking or be an overestimation based on approximation and rounding.)

Table 12. Percentage of time spend on nursing tasks

Item	Mean %	Rank
Clinical work (direct and indirect patient care)	**65**	**1**
Administration	**16**	**2**
Educating / training	**13**	**3**
Management	**12**	**4**
Cleaning / domestic	**7**	**5**
Other	**6**	**6=**
Professional development	**6**	**6=**
Research	**4**	**8**

Figure 29 shows a range of additional specific responsibilities.

Figure 29. Additional responsibilities



Respondents were also asked if they had a second employer with 15 per cent (143) indicating they did.

Figure 30. Secondary employment

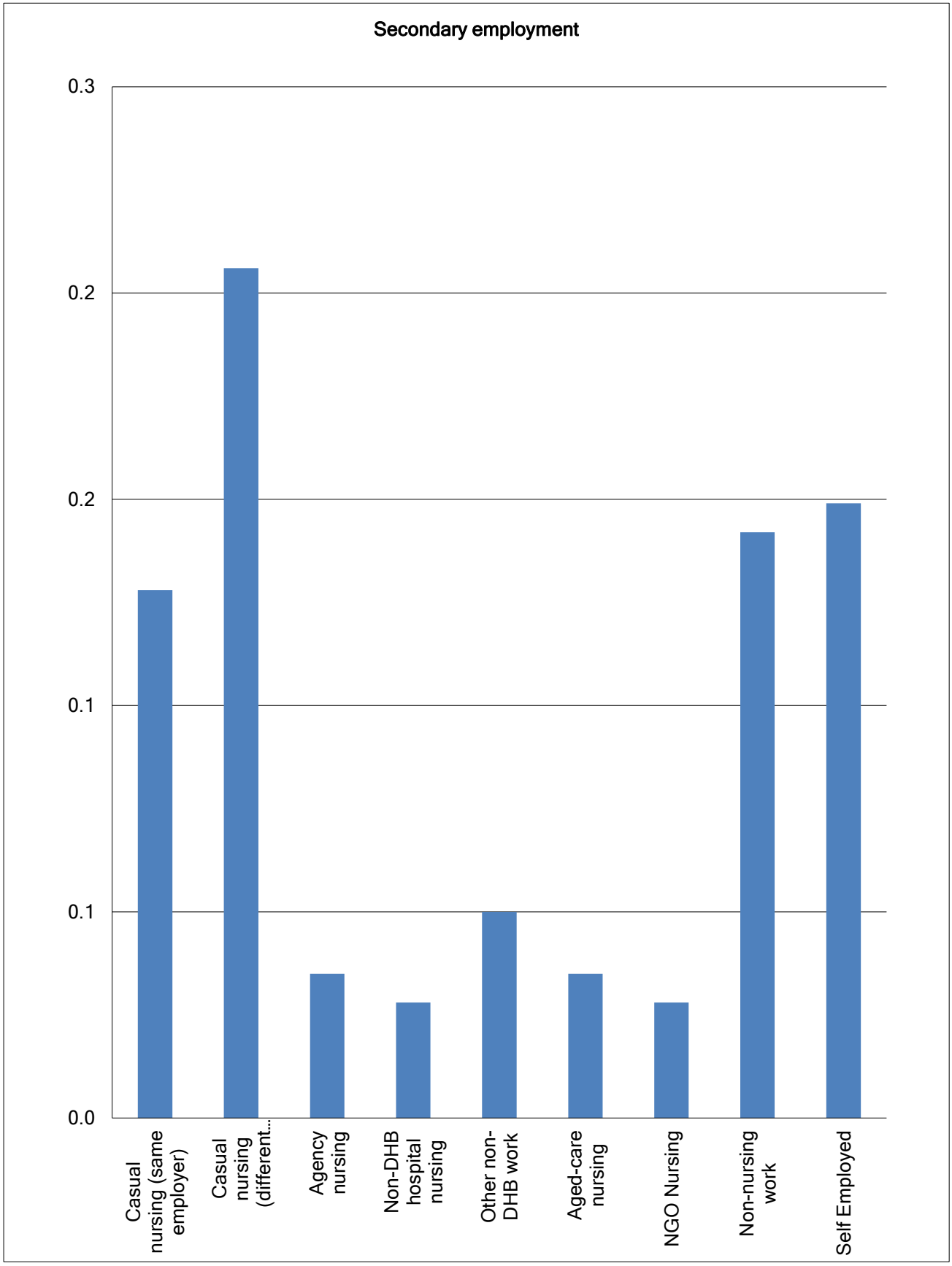
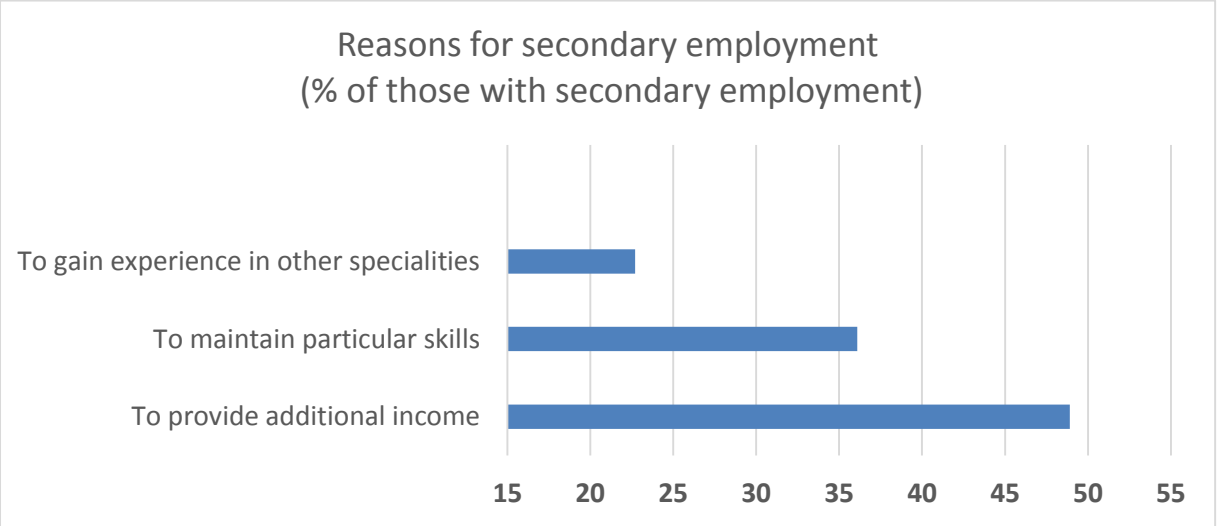


Figure 31. Reasons for secondary employment



A large number of other reasons for secondary employment were also stated – indicating a wide range of other interests, business connections and family reasons, in addition to evidence of retirement preparation.

4.8 Summary

> Rostered and rotating shifts, or daytime only "office hours" remain the commonest work patterns.

> The commonest shift length was eight hours.

> There is evidence of a difference in the age profiles of those doing rostered and rotating shifts, with younger nurses more likely to work shifts.

> Perceptions of the damaging nature of shift work were common, especially for older nurses. This will have to be addressed as the nursing workforce continues to age.

> There was evidence of poor rostering practices contributing significantly to lack of satisfaction with work hours.

> The number of hours worked per week has not changed significantly since the last employment survey, though the numbers of nurses aged over 65 who are choosing to do only one or two shifts per week has increased. This is especially true of the aged-care sector.

> A higher proportion (47 per cent vs 43 per cent in 2013) chose to work additional hours to provide cover. This use of additional hours may explain the reduction in the use of short-term contracts and slight increase in casual hours reported over the same time frame.

> Meal breaks are frequently missed by over a third of all respondents, though this varied by sector.

> Two thirds of respondents had additional responsibilities for mentoring and orientation, and just over half provided preceptorship to student nurses.

> Fifteen per cent of all respondents had a second employer: (no change since 2013). The total available nursing workforce requirements compared to the total number of available and willing registered nurses will therefore be increasingly hard to model with any degree of accuracy.

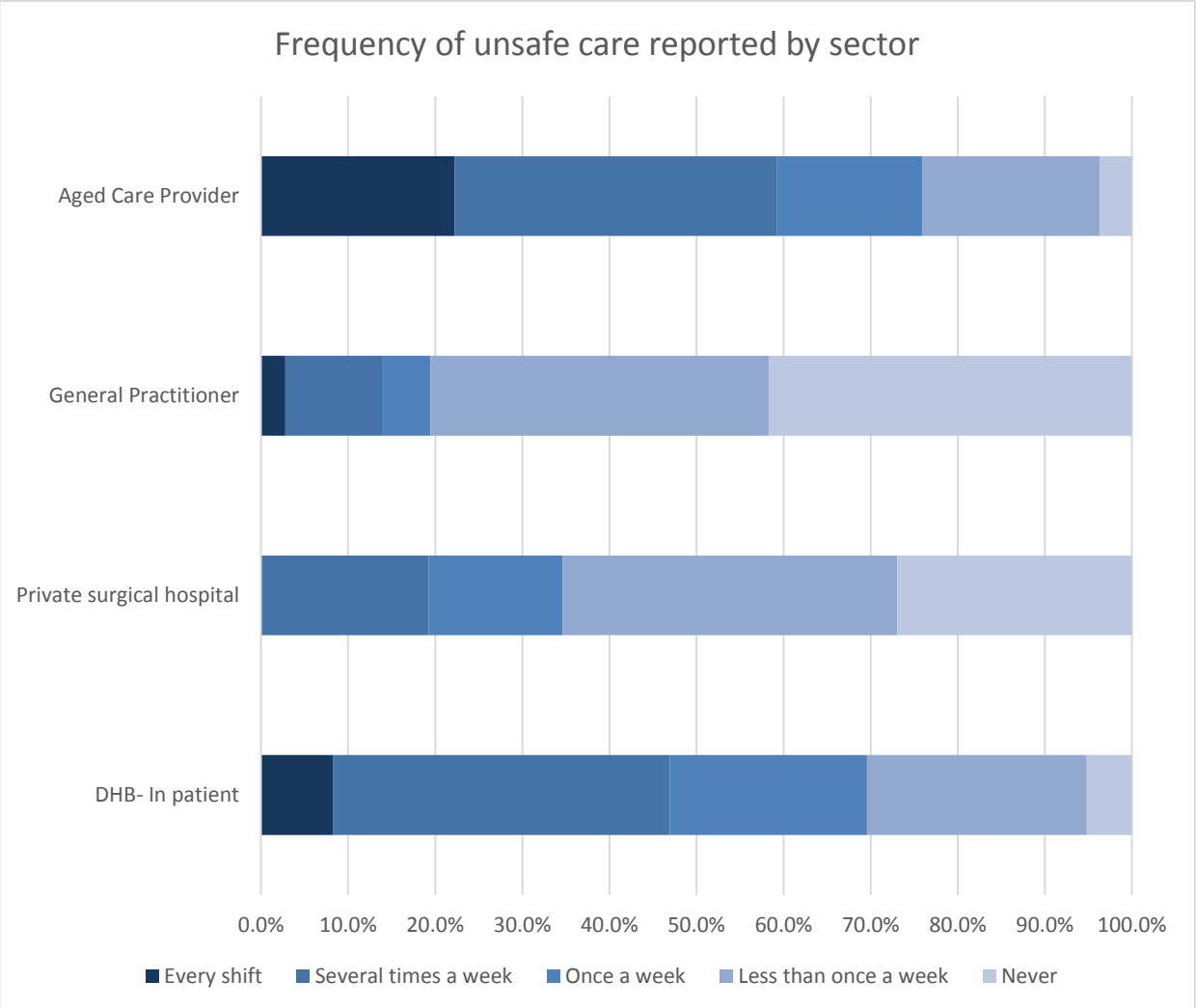
Chapter 5: Workload and staffing

5.1 Perceptions of clinical practice

81.5 per cent of respondents worked in a clinical setting. Responses to a standardised set of factors related to good patient care, replicated from 2011 and 2013 track perceptions over time. Of note, 45.2 per cent (slightly down from 46 per cent in 2013) felt there were enough nurses where they worked to meet patient needs. This remains a concern. This varied by employer, with those who worked in in-patient DHB settings least likely to report enough nurses to provide safe care, aged-care nurses most likely to report too few qualified nurses to provide safe care, and private surgical nurses most likely to report satisfaction with the numbers and skills of nurses to provide safe care.

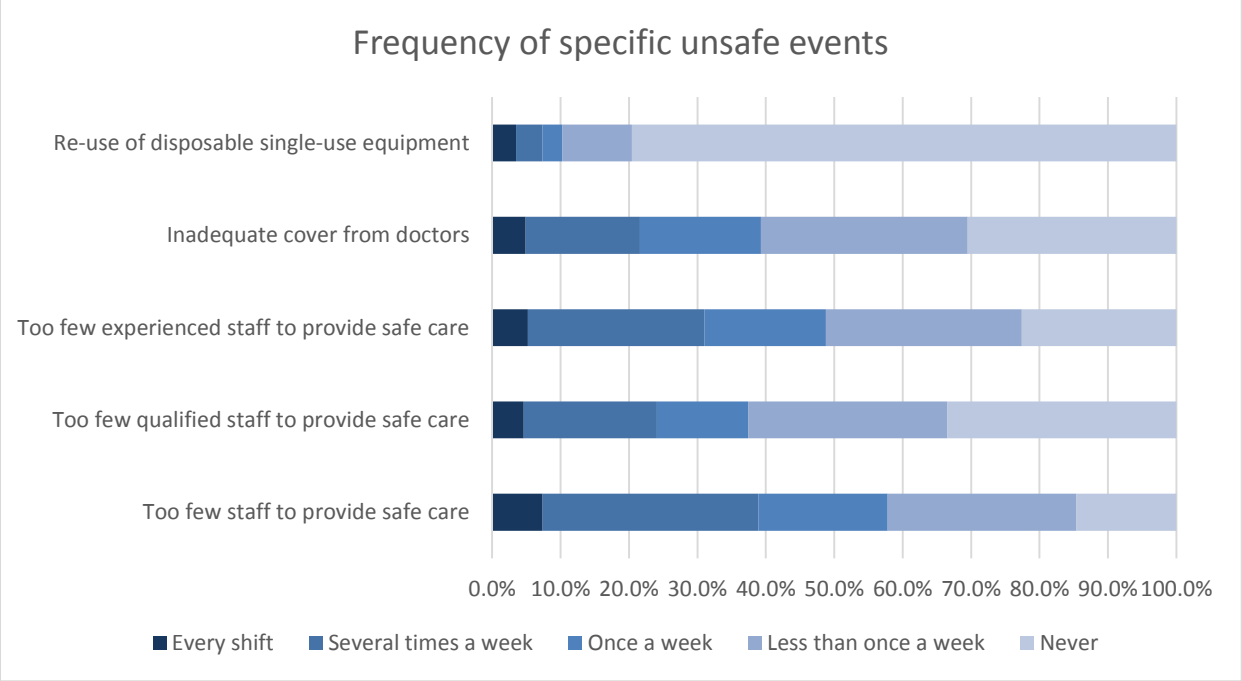
The frequency with which respondents reported there were too few nurses to provide safe care varied by employer. Numbers of respondents choosing each option from each employer type are shown in figure 32.

Figure 32. Respondent perspectives on whether there are sufficient nurses to provide safe care by employment sector



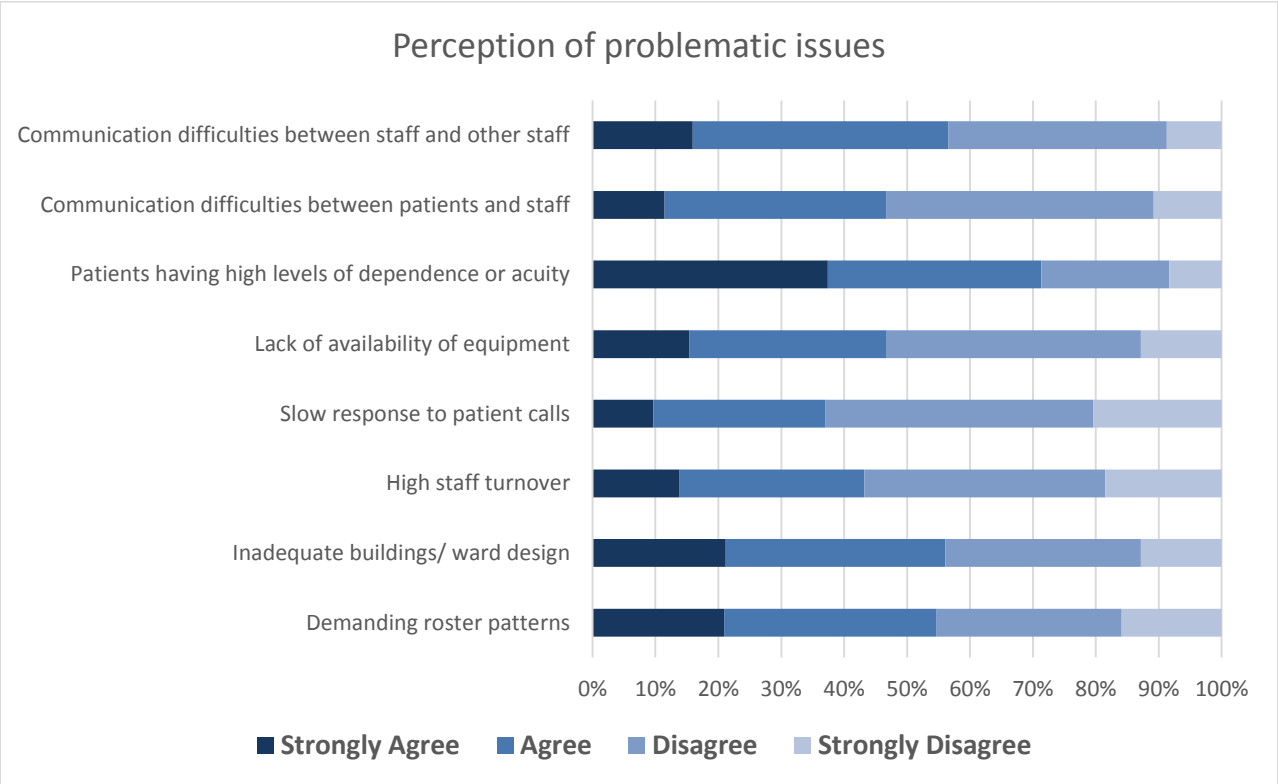
Asked about the frequency of unsafe events, the commonest event was too few nurses to provide safe care, which two thirds of respondents reported. Thanfully, the reuse of single-use equipment was far rarer!

Figure 33. Frequency of unsafe events



Agreement or disagreement about whether the following were issues is shown in figure 34.

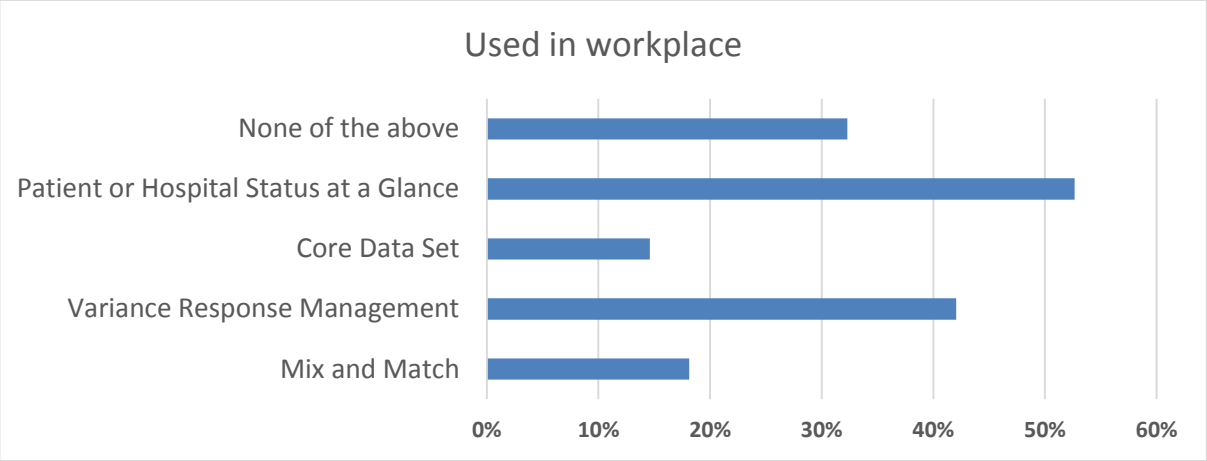
Figure 34. Perception of issues impacting on patient safety



5.2 Care capacity demand management

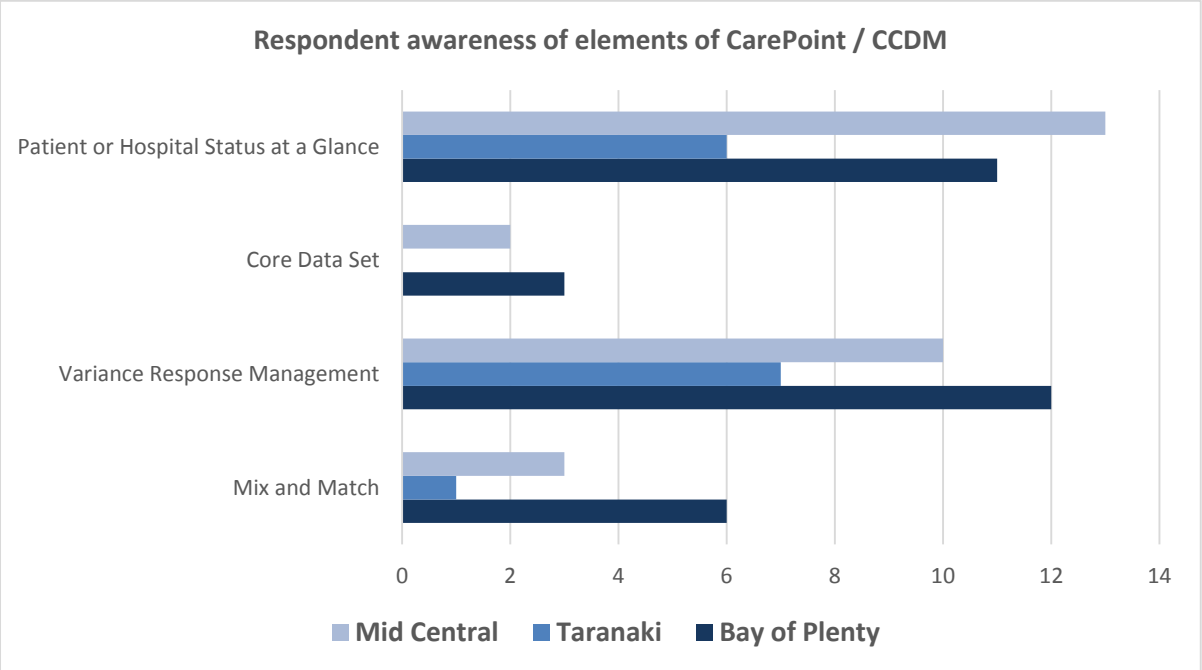
618 respondents who worked in the DHB sector were directed to a suite of questions related to care capacity demand management (CCDM). Thirty-five- and-a-half percent were aware their workplace had a CCDM system in place. This is an increase from 25 per cent since 2013. Questions related to the elements of CCDM show evidence of patchy implementation. These results are shown in figure 35.

Figure 35. CCDM elements



Of the 221 respondents who were aware of CCDM in their workplace, 80.09 per cent used Trendcare, 4.4 per cent used a different acuity tool, 4.09 per cent did not use an acuity tool, and 11per cent were uncertain about whether their DHB used an acuity tool. 33.92 per cent had had training on the use of Trendcare.

Figure 36. Comparison of CCDM implementation in three DHBs



Different respondents also felt it had been of variable benefit. Asked to rate the impact on their workload since CCDM had been implemented, the responses were as shown below (multiple choices means the percentage of each respondent who picked each option is shown, thus the sum does not equal 100).(Changes / no changes in workload might reflect CCDM's introduction before/around 2013)

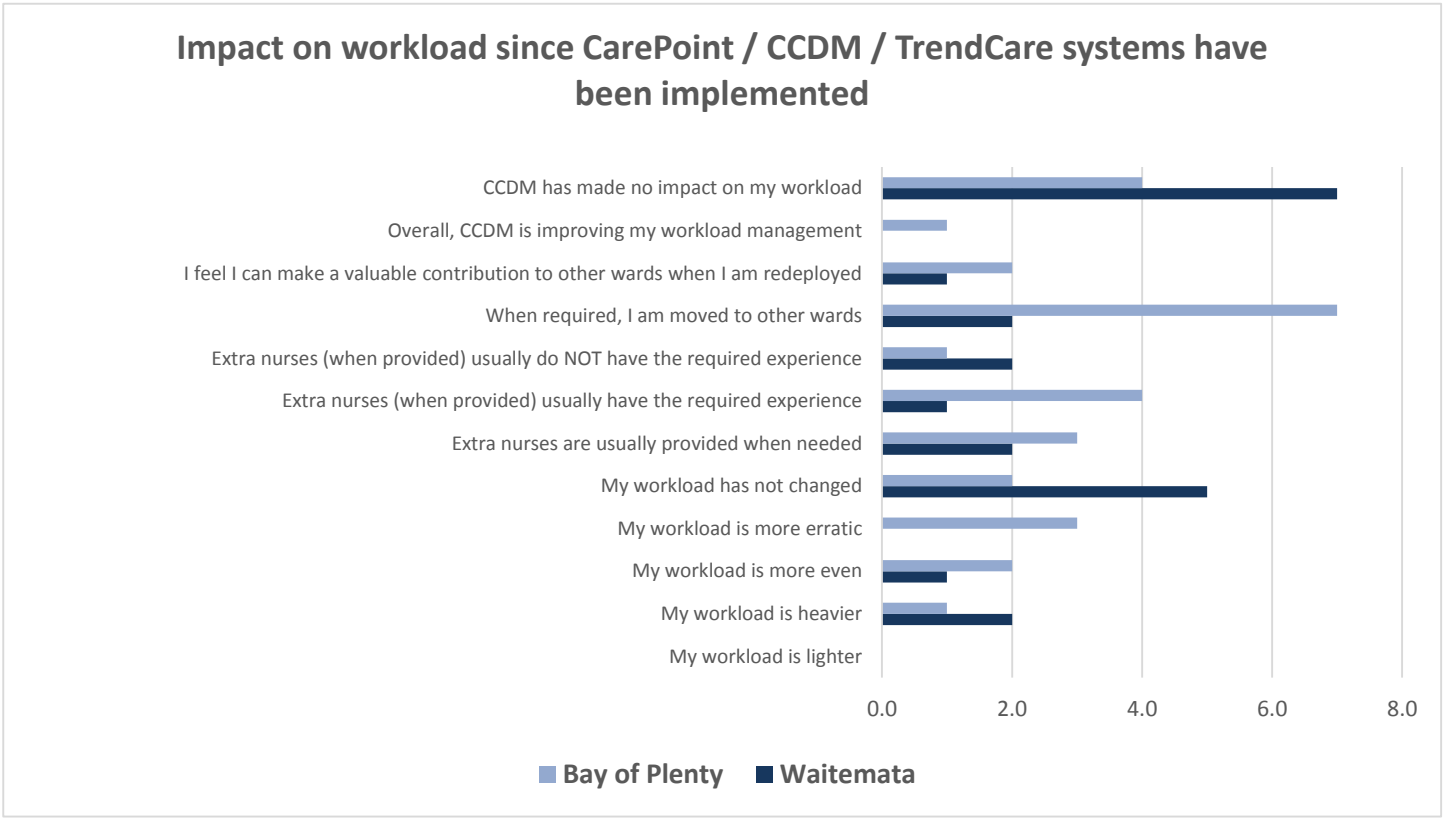
Table 13. Impact of CCDM on workload

Statement	Per cent agreeing 2015	Per cent agreeing 2013
My workload has not changed	50.29	33
My workload is more even	3.43	5.1
Extra nurses are usually provided when needed	8	9.8
My workload is heavier	21.14	9.4
Extra nurses (when provided) usually have the required experience	10.86	8
Extra nurses (when provided) usually do NOT have the required experience	15.43	8.8
My workload is more erratic	13.71	5.5
CCDM has made no impact on my workload	46.29	30
Overall, CCDM is improving my workload management	1.17	3.5

Two DHBs were chosen for comparison – an early adopter (BOP) and a later adopter (Waitemata)

Figure 37. Comparison of CCDM impact in two DHBs

Nb Caution required due to small numbers (<30 respondents from these two DHBs who answered this)



Additional free text comments about CCDM and Trendcare were also made by 91 respondents, both connected with this question set, and in the final comments. There were **no** positive comments about Trendcare or CCDM. The following is very representative of comments made about Trendcare.

Trend care does still not adequately capture our workload. CCDM has made very little difference to how we work.

TrendCare has never reflected accurately what I do on a rostered shift. Administrators use it's stats to remove staff when our TrendCare numbers are low but when they are high, we are often told there is no one available to help. At times our manager has altered our entries (I believe) when he has thought our numbers were too high.

A complete waste of time. More would be gained by managers walking around and seeing the acuity and the staff often struggling to meet patient needs.

Trendcare is extremely time consuming and has taken over as an INEFFECTIVE and unsafe handover tool as it is the main transferring of information rather than an adjunct.

Trend care data does not accurately reflect real workloads It seems to be a tool to justify chronic under staffing. There is rarely time to implement quality initiatives or to reflect on service improvement as any "spare" hours result in staff redeployment.

Is used to take staff away, no matter how heavy you are you never get any extra staff. Doesn't accurately reflect the work load on your ward. They have cut our staff recently due to trendcare saying we need less, now staff are stressed, overworked and moral low, staff leaving, increase in falls and pt and family complaints. Want to replace RNs with ENs so RNs stressed ++++. There will also be less jobs for new RNs as they want to employ more ENs now.

When in a negative variance on trendcare extra staff are very rarely deployed to assist these areas as often across the whole hospital there is a negative varianc.

5.3 Summary

> As in 2013, fewer than half of all nurses working in a clinical area felt there were usually enough nurses to provide safe care.

> There was a perception that patient load, throughput and acuity had risen over the previous two years. This may reflect the use of more objective workload tools including Trendcare.

> The aged-care sector was the most concerning in this regard, with general practice the least under staffed.

> There has been a slight fall in the perception of safe workloads as a general question since 2013.

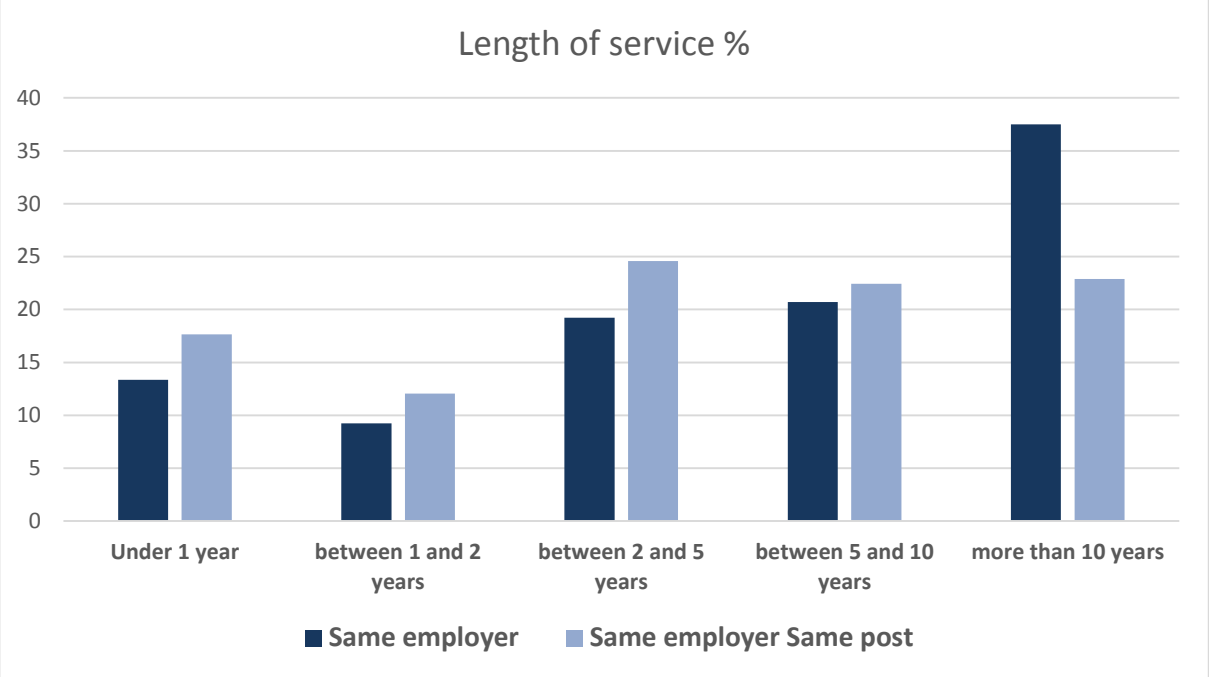
> Knowledge of, and confidence in the ability of CCDM to improve workload is still patchy even in DHBs where it has been rolled out. Considerable scepticism about its purpose and effectiveness exists.

Chapter 6: Job Changes and career progression

6.1 Length of service

Looking at changes both within and between employments, there is evidence of both stability and change. This is explored more fully in the section looking at restructuring.

Figure 38. Length of service



(To explain the legend more fully, more nurses changed posts within the same employer than changed employer)

6.2 Changing jobs

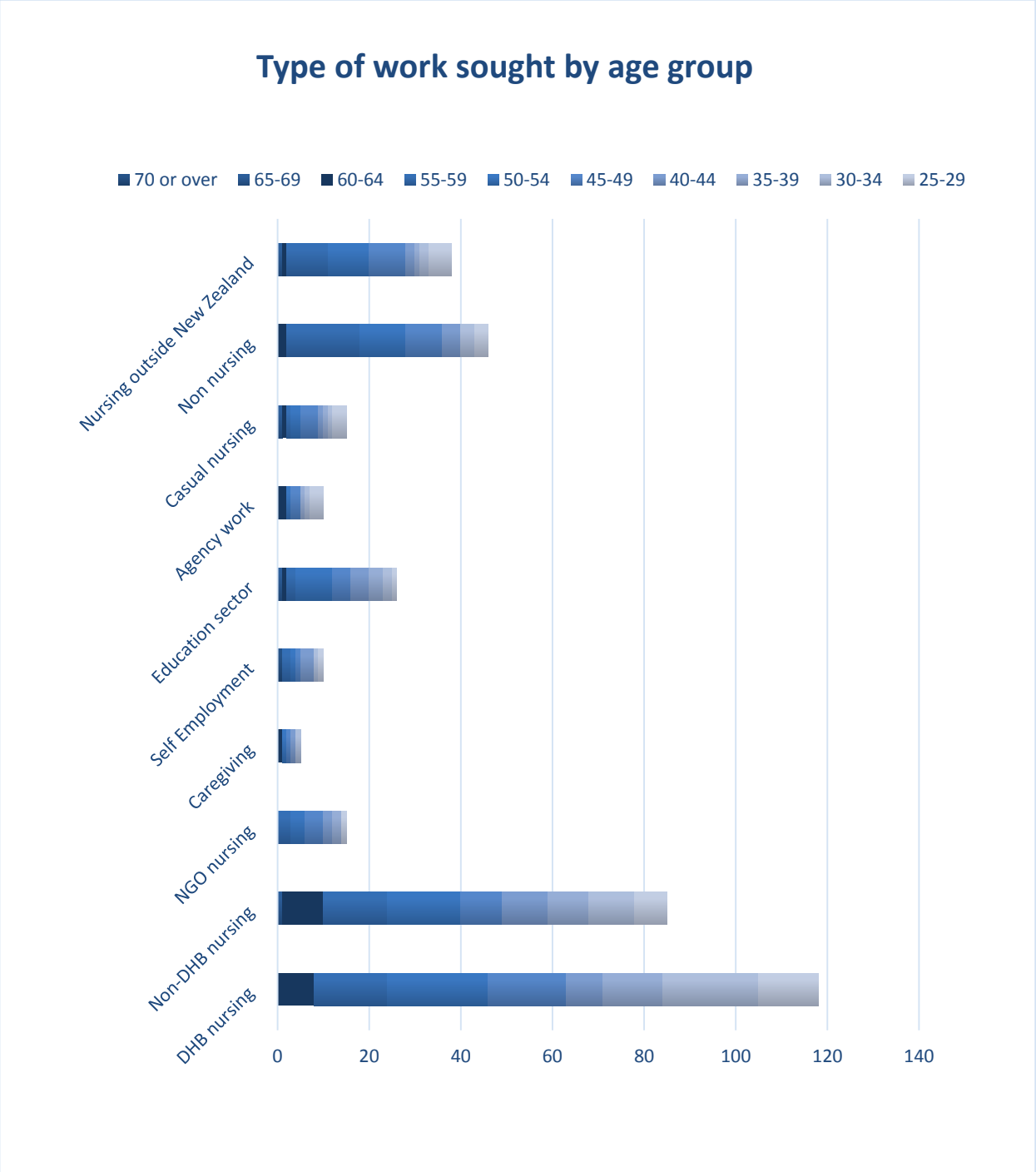
Twenty per cent (down from 26 per cent in 2013) had changed their employment within the previous two years. The reasons stated for changing jobs (in the order of most frequently chosen) are shown below, along with the percentage of the 231 who had changed jobs.

Table 14. Reasons why respondents had changed their job within the previous two years

	Response Percent	Response Count
Better prospects	27.7%	64
Better pay	22.1%	51
Promotion	9.5%	22
Gain different skills	39.8%	92
Change in hours	30.7%	71
Better terms and conditions	15.6%	36
Distance home to work	10.8%	25
Personal/ moving area	14.7%	34
Health problems	7.4%	17
Dissatisfied with previous job	30.3%	70
Stress/ workload of previous job	31.6%	73
Previous workplace closed	0.4%	1
Redundancy	0.4%	1
Redeployment	2.2%	5
Dismissed	0.4%	1
Bullying/ harassment	16.0%	37
Family reasons	9.5%	22
Educational opportunities	16.5%	38
semi-retirement	3.5%	8
Other (please specify)	23.4%	54
	answered question	231

A further 25.6 per cent were currently job hunting (up from 21 per cent two years ago) – both those in employment and those unemployed. While 49 per cent of these sought employment within the DHB sector, of most concern were the 16 per cent considering nursing outside New Zealand, and 18 per cent thinking of leaving nursing altogether. Both these figures are very similar to two years ago. The age profiles of those responding that they were thinking considering job change are shown in figure 39.

Figure 39. Percentage of respondents seeking to change jobs by age (Multiple choices = >100%)

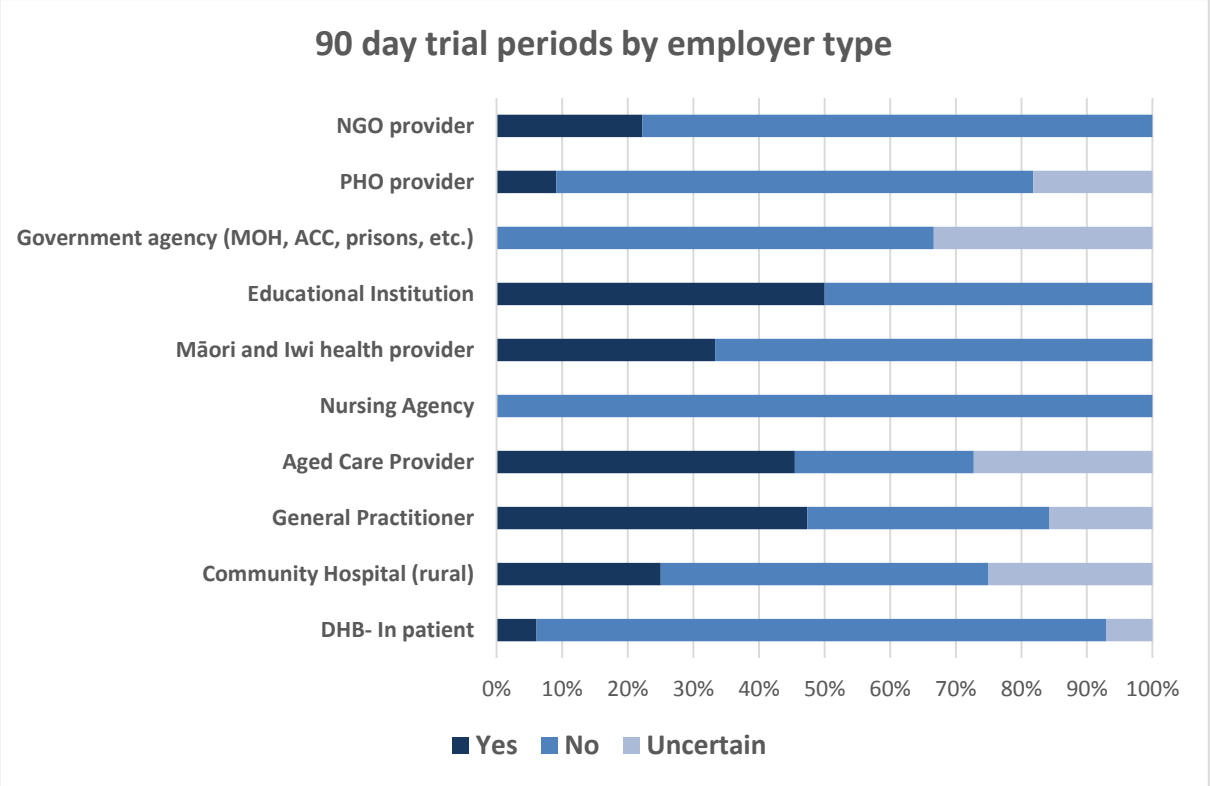


For the purposes of nursing workforce planning, it is essential not to assume that nurses currently aged 50-60 years will be available to nurse in New Zealand. Nurses aged 40-50 are more likely to move to Australia, but even some 26-30 year-old nurses with up to 10 years' experience are thinking of leaving the profession altogether.

In addition, 27 per cent of the 204 nurses who first trained as nurses outside New Zealand were currently job hunting. This compared to 25 per cent of those who first trained as nurses in New Zealand.

Of those who changed jobs, 42 or 17.9 per cent reported their new employer requested they agree to a 90-day trial period as part of the negotiations. The employers requesting a 90-trial period are shown in figure 40.

Figure 40. Respondents who changed jobs who were asked to agree to a 90-day trial period



Neither government agencies nor nursing agencies had requested 90-day trial periods.

6.3 Retirement planning

Nearly one third of respondents intend to retire in the next two to ten years. Table 15 shows these results.

Table 15 Retirement intentions

Answer Options	Response %
I intend to reduce my hours within the next two years or sooner	14.8%
I intend to change to day-time only work options within the next two years or sooner	14.4%
I intend to apply for more flexible work options within the next two years or sooner	15.2%
I intend to retire in the next two years or sooner	2.7%
I intend to retire within the next two to five years	5.8%
I intend to retire in the next five to ten years	21.8%
I have had access to financial retirement planning	12.8%
I am enrolled in Kiwisaver, or another retirement savings plan	76.3%
Other: If you otherwise plan to change your working circumstances, please explain	19.1%

6.3 Summary

> Thirty-seven and-a-half per cent (up from 30 % in 2013) of respondents had worked for their current employers for more than 10 years.

> Twenty per cent (down from 26% in 2013) had changed their employment within the previous two years.

> While gaining new skills or a promotion were frequently cited as reasons for the job change, dissatisfaction, stress and workload were also commonly chosen.

> Nearly one in four nurses is currently job hunting – with half of those looking to nurse outside New Zealand or leave nursing altogether. This included older nurses seeking to join their children and grandchildren in Australia.

> 27 per cent of the 198 nurses who first trained as nurses outside New Zealand were currently job hunting. This compared to 25 per cent of those who first trained as nurses in New Zealand.

> There was evidence across all sectors except the government sector and agencies that employers were asking for 90-day trial periods on uptake of new jobs.

Chapter 7: Organisational change and restructuring

7.1 Organisational change and restructuring

Twenty-seven point four percent of respondents had been affected by significant restructuring in their main employment within the previous two years. (This was up three percent since 2013.) Over half of the restructuring had involved reorganisation within the worksite, or across a wider employer such as an DHB, 27 per cent had involved the loss of senior nursing leadership positions, and 23 per cent involved a reduction of nursing skill mix (substitution of RNs with ENs or of RN/ENs with health care assistants or care givers). Other significant restructurings involved mergers of DHBs, PHOs or general practices, or the sale, privatisation or closing of facilities.

Figure 41. DHB areas most affected by organisational change and restructuring

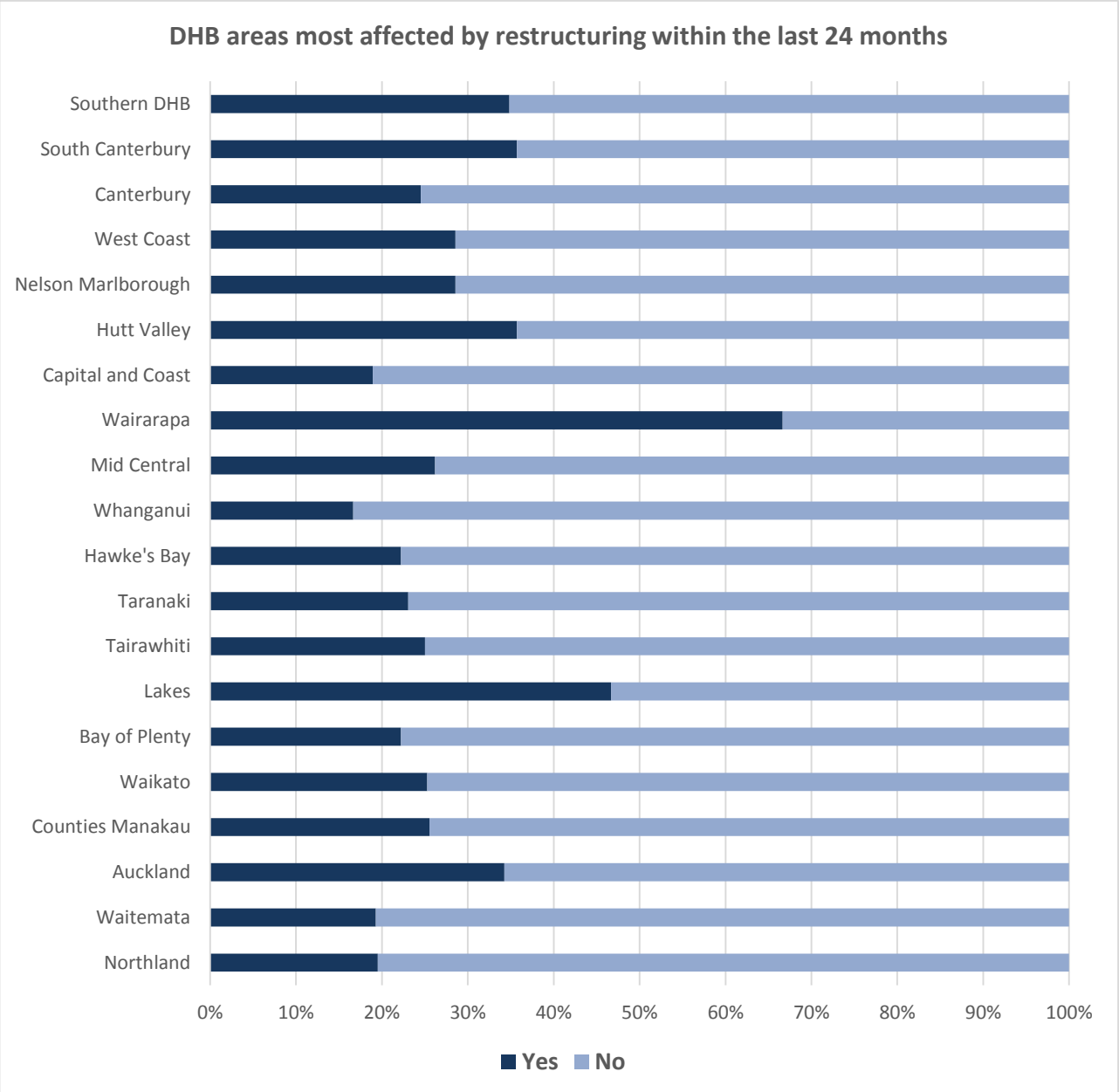


Figure 42. Employment sectors most affected by restructuring

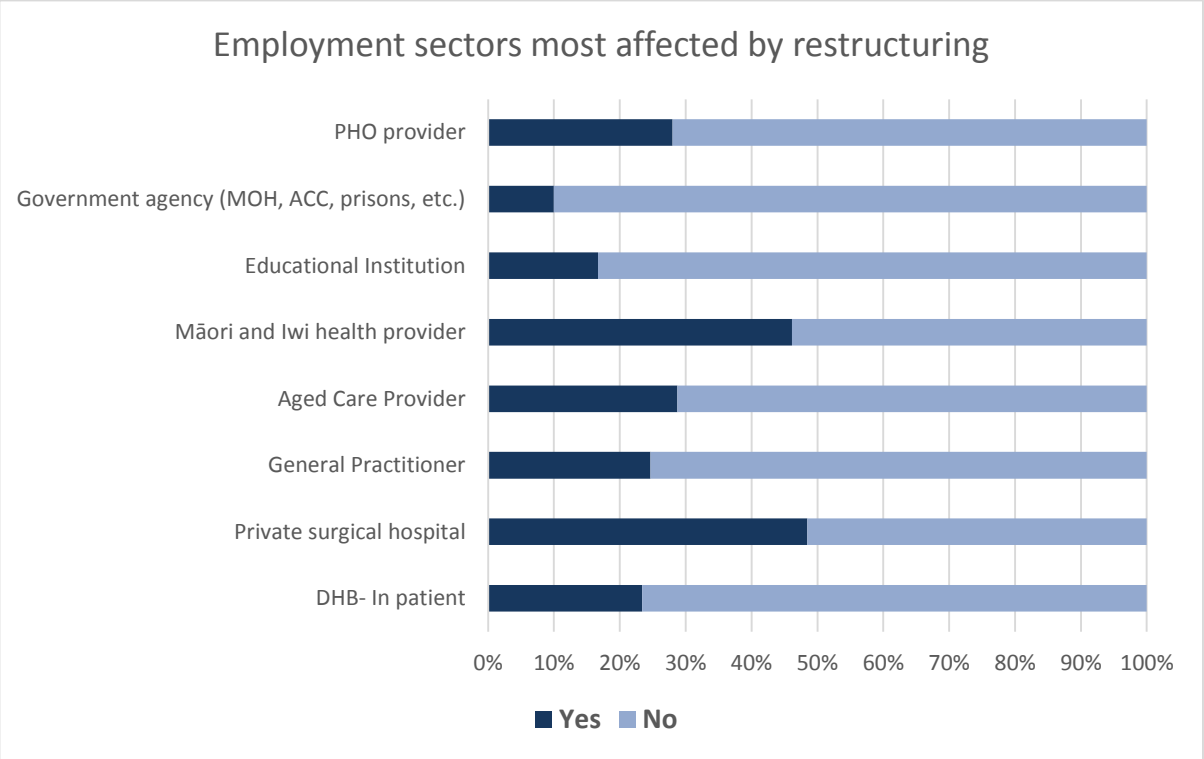
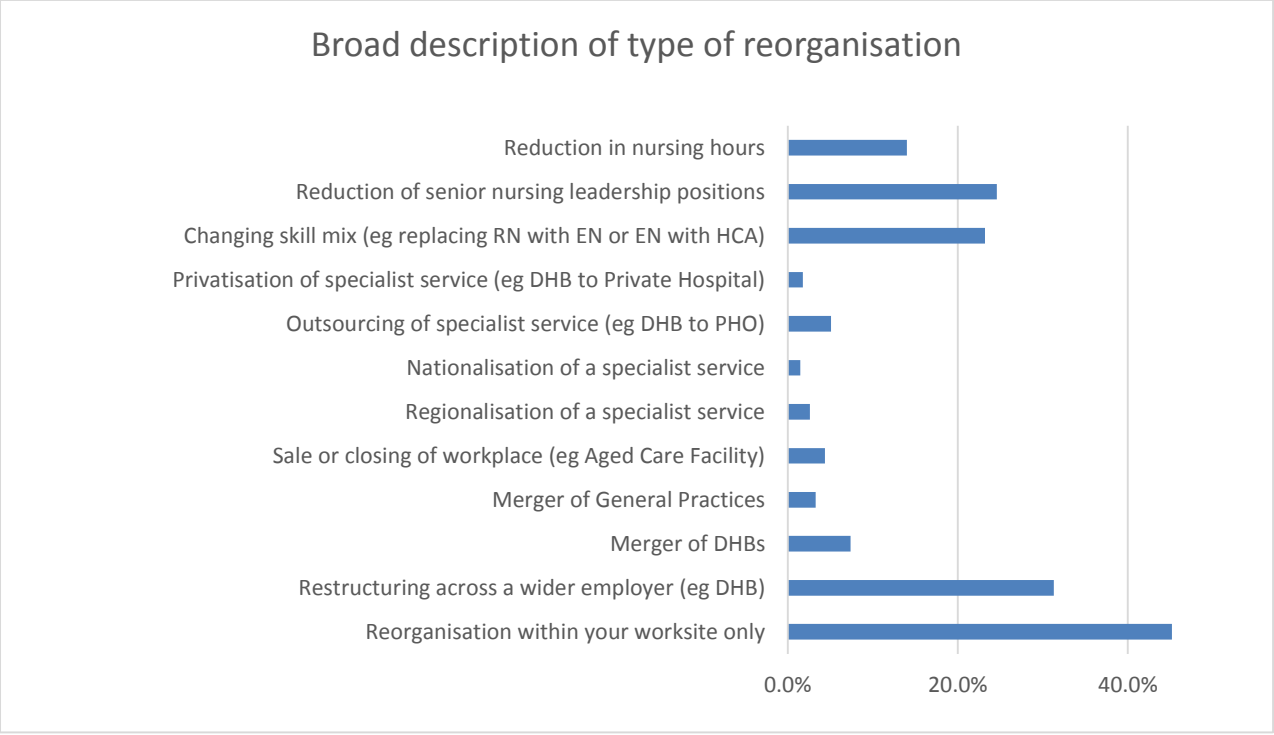


Figure 43. Broad description of the types of restructuring respondents had observed over the previous 24 months.



7.2 Statements related to being affected by organisational change and restructuring

152 free text comments were received related to the restructuring. A few of the representative comments are shown below:

Loss of senior nursing roles (one of the commonest cause of dissatisfaction)

Replacement of nursing positions with generic positions then filled by allied health. Senior experienced nurses demoted, lots of senior staff left as felt unsupported and devalued.

Several senior/experienced staff have left due to work load changes - pressure on staff from management. Replaced by junior staff.

Recently two 24 bed medical wards have joined together to become one 48 bed ward with 1.0FTE CNM and 1.4 FTE ACNM cover instead of 2.0 FTE CNM (1.0 in each previous ward) also completely changing the ways of working, moving towards team based nursing.

I applied for a CNS role which I was covering for on a temporary contract, but it was downgraded to a Specialty Nurse Role and my pay reduced.

Positive comments

My current health advisory role was upgraded and the pay and conditions improved to enable me to transfer from a part time agency post to a full time employee, which actually reduced the overall cost of my role.

Service review and introduction new model of care to improve service delivery to clients.

Less positive comments

It caused the current staff (who got along and made to work environment enjoyable) to leave as they were not being heard by the new management.

the nursing management was changed and rostering taken away from ward to the management in which they don't have the understanding of the mix and preferences of staff eg whether they enjoy pm or am duties better don't work with the staff to make it a better place.

management decided to 'restructure' to follow what has happened in another area of the organisation. We were told that there would be sufficient jobs for those that were disestablished but this is not true. Significant stress associated with the process.

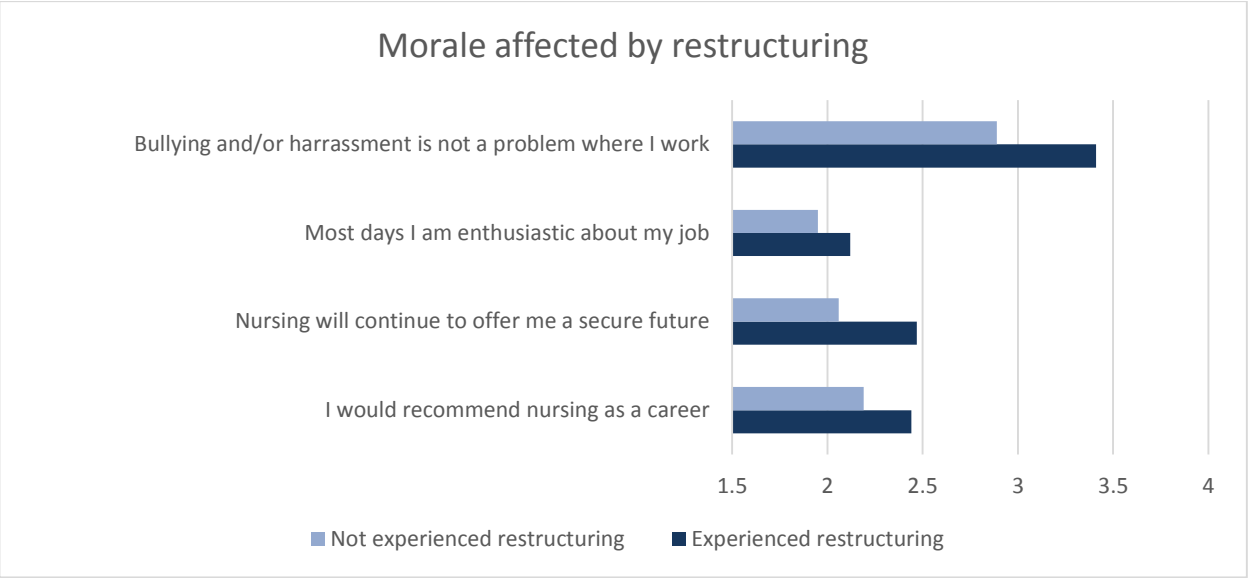
Constantly on the edge of restructure, unsettling, occurs every three years, with little of no progress from the last restructure. We waited for over a year for the last one which was very unproductive for everyone as they didn't know if their jobs were save and it halted project progress.

Combining services and loss of senior positions and nursing hours, replacing both with less qualified & experienced staff.

Changes not related to the categories above included:

Reduction of overtime for staff that work in my area of work and employing bureau that are not familiar with the area, changes to model of service and DHB contracts.

Restructuring of DHB mental health services.



The larger the number, the more negatively viewed the item was.
There was evidence that those who reported experiencing restructuring were less positive in their general morale and career confidence. However, there were also some contradictory differnces in other morale items such as perceptions of workload, or fears of redundancy: this might relate to *fears* of impending restructuring, whereas those who had come through the process were more secure in their jobs.

7.3 Summary

> 27.4 per cent reported significant restructuring in their main employment within the previous two years.

> Of these, nearly a quarter had involved the loss of senior / clinical nursing leadership positions.

> Nearly half stated that the restructuring was within their own worksite, while a third were across a wider employer, or caused by employer mergers.

> 23 per cent reported a reduction in the nursing skill mix (up from 18 per cent in 2013).

> Restructuring affected all sectors, and all DHB areas.

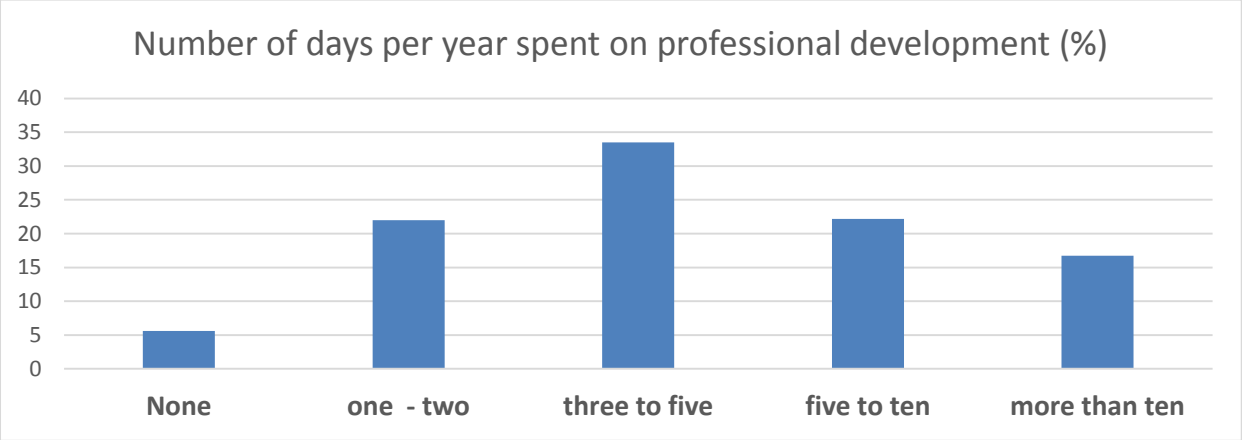
> Restructuring and reorganisation contribute s to loss of morale and confidence in employment.

Chapter 8: Continuing professional development, education and qualifications

8.1 Continuing professional development

The majority of respondents spent between one and five days per year on their professional development. Of this, most was fully supported by their employers.

Figure 44. Number of days spent on professional development



Looking at days professional development by employer type:

Figure 45. Days per year professional development by employer

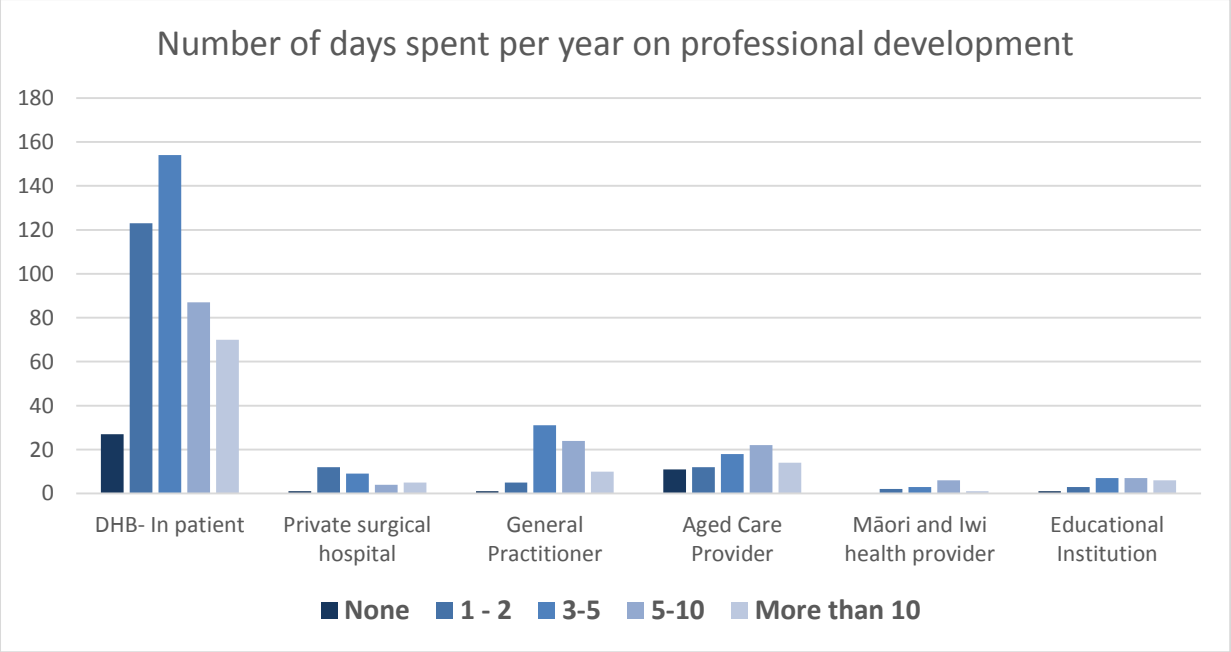
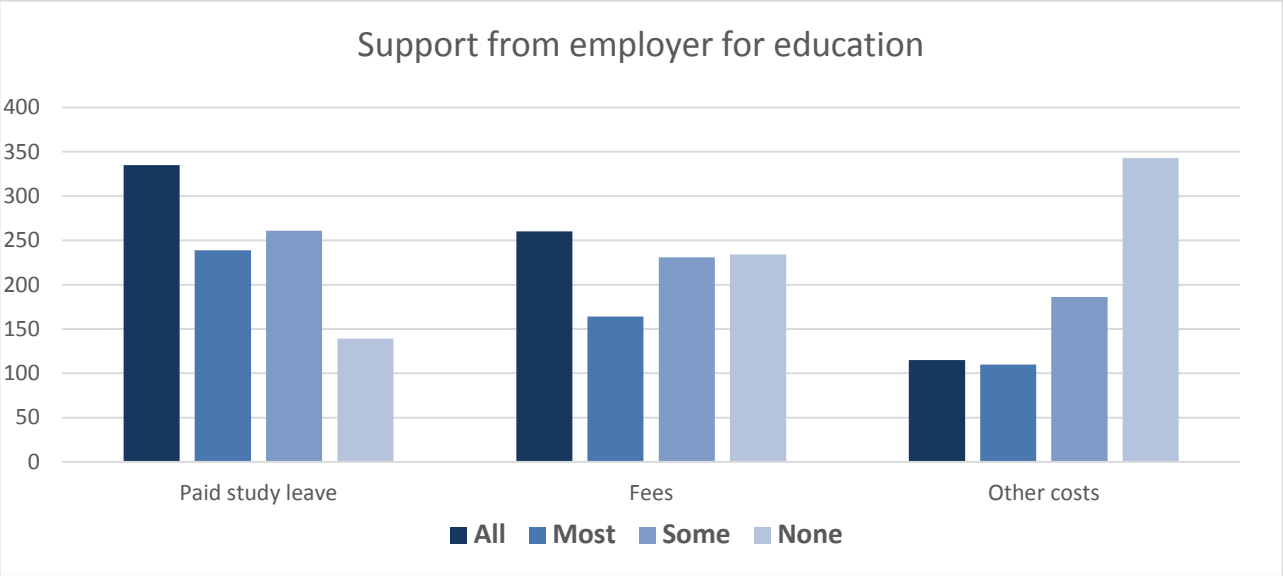


Figure 46. Employer support for professional development



Respondents from aged care providers were least likely to have paid time for professional development (41 per cent had no paid time compared to four per cent of those in educational institutions having no paid time) 55 per cent had none of their fees paid (compared to 29 per cent of those who work in private surgical hospitals getting none of their fees paid).

Comments from DHB employed respondents were particularly despondent – the following are representative:

> *We get very little funding support from our DHB. Doctors go on half day trips to Hawaii with their golf clubs for a week and it is fully funded. We have to fight for fees but get nothing for accommodation or travel.*
>
> *Most professional development (including core competencies) is done on days off now due to lack of availability of paid study days and staff cover.*

Although, more promisingly, from a practice nurse:

> *Employer paid for all five nurses to attend NZNO CPHCN conference in August this year.*

Fifty-six per cent reported having had an appraisal within the previous year. This compared to 64% in 2011. No pattern by employer was seen. A further 13 per cent had had an appraisal within the previous five years and 8.8 per cent had never had an appraisal. All these figures are markedly worse than 2013.

Of the respondents, 55.6 per cent had professional development recognition programme (PDRP) plans (up from 49% in 2011) and of these, 40 per cent had their manager's involvement in setting their PDRP.

Thirty-four per cent had had access to a timely PDRP portfolio review. A further 15 per cent had had a review, but timing had been an issue, and a further 22.5 per cent had not had a review, but needed one.

Twenty-three per cent had had recent access to career planning.

Asked what educational opportunities they had undertaken in the last three years to meet the professional development requirements of the Nursing Council, the largest categories were in-service training, followed by short courses and seminars. Within the last two years, 43 had undertaken, or were in the process of undertaking, masters study.

Table 16. Continuing professional development options and percentage undertaken

Options	Percent	Count
Nursing undergraduate papers	5.3%	52
Nursing graduate papers (level 700, post registration)	8.2%	81
Nursing post graduate certificate (level 800 papers)	12.5%	124
Nursing post graduate diploma (level 800 papers)	7.2%	71
Nursing masters	4.3%	43
Nursing PhD / research	0.3%	3
Interdisciplinary/ postgraduate papers/ qualifications (level 800 papers)	1.2%	12
Short courses	55.6%	550
Seminars	49.0%	485
Conferences	44.1%	436
In-service education	84.8%	839
Journal reading within a formal framework (eg. journal club)	15.3%	151
Writing journal articles	2.9%	29
Presentations to colleagues	35.3%	349
Non-nursing undergraduate papers	1.8%	18
Non-nursing graduate certificate	1.0%	10
Non- nursing postgraduate certificate	0.8%	8
Non-nursing postgraduate diploma	0.5%	5
Non-nursing masters	0.4%	4
Other (please specify)	6.4%	63

(Totals exceed 100 per cent as multiple options could be chosen)

The biggest barriers to completing the professional development requirements are shown in Table 17.

Table 17. Barriers to completing professional development requirements

Options	Percent	Count
Difficulties attending in work time	52.0%	449
Difficulties taking time off work even in own time to attend education/training	35.9%	310
Lack of support/encouragement by employer	22.7%	196
Shift work patterns a factor	31.4%	271
Part-time hours of work a factor	14.6%	126
Own motivation to complete	23.5%	203
Reluctance to complete work-related education / training in own time	26.7%	231
Cost to employer in fees	16.7%	144
Cost to self in fees	44.2%	382
Other time commitments	39.1%	338
Time and distance to travel for education/training	28.6%	247
Lack of confidence about the information technology skills needed	9.7%	84
Access to computer-based resources to complete assignments	5.0%	43
Concern about own ability to complete assignments	14.6%	126

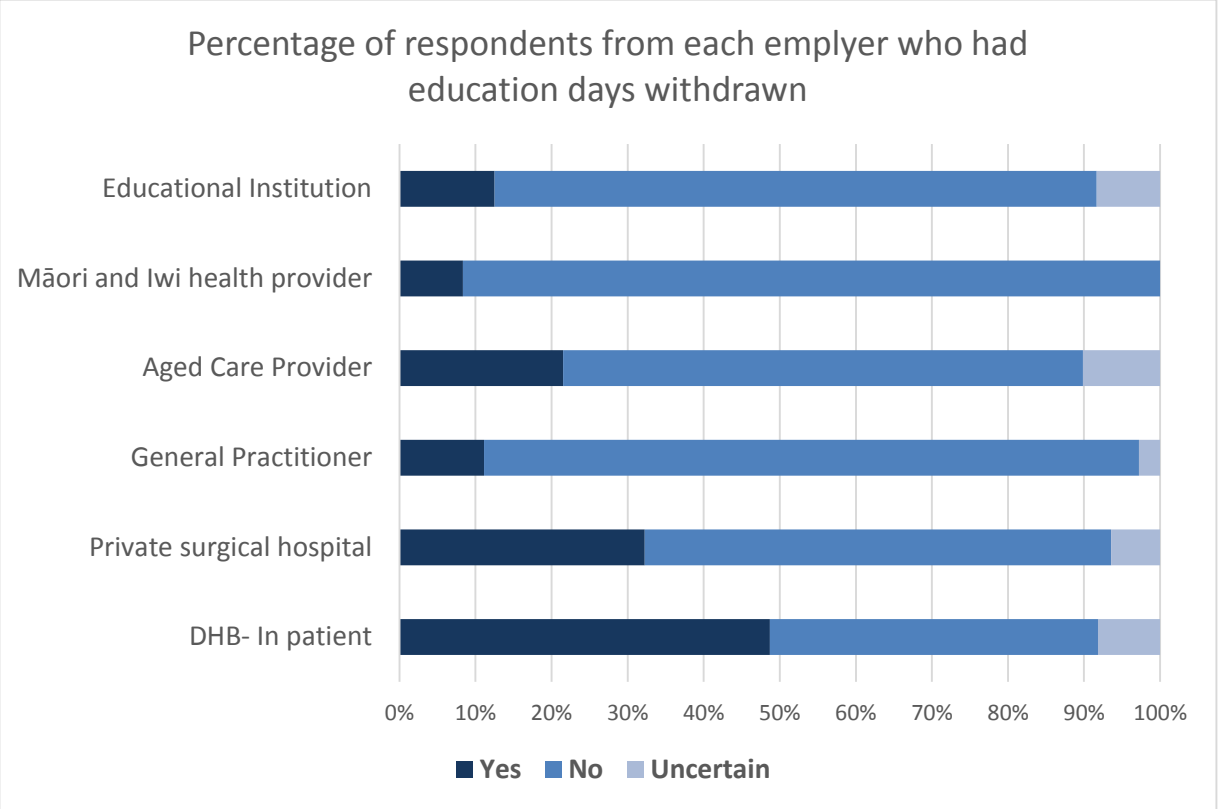
Over 37 per cent (up from 32 per cent in 2013) had had education days withdrawn or cancelled in their workplaces. This is shown graphically by DHB area in figure 47.

111 free text comments related to education were received. Many attested to the difficulties of studying on top of full-time work, travel and family commitments. The additional costs in time and petrol for rural nurses, and for parents of young children in child care was also a frequent concern. There were noticeably more comments related to on-line learning than have been received in previous years.

Some older nurses felt they were disadvantaged in funding applications compared to younger colleagues, due to their age alone, and many commented that funding and time release was less accessible than previously.

Very many comments related to a perception that PDRP portfolio preparation was overly bureaucratic and “tick box” and that, particularly for part-time or returning to work nurses, the requirements seemed out of proportion.

Figure 47. Education withdrawn by employer



Examples of responses related to professional development

Internet access for online training (are provided), educational scholarships and a good range of internal training provision also available.

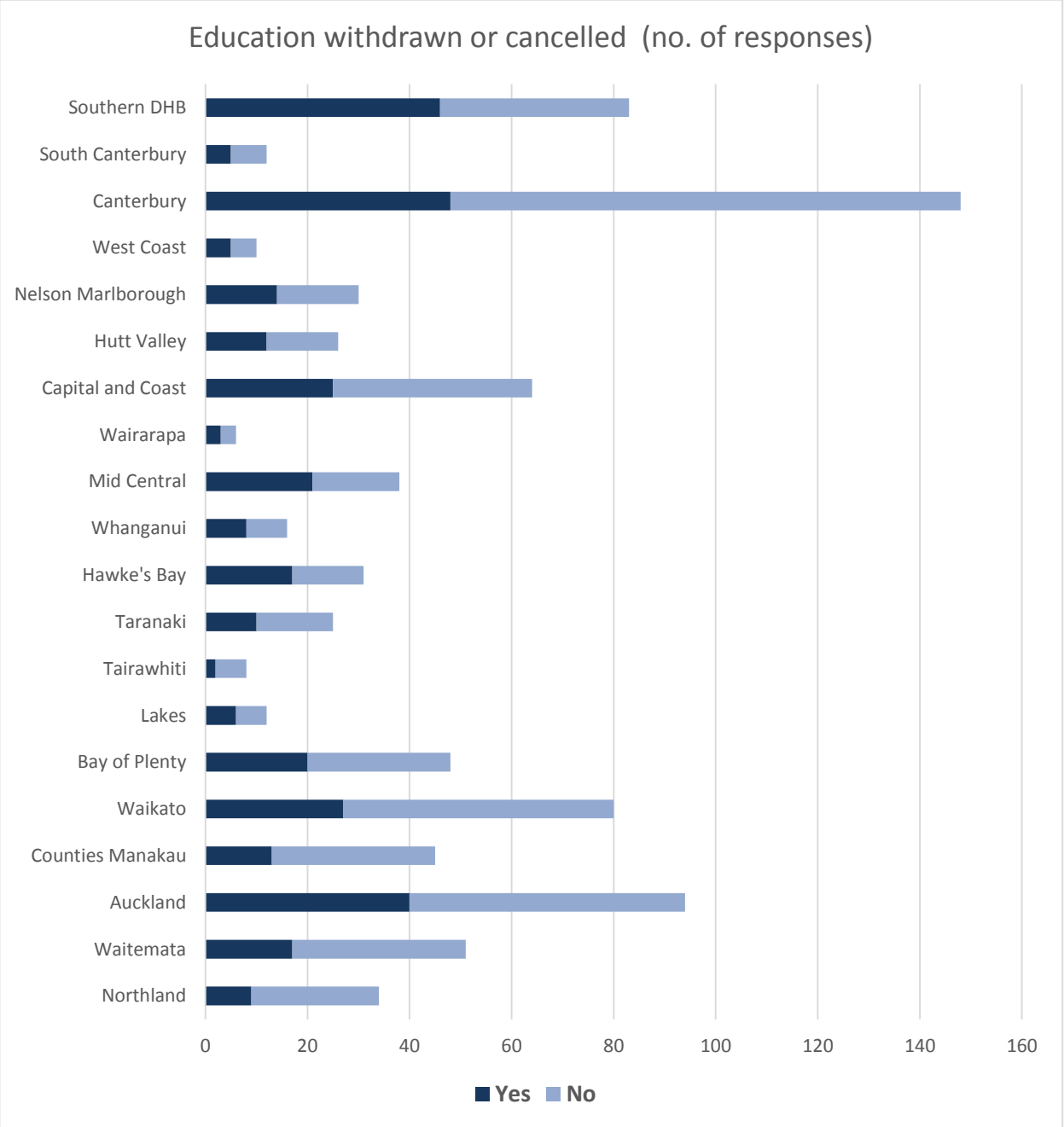
There is a lengthy process to apply for paid leave / cost. Often it is not addressed timely and the 'early bird' is no longer applicable, the employee than ends up paying. Most education is in the evening and that is not reimbursed in time or cost.

I have been encouraged to become a lactation consultant for my ward, yet when I asked for a) financial assistance to cover course fees b) more hours working with lactating mothers in other areas of the hospital c) paid hours in the community to gain the necessary clinical hours d) attend breastfeeding study days e) attend paediatric conference where relevant topics would be covered - ALL were declined. I am completing my lactation studies as my own expense in my own time.

All study days are paid for by me and done in my own time. If I have a study day to go to I have to ring in sick to be able to go in order to maintain the amount I need each year for my practising certificate

I applied for day off to attend a study day as it was a rostered day for me. It was declined. I needed to do the prof development hours and was getting pressure from nursing council. THAT'S THE MAIN REASON I LEFT. We have a mandatory update for client assessment every 2nd year. I am nearly due for next update and still haven't been re-embursed for previous update (online test). Nurse manager only lets her 'chosen' RN's attend education. I mostly have to go on days off or I will not achieve requirements for PDRP. Assessments have been 'down graded' by NM and I have stopped updating.....Won't get funding for studies unless I do courses our DHB wants us to take.....even if they ARE relevant to my field of expertise

Figure 48. respondents reporting that education had been withdrawn by DHB area



Shown as percentages from each DHB:

DHB	% YES	DHB	% YES	DHB	% YES	DHB	% YES
Northland	26.5	Bay of Plenty	42	Whanganui	50	Nelson M	46.6
Waitemata	33.3	Lakes	50	Mid Central	55.2	West Coast	50
Auckland	42.6	Tairawhiti	25	Wairarapa	50	Canterbury	32.4
Counties M.	29	Taranaki	40	Capital & Coast	39	S. Canterbury	42
Waikato	51	Hawke's Bay	55	Hutt Valley	46	Southern DHB	55.4

8.2 Qualifications

New Zealand nurses are highly qualified, with many holding graduate and postgraduate qualifications.

Table 18. Qualifications of respondents (number)

Qualification	Percent	Count
Enrolled nursing qualification	8.0%	81
Registered General Obstetric Nurse (hospital-trained)	29.3%	298
Registered Psychiatric Nurse	3.4%	35
Diploma in Nursing	20.5%	208
Bachelor of Nursing or equivalent nursing degree, eg Bachelor of Health Science (Nursing)	48.1%	489
Masters (nursing related)	7.1%	72
PhD	0.3%	3
Postgraduate Diploma	17.0%	173
Postgraduate Certificate	25.4%	258
Plunket Certificate	1.7%	17
Graduate Certificate	2.6%	26
Diploma of Advanced Nursing	3.2%	33
Caregiving qualification	4.4%	45
Other (please specify)	11.2%	114

The biggest category of other qualifications related to postgraduate midwifery study, and to non- nursing related qualifications.

8.4 Summary

> The New Zealand regulated nursing workforce is highly qualified, with over half having at least one postgraduate qualification, many having several.

> Most employers are allowing three to five days paid professional development time (this was four to six in 2013). Most registered nurses do at least twice this amount per year in their own time.

> Professional development opportunities ranged from university level 800 papers to conference attendance and journal article writing.

> The most commonly taken opportunities were in-service training and short courses.

> Barriers to further professional development include the time and cost, particularly (including distance) for rural nurses.

> Over 37 per cent had had education days in their workplaces withdrawn or cancelled. This is a 4 per cent increase on 2013.

> Education days had been withdrawn by employers in all sectors, and all DHB areas. For some, workforce shortages mean that obtaining the study leave cover is a significant barrier.

Chapter 9:

Health and occupational health and safety

9.1 Health of nurses

The survey utilised three items from the EQ5D-3L survey to explore nurses' self-rating of health-related quality of life, including a role function scale, a pain and discomfort scale, and the EQ VAS (EuroQol Visual Analogue Scale) – that generates a self-rating of health-related quality of life where the endpoints are labelled "Best imaginable health state" and "Worst imaginable health state" (Szende & Williams 2004). Overall, respondents gave very healthy scores for being able to perform their usual functions, and having no or moderate pain or discomfort.

Figure 49. Two-Item scores: physical and role function (number of nurses)

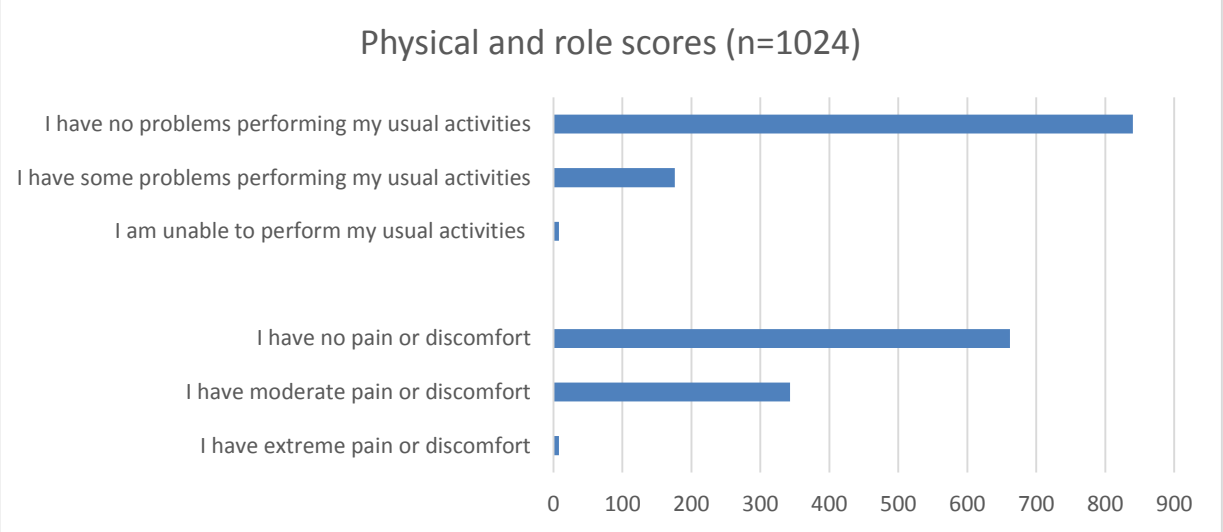
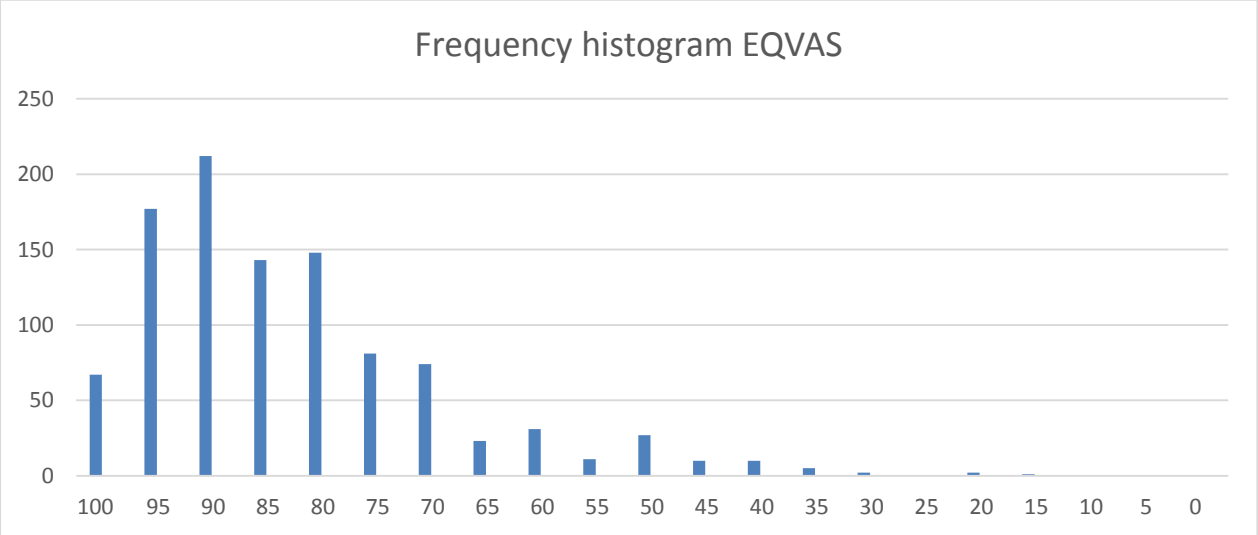


Figure 50. Distribution of self-rated health score EQVAS:

(100= best imaginable health, 0= worst imaginable health)



These varied by age:

Table 19. EQVAS scores are shown below for each age group

EQVAS	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69
100	4	3	4	6	2	10	19	11	3
95	9	13	11	14	21	28	35	33	9
90	7	11	15	23	30	38	38	27	13
85	11	8	5	4	20	28	31	14	10
80	15	10	9	13	13	29	26	16	9
75	3	5	6	7	9	21	9	15	5
70	3	3	7	8	16	16	9	6	2
65	3	1	1	1	4	3	5	1	0
60	2	5	4	1	5	4	6	3	0
55	1	0	0	3	3	0	4	0	0
50	2	3	0	4	2	3	11	2	0
45	2	1	0	2	1	1	2	0	0
40	1	1	1	1	0	1	2	1	0
35	0	0	1	0	1	1	1	0	1
30	1	0	0	0	0	0	1	0	0
25	0	0	0	0	0	0	0	0	0
20	0	0	1	0	0	1	0	0	0
15	0	1	0	0	0	0	0	0	0

It can be seen that those with the overall perception of being healthiest are the 30-40 year-olds. Above the age of 41, most nurses over 60 still in employment perceive their health as progressively better, even up to the age of 70 than their age cohort for NZ women. Note: the numbers over 70 were **very** small.
The implications for workforce planning (health, retirement intentions and attitudes to shift work) of the increasing age of the New Zealand nursing workforce have been extensively researched and reported recently. A full list of references to this work can be found in the reference list at the end of this document.

9.2 Smoking status

Table 20. Smoking status of the largest ethnic groups of respondents

	never smoked	ex-smoker	cutting down / quitting smoking	smoker	Total
NZ Māori	**33.33%** 22	**51.52%** 34	**9.09%** 6	**6.06%** 4	66
NZ European	**59.69%** 456	**34.16%** 261	**3.53%** 27	**2.62%** 20	764
Other European	**53.33%** 56	**37.14%** 39	**5.71%** 6	**3.81%** 4	105
South East Asian	**69.57%** 16	**21.74%** 5	**4.35%** 1	**4.35%** 1	23
Indian	**81.82%** 18	**13.64%** 3	**4.55%** 1	**0.00%** 0	22
Total Respondents	**544**	**322**	**39**	**27**	**932**

This shows continued progress reducing smoking, especially among Māori nurses (see Wong et al. (2007) and Gifford et al. (2013) for more discussion on this).

9.2 Occupational health and safety

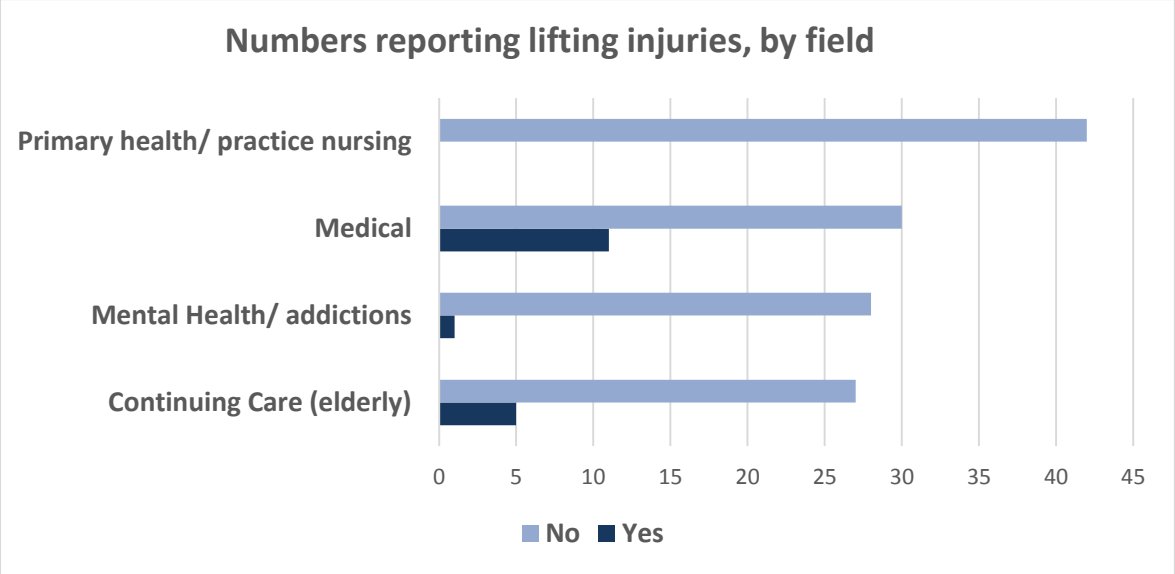
Summary

In the previous two years, 20.57 per cent (208) of respondents reported an occupationally - acquired infection or a workplace injury. This is a 100 per cent increase compared to 2013. Of these, 55 were injuries, and 153 infections. Of the injuries, six per cent were related to heavy lifting, 5.05 per cent related to work place violence. Nearly 10 per cent required time off work with a workplace-related infection, and 13 per cent were referred to the ACC. The commonest infections were flu or norovirus infections, A worrying fifteen (1.5 per cent) reported injuries caused by assaults on staff by patients, and one reported a needle-stick injury. Injury rates were slightly higher for those working 12 hour shifts (31%) compared to 8 hour shifts (25.7%).

Results for four different fields of practice are shown for each category.

Lifting injuries:

Figure 51. Lifting injuries



The following are very representative of responses from 55 people injured in lifting accidents

A manual handling event of rolling a 120 kg pt for a change of incontinence product & linen change resulting in a pulled a muscle in my shoulder. There were 4 people assisting with the move.

Operating theatre has many heavy/ cumbersome items that need to be lifted or moved around. The size of theatres is also an issue when crowded with equipment (& staff!) which creates difficulties getting around spaces. Crate weights are being addressed very well, but we still suffer many bruises & knocks in a day.

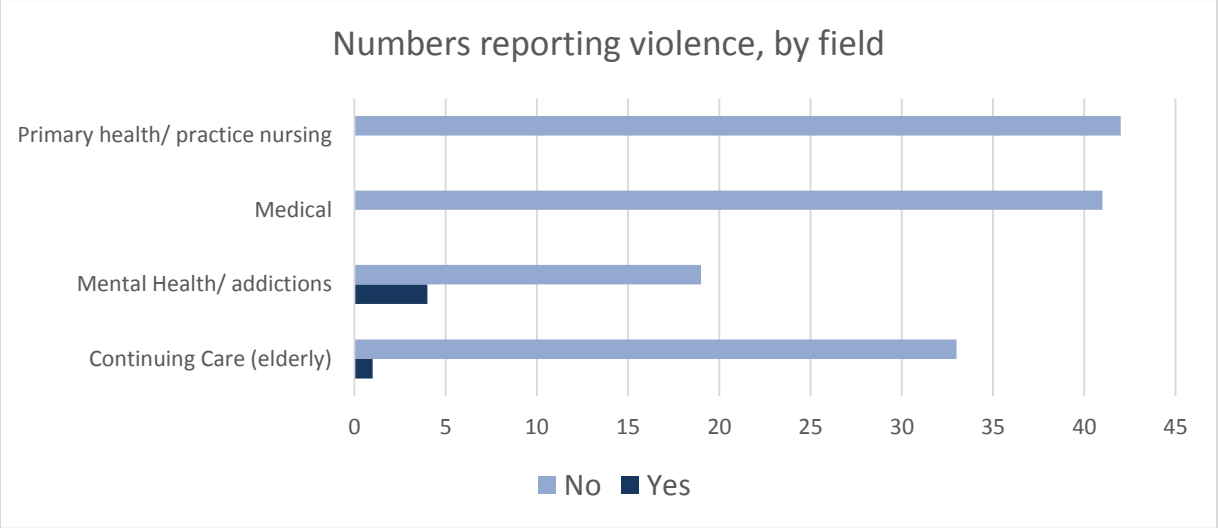
Ongoing lifting of heavy patients without suitable or adequate equipment. I am often called upon to help with lifting because of my siz.e

A heavy male patient was found on the floor and needed to be assisted back to bed. The manager refused the use of a hoist as she considers it a 'monstrosity' and 'undignified for the resident'. Had to suffer a relapse of a chronic back condition whilst assisting the patient up.

Very heavy man with dense CVA face first on floor. Rejected by ACC: said back injury was 'degeneration'.

Violence

Figure 52. Reported violence by field



(Selected fields only shown full data available on request.) The following are representative of responses from 15 respondents who had experienced workplace violence. Most were related to either mental health nursing or dementia-related violence. There was one instance of inter-staffing violence.

I was hit, bitten scratched by patient with dementia.

It was due to patient leaping at me who was 250kg and putting all her weight on my left shoulder.

Assaults by clients, injured during restraint.

Autistic patient attacked me around neck in his own home.

I was placed in a headlock by a female patient when I was 30 weeks pregnant.

We have lots of confused patients and we often get hit, bitten and verbally abused. Also family and relatives often verbally abuse staff.

Involved in restraint of violent patient. Punched in face and strained back.

*I work ********** in the acute ward, prior to that at ****a ward called **** assaults/death threats/verbal abuse occur on every shift. Thank for publishing the article in june on assaults on mental health , we deal all the time with violent criminals wasted on 'p', who have a mental history who come to hospital nurses. No one gives a shit, post an assault, kidnapping, wilful damage, being tasered, assaulting Police etc. I have been punched, spat in the mouth, kicked in the nuts, various death threats, followed home, involved in fires started by users. I have seen many fellow nurses HCA's punched and hurt (included attempted rape, hideous bites) Something needs to be done. Over the past three weeks here at least one nurse has been assaulted per day. The management doesn't encourage Police involvement (not that they would do anything anyway, judges do not give a shit). Career ending assaults happen to ICU nurses. We need to hit the streets. We need that NZNO to do more like the Police association and Prison Officers, there always in the media asking for more stuff. I do at least 2 restraints over 4 shifts, these are done with my bare hands, seclusion is no longer a option, we have people who do not work on the floor who are incapable of dealing with violent people but good at writing essays saying what we can or cannot do to avoid someone hurting nurses, other service users or themselves. In Australia I will have more rights. All over the world nurses are fighting for more rights, in New York state its is a felony offence to assault a nurse on duty, in the UK the NHS has its own security division they will prosecute. We have a legal right to have a safe work place, not a work place just focusing on service user rights, or having the health and disability commissioner, the coroner, the District Inspectors or the nursing council all waiting to have a go at front line mental health nurses.*

Fortunately, many had received appropriate support, such as phased return to work, counselling and occupational health support (OHS) as shown in figure 53 though not all were supported or confident in their OHS.

The occupational health department is set up in order to deny all liability. I would NEVER go to mine again. I would rather go through my GP and report it as a home accident and get actual support with ACC instead of AON.

None I had to pay for all my treatment and had to take unpaid leave.

Occupational health advised me to go to own GP at own expense for diagnostic tests.

Pressure from Occupational Health to return to work the following day post injury. - This was stressful for me. - Went without proper pay for 2 pay periods as ACC papers had not been sent. - Asked for home help that is part of the ACC package: had not been instigated and I had to follow it up myself.

No compensation or support was offered.

Occupational health and managers did everything they could to present the injuries as the fault of the nurse not following protocol. it is your fault if you are injured, and how dare you take time off work or even take sick pay when it is your stupidity that caused your injury by not following the hallowed moving and handling protocol available somewhere on the intranet on days the hyperlink isn't broken. DHBs foster an environment where there are not enough staff and equipment, sicker patients, and nurses have to count each second. then they pretend to be surprised when injuries happen. on the other hand, if patients are not turned over as often as they decree because it is not safe for you and you already have chronic back pain anyway from your injury, you are hauled in for punishment because you obviously don't care about holistic care of patients. in summary, nurses are expected to sacrifice themselves for the good of the system

Though others were more so:

My employer has an excellent ACC accreditation partnership scheme

Infections

Figure 53. Workplace infections by field

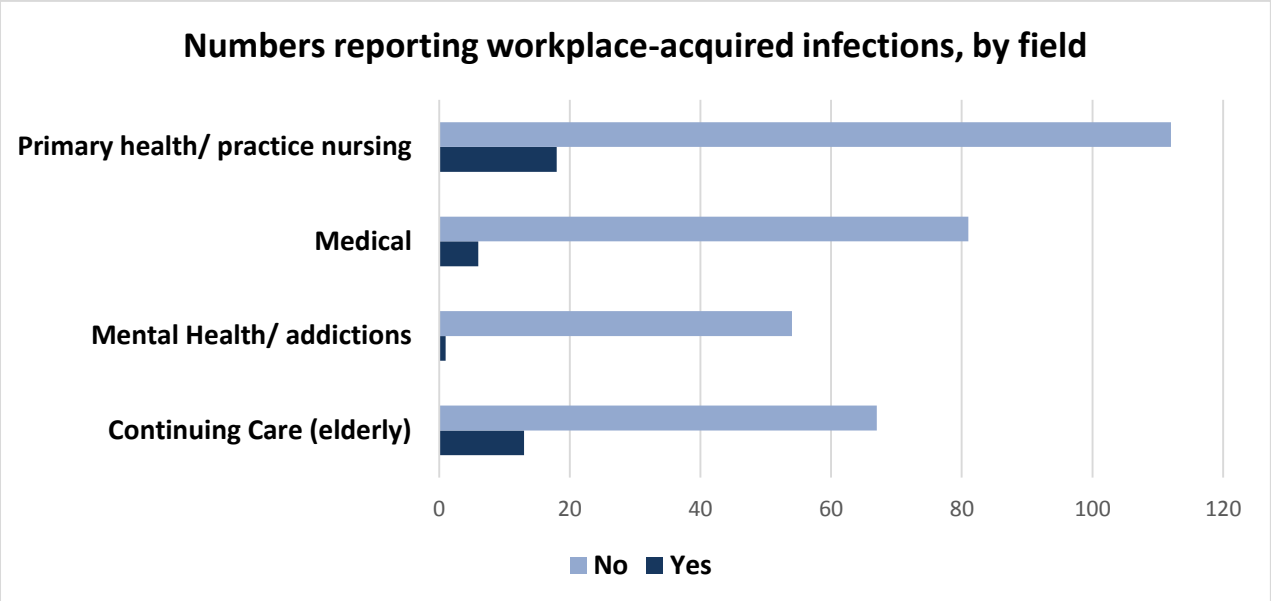
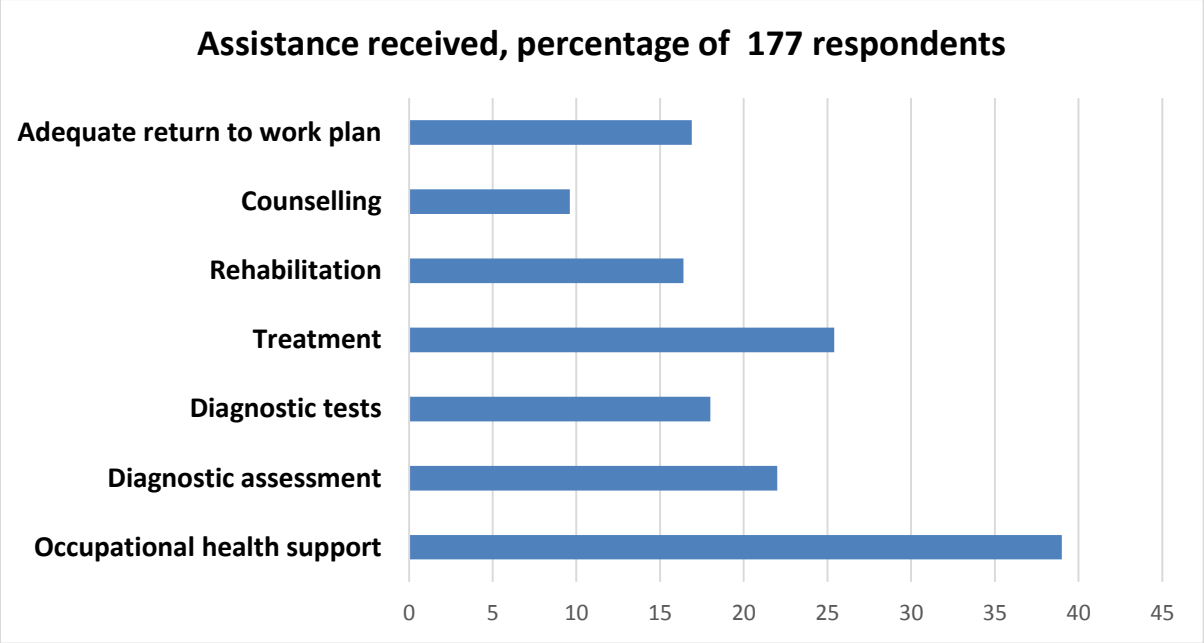


Figure 54. Workplace assistance received



Asked about time off required for illness in the past year, the results are shown in the table below:

Table 21. Days off work

Days off work past year	No	Percentage
None	273	27
1-2	285	28
3-5	251	24.5
6 or more	186	18
Not applicable	27	2.6

Fourteen per cent of the respondents had been diagnosed with an illness or injury that impacted in some way on their ability to nurse.

The majority (50.57 per cent) had used none or some of their sick days, whereas, 3.55 per cent had used most of their sick days, 2.93 per cent used all, 4.81 per cent had used all their sick leave and some annual leave and 3.66 per cent had also used some leave without pay. 3.97 per cent had had to decrease their hours due to illness, and 2.4 per cent changed their jobs. There was little difference in this by age group, except those over 65 decreasing their hours.

Table 22. Days off by age group (percentage and numbers given)

Age group	None	used some sick days	used most sick days	used all sick days	used all sick days & some annual leave	used all sick days & taken leave without pay	had to decrease the number of hours worked each week	had to change jobs due to illness or injury
25-29	**22.58%** 14	**30.65%** 19	**4.84%** 3	**4.84%** 3	**6.45%** 4	**4.84%** 3	**1.61%** 1	**0.00%** 0
50-54	**21.26%** 37	**21.26%** 37	**4.02%** 7	**2.30%** 4	**4.02%** 7	**3.45%** 6	**4.02%** 7	**2.30%** 4
65-69	**26.00%** 13	**24.00%** 12	**6.00%** 3	**2.00%** 1	**0.00%** 0	**2.00%** 1	**12.00%** 6	**4.00%** 2
Total respondents	64	68	13	8	11	10	14	6

9.3 Summary

> Overall, respondents gave very healthy scores for being able to perform their usual functions, and having no or moderate pain or discomfort.

> Those with the perception of being healthiest are the 30-40 year-olds.

> Above the age of 41, nurses still in employment perceive their health positively compared to age match NZ women, even up to the age of 70.

> In the previous two years, 20.57 per cent (208) of respondents had suffered an occupationally - acquired infection or a workplace injury. This is a 100 per cent increase compared to 2013.

> Ten per cent of workplace accidents or injuries severe enough to require time off work were referred to ACC.

> The commonest causes were back, knee, wrist and shoulder injuries relating mostly to slips and lifting, and flu or norovirus infections.

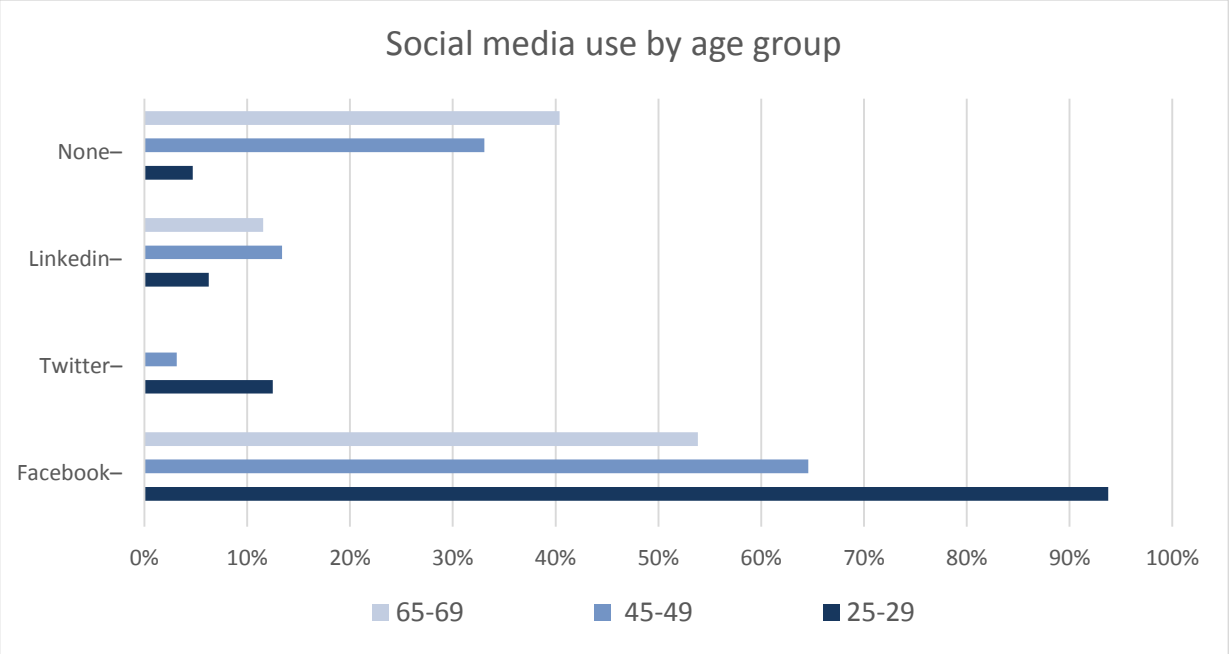
> Forty six reported assaults by patients. Fifteen (up from 3 in 2013) of these reported injuries caused by assaults from patients, and one (a decline from 4 in 2013) reported a needle-stick injury.

Chapter 10: Social media

Respondents were asked which social media applications they used. While some 26 per cent (down from 35 per cent in 2013) do not use social media, 74 per cent use Facebook, 12.71 per cent (up from 7.4 per cent) use Linkedin and 4.3 per cent (up from 3.6 per cent) use Twitter.

There were differences by age group between the two biggest groupings, those who use Facebook and those who do not use social media, as shown in figure 53. This confirms that, while the use of social media as marketing and communications tools when trying to reach under 30s is important, there are also very significant numbers in other age groups who will not access these media.

Figure 55. Use of social media in three age groups



10.1 Summary

> Twenty-six per cent of respondents do not use any social media (down from 35 per cent in 2013), 70.41 per cent use Facebook (up from 62 per cent in 2013), 12.71 per cent use Linkedin and 4.27 per cent use Twitter.

Chapter 11: Morale

11.1 Morale

This section describes the views of nurses and is based on the analysis of a 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 have been changed slightly on advice following piloting (but are essentially the same in meaning). Although for the purposes of analysis the statements are grouped together in the table below, the statements in the questionnaire were scattered randomly through the set, in order to check the degree of congruence of answers to similar statements. Some statements were positively and some negatively worded, to check for internal consistency and avoid response pattern repetition. Although these are subjective scores, the internal consistency checks, and very similar patterns and concerns seen year to year increase confidence in the interpretations. For ease of comparison, the percentage shown are the sum of those agreeing or strongly agreeing with the statement.

Positivity scores are calculated from the percentage agreeing with statements in each theme block. Negatively-worded statements are reported in reverse to allow easy comparison. (For example, the percentage disagreeing with "*I would leave nursing if I could"* are reversed, showing instead as percentage agreeing with "*I would (NOT) leave nursing if I could, to allow comparison* with "*I would recommend nursing as a career".)* Results from 2013 are shown for comparison.

The summary of the themes reveals that nurses are ***most*** positive about the quality of care they deliver and nursing as a career. 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, 2011 and 2013, New Zealand nurses' morale scores with most aspects of nursing as a career have continued to decline across the board. Falls in confidence about career progression and job security are seen, and there has been a slight increase in perceptions of bullying.

Table 23. Weighted scores from the validated attitudinal question set

Themes / Statements	Per cent agreeing 2013	Per cent agreeing 2015
1. **Nursing as a career**		
I would recommend nursing as a career	82.9	77.09
I would (NOT) leave nursing if I could	75.2	69.34
I am (NOT) in a dead end job	88.3	83.28
Mean "positivity" score	**82.1**	**76.57**
2. **Career progression**		
It will (NOT) be difficult to progress from my current salary	26.8	21.12
Career prospects are (NOT) becoming less attractive	56.4	46.99
Mean "positivity" score	**41.6**	**34.05**
3**. Bullying/harassment**		
Bullying and harassment are not a problem where I work	55.2	50.2
I'd be treated fairly if I reported being harassed	67.1	62.04
Mean "positivity" score	**61.1**	**56.12**
4. **Working hours**		
I am happy with my choice of shifts	82.3	78.58
I feel able to balance home and work lives	73.6	72.9
Mean "positivity" score	**77.9**	**75.74**
5**. Job satisfaction**		
Most days I am enthusiastic about my job	88.9	87.4
I feel satisfied with my present job	77	72.73
I feel my work is valued	73	50.2
I feel part of a team	88.4	84.97
I am able to practise autonomously	87.3	84.49

My opinions about nursing are valued by my manager	75.6	70.78
Mean “positivity” score	**81.7**	**75.09**
6**. Pay**		
I am well paid considering the work I do	38.4	34.87
Nurses are paid well compared to other professionals	22.6	19.6
Mean “positivity” score	**30.5**	**27.23**
7. **Quality of care**		
The quality of care provided where I work is good	**92.8**	**90.62**
8**. Job security**		
Nursing will continue to offer me a secure future	85.7	82.67
I am (NOT) worried I may be made redundant	84.6	81.87
I would find it easy to get another job with my skills	69.2	64.34
Mean “positivity” score	**79.8**	**76.29**
9. **Training and education**		
I am (ABLE) to take time off for training	71	67.03
I am able to keep up with developments to do with my job	79.2	78.47
I have regular dialogue about my work with my manager	63.3	60.54
Mean “positivity” score	**71.6**	**68.68**
10**. Workload**		
My workload is (NOT) too heavy	50.5	41.56
I am (NOT) under too much pressure at work	54.4	47.48
(NOT) too much time is spent on non-nursing duties	57.5	54.71
There are sufficient staff to provide good care	57.8	50.46
Nurse staffing levels have improved over the last year	34.7	28.99
Mean “positivity” score	**50.98**	**44.64**

10.2 Qualitative results

The free text comments in response to the question: *Ís there anything else you would like to add about nursing, or your career as a nurse?*" were analysed thematically, and the number of times different respondents made comments that fitted within the themes was counted. 340 separate respondents made comments in this section.

Themes: these are further analysed into positive, negative and specific themes.

Table 24. Positive themes

Theme	Description	count
Happy	This theme captured statements related to happiness with career, loving the job, enjoying the work, recommending nursing as a career.	67

Nursing has been a great career for me for the last 44 years. I am still passionate about being able to work with patients to improve their health.

I love my current job! It's awesome! The pays not great but the work satisfaction is good and the support the team give is brilliant! I'm encouraged by my boss to do post grad which I am enrolling in next year and I know I have the support if I need time off.

Love nursing - always have!

Nursing has given me a great career, allowed me to look after my family, and feel like I have contributed to society. I have also travelled all over the world nursing (for example with the mercy ships) and always given me secure employment.

Nursing is a very valued satisfying career, but it is hard work and takes a high level of commitment, many times to the detriment of family and friends time.

As I began my nursing career at an older age, I have and continue to thoroughly enjoy every day that I come to work. I leave with job satisfaction and know that I have given my best to every patient I have had contact with.

Wonderful career which I have enjoyed greatly. Nurses have to remain focussed and make the most of opportunity - not just wait for the world to come to them. We need to maintain our professional status by demanding to be treated with respect and give respect and excellent care in exchange and have pride in ourselves and this wonderful profession.

Flexibility	This theme related to nursing providing flexibility with shifts and hours, and family friendly working practice, relating to caring responsibilities for children and parents.	25

I wish to work part time so have no opportunity to apply for other senior roles. I might choose to work in other areas if not necessary to work night shift.

I love nursing children but the amount of pressure, due to high staff turn-over, inflexibility with shifts for all staff and the increasing acuity with often insufficient staff/experienced staff is demoralising. I intend to retire at 55yrs.

Nursing has given me the flexibility to work in the UK, India and NZ in different specialities (general surgery, theatre and now primary care).

I really enjoy nursing especially now that my children are no longer dependent and I am not juggling home life and career.

I am formally retired but choose to work at my old job as a casual employee - for which I am well paid and have the flexibility to work when I want to.

If it weren't for the flexibility of the hours, I would not stay and am actively seeking alternatives while I work to encourage change.

It has enabled me to work and travel overseas Nursing has made finding work easy with a reasonable wage.

I would like to reduce my hours by one day a pay period and finding it very difficult in order to reduce my working hours i would probably need to resign my position as a charge nurse .

I can, to a certain degree choose my own hours, I guess my work ethic is very strong, and I miss breaks of my own choosing to try to keep up with work.

Shift work is very difficult on the body as you get older, which contributes to health issues. Nursing can be flexible if you can get into other nursing jobs as hours are better, this can take a couple of years to do and brings on further health issues while you apply, go through the process, and wait for the outcome.

Employers need to be more accountable for adjusting staff work hours i.e. if a staff member does a course and agrees to change hours while on the course, give the hours back when the staff member comes back as agreed in the original conversation.

Support	This included supportive and empowering management, collegiality and encouragement/recognition for good work.	6

This is a very rewarding environment to be employed in. The unit has very good teamwork, and most of us get on very well and our day is mostly enjoyable, as we have all built nice rapports with our patients.

I love my job and feel very well supported.

I have a very generous employer, who considers professional development for all staff vital.

My manager has been very supportive and also the team I work with. They are understanding of my medical condition.

Table 25. Negative themes

Theme	Description	count
Low morale	This included low morale, leaving nursing, pressure, stress, burnout and exhaustion/fatigue.	43

I feel very disillusioned about nursing these days as it feels like there is no time to care for our patients.

I love my job but not happy in the workplace - bullying, no parking on site for any staff, not safe, hardly ever finish on time but never get paid overtime . Not what the job used to be .....

I would not recommend nursing as a job to a young person as the hours are too unsociable the workload too high. I am valued. Nurses do too many late unpaid hours. different language and culture is proving to compromise effective, assertive communication and compromise patient care.

It is a thankless job, and very stressful. I do not enjoy it. Employers can be very unsupportive.

Nurses are not appreciated, pay is poor for what we do, specialised nursing areas are not appreciated or recognised.

Have worked in aged care for the last 2 years due to where I live. Very understaffed with low morale .Don't have time to really spend time with each resident due to time restraints. Also need wage increases-to be on par with hospital base rates. We get $1 an hour more at the weekends which is pathetic. Elder care is really downgraded and should be given more funds and respect from financers etc. this is all why I left!!!!! And its hard work mentally and physically with no rewards!

Going home knowing you have not done all you needed to do for client group has an accumulating effect on mental wellbeing

The government / CEO needs to increase the amount of nurses DHB's are allowed to employ, to help lighten the patient work load, give nurses time to; have quality nursing time with patients/family, teach (students, new grads and new staff), professional development, research, update policies and procedures, paperwork/administration, improve processes.

I have become cynical and disillusioned with both nursing and NZNO and our pay and working conditions.

Present DHB particularly in mental health service has a strong culture of bullying. Nursing morale in mental health service very low. Staff stressed and in some areas working at high level of patient acuity at a dangerous level. Oppositional responses from management.

Workload	**This included patient load, increased acuity, less down time, working long hours/extra hours.**	**30**

Going home knowing you have not done all you needed to do for client group has an accumulating effect on mental wellbeing.

Low staffing levels make it very difficult to get time off when you want as only one person can go on leave at one time. When someone is off you are then doing that persons work as well as clinics are still running.

Constantly working with rosters unfilled or with staff not fully orientated.

Despite the use of the Trend-Care system predicting a shortage of hours and that help is needed, there is 'often' no staff available and are told we just have to manage with what staff we have. An example was Sunday, on a morning shift, a busy 24 bed acute medical/delirium/safety watch ward had to run the ward with 4 RNs. I heard about it the next day and the stress that was again put on the RNs working that day.

Over the years, patient acuity levels have increased dramatically, sicker patients, then out to community quickly, replaced by more high acuity patients, so work load increased.

Workload definitely greater - more complex cases, greater needs. Difficult to find replacement staff when staff of sick.

I feel very disillusioned about nursing these days as it feels like there is no time to care for our patients.

Constantly working with rosters unfilled or with staff not fully orientated

Lack of staff, increased patient load, high expectation of work accuracy put staff and patients at risk.

Stress, short staffing and overwork is a daily occurrence. Only better staffing can improve this

Low staffing levels make it very difficult to get time off when you want as only one person can go on leave at one time. When someone is off you are then doing that persons work as well as clinics are still running.

For myself, the two days i have off per week is to catch up with sleep, social life and my hobby. Sounds all negative but despite all this 70 % of nursing is great.

We are able to provide great nursing care on our ward, we work as a team, but we are often pushed to the limit due to high patient acuity and we don't always have time to do smaller cares such as oral hygiene and hair washing etc, feeding. We often take short breaks or sometimes no breaks, in order to complete our work, especially on night shift with a 10 :1 ratio.

Left DHB due to stress and the effects it had on my health.

We are nearly always short staffed, our workload has increased due to resident health status deteriorating and their level of care changing.

Patient care and safety is being compromised. I feel vulnerable and concerned that my registration is compromised as I am pressured to do more with less, to do it quicker, faster, which makes me more at risk of making mistakes.

Burnt out due to work related stress last year. While work conditions have improved, I haven't, and anxiety at work and in my personal life have become a real issues.

Theme	Description	count
Changing nature of nursing	This included perceptions that nursing was changing, losing its way, becoming overly technical and remote, and of changes to nurse education not having delivered better nursing care.	21

I believe that nurses are not respected as they once were and that as a workforce we are repeated abused both verbally and physically.

I think nursing has changed so much, it has become more demanding , huge amount of paper work, due to this nurses are burned out. some new graduates at my work already stated they have made the wrong career move. which is sad.

We are getting further away from the ideal taught at university and just doing what we have to do to keep our reg. No holistic nursing: band aid nursing - and we really need to alter our processes in gerontology dementia care as already causing major problems.

Loved nursing but it has changed so much and is more about the paperwork and not the hands on care that patients should be entitled to be provided with for best recovery to regain good health.

What has changed the most is the time spent on patient contact with too much paper shuffling and computer work and not enough time for the patient and their cares.

Nursing has changed dramatically since I trained in the Hospital.

I Started my Nurse training in 1977 at 18yrs. Nursing at that time was about caring for patients learning on the job. Today nursing seems more technical and taking on more duties previously done by Doctors with no extra recognition even when extra training has taken place - Nurse prescribing, Consultants. In these challenging financial times nurses are rescuing the health service but the expense of our traditional caring for patients.

Whilst I am incredibly passionate about nursing, the work I do, and the philosophies that underpin my practice, I am becoming increasingly disheartened that I am not able to practice in the way that I aspire to, and that compromises my values as a nurse.

I feel very strongly that nursing has changed to a workforce of computer competent nurses who spend the majority of their time looking at screens instead of spending time at the bedside. Care assistants are doing the work that nurses used to do. We have gone too far the other way **.**

Paperwork	This included patient paperwork, incident reporting, Key Performance Indicators , targets, and over-onerous/repetitive nature of PDRP.	21

Nurses are spending more and more time filling in forms and going to study days to be able to justify what they do. There is a whole industry that has grown up around just documenting what you do and have done for years e.g. PDRP. It is wasting a considerable amount of the employees' time and is costing the employer.

Nursing is now less focused on care and too much time wasted on excess paperwork that no one cares about.

Doing PDRP I find very stressful, as I am not very articulate with my writing and it takes me a long time to do. I don't believe it shows what sort of a nurse you are, just how well you can write or how badly you can write.

I have become disillusioned with the future of nursing. there is so much paperwork and computer work that now the focus is away from the patient. I feel there needs to be a fundamental shift back towards the care of the patient, rather than audits that focus on paperwork and tasks.

I don't like the PDRP system as it is assumed that after three years you have lost the knowledge previously gained. I don't believe we should continually be paid more for doing ongoing education but it seems like jumping through hoops on a three yearly cycle for a reward. I believe nurses have ongoing education continuously which is unrecognised.

The annual competencies we have to do in our own time unpaid is ridiculous even though we can do this on line. Many of these competencies take two hours and there's approximately 15 to complete.

The current recertification audit influenced my decision to retire. I feel that the recertification audit is excessive and the process is made more difficult for a sole nurse in general practice. In addition a sole nurse can never be classified as Proficient or Expert despite having to complete the same background requirements as any nurse working in a non-solo position.

Theme	Description	count
Poor management	Included bullying, remoteness, unsupportive, poor leadership, poor advocacy	26

Where I work, the nurses have been unsupported by non-clinical managers for the last 10 years and it's getting worse as we have no nursing line management.

I was hospitalised with a back injury 3 months ago and I have not worked since, I work casually and apart from friends from work not a single nurse manager or otherwise has made any kind of contact to see how I am or even if I am planning on coming back to work.

With that kind of lack of care about their staff is there any wonder that I am considering quitting. Seems like they are more interested in filling the roster gaps rather than actually caring for the staff.

Too many managers not enough workers.

My line managers do their best but their budget for staff and equipment is not keeping up with the ward needs and the nursing staff are working harder with less time and equipment to manage increasingly more complicated patients. The upper management and government are so disconnected that they have no idea how difficult it is to provide the quality of care I would like to.

I love the work I do but I'm becoming increasing disillusioned with the number of non-clinical people and ridiculous policies that impact negatively on myself and colleagues' ability to deliver the professional standard of care we would like.

We NEED a national culling team to slash & burn through the overburdening management structure and numbers to free up funds for allocation to where they are actually needed.

Pay	Poor pay relative to other professions, levels of education and responsibility, and lack of promotional opportunities and the linked pay.	48

I still feel that for the work we do, we deserve more pay.

If I compare my wages to other professions I become disheartened a bit because I feel that nurses work very hard in quite difficult, challenging situations/environments.

I enjoy the type of nursing I am engaged in, however nursing is hard work under paid ,nurses are under valued.

Nurses are not appreciated, pay is poor for what we do, specialised nursing areas are not appreciated or recognised

Many nurses work unpaid hours to make sure the work is completed and the clients will not be disadvantaged. If we divided our take home pay by the hours we actually work the hourly rate would certainly look markedly less. Also too little respect for nurses as individuals with a variety of talents- just dots on a roster I think.

Aged care workers are under paid and under staffed i would like to have a collective agreement contract i feel aged care staff are under-valued by the providers we should be paid the same wage as DHB nurses .

I believe we are very undervalued wages wise when compared to many other occupations, and the high level of work/skills involved.

We are under paid compared with the working load, physically and mentally stressed at work place.

I am saddened that nurses still have to fight for a pay rate that declines to an average of 1% over the last 3 years with the increases in cost of living when stronger unions e.g doctors get so many benefits e.g. fully funded education, and great educational stay up to date opportunities, paid non-clinical time to do quality work etc.

Nursing seems a hard road to go down; hard work for little pay and even smaller recognition.

Our pay does not and never has reflected our ability and experience or the challenge/difficulty of our work.

11.3 Specific and separate themes

Table 26. Specific and separate themes

Theme	Description	count
Unemployment	This included unemployment, job hunting, lack of new graduate positions, and job insecurity.	37

I have just recently been made redundant from my practice nurse position due to business not being busy enough for a full time nurse. I have been applying for jobs and have not been successful in gaining an interview let alone a new job; I am experienced with over 30yrs nursing experience. I have not had this many rejections since I was 17yrs old and I am now 46yrs!! I have never been out of work before and feel very stressed at not being able to find work (I am a single parent).

It is very difficult to find permanent work that I can fit in with the children. When you have husband working shift work and 4 young children and a work place that doesn't seem to allow for a work life balance finding permanent hours is nearly impossible. I feel i would be better off working away from the industry I love.

I have now been unemployed for 7 weeks and hadn't anticipated how difficult it would be to find suitable employment; very disillusioned in nursing now :(This has never happened to me before!

It is very challenging getting employment as a newly graduated nurse. I think the nursing schools need to take more responsibility regarding intake numbers which are increasing annually, however the jobs just simply are not there. I am aware the plan is for the need for more nurses due to our aging population however nurses qualifying now still have bills to pay and student loans and other debts to pay off when they graduate.

Had to relocate from Taranaki to Canterbury in order to secure a nursing position in mental health, as no available positions available in Taranaki once graduated from BN nursing in 2011. This involved having to relocate all of my family - not easy.

I am a new graduate nurse that has been actively searching for work for the last 4 months since graduating. There are very few jobs that do not require previous post-registration experience.

I work casually. I am very discouraged that I struggled financially for 3 years to complete a BN to find non-permanent work - I have not recovered financially.

Why spend so much money on new grads to then not require them after the course finishes. Not done in any other industry.

I've been applying for jobs every day, everywhere for a hospital or gp practice position since I graduated . Still to this day I haven't had a single interview. All the explanations I have ever gotten back is that I don't have the experience - so frankly I feel like my degree is worth toilet paper because I cannot even get the experience I want because I don't have experience - it's a bit moronic. Due to this I have no clue if my portfolio is even up to standard. I feel greatly unappreciated , unwanted , and losing my confidence more every day that I get another rejection email back- is moronic as they are apparently short staffed on nurses but they won't hire the ones available - I am willing and begging to work and help but I'm starting to feel like the rubbish that they don't want and need.

Internationally Qualified Nurses	This included both comments from IQNs about experiences of nursing in New Zealand, or disappointment about opportunities or scopes, and about IQNs: concerns about taking NZ jobs, having poor skills or communication, there being too many, or a lack of vocational ethic.	9

I find that the place values those nurses who are more outspoken than those who are naturally more introvert. Just because English is not my first language, or that it is just not my habit to tell everyone what I am doing during nursing cares, should not make me a less skilful nurse, and having opportunities to look after more complex patients stripped away from me and given to kiwi nurses who often know "how to talk", but does not necessarily have the same level of ability. I often find that my abilities are doubted purely because of my quiet personality and also sometimes, my skin colour.

In my opinion it very important to provide overseas graduate nurses an in-depth orientation of the NZ health care system, aside from the Treaty of Waitangi, so they can fully grasp and not be left out on what to do specially the inter/interrelationships of the different entities in the health system i.e. the intricacies of the referral system; when, to whom, etc to refer a patient based on their needs.

The influx of international Nurses is impacting directly on patient care and outcomes. Many have learned only by rote, have no concept of critical thinking and are unable to practice autonomously.

Disappointed at the lack of job opportunities within NZ at the moment and the lack of courtesy from employers who do not acknowledge job applications, at least to offer encouragement to continue applying. Lack of employment opportunity limits the chance to continue professional development. Have applied to work overseas with Medicins sans Frontieres.

There has been a great incidence of discrimination against foreign nurses. I almost always get assigned difficult, challenging patients, and sometimes caregiver role instead of nursing role. I became a casual staff with the DHB but the same thing is happening. This would be the main reason I would move to another country to practice nursing despite spending so much to come to NZ.

Nursing in Australia	This related to better opportunities, pay and conditions, came from those planning to go to Australia or having returned from Australia	8

I am due to retire within the next 12 months. I also currently work as a Remote Area Nurse in Australia because I wanted some adventure before retiring.

DHB's have a problem employing hard working women over 50 yrs of age. Shame because we have had no problems working in Australia. Would love to come home to NZ, but can't if all the DHB's do is reject based on age.

After working overseas with an NGO and in the Australian outback, for 10 years, I was told that all this experience was "irrelevant" and I was "unemployable", by a nursing career advisor. I did not agree and felt insulted.

Caring responsibilities	This related to responsibilities for children, parents, being part of the sandwich generation, requirement for flexibility related to caring	3

As nursing is a female dominated profession and traditionally females are the primary caregiver to children in the family, I believe nursing retention could be helped if there was more flexibility in places such as the hospital setting to accommodate parents with limited child are options.

Due to family reasons I can no longer happily work weekends but my employer has denied the request I do wish to continue nursing as it is my passion but may have to change direction for the sake of my children!

I am happy in my career and work place offers me the same shifts each week even though they are a mix of day and evening. This is the biggest factor in providing for my family and a good work life balance.

Enrolled Nurses	Data from and about ENs has been captured separately and is reported elsewhere	3

I have enjoyed my career as an enrolled nurse and I am pleased to see they are now retraining enrolled nurses. This makes me feel we are valued for our skills. But I would like to see more courses and training in a variety of areas available to us so we can keep up skilled and learning more.

I feel I am being undervalued as a new enrolled nurse, in New Zealand I have not had a pay rise in the 2 years I have been working in my job and some senior caregivers are on a higher wage whereas I have the responsibility of looking after residents in my care, medications and wounds etc

I am an enrolled nurse in XXX, pleased to see they are FINALLY employing ENs on the Pool. We are a dying group of nurses. Even though I have been employed for 25yrs, if I left, I would be replaced with a RN.. Quite sad! Also, i feel the wage scale between RNs and ENs have widened significantly about $9 per hour between my hourly rate and an RN level 5.

11.4 Summary

> Resilience and professionalism and a love of nursing were very evident.

> Nurses are mostly positive about the quality of care they deliver, nursing as a career and job satisfaction.

> They are less positive about access to training, career progression, choice of hours and bullying.

> They are least positive about workload and pay, especially in comparison with other professionals.

> Compared to the responses from 2011 and 2013, New Zealand nurses' morale scores with most aspects of nursing have continued to decline slightly.

> Compared to the responses from 2011 and 2013, continued falls in confidence about career progression and job security were seen.

Summary:

> Comparative pay (especially relative to other professions) remains a considerable source of dissatisfaction. Without fair remuneration (reflecting nurses' skills, knowledge, responsibility and hard work) recruitment and retention of existing nurses, and nursing as a career choice, will lose appeal.

> Workload, stress and lack of job satisfaction also contribute to staff turnover and to lower morale, and must be better managed. Safe levels of staffing, better shift rostering, and appropriate access to continuing professional development support and study leave must be ensured.

> Violence against nurses appears to be increasing and more ***must*** be done to protect nurses. This should include increased staff training in handling violent, or ill patients (especially safe restraint where necessary), increased staffing, and systemic investigations of all serious incidents.

> Access to flexible working options, especially for nurses over 50 (including looking at the requirement to do night shifts) must be addressed to ensure workforce supply and continuity.

> The CCDM project, with its aim of better managing nurse workload and patient safety should be given greater support, visibility and resourcing, if the potential of the project is to be realised.

> Nurses suffering workplace injuries and illness need greater recognition and workplace support – particularly financial assistance with the cost of care required as a result of the injury or illness.

> The impacts on workforce morale of continual restructuring and change must be recognised and better mitigated. In particular, disruption and uncertainty in senior roles impacts at all levels, and the long term effect of loss of clinical nursing leadership is of concern.

> Uncertainty about redundancy, unemployment, and the inability of new graduates to get jobs is widespread and will impact on nurse training and longer term workforce supply if not better managed.

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Principal author: Dr Léonie Walker
Correspondence to: leoniew@nzno.org.nz

Mission statement
NZNO is committed to the representation of members and the promotion of nursing and midwifery. NZNO embraces Te Tiriti o Waitangi and works to improve the health status of all peoples of Aotearoa/ New Zealand through participation in health and social policy development.

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