RESEARCH

EMPLOYMENT SURVEY

NEW ZEALAND NURSES ORGANISATION

# NZNO Employment Survey 2013

## Our Nursing Workforce: "For Close Observation"

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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.


**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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# Executive Summary

This is the third biennial employment survey of the New Zealand Nurses Organisation (NZNO) nurse membership. The web-based survey of regulated nurse members (Registered & Enrolled Nurses, and Nurse Practitioners) was undertaken in February 2013. 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 in 2008/9 and 2010/11, allowing change over time to be tracked, and kept as similar as possible to the standardised Royal College of Nurses (RCN) set to allow international comparisons. New questions for 2013 included questions on health and safety, employment law changes and responses to the introduction of care capacity Management (CCDM, a joint project being rolled out in district health boards (DHB) designed to better match nursing resource with patient requirements).

Of the 4571 invitations sent out, 43 were returned as not known at the address available, and 1448 responses werereturned, giving a response rate of 32 per cent. This is considered a very good response rate for a detailed, web-based questionnaire where one reminder is sent out. Respondents' profiles by age, gender, DHB area, health sector and fields of practice showed good concordance with both NZNO regulated nurse membership, and Nursing Council.

Overall, once again nurses demonstrated resilience and commitment to their profession in the face of significant and continuing restructuring and fiscal restraint. Themes identified in previous NZNO research related to the retention of nurses in the workforce (especially that of older nurses) emerged strongly in this survey too. In particular, for many, the loss of clinical nurse leadership, 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. The profession is in good heart, if vulnerable to badly handled and on-going change, long-term staffing issues, and growing disenchantment with workload and pay.

# Significant and emerging themes

## Profile of the Nursing Workforce

The Aotearoa New Zealand nursing workforce, in common with the workforce as a whole, appears to have responded to uncertainty in general employment, and to unemployment, by working extra shifts and changing employment less frequently than was seen two years ago. There are also ongoing changes to the regulatory structures, roles and scopes of practice, and to the education of nurses. While other data about age, ethnicity, gender and qualifications exist, this survey also documents the proportions of such nurses, their employers and job titles. This allows comparisons with other items in the survey, such as pay, working patterns, second jobs, career plans and perceptions of nursing roles and careers. The period from 2011-2013 was one of continuing national and international recession and continued substantial structural and organisational change in the New Zealand health system. Changes over the previous two years have been captured, and will be reported where significant.

## Restructuring

Nearly a quarter 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. 27 per cent reported reductions of senior nursing leadership positions, and changes to skill mix. Regionalisation and privatisation of specialist services, and mergers of general practices were also recorded. The processes involved had severely impacted on morale, damaging feelings about their employer, and leading to 43 per cent of those affected questioning their nursing future.

## Workplace-acquired infections and injury

Eleven per cent had required time off work in the previous two years with workplace-acquired infections and injury. Of these, 10 per cent were referred to ACC. The commonest causes were flu or norovirus infections, and back, knee, wrist and shoulder injuries relating mostly to slips and lifting. Three reported injuries caused by assaults from patients, and four reported needle-stick injuries. Only 41.5 per cent of all respondents felt their employer was fully compliant with Occupational Health and Safety standards.

## Nurses' own health

The internationally validated EQ5D health tool was used. Thirteen percent reported having some problems with performing their usual work, study, housework, family or leisure activities, 14.4 per cent felt moderately anxious or depressed, and 28 per cent reported moderate pain or discomfort. These are nearly all lower than for NZ women at all age groups. This may be a real effect, perhaps reflecting nurses looking after their own health. It might also be that nurses self-select out of the workforce if less healthy, or that their perceptions of their own health are more positive than the general population. The exception was that women aged 30-39 in a NZ general population reported less moderate levels of pain and discomfort than nurses of the same age (Nelson Bays Health status survey 2010).

## Morale

There is no doubt the morale of nurses (particularly those employed in DHBs), has continue to decline slightly. While it is not possible to directly assess the causes, heavier workloads, higher patient acuity, restructuring and the financial climate are cited more 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 their job and report enjoying working with great colleagues and managers, *very many* also expressed concerns about the state of nursing.

## Access to, and use of, NZNO 2013 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 2013 NZNO Employment Survey

The New Zealand Nurses Organisation is the leading professional and industrial organisation of nurses in Aotearoa New Zealand, representing more than 46,000 nurses, midwives, students, kaimahi hauora and health workers on a range of employment-related and professional issues. NZNO has a commitment to the Treaty of Waitangi (te Tiriti o Waitangi) as the founding document of Aotearoa New Zealand and articulates itspartnership with te Tiriti through Te Runanga o Aotearoa.

NZNO provides leadership, research and support for professional excellence in nursing, negotiates collective employment agreements on behalf of its members and collaborates with government and other agencies throughout the health sector. This report documents the results of a survey of a random sample of NZNO members comprising around 5000 regulated nurse members (registered nurses, enrolled nurses and nurse practitioners) drawn by computer from across New Zealand. Midwives and caregivers were excluded from the sample on this occasion.

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

## 1.2 Context

This is the third biennial employment survey of NZNO nurse membership, and was undertaken in February 2013, five years into a major recession, and 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 February 2013. Midwives were excluded from the 10 per cent random sample on this occasion, though dual registered nurse/midwife members could have been selected. Invitations to participate in the web-based survey were sent by e-mail link, along with a covering letter. Participants were also offered a reward for their time spent participating, with (voluntary) entry into a 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 in 2008/9 and 2010/11, allowing change over time to be tracked, and kept as similar as possible to the standardised RCN set to allow international comparisons. New questions for 2013 included questions on health and safety, employment law changes and responses to the introduction of 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 4,571 invitations sent out, 43 were returned as not known at the address available and 1,448 responses were returned, giving a response rate of 32 per cent. This is considered a very good response rate for a detailed web-based questionnaire where one reminder is sent out.

## 1.4 Report Structure

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

| | |
|---|---|
| Chapter 1 | Introduces the context and methodology of the 2013 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 | Utilises a combination of the attitudinal scales and the 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.

Nearly 98 per cent held annual practising certificates, with 0.4 per cent awaiting registration with the Nursing Council, and a further one per cent not seeking re-registration.

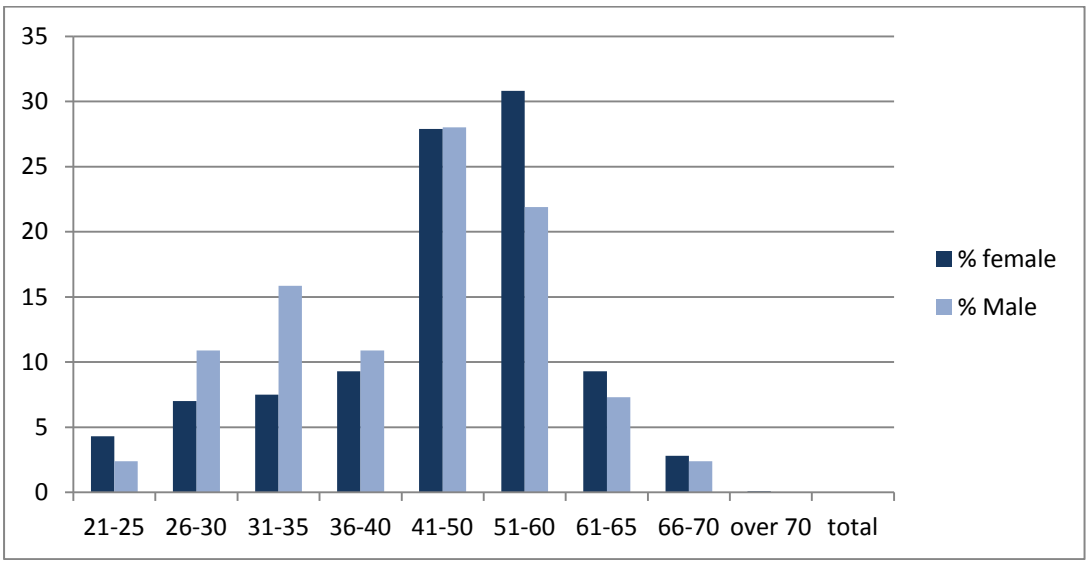
## 2.1 Age and gender profiles

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 | % (of female) | Male | % (of male) |
|---|---|---|---|---|
| **21-25** | **59** | 4.3 | 2 | 2.4 |
| **26-30** | **96** | 7 | 9 | 10.9 |
| **31-35** | **103** | 7.5 | 13 | 15.85 |
| **36-40** | **126** | 9.3 | 9 | 10.9 |
| **41-50** | **379** | 27.9 | 23 | 28 |
| **51-60** | **419** | 30.8 | 18 | 21.9 |
| **61-65** | **127** | 9.3 | 6 | 7.3 |
| **66-70** | **39** | 2.8 | 2 | 2.4 |
| **over 70** | **11** | 0.08 | 0 | 0 |
| **total** | **1359** | **94.3% of total** | 82 | **5.6 % of total** |

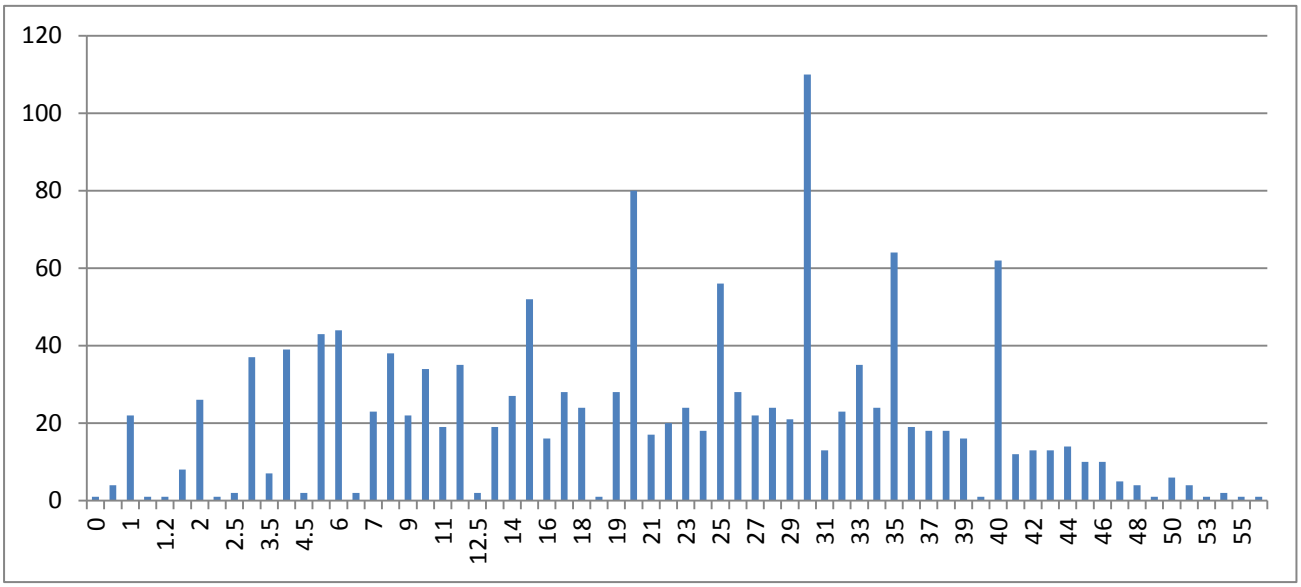
### Figure 1. Age and gender profiles of respondents




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.

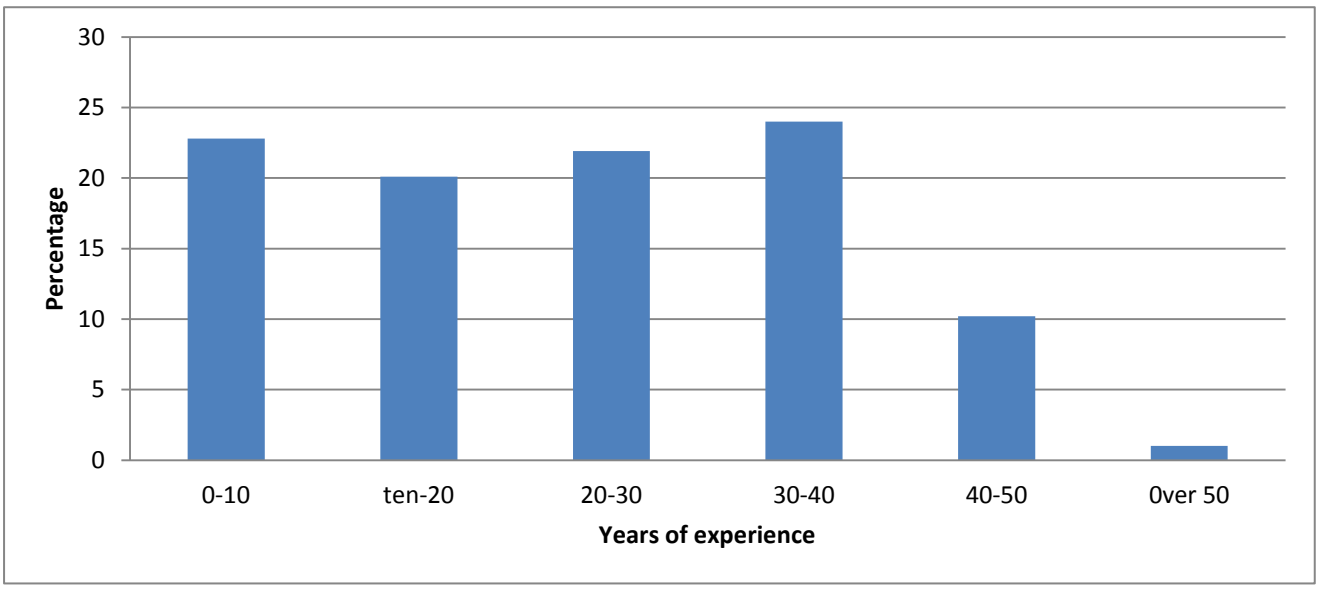
The nursing workforce, in addition to ageing, has accumulated a large number of years of experience as a nurse:

## Figure 2. Years of nursing experience




Shown in 10-year brackets, a very even spread is shown: 35 per cent of nurses have more than 30 years experience.

## Figure 3. Percentage of respondents with numbers of years of experience



## 2.2 Ethnicity

### Table 2. Ethnicity

| Ethnicity | Number | Ethnicity | Number |
|---|---|---|---|
| **NZ European** | 1021 | **Other Asian** | 38 |
| **NZ Māori** | 88 | **Chinese** | 25 |
| **Other European** | 173 | **Indian** | 36 |
| **South East Asian** | 41 | **Pacific Islander** | 27 |
| **Other Asian** | 38 | **African** | 10 |

Of all the respondents, 24.9 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, and the recent NZNO research 'N2N' study.

## 2.3 Scope of Practice

### Table 3. Scopes of practice

| | |
|---|---|
| **RN** | **1373** |
| **EN** | 38 |
| **NP** | 11 |
| **Midwife** | 13 |

## 2.4 Employment Situation

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

### Table 4. Respondent profile by employment status

| Employment status | Number | Percentage |
|---|---|---|
| Employed, working | 1341 | 93 |
| Employed, parental leave | 17 | 1.12 |
| Employed, long term sick leave | 3 | 0.02 |
| Retired, still in paid employment | 16 | 1.1 |
| Fully retired | 2 | 0.01 |
| Unemployed, looking for work | 14 | 0.96 |
| Unemployed, on a career break | 16 | 1.1 |
| Other | 32 | 2.1 |
| Total respondents | 1448 | 100 |

## 2.5 Job Title

Table 5. Job title

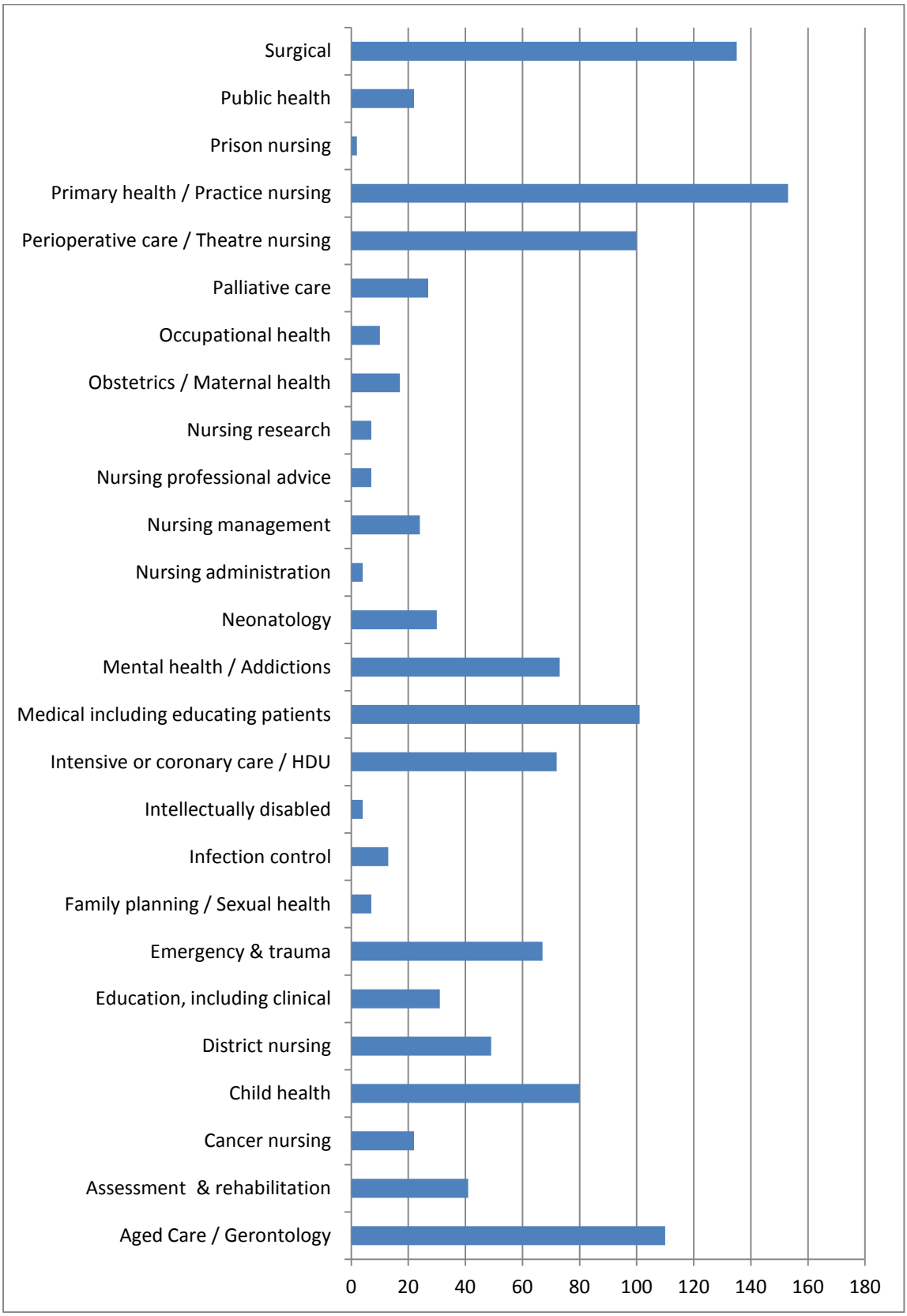
| Title | Number | Title | Number |
|---|---|---|---|
| Caregiver | 1 | Midwife | 13 |
| Charge nurse / manager | 84 | Nurse practitioner | 11 |
| Clinical nurse specialist | 83 | Other | 150 |
| Community nurse | 40 | Pacific Island nurse | 1 |
| Director of nursing | 3 | Practice nurse | 119 |
| District nurse | 34 | Public health nurse | 22 |
| Educator / researcher / lecturer / tutor | 58 | Registered nurse /staff nurse | 706 |
| Enrolled nurse | 38 | School nurse | 2 |
| Māori and iwi nurse | 4 | Service manager | 14 |
| Mental health nurse | 25 | | |

## 2.6 Nursing Field

Table 6. Field of practice

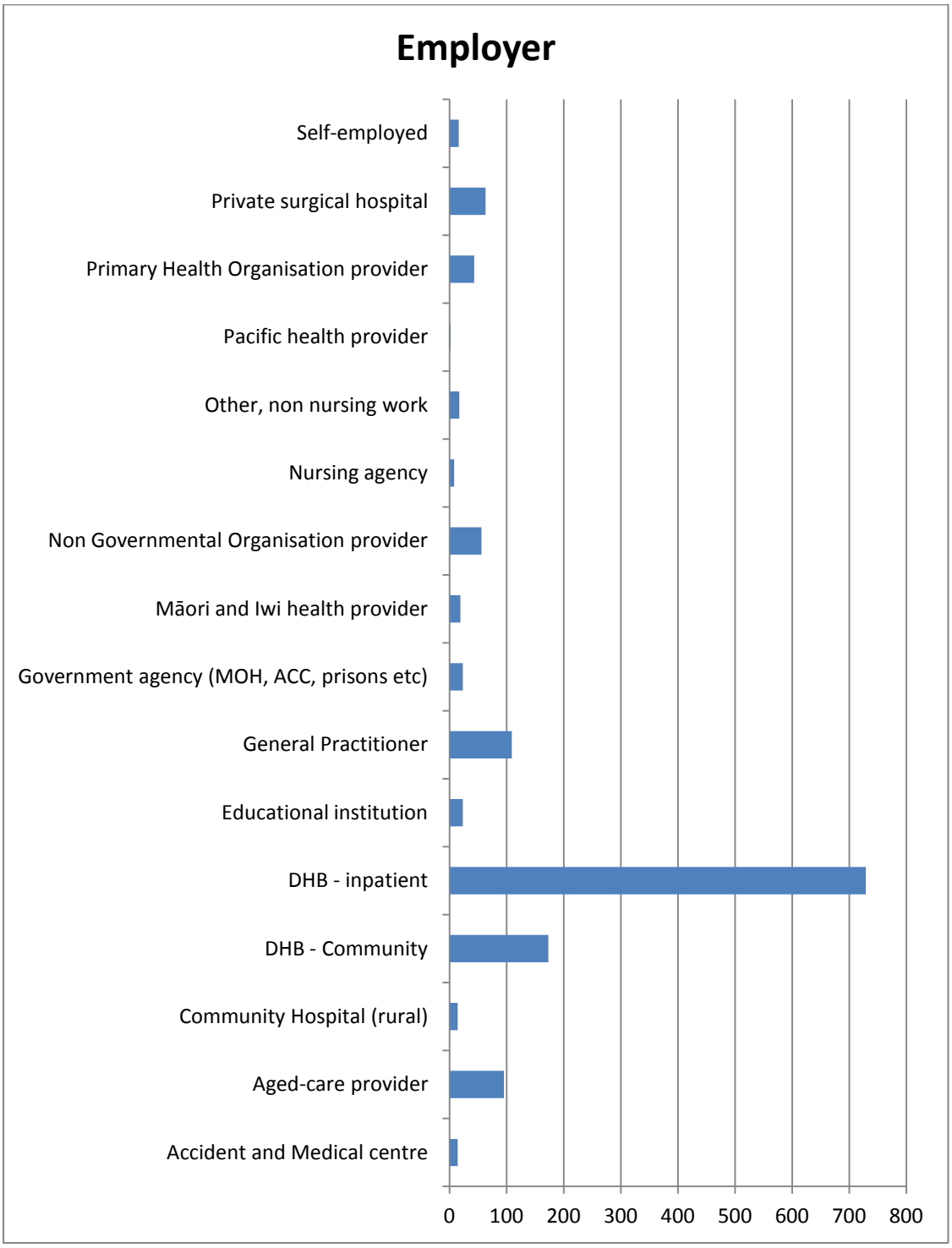
| Field | Number | Field | number |
|---|---|---|---|
| Aged Care / Gerontology | 110 | Nursing administration | 4 |
| Assessment & rehabilitation | 41 | Nursing management | 24 |
| Cancer nursing | 22 | Nursing professional advice | 7 |
| Child health | 80 | Nursing research | 7 |
| District nursing | 49 | Obstetrics / Maternal health | 17 |
| Education, including clinical | 31 | Occupational health | 10 |
| Emergency & trauma | 67 | Other | 172 |
| Family planning / Sexual health | 7 | Other - non nursing | 3 |
| Infection control | 13 | Other - nursing | 23 |
| Intellectually disabled | 4 | Palliative care | 27 |
| Intensive or coronary care / HDU | 72 | Perioperative care / Theatre nursing | 100 |
| Medical including educating patients | 101 | Primary health / Practice nursing | 153 |
| Mental health / Addictions | 73 | Prison nursing | 2 |
| Neonatology | 30 | Public health | 22 |
| Non-practicing | 2 | Surgical | 135 |

Figure 4. Field of practice



## 2.7 Employer

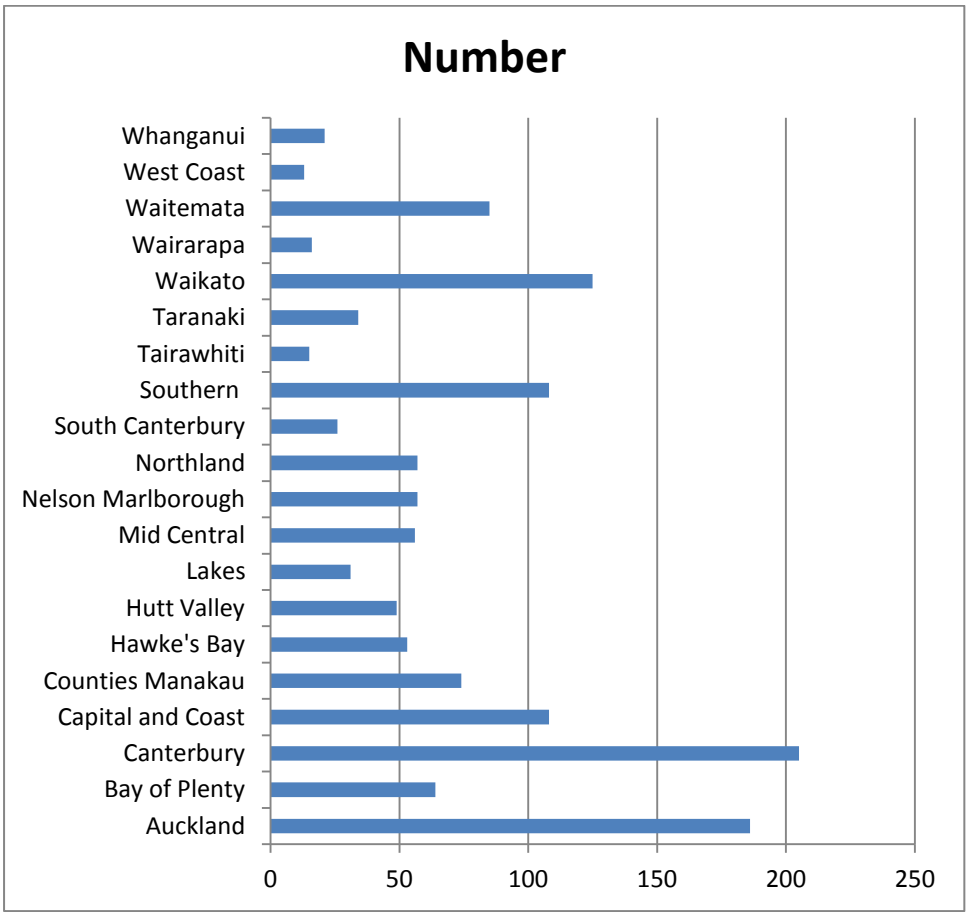
Figure 5. Employer



## 2.8 DHB area

A representative sample by DHB area was achieved.

Figure 6. DHB area



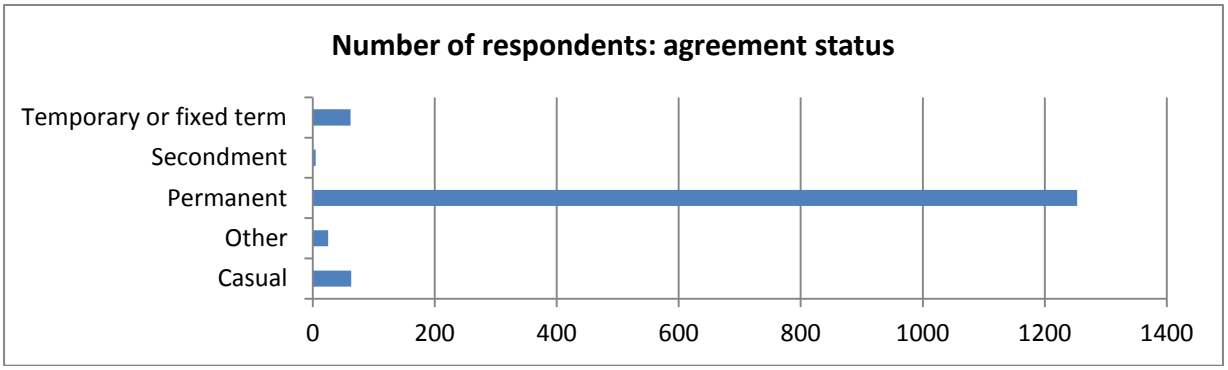

## 2.9 Employment contract status

This is shown in the table and graph below.

Table 7. Employment agreement status

| Employment agreement | number | per cent ES 2013 | per cent ES 2011 | per cent ES 2009 |
|---|---|---|---|---|
| **Casual** | 63 | 4.5 | 11 | 4.9 |
| **Other** | 25 | 0.6 | 1.4 | 2.7 |
| **Permanent** | 1253 | 89.1 | 81 | 88.7 |
| **Secondment** | 5 | 0.4 | - | - |
| **Temporary or fixed term** | 62 | 4.4 | 5.3 | 2.8 |

Figure 7. Agreement status




The increase in casualisation and use of temporary agreements seen between 2009 and 2011 has been reversed.

## 2.10 Summary

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

> The ethnicity, age and gender profiles of respondents match available nursing council data.

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

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

> The employment agreement status, in comparison to 2011 has improved.

> The increase in casualisation and use of temporary agreements seen between 2009 and 2011 has been reversed.

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

# Chapter 3. Pay and Employment agreements

## 3.1 Pay

Respondents were asked to give their pay in dollars per hour.

Table 8. Pay rates (dollars per hour)

| | Valid N | Mean | Minimum | Maximum | Standard Deviation |
|---|---|---|---|---|---|
| Pay 2013 ES | 1212 | 31.70 | 13.60 | 120.00 | 8.74 |
| Pay RN 2011 ES | 165 | 30.99 | - | - | 7.68 |

Figure 8. Histogram of pay rates (dollars per hour)

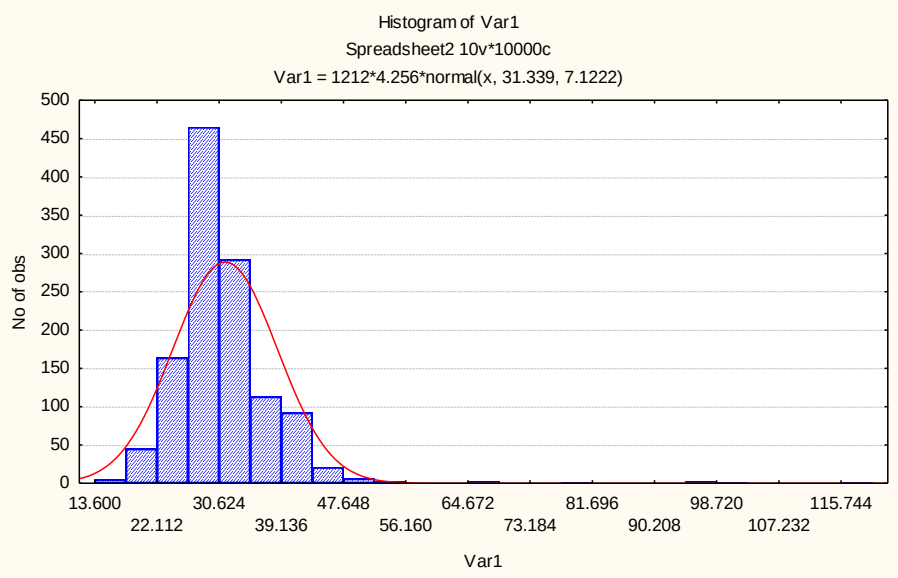



Table 9. Pay rates by employer (dollars per hour)

| EMPLOYER | Number | Mean pay ($) |
|---|---|---|
| **Accident and Medical centre** | 14 | 28.32 |
| **Aged-care provider** | 84 | 27.08 |
| **Community Hospital (rural)** | 10 | 31.2 |
| **DHB - community** | 147 | 32.86 |
| **DHB - inpatient** | 628 | 33.82 |
| **Educational institution** | 19 | 38 |
| **General practitioner** | 95 | 29.98 |
| **Government agency (MOH, ACC, prisons etc.)** | 17 | 35.9 |
| **Māori and iwi health provider** | 18 | 28.08 |
| **Non-governmental organisation (NGO) provider** | 48 | 33.8 |
| **Nursing agency** | 7 | 29 |
| **Primary health organisation (PHO) provider** | 36 | 33.3 |
| **Private surgical hospital** | 55 | 32.3 |

Figure 9. Mean pay rates by employer (dollars per hour)

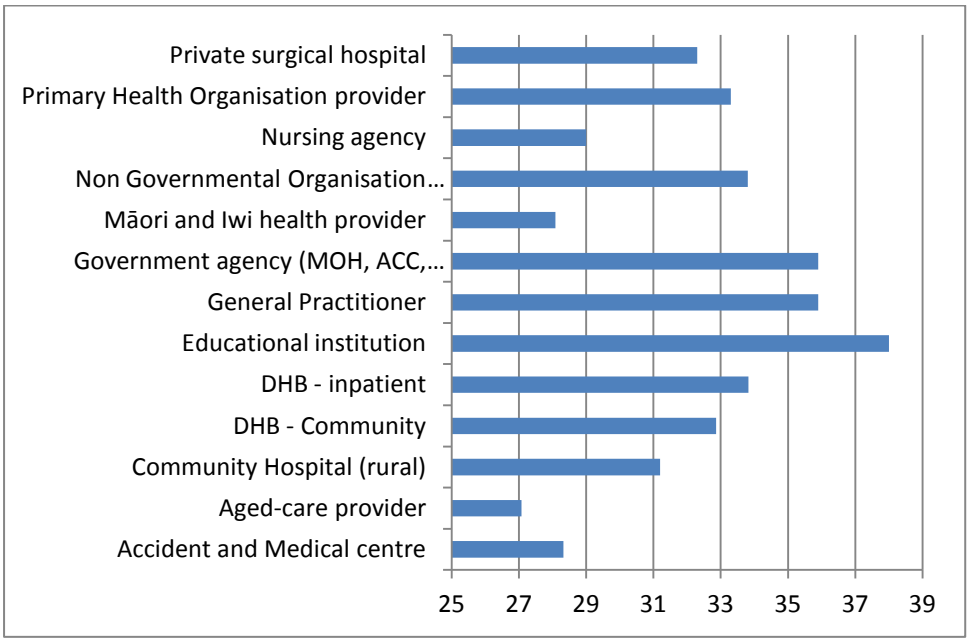
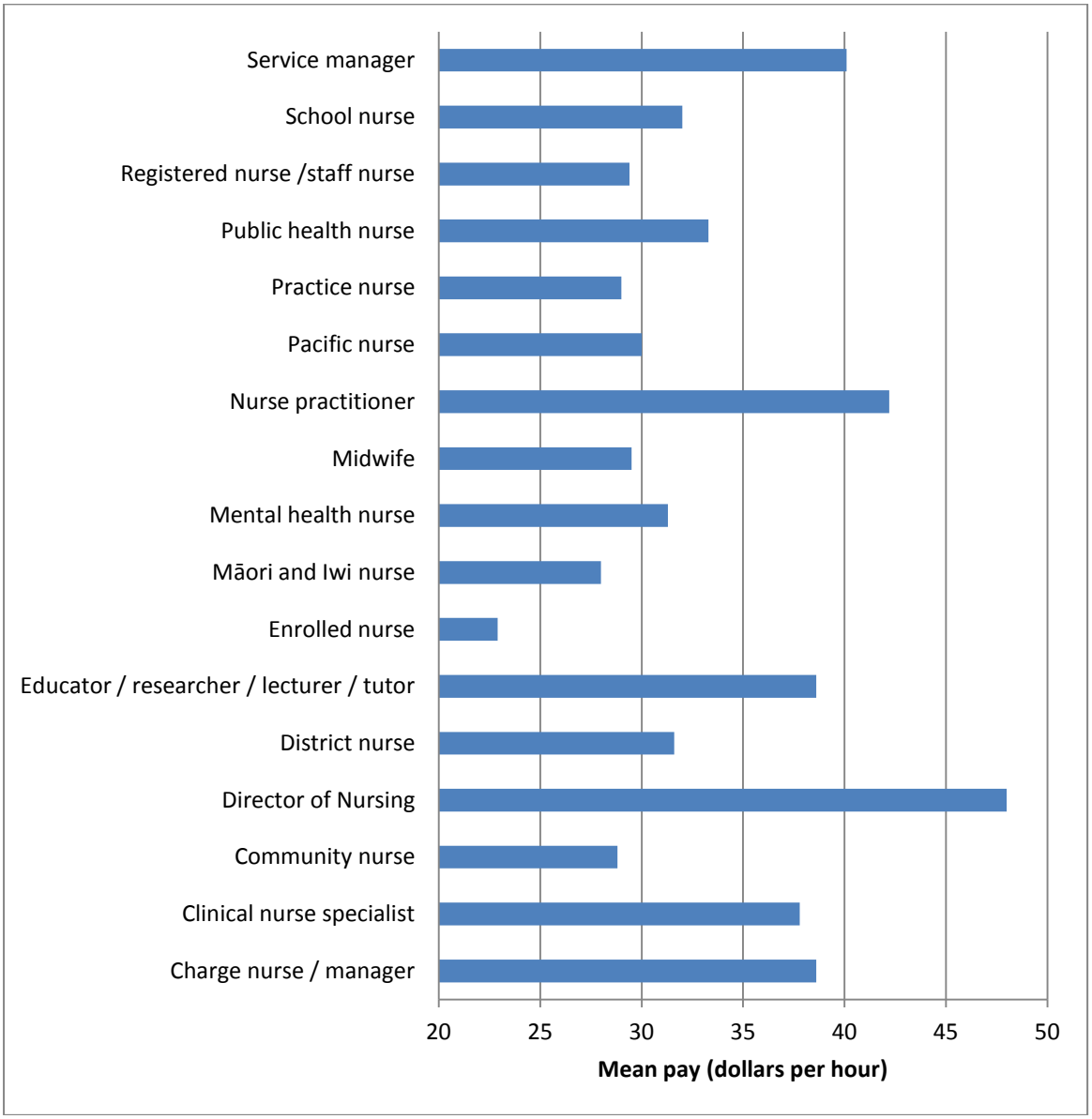



Table 10. Pay rate by job title (dollars per hour)

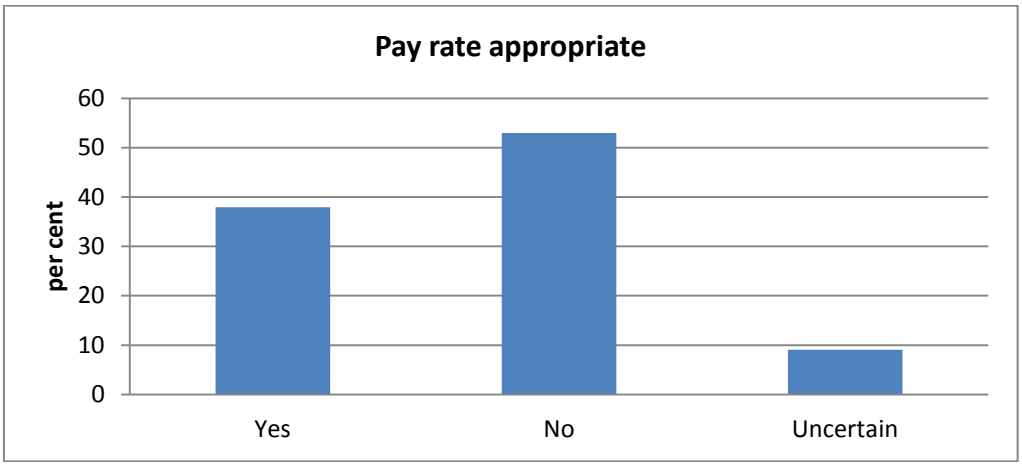
| Title | Number | Mean pay $ /hr |
|---|---|---|
| **Charge nurse / manager** | 67 | 38.6 |
| **Clinical nurse specialist** | 76 | 37.8 |
| **Community nurse** | 36 | 28.8 |
| **Director of nursing** | 3 | 48 |
| **District nurse** | 26 | 31.6 |
| **Educator / researcher / lecturer / tutor** | 46 | 38.6 |
| **Enrolled nurse** | 31 | 22.9 |
| **Māori and iwi nurse** | 3 | 28 |
| **Mental health nurse** | 20 | 31.2 |
| **Midwife** | 10 | 29.5 |
| **Nurse practitioner** | 6 | 42.2 |
| **Pacific Island nurse** | 1 | 30 |
| **Practice nurse** | 106 | 29 |
| **Public health nurse** | 19 | 33.3 |
| **Registered nurse /staff nurse** | 618 | 29.4 |
| **School nurse** | 2 | 32 |
| **Service manager** | 9 | 40.1 |

Figure 10. Mean pay rate by job title (dollars per hour)




There was little discernible pattern of pay satisfaction by job title, though a higher proportion of those with job titles of enrolled or registered /staff nurses were unhappy with their pay than most other titles.

Figure 11. 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 this perception by employer type also.

Figure 12. Perception of mean pay rate (dollars per hour)

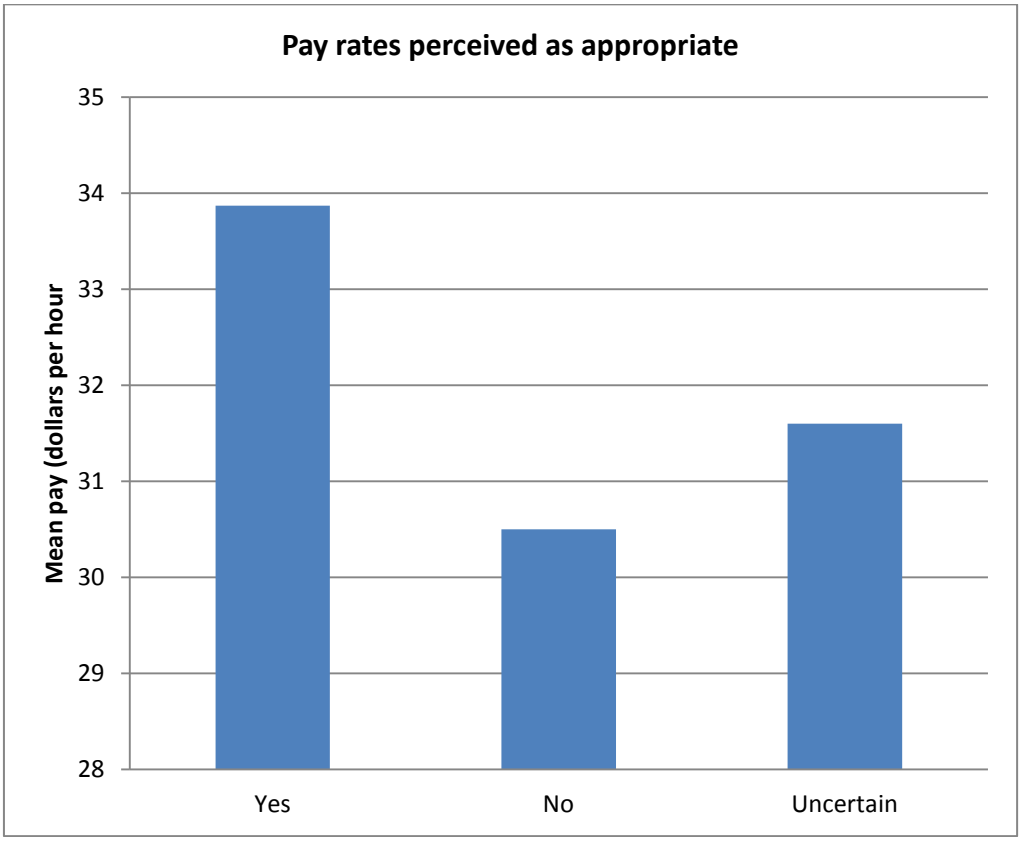
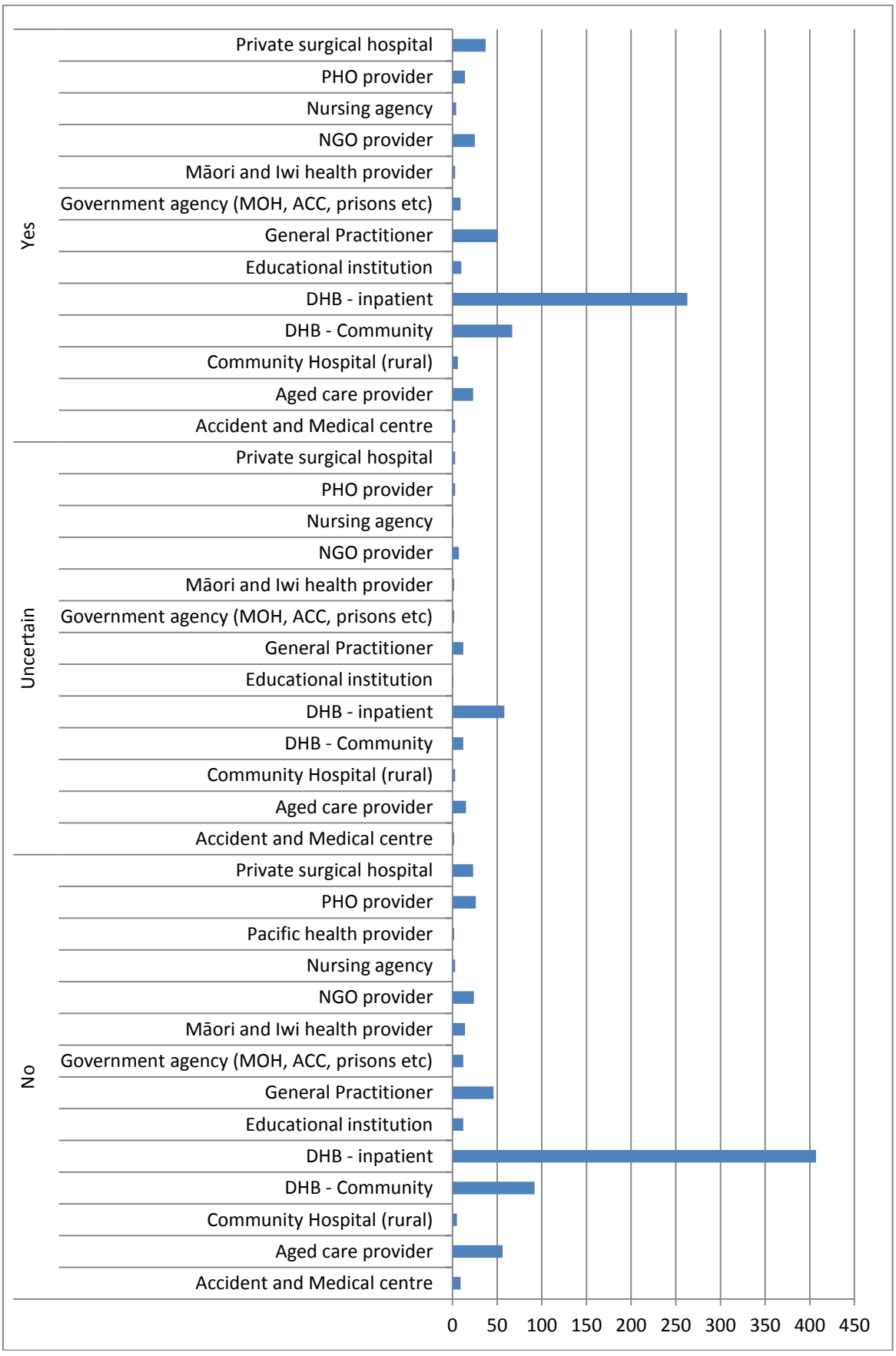


Figure 13. Perception of pay by employer (number). Yes = paid appropriately, No = not paid appropriately and Uncertain = not sure if paid appropriately



## 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 14. Proportion of income that contributes to household income

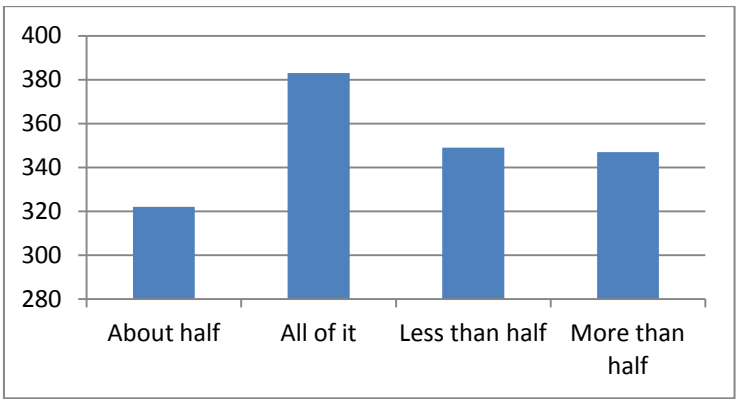
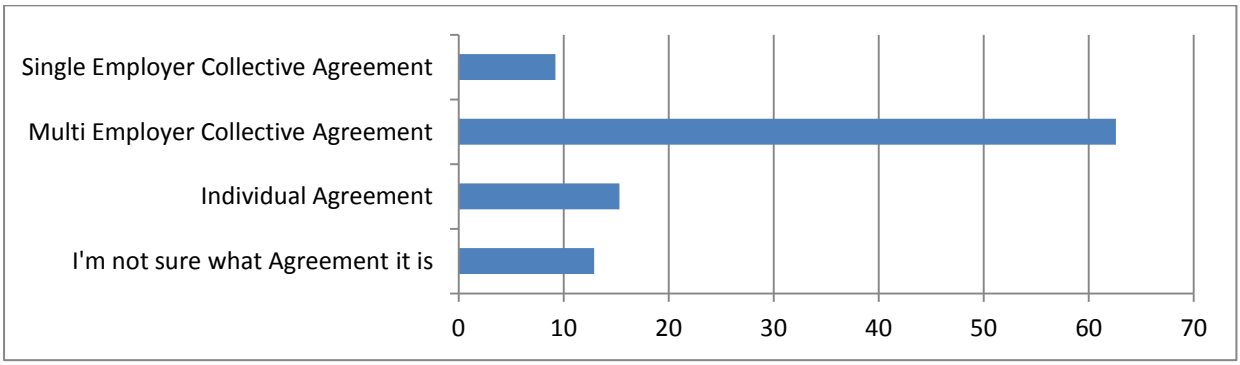



Table 11. Responsibility for dependent children or adults

| Responsibilities | Number |
|---|---|
| Responsibility for children | 598 |
| Responsibility for adults | 170 |
| Responsibility for both children and adults | 68 |
| Responsibility for neither | 714 |

## 3.3 Employment Agreements

Figure 14. 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, especially in comparison with other professionals, and nurse wages in Australia.

> The mean rate of pay for registered nurses has increased very slightly since 2011.

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

> The lowest rates of pay were for enrolled nurses, Māori and iwi nurses and practice nurses.

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

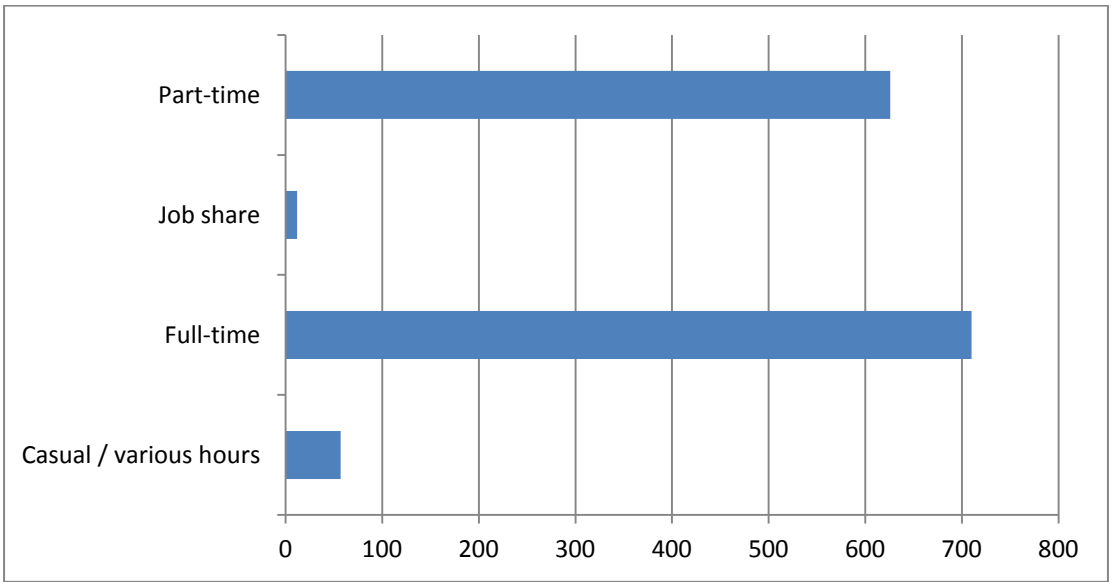
> Nurses' salaries make a significant contribution to the household budget, with around two thirds contributing half or more than half of all income to families.

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

# Chapter 4 Working patterns

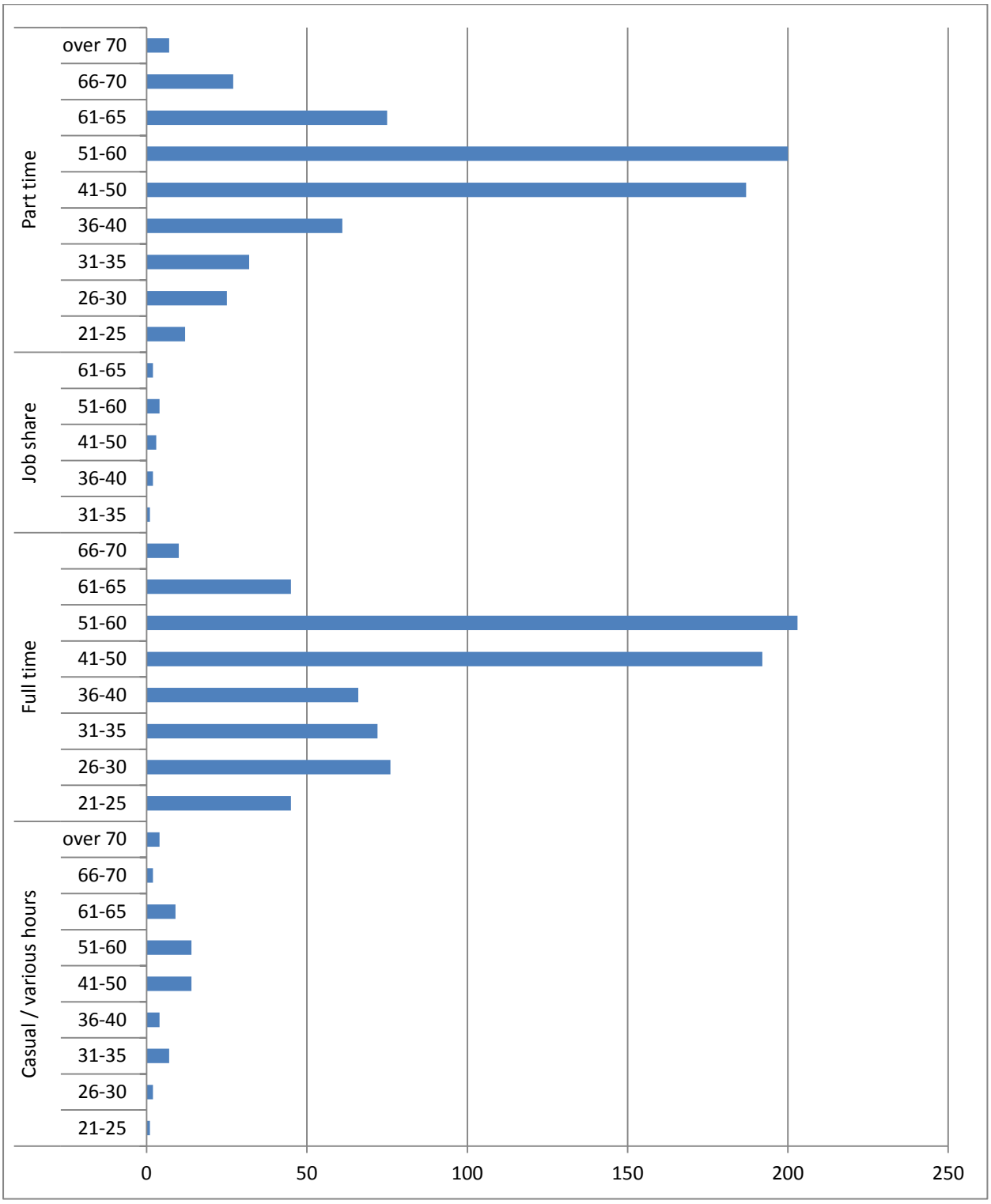
## 4.1 Contracts

Figure 15. Type of contract



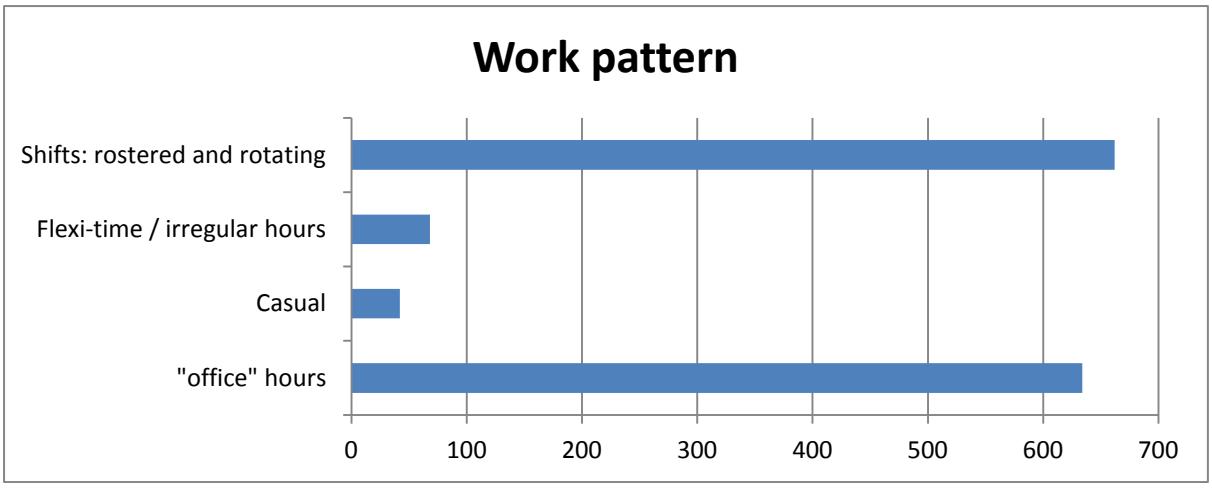

There were differences in the types of contracts in the various age groups, as shown in figure 16:

Figure 16. Types of work contract by age



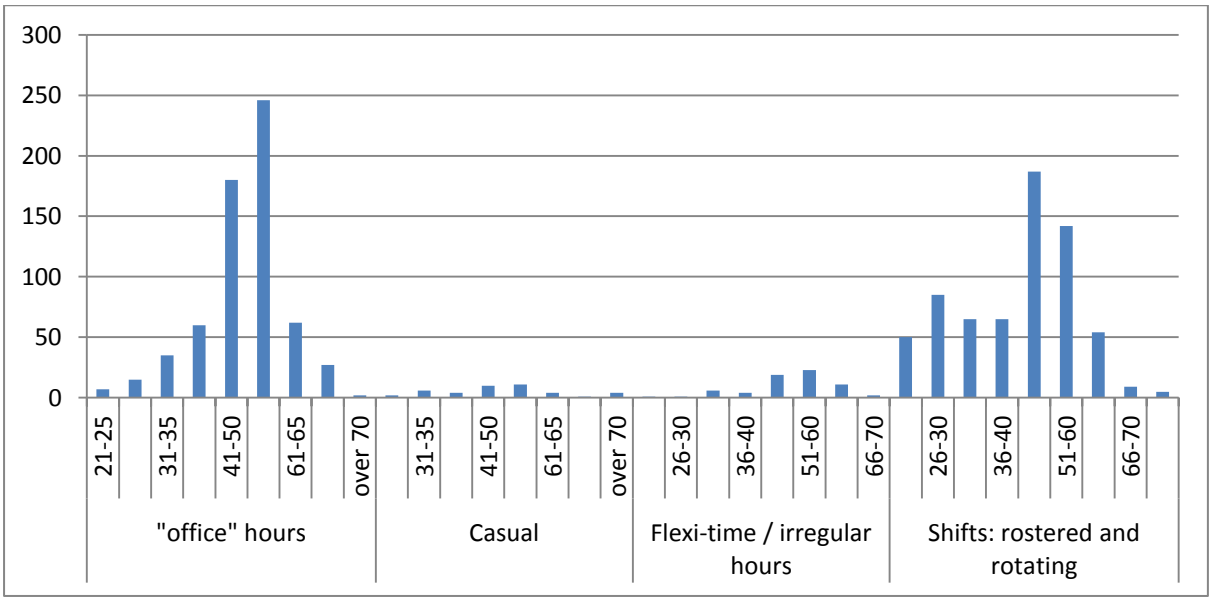
## 4.2 Work pattern

Figure 17. Work pattern




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

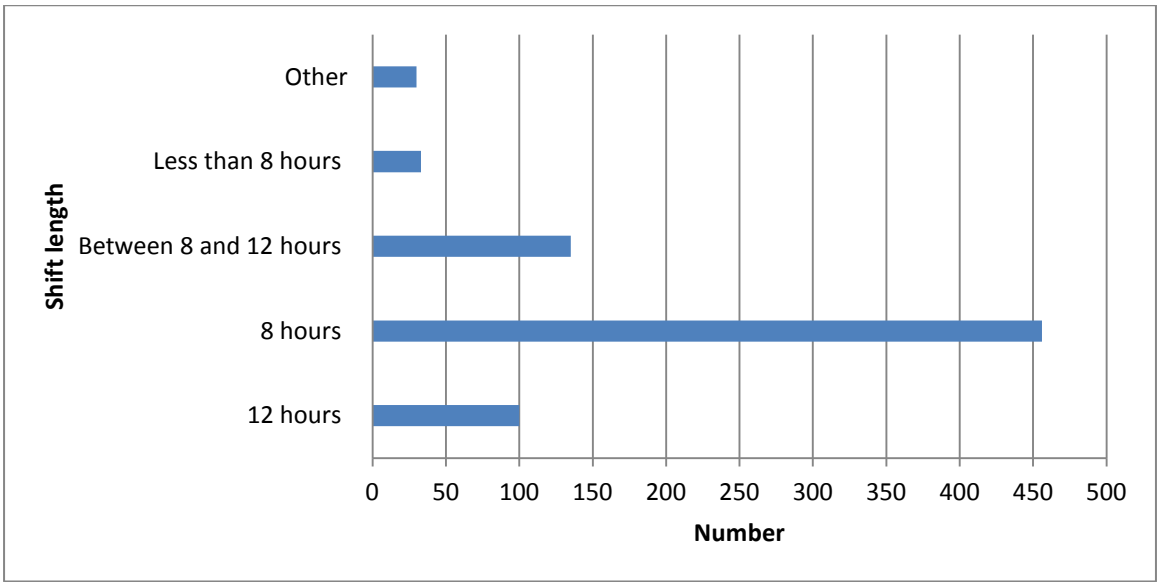
Figure 18. Number of nurses in each age group working particular shifts



## 4.3 Shifts

The commonest shift length was eight hours.

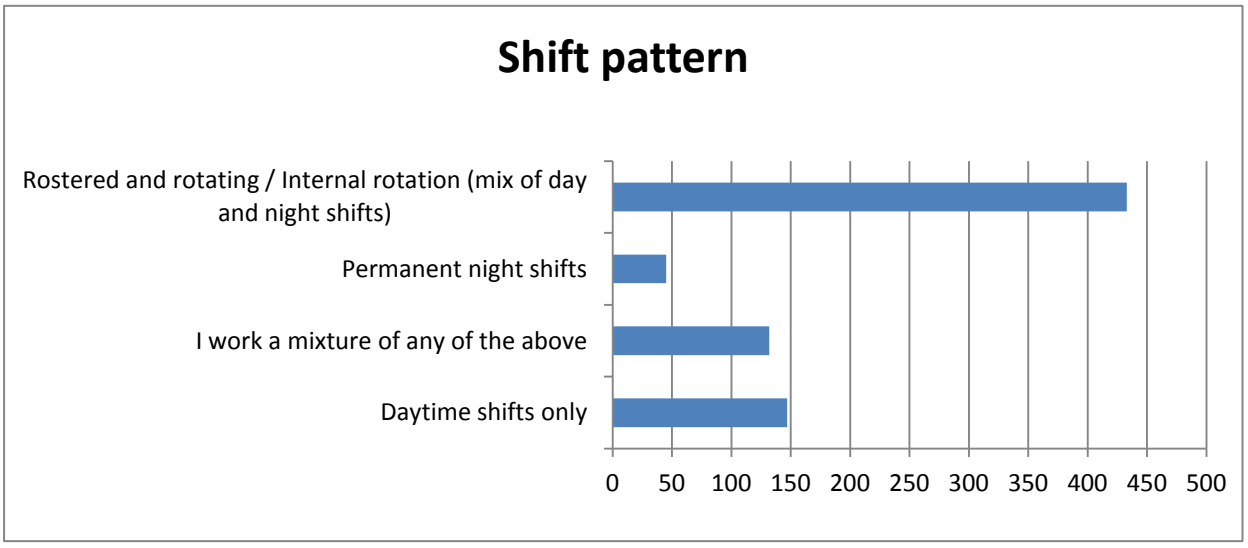
Figure 19. Shift length




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 two DHBs with significant 12-hour shift options were Auckland and Counties Manukau.

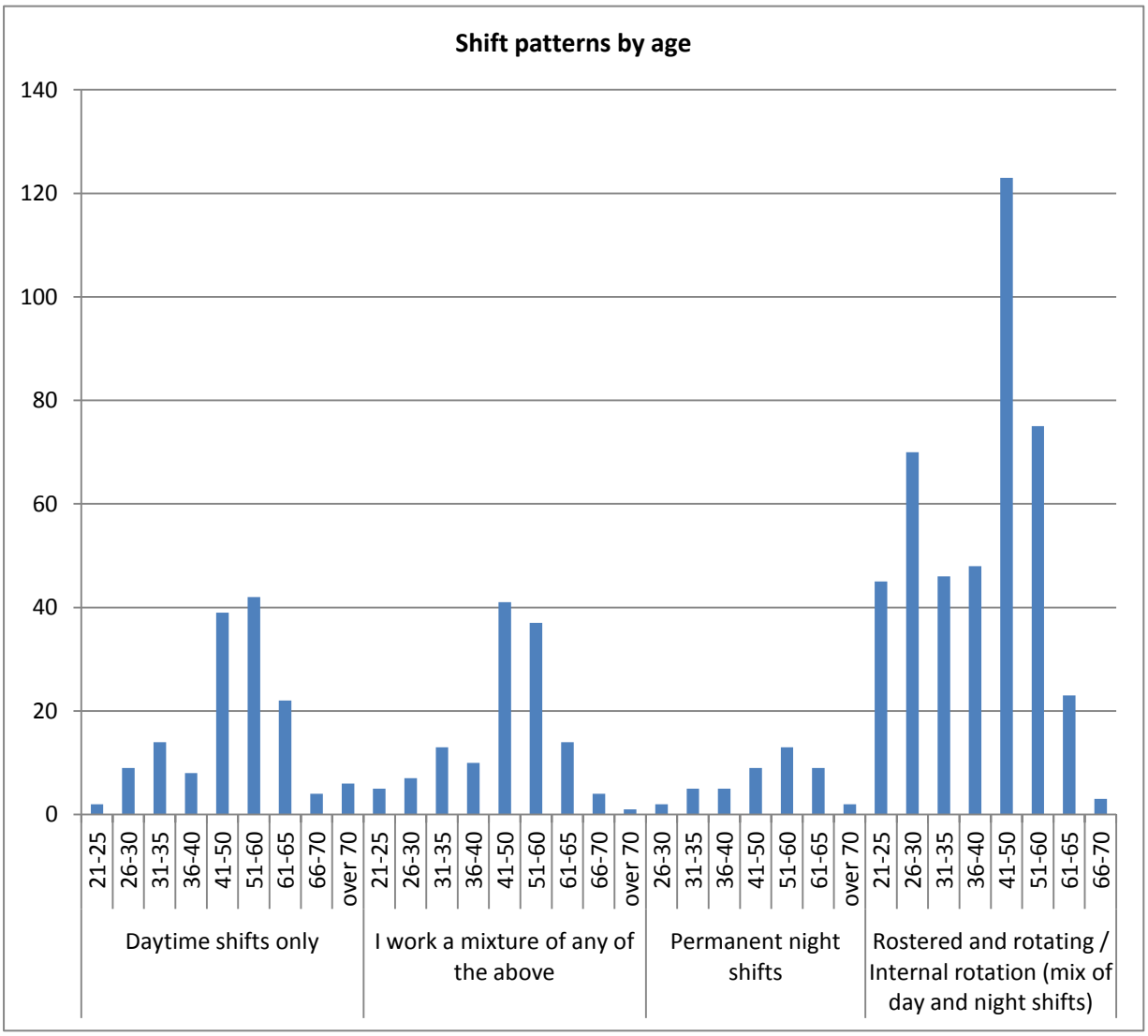
Of those (754) who worked shifts, 57 per cent worked rostered and rotating shifts

Figure 20. Shift pattern



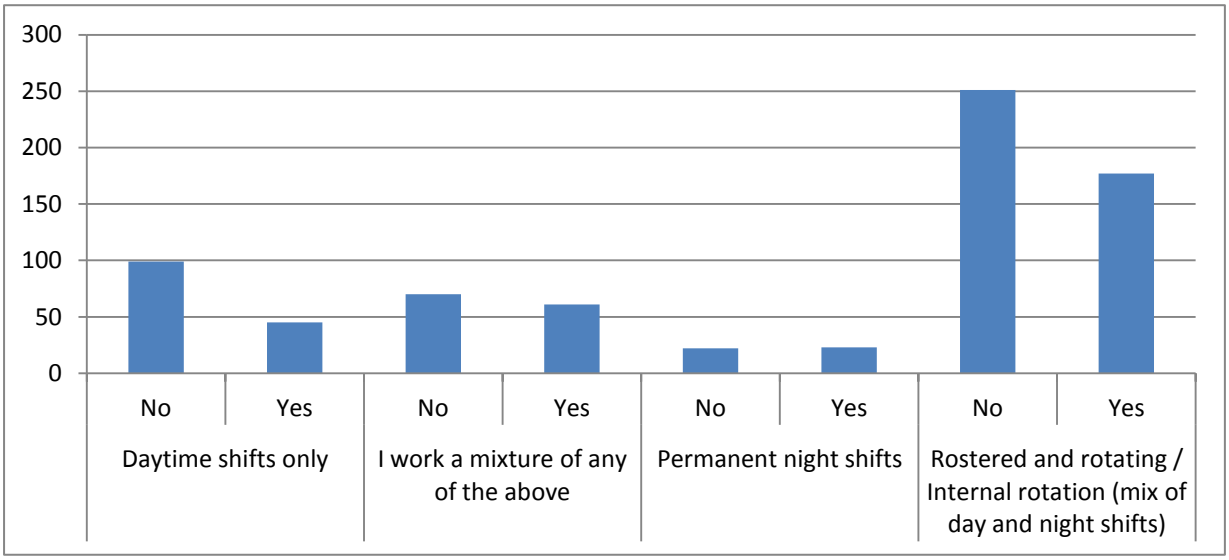

Comparing the age profiles of the shift workers, it can be seen that of those who work permanent nights, many were in the older age groups. Very few under 40-year-olds worked day shifts only. See figure 21.

Figure 21. Shift pattern by age



Having dependent children was not associated with particular shift patterns.

Figure 22. Shift pattern and dependent children (marked yes)




Those who worked shifts (n=756) were asked their agreement/disagreement with a series of five *statements* about shift preferences and management.

Figure 22. Rosters are available well in advance

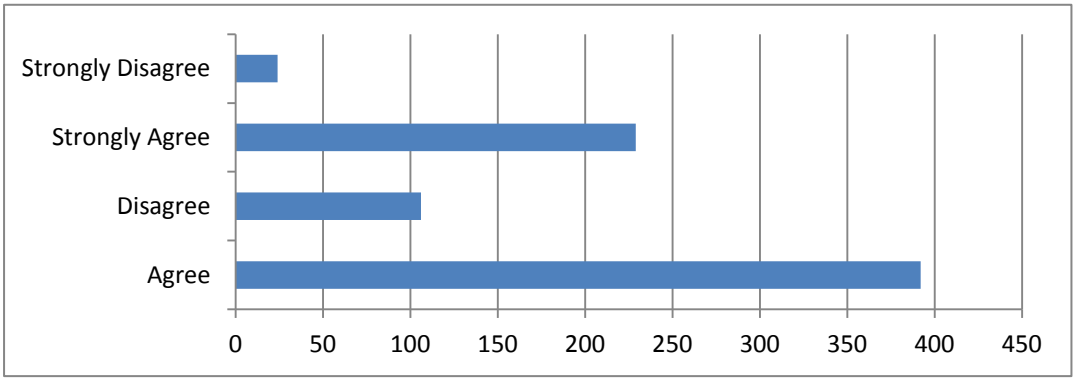



Figure 23. There is flexibility in rosters when needed

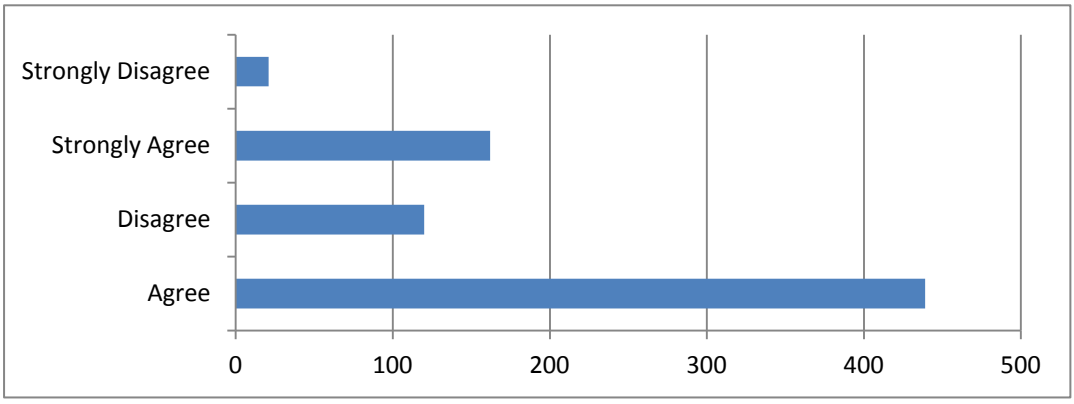


Figure 24. The choice of shifts in rosters is allocated fairly

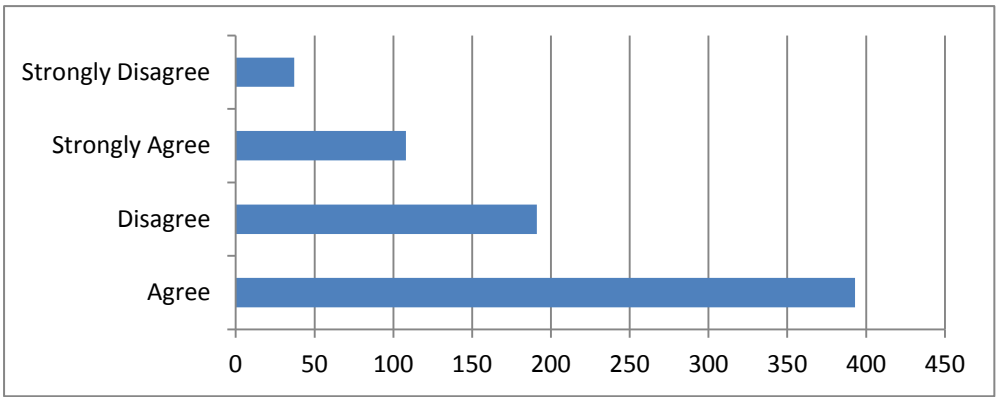
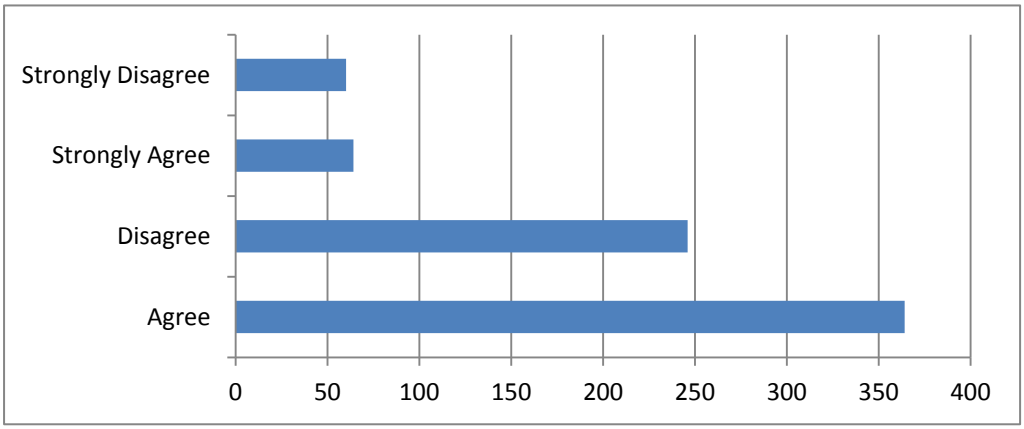
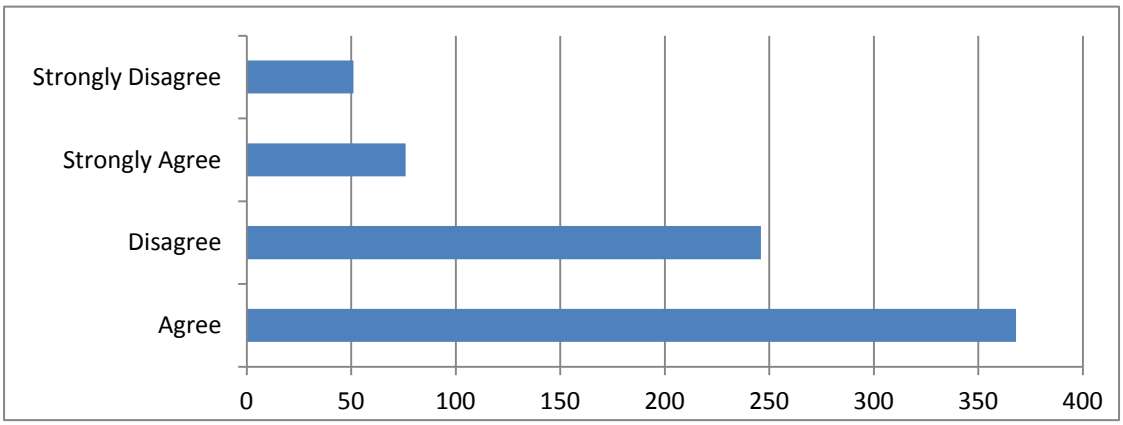



Figure 25. Nurses get adequate recovery time between shifts



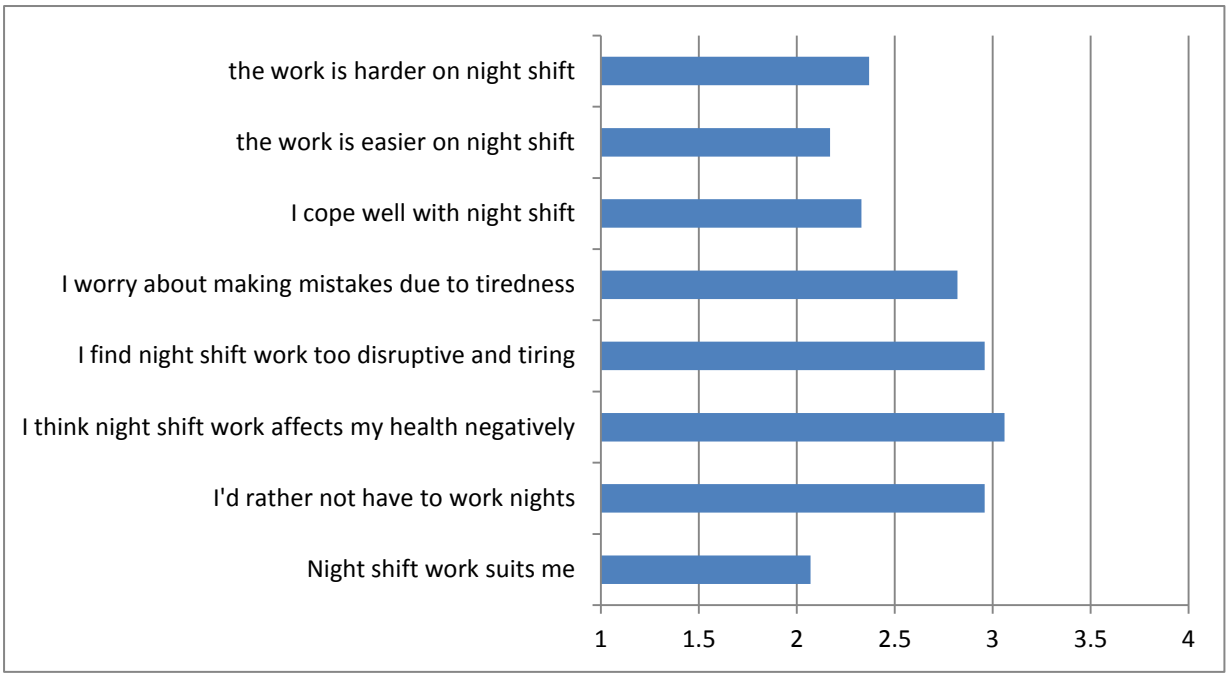

There was no one employer type where nurses reported inadequate recovery time disproportionately.

Figure 26. Nurses mostly work the shifts they prefer



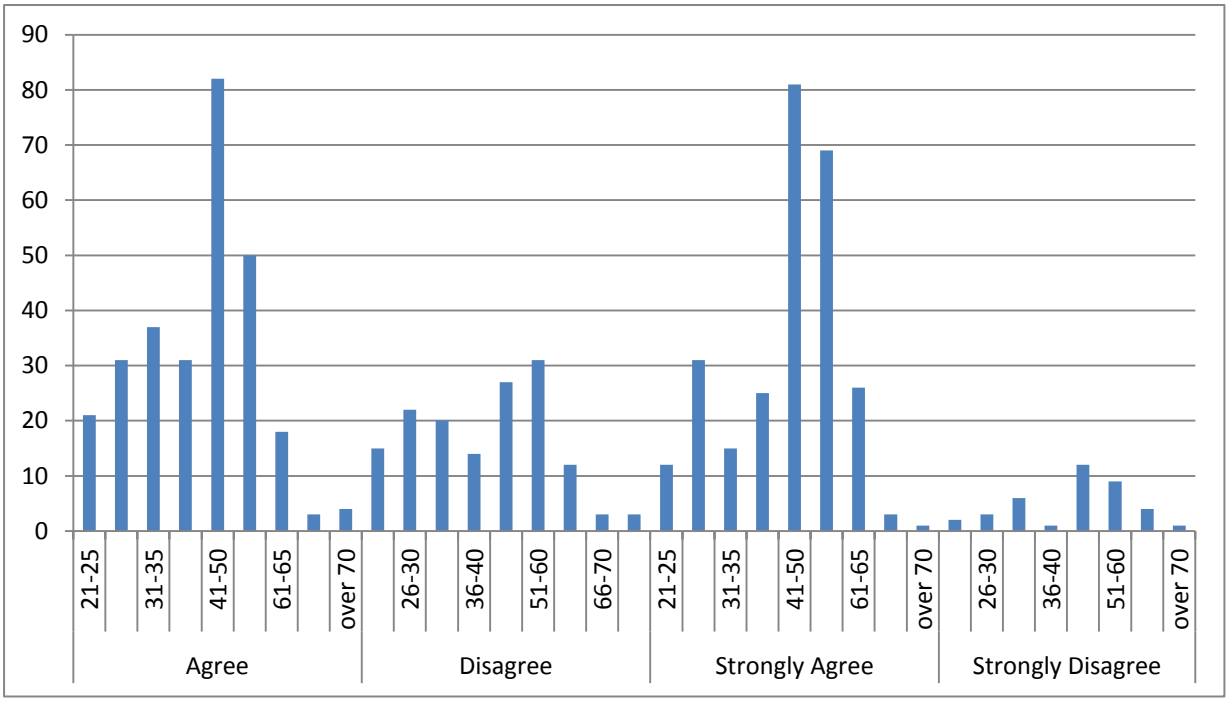
Asked about agreement with another series of views about the effects on their own health and function associated with night shift, the following weighted scores were produced. For all statements, a score of 4 = strong agreement, and 1 = strong disagreement.

## Figure 27. Opinions about night shift: weighted scores




There was evidence that older nurses felt more strongly about the negative health effects of night shift work.

## Figure 28. "Night shift work affects my health negatively"



## 4.4 Qualitative data related to shift work (nights)

(These are just a few representative quotes from each category.)

### Negative effects

*I specifically work for the bureau because I cannot work night shift safely and without having my health affected.*

*Work on nights is just as hard as days but in a different way, you are more independent relying on assessment skills as medical backup is often not as accessible. Sick people do not sleep.*

*It often takes several days to recover, mental faculties are impaired, more likely to make errors at work and when driving.*

*Destroys your body clock, makes me feel so very ill and takes days to recover from. I HATE working nights and there are times I cannot stop myself falling asleep. Nights suck, suck!*

*Have trouble sleeping in the day well enough to return to work the next night. It is even more difficult in the warmer months.*

*I find night shift exhausting, it affects my sleep patterns, my bowel movements, my legs and feet swell, I have difficulty concentrating and have had an accident in the car on the way home because I couldn't keep awake.*

### More positive comments

*I think night shift is necessary, and am more than happy to complete my fair share. I like to know in advance so I can prepare and organise so I can have the required amount of rest before starting my run of nights, and I get that so it works well for me.*

*I have done part-time night shift for 28 years. It suited well when children were little. I now continue to enjoy and have certainly a good routine for sleeping and easily manage a power nap most nights with no problems. Have attended two night duty conferences.*

*I have done a lot of nights over the years. I enjoy it but it is absolutely necessary to get adequate sleep and preferably with a good stretch of night duties not to have single shifts interspersed with days.*

### Shift work and rostering effects

*It's not night shifts that are so tiring/ it's the constant change from days to night so sleeping patterns can never be established.*

*In my area the nightshift can be more hectic than the day with less cover. I would rather do a month of nights then one of days, instead of changing every few weeks, you can get in a routine that works but it's harder to swap between the two shifts.*

*Not enough recovery time after doing night shift before back on. May work Tuesday night then could be back on Thursday am/pm shift.*

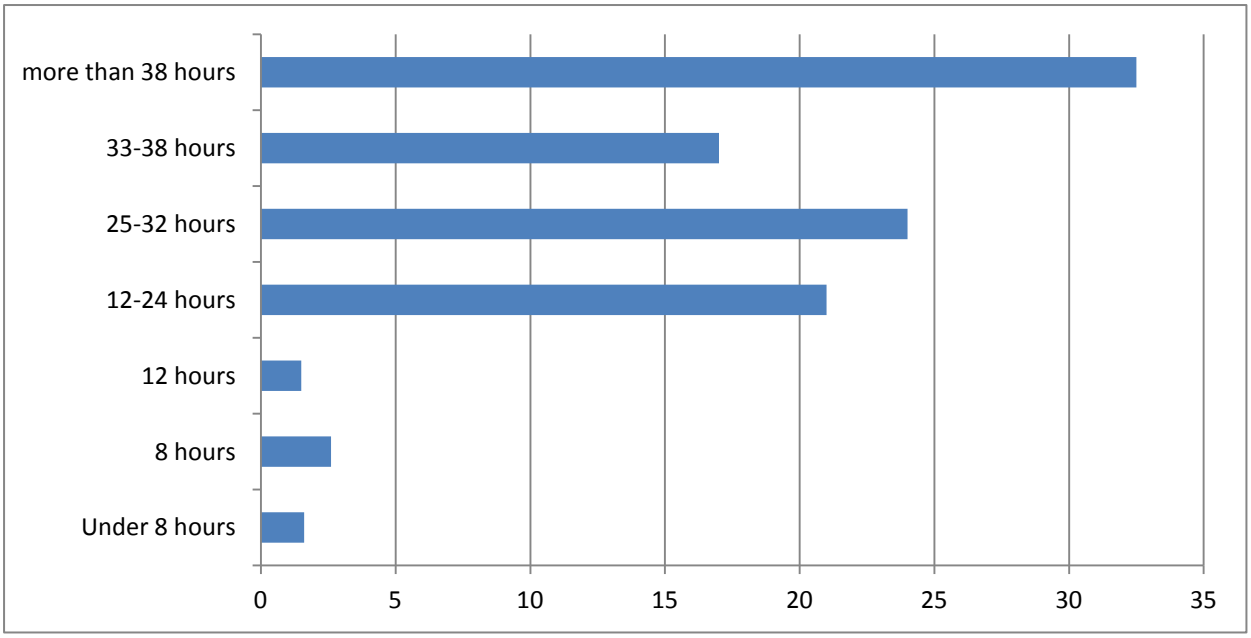
*The cumulative effect of swapping shifts all the time is tiring.*

*Swapping back and forth between nights and days regularly is disruptive to body clock- it would be better if did all nights for month together rather than some every week mixed with days.*

## 4.5 Hours worked

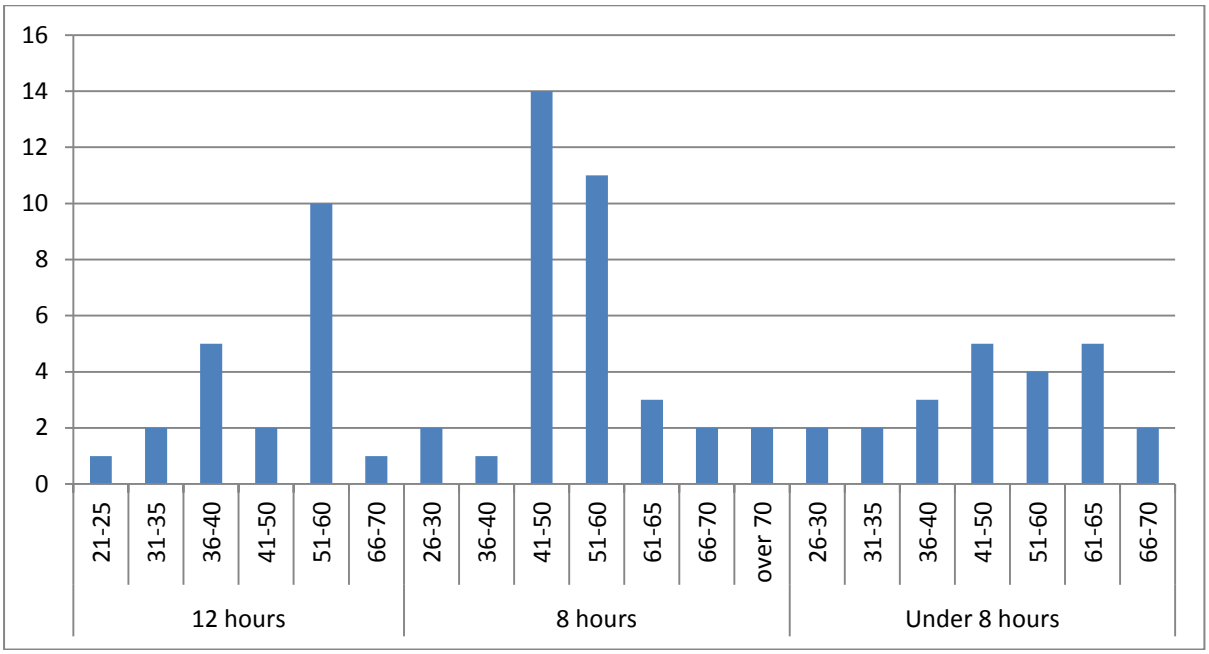
Only around a third of nurses are contracted to work more than 38 hours per week in their main job, with very small numbers working the equivalent of one eight- or 12-hour shift per week. This has not changed significantly since 2011.

Figure 29. Percentage working different hours per week



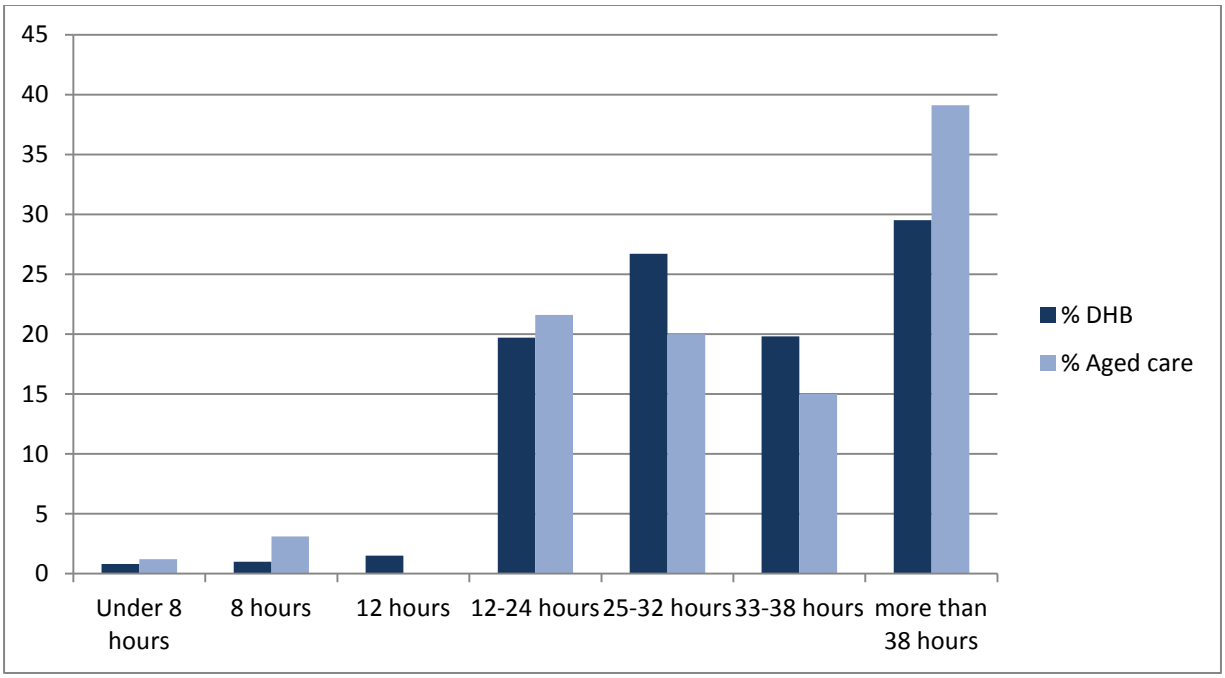
For those working 12 hours per week or less, this is seen at all age groups, though the over 65s are over represented.

## Figure 30. Hours of work by age




Comparing DHB and aged-care employers, the hours worked (as a percentage of all DHB or AC staff) can be seen in figure 31.

## Figure 31. Percentage of hours worked by DHB or aged-care setting

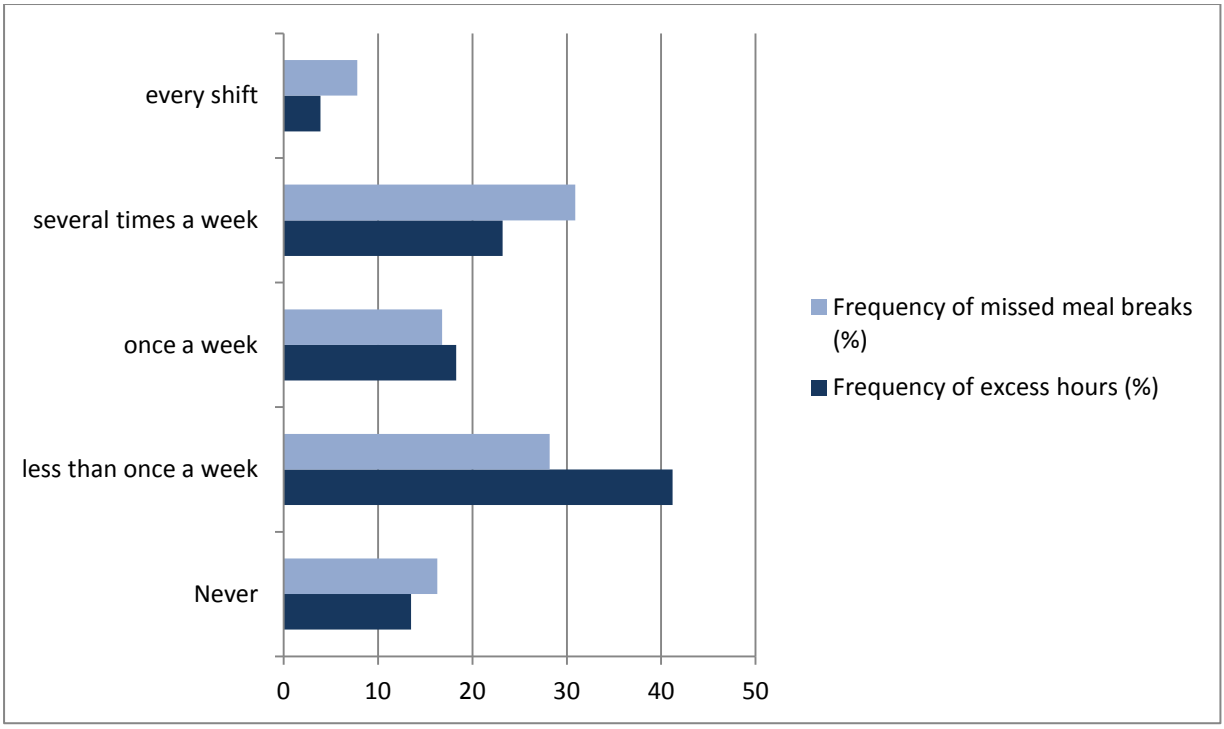



Sixty seven per cent of nurses reported regularly working extra hours to provide cover, 53 per cent at the normal pay rate, and 28 per cent at a higher rate; 3.5 per cent had time off in lieu, and 5.3 per cent received no financial reward for working extra to provide cover.

## 4.6 Extra hours

Asked specifically about the previous week, **46.6 per cent (652 nurses) had worked extra hours the previous week.** Of these, 88 had worked an extra eight- or 12-hour shift, 167 four to eight hours extra, 187 two to four hours extra and 153 one to two hours extra.

Figure 32. 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 33.

Figure 33. Percentage of those who worked excess hours by work setting – surgical, primary health/practice nursing, aged care/gerontology

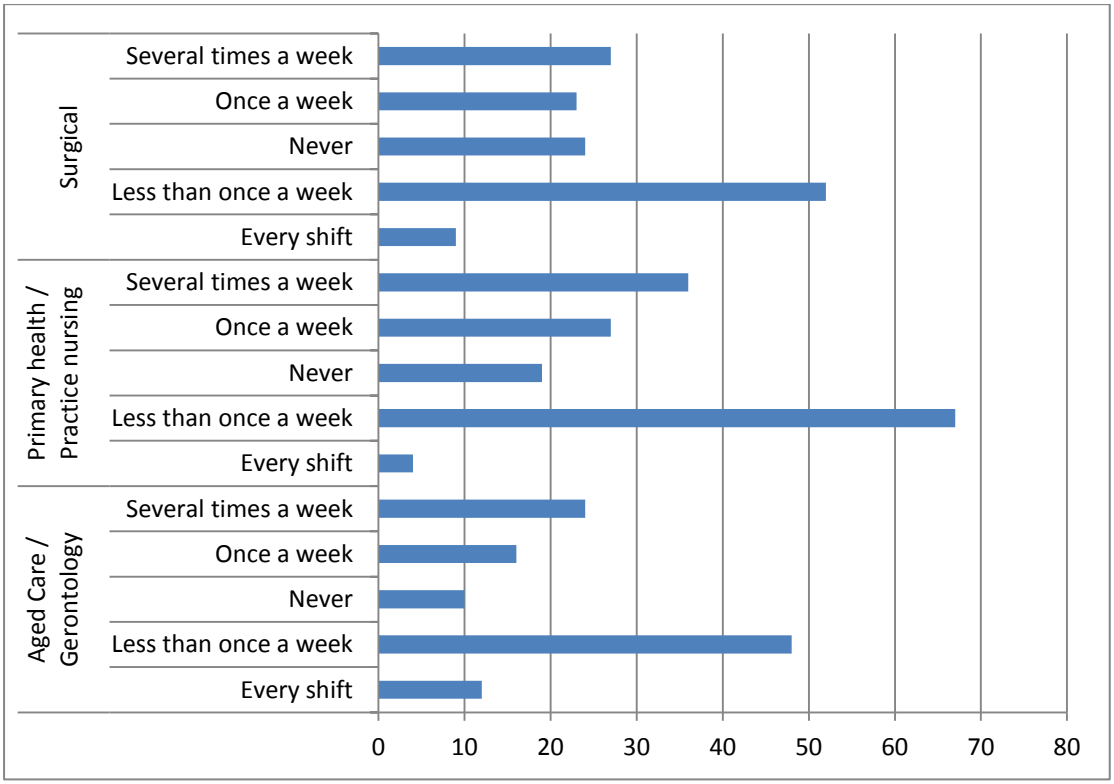
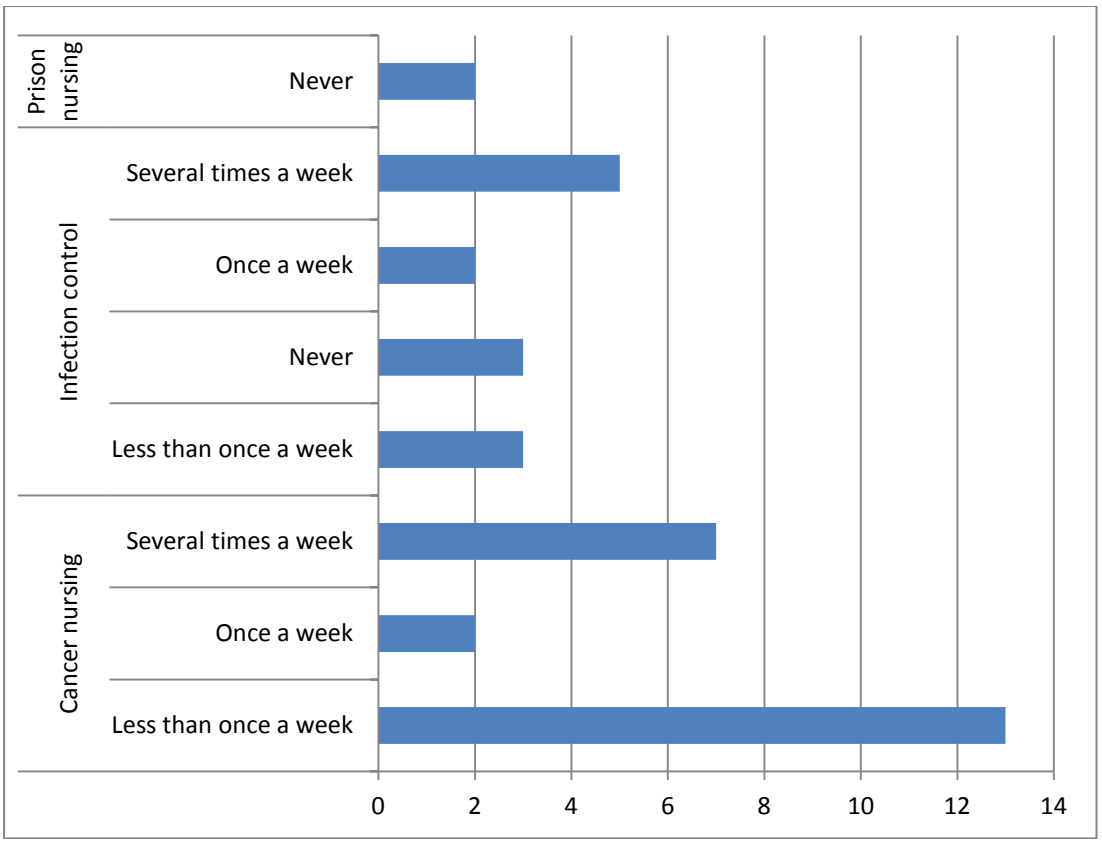



Figure 34 on the following page shows the differences for prison nursing, infection control and cancer nurses (who likewise, had similar numbers of respondents).

Figure 34. Percentage of those who worked excess hours by work setting – prison nursing, infection control and cancer nurses




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

## 4.7 Nursing tasks

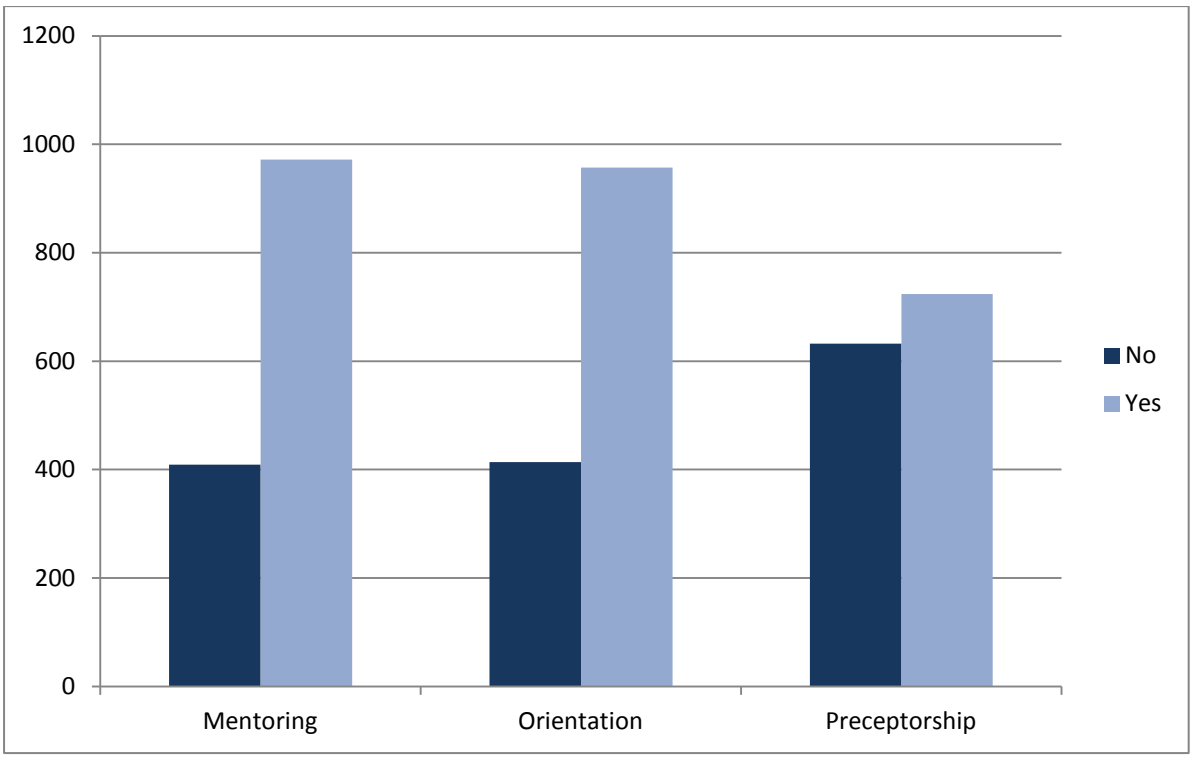
The approximate percentage of time spent on a variety of nursing tasks was also recorded. Table 12 shows a variety of tasks listed in reverse order of the highest proportion of time allocated to each item. (The sum of 140 per cent of time spent on all activities may reflect the excess time, multitasking 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) | **65.34** | **1** |
| Administration | **16.21** | **2** |
| Management | **15.04** | **3** |
| Educating/ training | **13.57** | **4** |
| Other | **9.98** | **5** |
| Professional development | **7.7** | **6** |
| Cleaning / domestic | **7.08** | **7** |
| Research | **5.09** | **8** |

Figure 35 shows a range of additional specific responsibilities.

Figure 35. Additional responsibilities




Respondents were also asked if they had a second employer with 16 per cent indicating they did.

## 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 one or two shifts per week has increased. This is especially true of the aged-care sector.

> A higher proportion (46 per cent vs 32 per cent in 2011) chose to work additional hours to provide cover. This use of additional hours may explain the reduction in casual and short-term contract nursing 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.

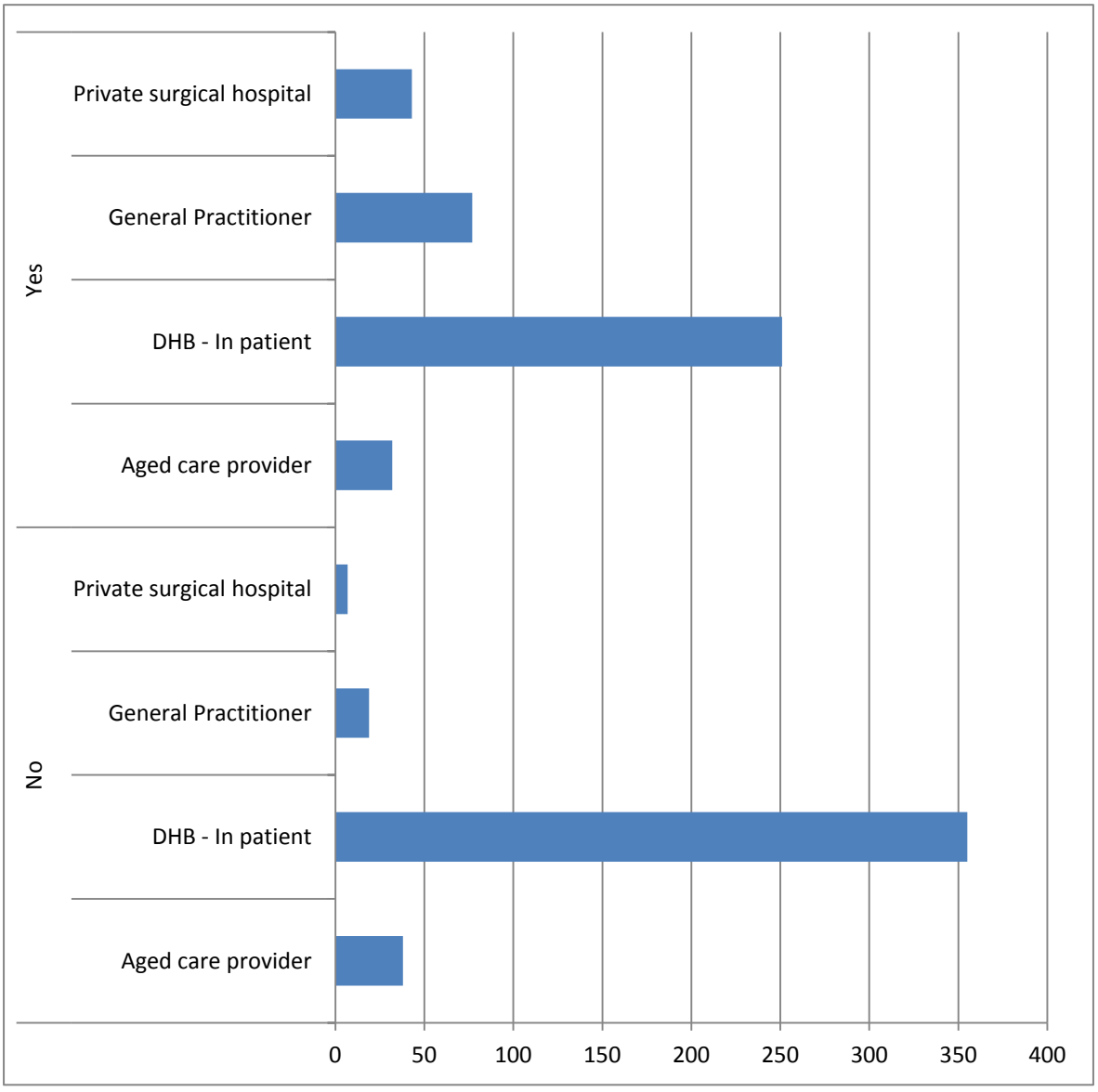
> Sixteen per cent of all respondents had a second employer: the total available nursing workforce requirements compared to the total number of available and willing registered nurses will therefore be increasingly hard to model with any degree of accuracy.

# Chapter 5: Workload and staffing

## 5.1 Perceptions of clinical practice

Just over 85 per cent of respondents worked in a clinical setting. Responses to a standardised set of factors related to good patient care produced some interesting findings. Of note, less than 50 per cent (46.4 per cent) felt there were enough nurses where they worked to meet patient needs. This is a slight improvement compared to two years ago but 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 satisafaction with the numbers and skills of nurses to provide safe care.

Figure 36. Respondents perspective on whether there are sufficient nurses to provide safe care by employment sector



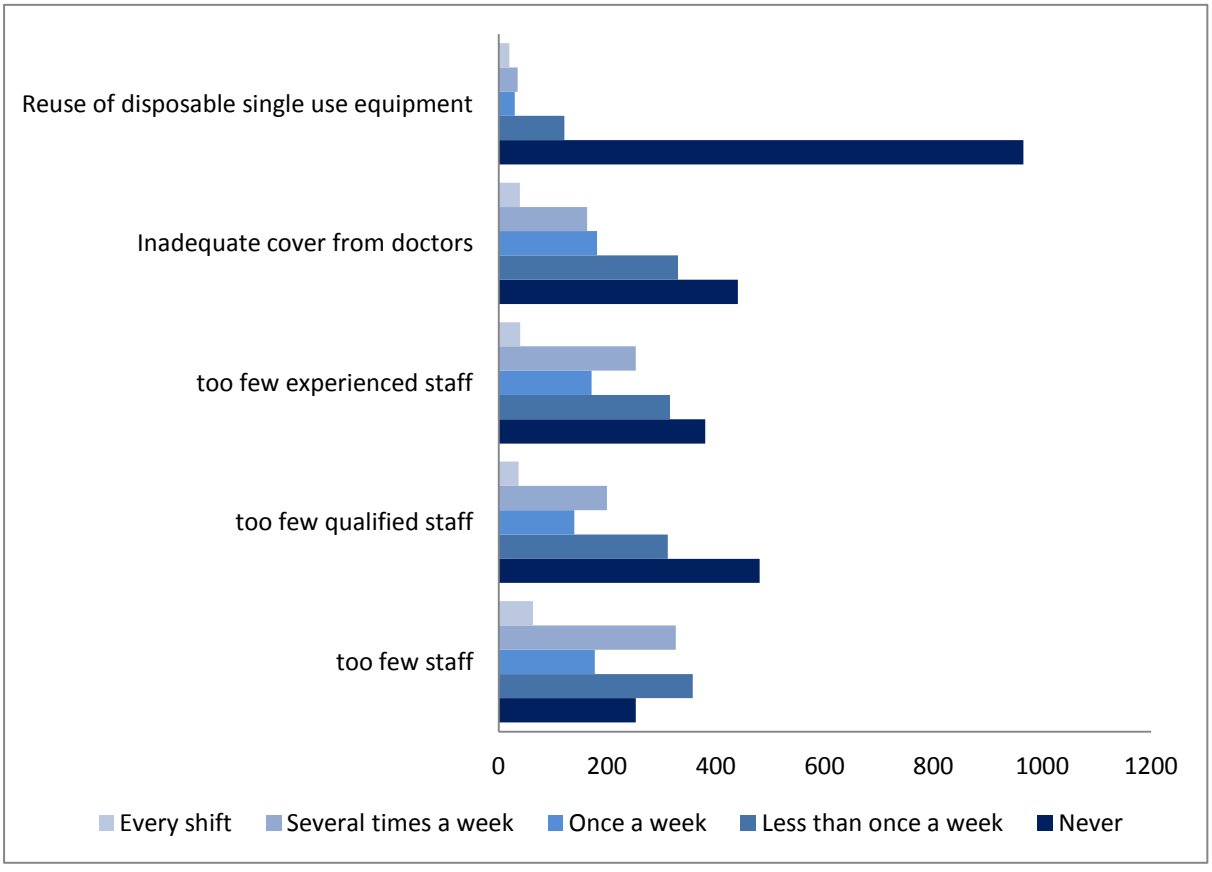
The frequency**with which** respondents reported there were too few nurses to provide safe care varied by employer. Numbers of respondents choosing each option from each employer type are shown in table 13.

## Table 13. Frequency with which there were too few nurses to provide safe care by employer

| Employer | Frequency | | | | |
|---|---|---|---|---|---|
| | Never | Less than once a week | Once a week | Several times a week | Every shift |
| Aged –care provider | 13 | 14 | 13 | 26 | 14 |
| DHB in patient | 62 | 204 | 127 | 239 | 0 |
| Private surgical | 22 | 24 | 5 | 6 | 0 |
| General practice | 63 | 25 | 6 | 7 | 0 |

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

## Figure 37. Frequency of unsafe events



## 5.2 Care Capacity Demand Management

Twenty-five percent of respondents (virtually all working in the inpatient DHB sector), were aware their workplace had a CCDM system such as Trendcare in place. Of these, there was evidence of a feeling of patchy implementation and variable benefit. Nearly half of those who knew about CCDM in their workplace felt uninformed about Trendcare, and around a third used it. Asked to rate the impact on their workload since CCDM/Trendcare systems 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).

Table 14. Impact of CCDM/Trendcare systems on workload

| Statement | Per centage agreeing |
|---|---|
| My workload has not changed | 33 |
| My workload is more even | 5.1 |
| Extra nurses are usually provided when needed | 9.8 |
| Extra nurses are usually NOT provided when needed | 16.4 |
| My workload is heavier | 9.4 |
| Extra nurses (when provided ) usually have the required experience | 8 |
| Extra nurses (when provided ) usually do NOT have the required experience | 8.8 |
| My workload is more erratic | 5.5 |
| CCDM has made no impact on my workload | 30 |
| Overall, CCDM is improving my workload management | 3.5 |

Additional comments about Trendcare were also made, 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 is an absolute waste of time it does not work in real life it takes so long to complete every shift we are busy enough without having this added stress the ward is stressful enough without adding to it .....it is a joke the management is really fast to remove staff when they feel that we are overstaffed but never seem to replace staff when we need it."*

## 5.3 Summary

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

> Patient load, throughput and acuity were all cited as having risen.

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

> There has been a slight improvement in the perception of workload as a general question since 2011.

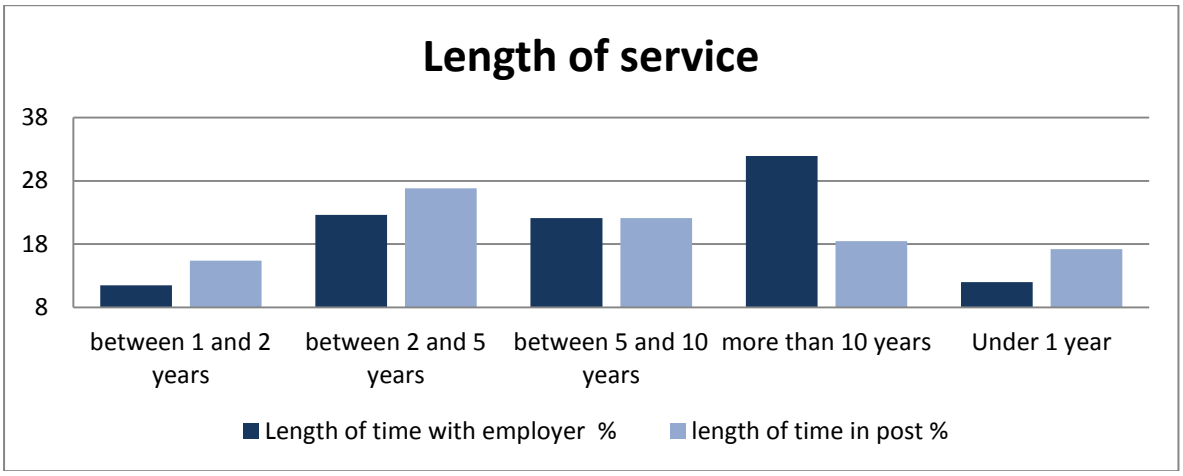
> Knowledge of, and confidence in the ability of CCDM to improve workload is very low, and a degree of scepticism exists.

# 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




## 6.2 Changing jobs

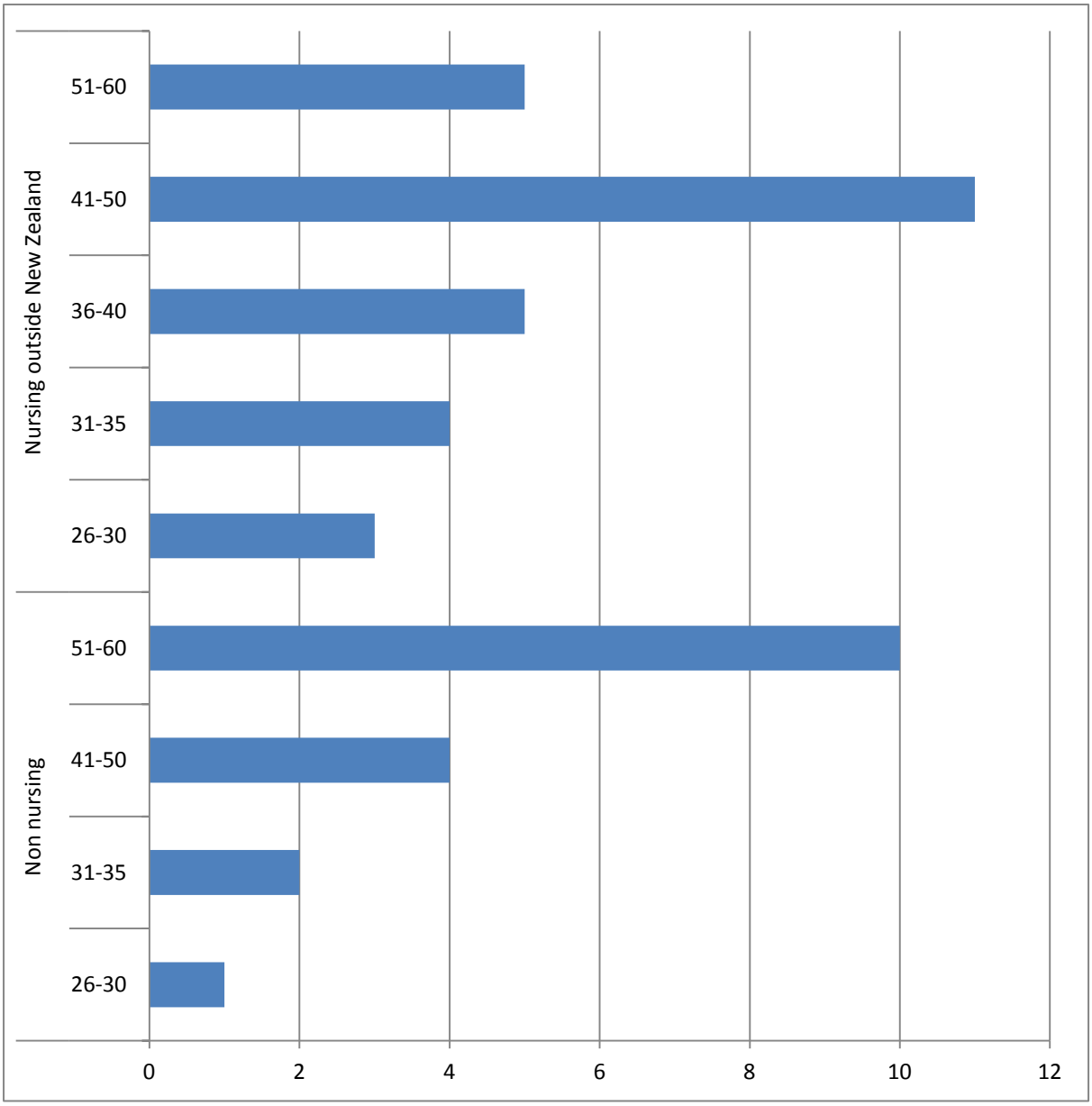
Twenty-six per cent had changed their employment within the previous two years. The reasons stated for changing jobs (in the order of most frequently chosen) are shown below, along with the percentage of the 370 who had changed jobs.

Table 15. Reasons why respondents had changed their job within the previous two years

| Reason | Per cent | reason | Per cent |
|---|---|---|---|
| Gain different skills | 42.4 | Better terms and conditions | 17.8 |
| Better prospects | 26.5 | Educational opportunities | 16.8 |
| Dissatisfied | 26.5 | Family reasons | 13 |
| Change in hours | 26.2 | Bullying / harassment | 11.9 |
| Stress/ workload | 23.2 | Promotion | 11.1 |
| Better pay | 20.8 | Distance home to work | 9.5 |
| Personal/moving area | 18.9 | Health problems | 3.5 |

A further 21.3 per cent were currently job hunting – both those in employment and those unemployed. While 56 per cent of these sought employment within the DHB sector, of most concern were the 21.7 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 of nursing outside New Zealand or leaving nursing altogether are shown in figure 39.

Figure 39. Percentage of respondents considering leaving nursing or nursing outside New Zealand by age.




For the purposes of nursing workforce planning, it is essential not to assume that the current 50-60 year-old nurses 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, 17 per cent (91) of the 352 nurses who first trained as nurses outside New Zealand were currently job hunting. A quarter (24) were seeking nursing outside New Zealand, of whom two thirds (16) were from South East Asia, and nine were New Zealand Europeans who initially trained abroad.

Of those who changed jobs,  56 or 15.4 per cent reported their new employer requested they agree to a 90-trial period as part of the negotiations. The employers requesting a 90-trial period are shown in table 16.

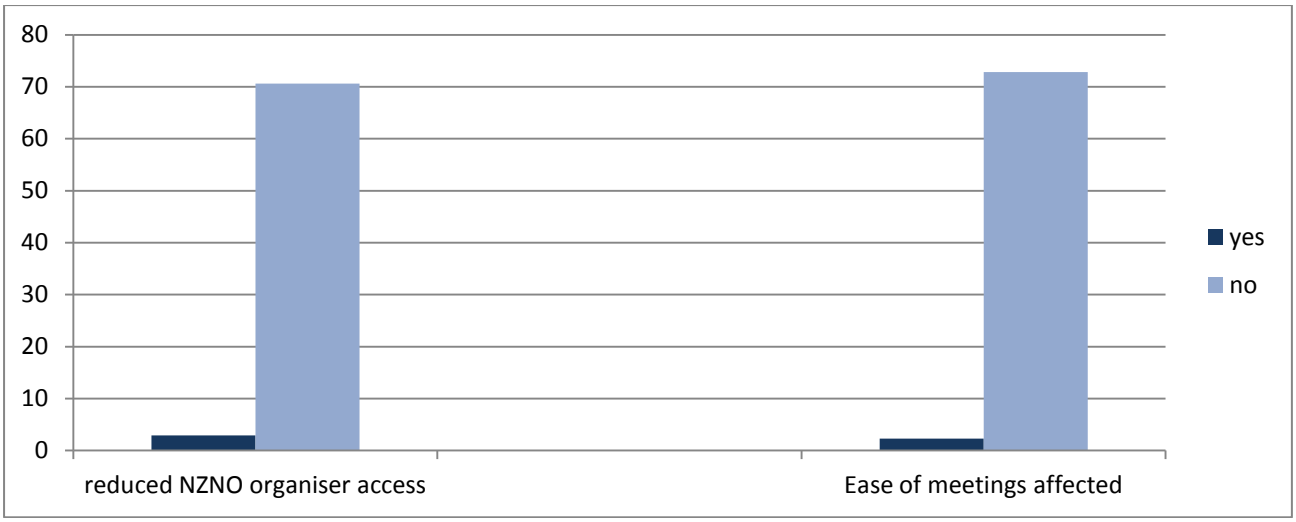
Table 16. Respondents who changed jobs who were asked to agree to a 90-day trial period

| Employer | Number |
|---|---|
| Aged-care provider | 8 |
| DHB - community | 2 |
| DHB - inpatient | 11 |
| Educational institution | 1 |
| General practitioner | 16 |
| Government agency ( MOH, ACC, prisons etc.) | 1 |
| Māori and iwi health provider | 4 |
| NGO provider | 4 |
| Nursing agency | 1 |
| Other, non-nursing work | 1 |
| PHO provider | 4 |
| Private surgical hospital | 3 |

## 6.3 Union access

There was little evidence of employers reducing the ease of access to union organisers, or of the ability to attend meetings.

Figure 40. Union access (percentage)



## 6.4 Summary

> Thirty per cent of respondents had worked for their current employers for more than 10 years.

> Twenty-six per cent 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 five nurses is currently job hunting – with half of those looking to nurse outside New Zealand or leave nursing altogether.

> Seventeen per cent (91) of the 352 nurses who first trained as nurses outside New Zealand were currently job hunting. A quarter (24) were seeking nursing outside New Zealand, of whom two thirds (16) were from South Eat Asia, and nine were New Zealand Europeans who initially trained abroad.

> There was evidence across all sectors (but especially in general practice) that employers were asking for 90-day trial periods on uptake of new jobs.

> There were very few reports of employers deying access to union organisers, or making union meetings harder to attend.

# Chapter 7: Organisational change and restructuring

## 7.1 Organisational change and restructuring

Twenty-four percent of respondents had been affected by significant restructuring in their main employment within the previous two years. Over half 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 18 per cent 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

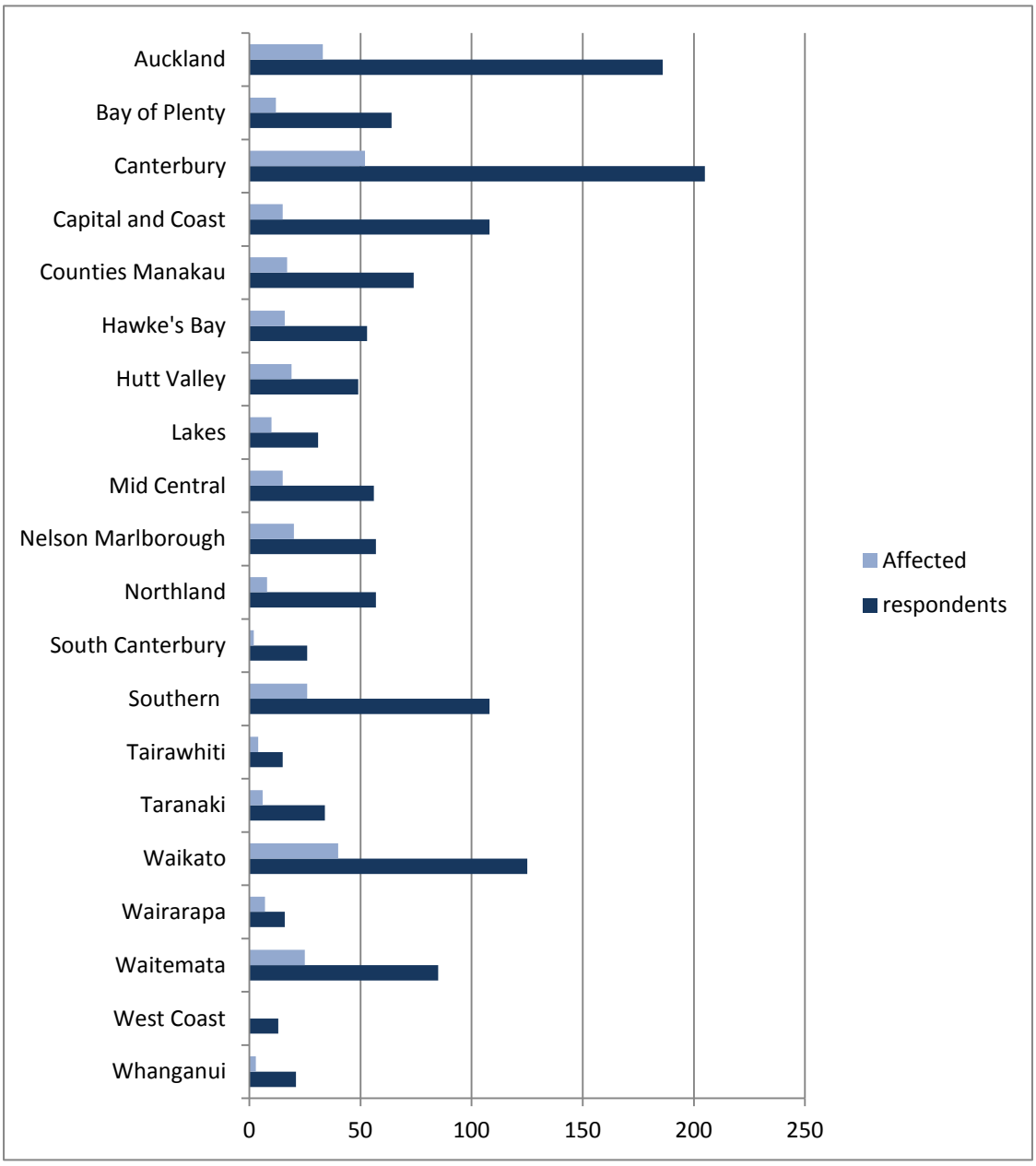


Figure 42. Respondents affect by organisational change and restructuring by employer

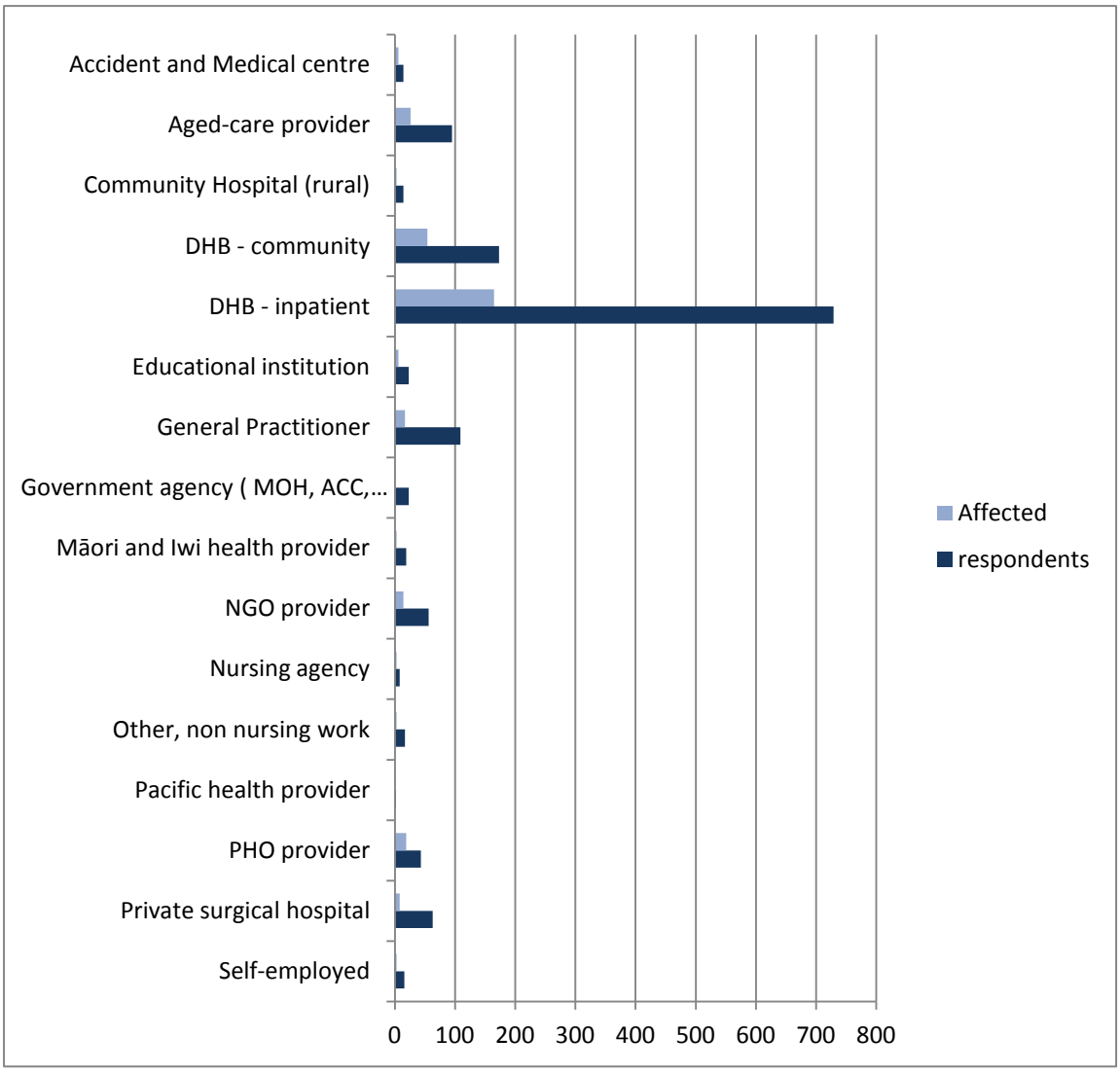



Table 17. Impact of restructuring on nursing morale

| Statements related to restructuring | Percent |
|---|---|
| The process has damaged my feelings about my employer | 44.7 |
| The process has made me question my nursing future | 43.8 |
| The nursing service was adversely affected as a result | 39.8 |
| My own nursing role was affected | 34.7 |
| We were kept informed of the process and outcome | 28.3 |
| I don't know what the effect with be | 23.7 |
| The process was managed well | 13.7 |
| The nursing service was improved as a result. | 7.3 |

## 7.2 Statements related to being affected by organisational change and restructuring

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

**Positive comments**

*It was handled well by keeping us up to date, which they had learnt from mistakes in the past, i.e. not informing staff.*

*The main restructuring followed correct process however some areas have had change implemented without consultation. The employer has had to be reminded of the correct process -even then there are instances where they have not followed this completely.*

**Less positive comments**

*Sometimes we were kept up to date with changes (there have been many) and progress with integration of health centres. At other times some nurses have been unfairly disciplined and reprimanded. This has lead to low staff morale and some staff leaving.*

*The biggest challenge was the removal of a weekly multi disciplinary team meeting. Working in isolation this meeting is a vital part of connection and peer support and I feel deeply upset by its cancellation without an effective replacement.*

*Lots of new innovations poorly communicated and supported adding stress and fear.*

*New non-nursing team leader lack of clinical leadership.*

*The process was not managed well and communication was poor. There were inconsistencies across the units and the CNSs appeared to have received different information as well as differing expectations (from the review team) and time frames.*

*Two Associate Clinical Nurse Manager positions were restructured to Clinical Nurse Coordinator, mine being one of them. I had the opportunity to apply for a Clinical Nurse Manager position of another service which I did and was successful.*

*Very poor communication from management, almost a bullying attitude by senior management.*

*Although many of the process boxes will doubtless have been ticked, from my perspective it has seemed like a very directive process with predetermined outcomes and little consultation with those affected.*

*Whilst we were kept informed about changes there was a period of huge instability within the workplace for at least 12 - 18 months whilst several senior management roles within the DHB were advertised/ re-advertised, or left vacant in the interim*

*We are in the thick of it, not sure how it will all work out, but fearful of changes.*

*With our change, we did not feel supported by the union and the employer ticked all the boxes , consulted, and continued with their changes regardless.*

*Restructuring without consultation from 'invisible' managers who do not know or seek to understand the specialty within which I work.*

*Within the DHB, restructures is constant and ongoing the next round is due to start in June Pre-Christmas round left all staff unsettled and some staff feel the constant changing actually affects their ability to nurse.*

*The manner in which both the former midwifery and nursing leaders' roles were disestablished was, in my opinion, unprofessional and without care and support.*

*Biggest problem that I see within the DHB that I work for is POOR communication. Not from my direct manager but from the hierarchy above her not really having a frontline understanding of the impacts of their decisions or indecisions.*

*Process was not transparent. Not enough Management input. No Manager on site to answer questions. There was a lack of understanding of local health concerns/concepts. Total doubt and confidence in decision making of Senior Management staff after this process.*

*Nurses leaving or changing jobs are not being replaced. The remaining nurses have to pick up the shortfall. We have to use more technological tests (non-nursing)as part of our patient assessment which were previously done by medical specialists.*

*No communication until day of changes - resulted in staff member being dismissed without warning and rest of staff forbidden to have any contact with her.*

*New CEO with a very different approach and philosophy - remote and unapproachable. Previous CEO knew all employees and interacted daily. Many good people have left.*

## 7.3 Summary

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

> Twenty-seven per cent had involved the loss of senior / clinical nursing leadership positions.

> Eighteen per cent reported a reduction in the nursing skill mix.

> Restructuring affected all sectors, and all DHB areas.

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

> There was some scepticism that consultations preceded forgone conclusions.

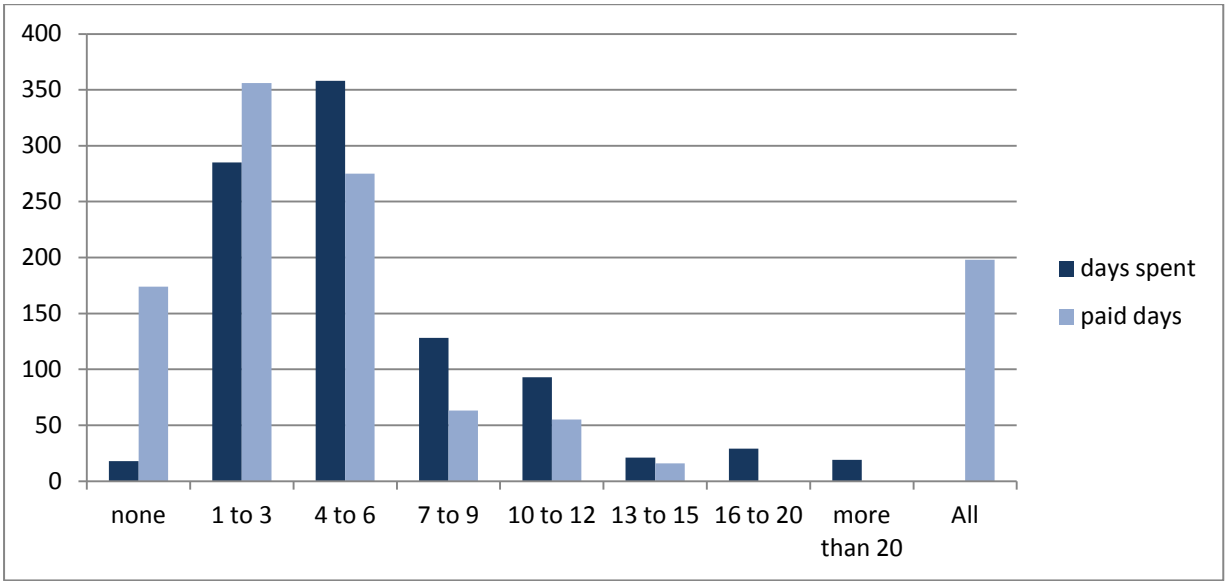
> Where communication and processes had been well handled, the impact was more positively received.

# Chapter 8: Continuing professional development, education & qualifications

## 8.1 Continuing professional development

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

Figure 43. Number of days spent on professional development




A higher proportion of those who answered '*none, zero'* worked in aged care than any other sector. The highest proportion of those answering '*all, mostly all, 100*%' worked for DHBs and private surgical hospitals.

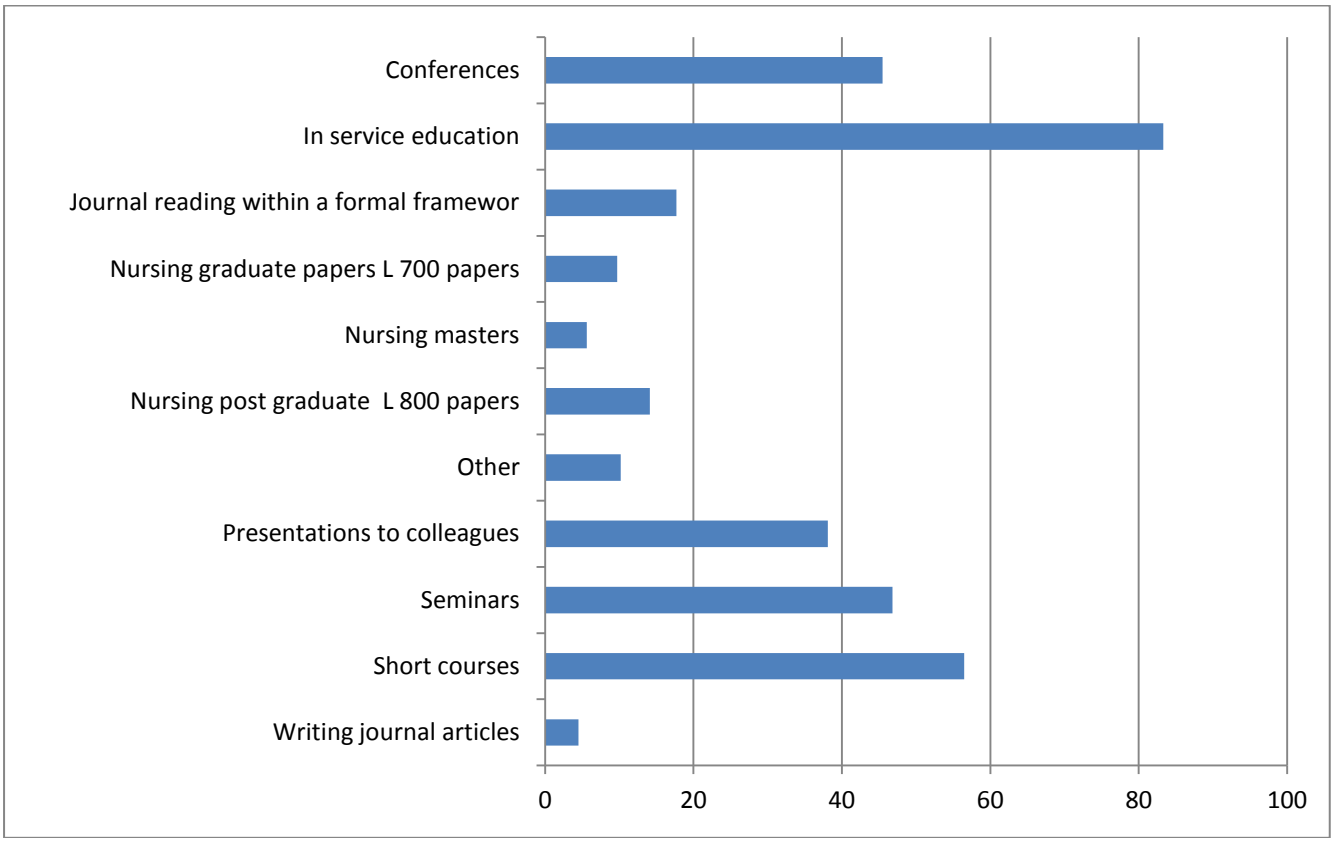
Sixty-five per cent reported having had an appraisal within the previous two years. No pattern by employer was seen. A further 18 per cent had had an appraisal within the previous four years and 3.4 per cent had never had an appraisal.

Of the respondents, 65.8 per cent had professional development recognition programme (PDRP) plans and the vast majority had their manager's involvement in setting their PDRP.

Thirty-nine 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 17 per cent had not had a review, but needed one.

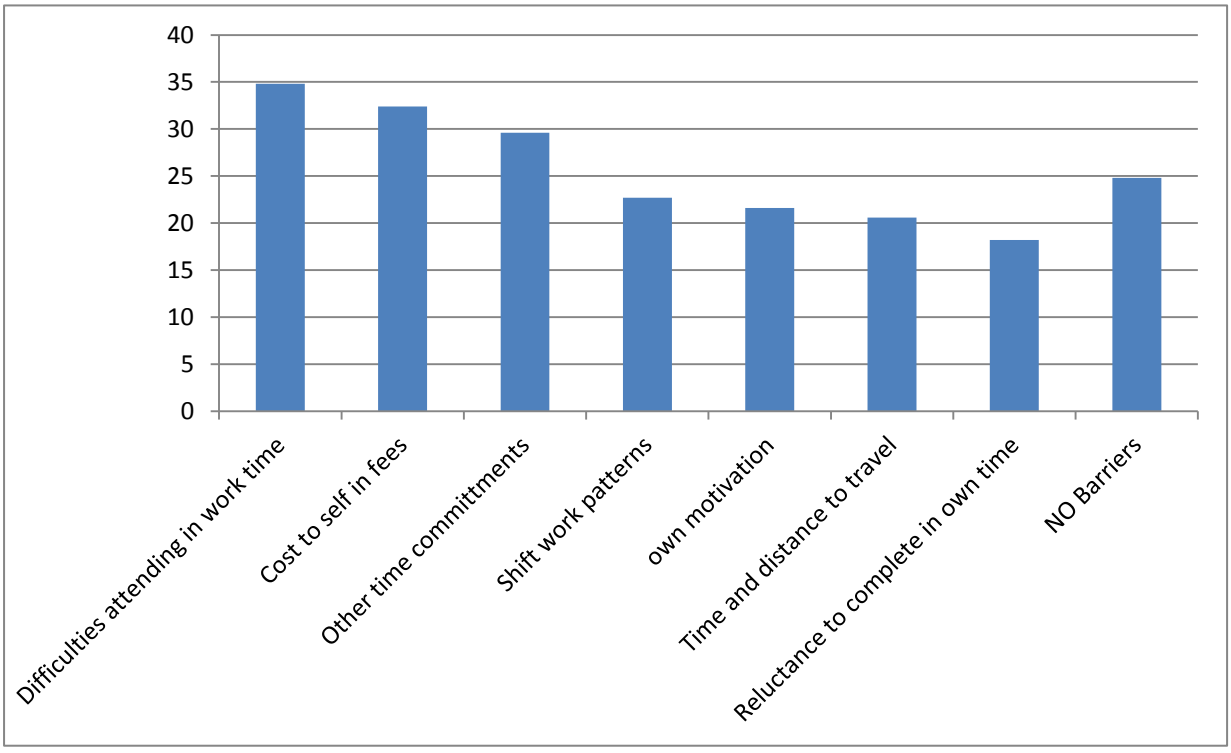
Asked what educational opportunities they had undertaken in the last three years to meet the professional development requirements of the Nursing Council, the largest categories were in-service training, followed by short courses and seminars. Within the last two years, 78 had undertaken, or were in the process of undertaking masters study. The graph is shown below, as a percentage of those replying who picked from multiple options.

Figure 44. Continuing professional development options and percentage undertaken




The biggest barriers to completing the professional development requirements are shown in figure 45.

Figure 45. Barriers to completing professional development requirements



Over 32 pe rcent had had education days withdrawn or cancelled in their workplaces. This is shown graphically by DHB area in figure 46. Only nine per cent felt this might have, or had impacted on their annual practiscing certificate requirements.

254 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.

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, due to the financial climate. 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 46. Education withdrawn by employer

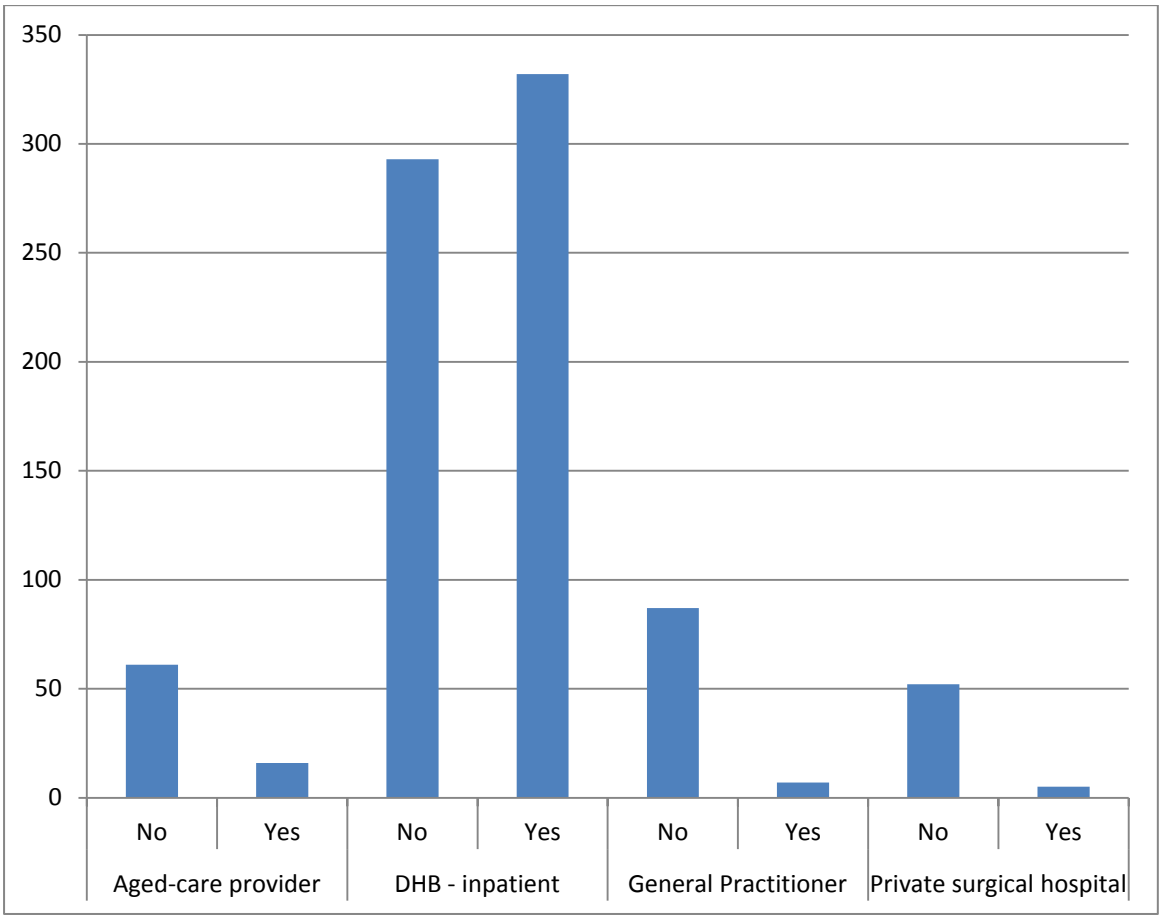
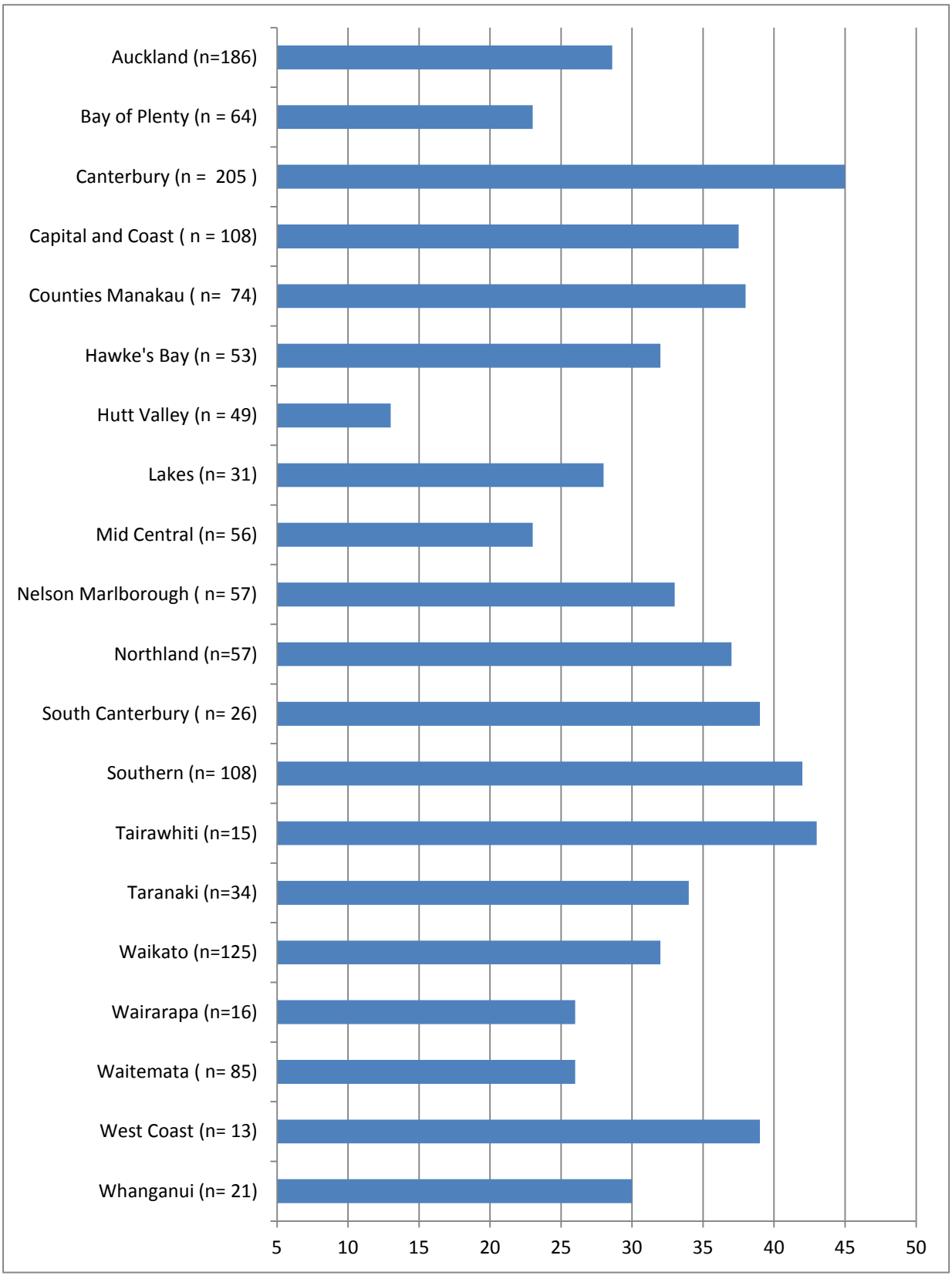


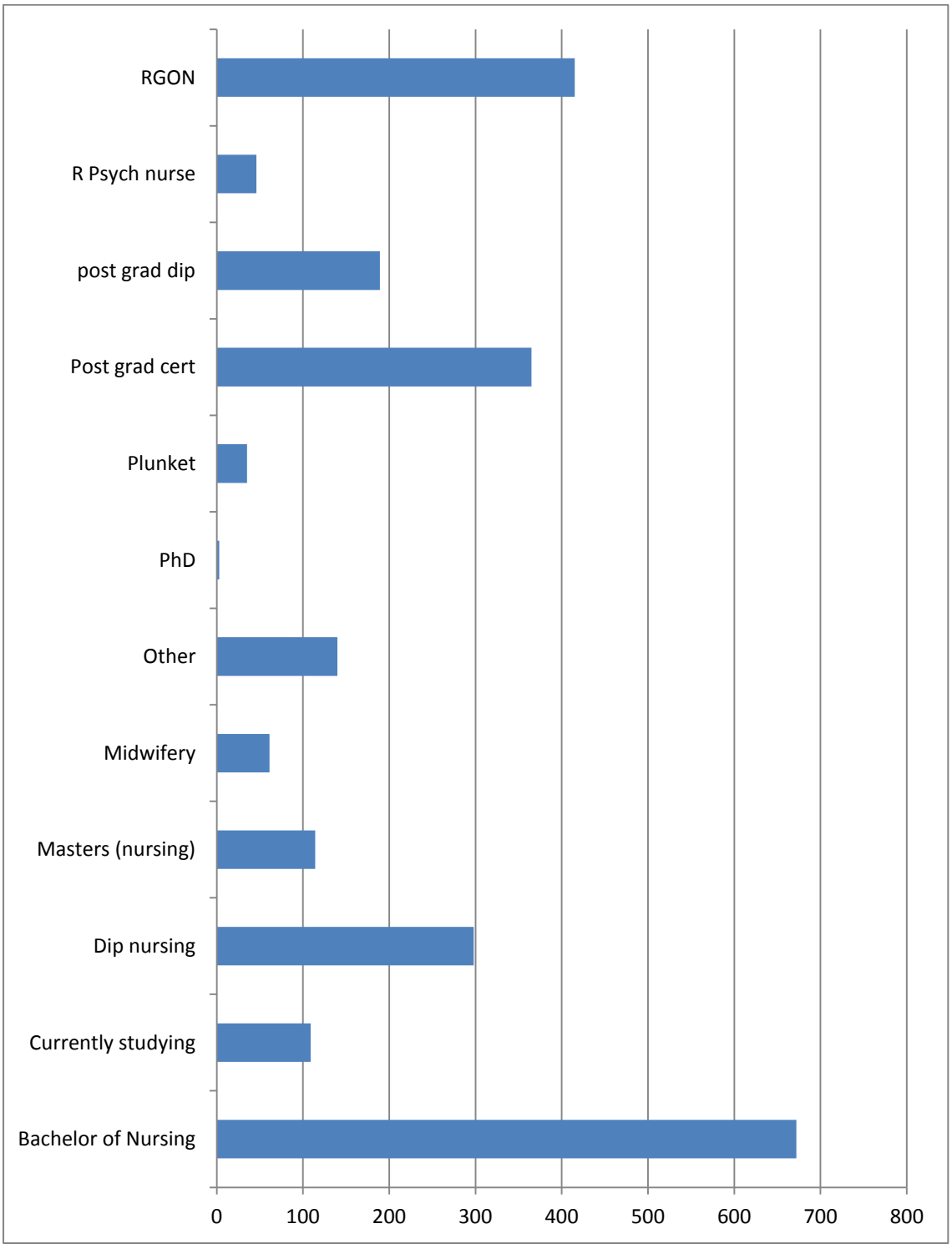
Figure 47. Percentage of respondents reporting that education had been withdrawn (number of respondents per DHB also shown) by DHB area



## 8.2 Qualifications

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

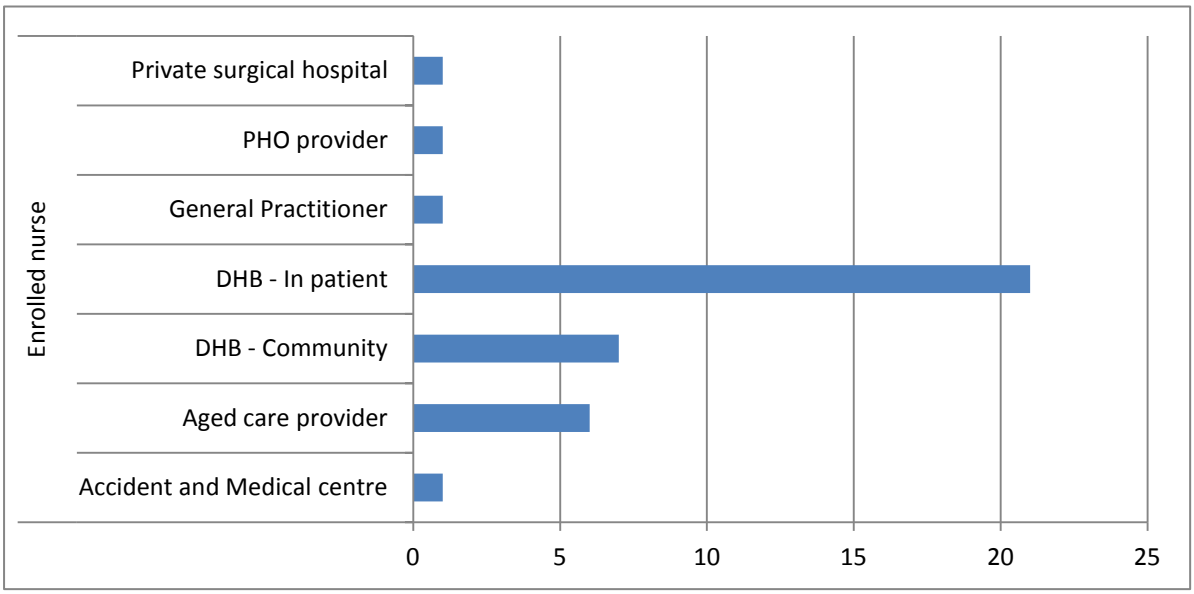
Figure 48. Qualifications of respondents (number)



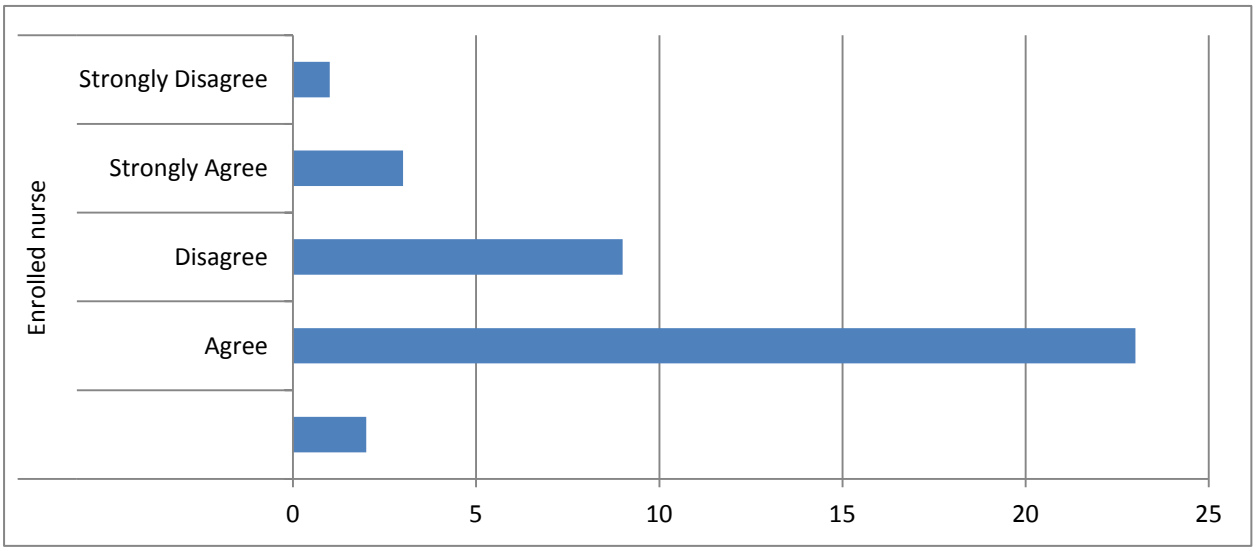
## 8.3 Enrolled nurses

Two years on from the re-introduction of the enrolled nurse (EN) scope of practice, it seemed timely to report on this group separately. Forty two  ENscompleted the survey.

### Figure 49. Employers of enrolled nurse respondents




### Figure 50. Enrolled nurse perspective on whether they felt nursing offered them a secure future




Of the 96 who held EN qualifications, 35 had subsequent RN or other qualifications, while 42 were working as enrolled nurses, and able to fully nurse to the EN scope of practice. Of those working to the EN scope of practice, 91 per cent carried out patient assessments, 96 per cent contributed to care planning and 83 per cent  administered medication.

A further 16 were not able to work as ENs, several were seeking employment.  Free text comments related to the recent changes in scope and employment opportunities for ENs are shown below.

*I look forward to the Enrolled Nurse being treated as valued members of the nursing team instead of the second class status we are sometimes deemed.*

*I trained as a hospital EN in 1979, and have successfully transitioned into the new scope of practice. I would love to continue working as an EN but in XXXX we are so undervalued. Following redundancy with Radius I have been unable to gain employment apart from a 6 month fixed term in aged care. I went on the casual pool at SCDHB but after only 2 orientation shifts I was told I was not up to scratch and to go back to aged care. However there are very few opportunities here, the SCDHB is not supportive of ENs and will not replace them on termination of employment, they would like to only have RNs, and there is even discussion of not employing them in their aged,care facility. At my age I am not prepared to locate to another city. Sadly this reflects the attitude of management at SCDHB. There seems to be nothing one can do, apart from working as a HCA at a much lower rate of pay yet still be accountable for practice with having trained as an EN.*

*I am very concerned regards the new training for ENs as to where all the positions will come from once they qualify. I do believe that more should be done from NZNO and the nursing council to encourage employers such as SCDHB to retain ENs especially in light of the new training. Further there should be a mandatory clause that aged care facilities employ ENs. I am gutted that I will lose my practising certificate this year after many years of nursing, not being able to work in my local DHB where I trained many years ago, the private aged care facilities have also cut back on ENs to save costs, but at the detrimental cost to residents.*

*Feel at times that Enrolled nurses are used and abused depending on the staff allocations and patient work load. Would like to see Enrolled nurses have a more wider scope of practice*

*As an enrolled nurse there are still very limited jobs for us out there.*

*As an Enrolled Nurse, I work in an environment fully supported by my RN's GP, and Admin staff. I was encouraged and supported through the transition to the new Enrolled Nurse Scope of Practice and am able and encouraged to work to my full scope of practice. I feel very fortunate to work with such a great team.*

*I always regret not doing my Registered Nurse training as there never quite seemed a time when I could either not afford it or had other commitments at that time.*

*Trained as an enrolled nurse and worked in acute 550 bed hospital. Employed as a permanent pool nurse so my skill base was great. I worked mostly in surgical wards in Brisbane. New Zealand is truly behind the times with the use of enrolled nurses. Since returning from Australia, nursing has not been the same, and currently thinking of not continuing as unable to work in acute sector here in Nelson. Greatly disappointed and disheartened.*

*I feel very fortunate to have been able to do an enrolled nurse course. I was 36 before I could become a nurse. I wanted to be a registered nurse but at the time I was the only income earner in the household, and the training had moved to the polytech and I could not afford the fees. Enrolled nursing was hospital based and paid training. I have never regretted my decision to become an EN.*

*I have worked in a number of services at TDH. Starting as an EN 1989-1992. I was supported during my shorten diploma for comprehensive nursing in 1996-1998. Over my nursing career I have always felt supported by my colleagues and valued by them.*

## 8.4 Summary

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

> Most employers are allowing four to six days' paid professional development time. Most 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 requirements, especially for parents of children who require paid childcare, and the cost and distance of travel especially for rural nurses.

> Over 32 per cent had had education days in their workplaces withdrawn or cancelled..

> Education days had been withdrawn by employers in all sectors, and all DHB areas.

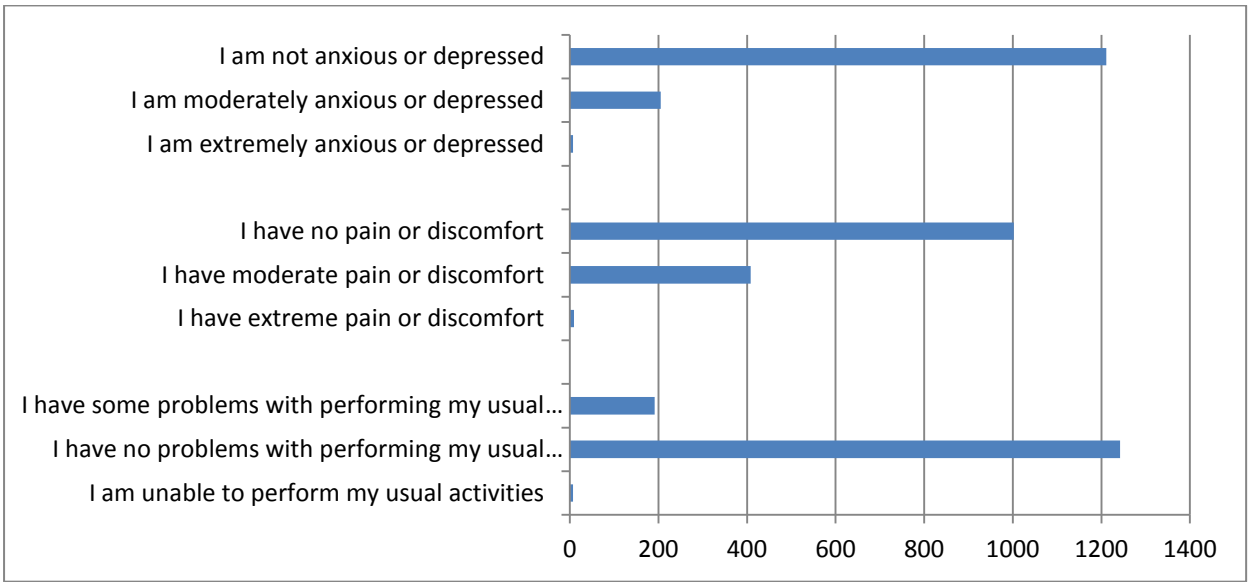
> Enrolled nurses have very patchy employment opportunities and very many feel their employment as ENs is precarious.

# Chapter 9: Health and occupational health and safety.

## 9.1 Health of nurses

The survey utilised the EQ5D-3L survey to explore nurses self-rating of health-related quality of life, including the EQ VAS (EuroQol Visual Analogue Scale) – a 20 cm vertical 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 anxiety and depression, being able to perform their usual functions, and having no or moderate pain or discomfort.

Figure 51. Three-Item scores: mental, physical and role function (number of nurses)




These varied by age: with the healthiest scores coming from nurses in their 50s and 60s.

Table 18. Mean and distribution EQVAS scores are shown below for the whole sample

| n | mean | min | max | Std dev |
|---|---|---|---|---|
| 1438 | 84.88 | 15 | 100 | 12.55 |

## Figure 52. Distribution of EQ5-VAS scores

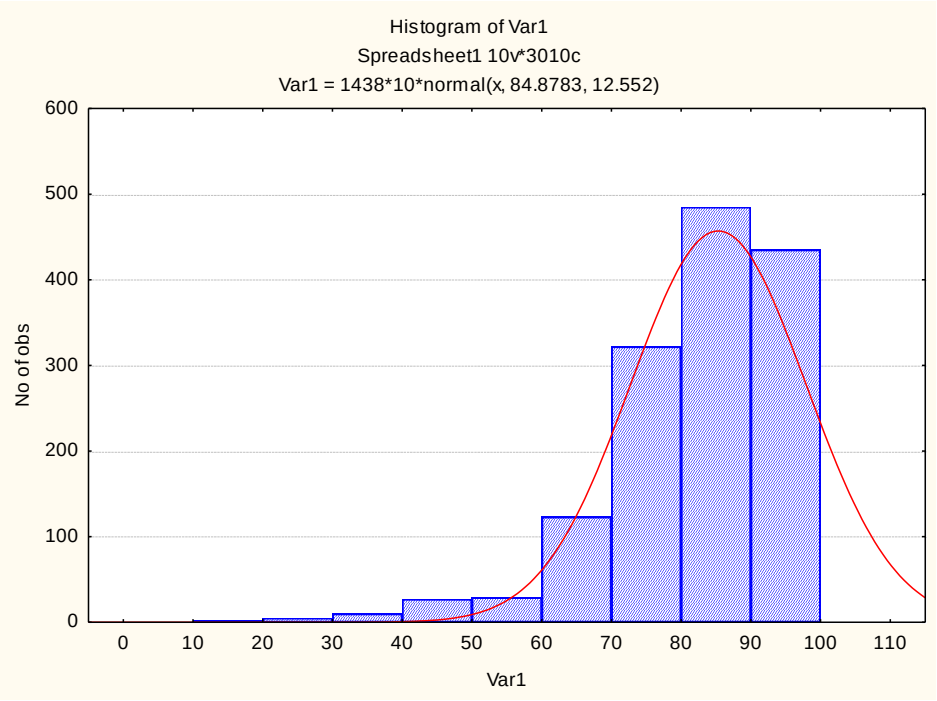
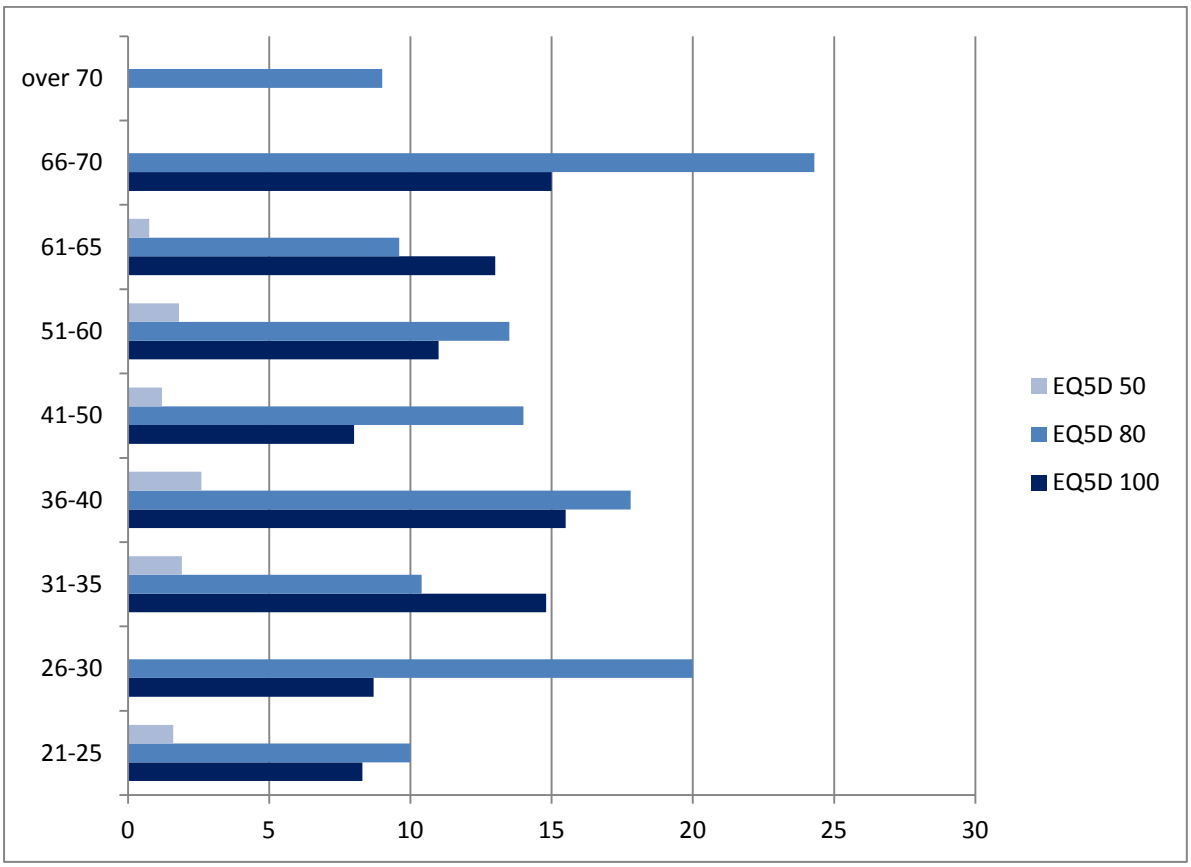



Figure 53 shows the percentage of respondents in each age group who reported EQ-VAS scores of 100 per cent, 80 per cent or 50per cent of 'best possible health' where best possible health = EQ-VAS 100%.

## Figure 53. Percentage of respondents reporting EQ-VAS scores of 100 per cent, 80 per cent or 50 per cent of 'best possible health'



It can be seen that those with the overall perception of being healthiest are the 31-41-year-olds. Above the age of 41, nurses over 60 still in employment perceive their health as progressively better, even up to the age of 70. Note: the numbers over 70 were **very** small.

Table 19 shows t-tests comparing the means and standardisations between the pairs of values for each age group. Although (as also found in the late career nurse survey) at the older age groups nurses perceive themselves as healthier than their age-matched controls from the New Zealand women's population, in this survey perhaps due to smaller numbers in each age group) the difference did not reach statistical significance.

Table 19. t-test comparison of means and standardisations between age groups

| **EQ VAS all NZ women** | | | | **EQ VAS NZ nurses** | | | | |
|---|---|---|---|---|---|---|---|---|
| **Age** | Mean score | SD | N | **Age** | Mean score | SD | N | P value |
| **18-29** | 82.4 | 13.2 | 95 | **20-29** | 82.9 | 16.3 | 166 | 0.98 |
| **30-39** | 83.5 | 14.2 | 138 | **30-39** | 82.7 | 14.5 | 251 | 0.60 |
| **40-49** | 83.4 | 13.4 | 154 | **40-49** | 81.7 | 15.3 | 402 | 0.97 |
| **50-59** | 83 | 16.6 | 144 | **50-59** | 83.4 | 14.6 | 437 | 0.60 |
| **60-69** | 80.9 | 16.3 | 114 | **60-69** | 81.8 | 15.9 | 41 | 0.44 |

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.

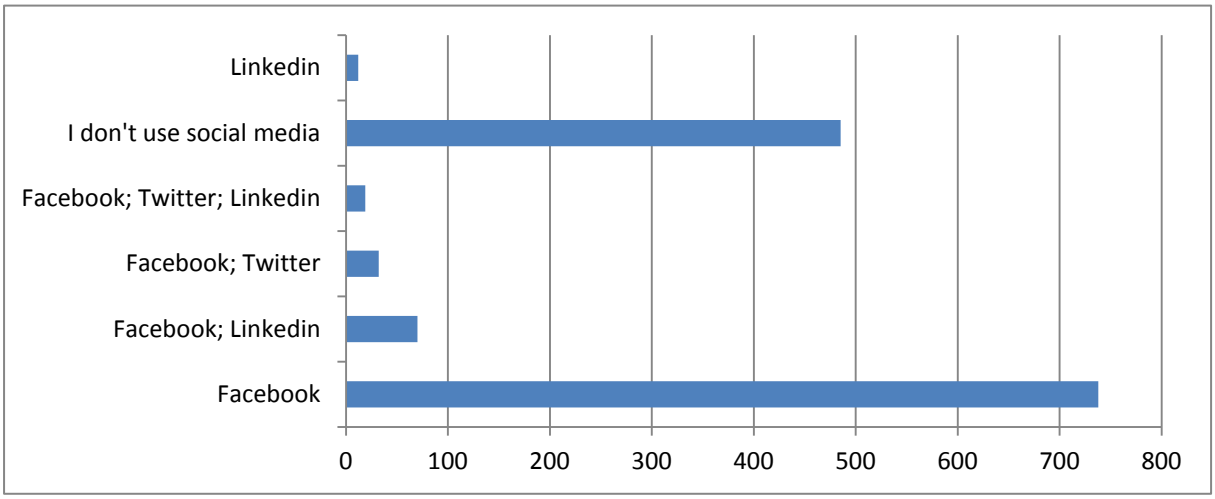
## 9.2 Occupational Health and Safety

In the previous two years, 11.6 per cent (166) of respondents had required time off work with an occupationally-acquired infection or a workplace injury. Of these, 10 per cent were referred to the Accident Compensation Corporation (ACC). The commonest causes were flu or norovirus infections, and back, knee, wrist and shoulder injuries relating mostly to slips and lifting. Three reported injuries caused by assaults from patients, and four reported needle-stick injuries. Only 41.5 per cent of all respondents felt their employer was fully compliant with Occupational Health and Safety standards.

## 9.3 Social media

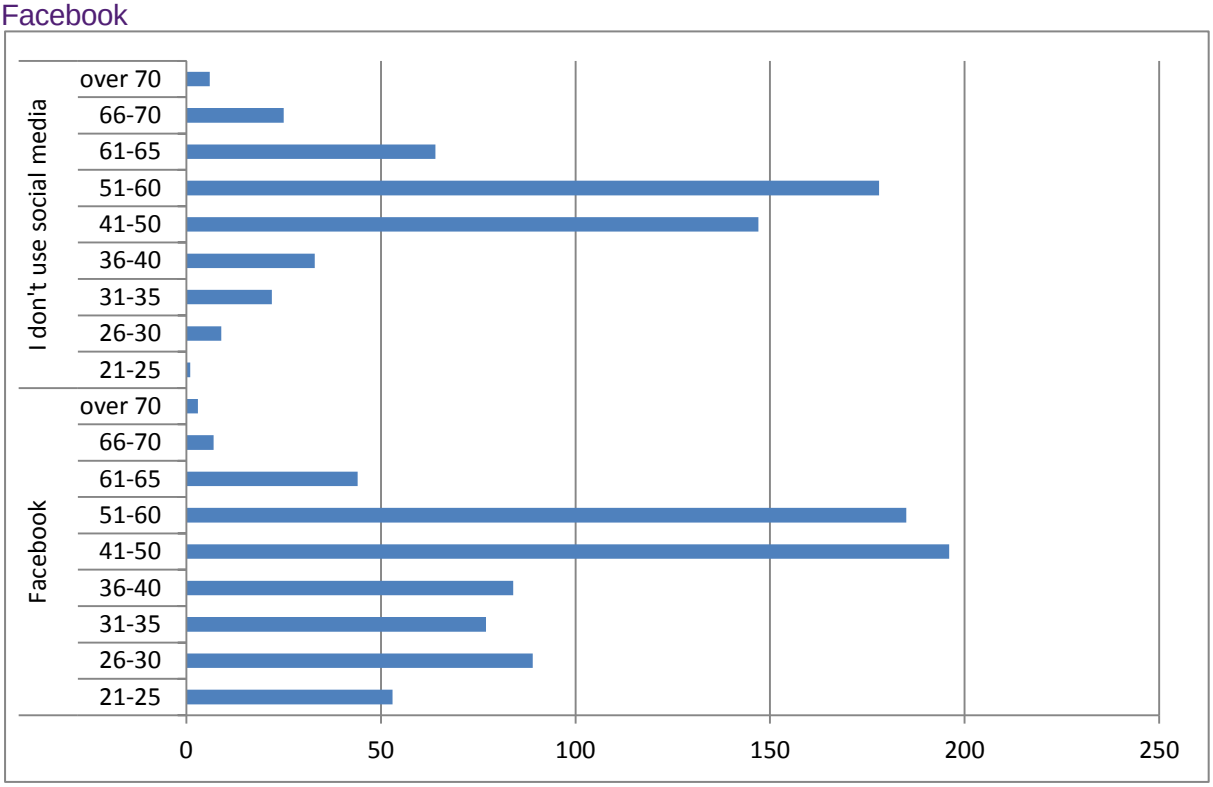
Respondents were asked which social media applications they used. The responses are shown in figure 54. As can be seen, while some 35 per cent do not use social media, 62 per cent use Facebook, 7.4 per cent Linkedin and 3.6 per cent Twitter.

### Figure 54. Social media




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 55. This confirms that while the use of social media as marketing and communications tools when trying to reach under 40s is important, there are also very significant numbers in other age groups who will not access these media.

### Figure 55. Numbers in each group who don't use social media at all and those who do use Facebook



## 9.4 Summary

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

> Those with the perception of being healthiest are the 31-41 year olds.

> Above the age of 41, nurses still in employment perceive their health as progressively better, even up to the age of 70.

> The older age group nurses perceive themselves as healthier than their age-matched controls from the New Zealand women's population.

> In the previous two years, 11.6 per cent of respondents had required time off work with an occupationally-acquired infection or a workplace injury.

> Only 10 per cent of workplace accidents or injuries severe enough to require time off work were referred to ACC.

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

> Three reported injuries caused by assaults from patients, and four reported needle-stick injuries.

> Only 41.5 per cent of all respondent felt their employer was fully compliant with Occupational Health and Safety standards.

> Thirty-five per cent of respondents do not use social media, 62 per cent use Facebook, 7.4 per cent Linkedin and 3.6 per cent use Twitter.

# Chapter 10: Morale

## 10.1 Morale

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

The majority are identical to those used in the RCN survey, a few 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. These measures increase confidence in the interpretations. 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 % disagreeing with "*I would leave nursing if I could"* are shown instead as % agreeing with "*I would NOT leave nursing if I could, to allow comparison* with " *I would recommend nursing as a career".)* Results from 2009 and 2011 are shown for comparison.

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

Compared to the responses from 2009 and 2011, New Zealand nurses' morale scores with most aspects of nursing as a career are very similar. Slight falls in confidence about career progression and job security are seen, and there has been a slight improvement of perception of bullying.

Table 20. Weighted scores from the validated attitudinal question set

| Themes / Statements | Percentage Agreeing 2009 | Percentage Agreeing 2011 | Percentage Agreeing 2013 |
|---|---|---|---|
| **1. Nursing as a career** | | | |
| I would recommend nursing as a career | 81.4 | 84.4 | 82.9 |
| I would (NOT) leave nursing if I could | 70.44 | 75.4 | 75.2 |
| I am (NOT) in a dead end job | 86.24 | 76.9 | 88.3 |
| **Mean "positivity" score** | **79.4** | **79** | **82.1** |
| **2. Career progression** | | | |
| It will (NOT) be difficult to progress from my current salary | 29.9 | 28.6 | 26.8 |

| | | | |
|---|---|---|---|
| Career prospects are (NOT) becoming less attractive | 60.6 | 55.1 | 56.4 |
| **Mean "positivity" score** | **45.25** | **42** | **41.6** |
| **3. Bullying / Harassment** | | | |
| Bullying & harassment is not a problem where I work | 62.15 | 50.3 | 55.2 |
| I'd be treated fairly if I reported being harassed | 60.12 | 62.6 | 67.1 |
| **Mean "positivity" score** | **61.1** | **56** | **61.1** |
| **4. Working hours** | | | |
| I am happy with my choice of shifts | 74.75 | 80.2 | 82.3 |
| I feel able to balance home and work lives | 77.4 | 79.3 | 73.6 |
| **Mean "positivity" score** | **76** | **79.5** | **77.9** |
| **5. Job satisfaction** | | | |
| Most days I am enthusiastic about my job | 87.7 | 90.3 | 88.9 |
| I feel satisfied with my present job | 77.07 | 76.4 | 77 |
| I feel my work is valued | 75.91 | 72.7 | 73 |
| I feel part of a team | 87.38 | 84.6 | 88.4 |
| I am able to practise autonomously | 82.03 | 79.2 | 87.3 |
| My opinions about nursing are valued by my manager | 71.83 | 69.2 | 75.6 |
| **Mean "positivity" score** | **80.2** | **79** | **81.7** |
| **6.Pay** | | | |
| I am well paid considering the work I do | 36.55 | 33.7 | 38.4 |
| Nurses are paid well compared to other professionals | 17.57 | 23.9 | 22.6 |
| **Mean "positivity" score** | **25.9** | **32** | **30.5** |
| **7. Quality of Care** | | | |
| The quality of care provided where I work is good | 87.77 | 87.4 | 92.8 |

| | | | |
|---|---|---|---|
| **8. Job security** | | | |
| Nursing will continue to offer me a secure future | 87.0 | 82.8 | 85.7 |
| I am (NOT) worried I may be made redundant | 84.7 | 71.5 | 84.6 |
| I would find it easy to get another job with my skills | 73.48 | 60.5 | 69.2 |
| **Mean "positivity" score** | **82** | **72** | **79.8** |
| **9. Training & Education** | | | |
| I am (ABLE) to take time off for training | 71.58 | 65.4 | 71 |
| I am able to keep up with developments to do with my job | 75.48 | 77.9 | 79.2 |
| I have regular dialogue about my work with my manager | 62.03 | 62.8 | 63.3 |
| **Mean "positivity" score** | **69.7** | **68.7** | **71.6** |
| **10. Workload** | | | |
| My workload is (NOT) too heavy | 44.94 | 47.3 | 50.5 |
| I am (NOT) under too much pressure at work | 51.7 | 56.3 | 54.4 |
| (NOT) too much time is spent on non-nursing duties | 56.28 | 51.6 | 57.5 |
| There are sufficient staff to provide good care | 55.15 | 49.4 | 57.8 |
| Nurse staffing levels have improved over the last year | 35.6 | 40.1 | 34.7 |
| **Mean "positivity" score** | **48.7** | **49** | **51** |

## 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. 423 separate respondents made comments in this section.

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

### Table 21. 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. | 82 |
| *Occupational health nursing rocks!!! I love my job:-)*<br><br>*I love district nursing and work within a really supportive team.*<br>*I have found nursing to be a fulfilling career and a privilege to be part of so many lives.*<br><br>*excellent employers. good working relationships. able to provide good care to patients. very fortunate nurse!*<br><br>*I have changed career pathways several times and am very content with the skills, clinical and life experience, gained along the way. I have cried, laughed and worried along the way, but I have never been bored.*<br><br>*I have made life long friends, been educated in many fields and been privileged to work with some amazing talented dedicated people.*<br>*I have been blessed with a career that I have enjoyed, has been fulfilling and meet my needs. I would recommend nursing to anyone who asked.*<br>*Despite the changes in nursing, I still think it is a grand profession with amazing camaraderie.*<br><br>*There is plenty of potential to help other people and engage in a huge variety of different kinds of nursing.*<br><br>*I love nursing and my current job is amazing.*<br><br>*I would do it all again - the career that is.*<br><br>*I have enjoyed and embraced nursing, finding it invaluable for my personal and professional development , I look back now and see how varied the specialties I have been privileged to work and teach in, also sharing my practice wisdom, both here in NZ and overseas. Not to forgetting to mention the wonderful company of colleges I have enjoyed along the way.* | | |
| 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. | 29 |
| *Also, work life balance, and time to do other important things outside work due to reduced hours.* | | |

| | | |
|---|---|---|
| *My current employer provides me every opportunity for professional development and career advancement. They also understand about the need for work/life balance and that sometimes family has to come first.*<br>*my employers are flexible, we can request for shifts convenient for our family needs.*<br><br>*My employer has been very accepting of reduced hours of work which makes my position one that I enjoy and works well for me.*<br><br>*I enjoy my work. It is very busy & some days very stressful. I work 3days/week so I have time to enjoy my hobbies.*<br><br>*The biggest factor that would keep me nursing is flexibility of rostering and being able to work part time.* | | |
| Support | This included supportive and empowering management, collegiality and encouragement / recognition for good work. | 10 |
| *I have a good relationship with my immediate manager who is flexible and accommodating, which makes all the difference for me as a mother, and a nurse.*<br><br>*My manager however is extremely supportive.*<br><br>*Fair & responsible employer (Private surg hospital) who responded exceptionally well to staff needs following the earthquakes.*<br><br>*I do feel well supported by my colleagues and manager and derive job satisfaction apart from the long hours.*<br><br>*I believe i have a very good job for which i am well paid. The DHB I work for is mindful of its staff and I have a manager who treats us well.*<br><br>*My immediate Ward Manager is a very caring person and manager. There is no long term sickness or very rarely are there any odd days sickness taken amongst the nurses who work for her.*<br><br>*Generally I am happy with my employment. I am lucky to have a Unit Manager who understands and appreciates her staff and is open to discussing any issue.* | | |
| Career development | This included educational opportunities and new learning, variety and positive changes in nursing employment and field, in NZ and abroad. | 7 |
| *I feel really well supported by our PHO who have supported me to begin my post grad studies. My employers have been fantastic and helpful regarding studying.* | | |

Table 22. Negative themes

| Theme | Description | count |
|---|---|---|
| Low morale | This included low morale, leaving nursing, pressure, stress, burnout and exhaustion/fatigue. | 53 |

*It's getting pretty depressing at work.. The group that I work with are one of the most overworked people, yet we feel as though we are undervalued by our employers.. we are constantly criticised and loaded up with more and more work.*

*Demoralising  I don't believe that we are valued. Staff morale is very low.*

*Change always inevitable but after 37yrs am seeing the same patterns of mismanagement leading to dissecting health services and creating too many office jobs. A touch of despondency setting in, sadly.*

*I felt my place of work was unsafe and my patients were at risk. At times there was no clean linen and not even a bed to put the patient on. I lost the passion for my profession. It is such a shame because prior to the move i had on occasion worked in all three hospitals patient care and nurse morale was much better than today.*

*I look forward to when I can retire as I feel undervalued and not appreciated in my current workplace.*

*I have lost all faith, trust and confidence in the management team at my place of work. I will shortly be handing my resignation. At this stage I am unsure if I will continue nursing.*
*So much pressure at work. Stress most of the time. Thinking of looking for a new and less stressful job.*

*after 40 years of nursing I have begun to look for another job that does not entail the demanding, draining, disillusioning, disheartened, disjointed, disregarded, distressing, disturbing, disenchantment, disrespectful occupation that nursing has become.*

*Nursing staff do not see any benefit in completing incident reports as nothing changes.*
*Stress has definitely become an issue in the workplace and fatigue.*

*Staff are unhappy and feel they have no voice, but also feel trapped as the hours suit and if it wasn't for the constraints we would enjoy our jobs.*

*Our DHB has implemented a very militaristic right wing style of management which has impacted on the ability of nurses to feel empowered in their workplace. in combination with computerised rostering there is a huge demoralised feeling among staff at the current time.*

*Currently having issues with inflexible shifts and rosters and childcare balance. Don't have much faith or value in my employment and about to resign. Considering leaving nursing.*

*Due to changes in the ratio of registered Nurses to patients in the last year, and the non - replacement of staff leaving, and bullying in the workplace, and my perception of a general lack of strong leadership, I am taking a career break, and exploring a different career.*

*At the moment, we only have 6nurses, with a acting team leader. no educator, no one does quality assurance, as a staff nurse, i feel like this place is so toxic, and my practicing is unsafe.*

*In my opinion nurses on the ward are often physically and mentally exhausted. They are very rarely praised but frequently criticised and expected to do more.*

*feeling pretty disillusioned with my employer at the moment - and with nursing in general. I do feel that I would be better off if I left nursing but I have been a nurse my entire working life*
*I love nursing but am increasingly frustrated and unimpressed with the DHB focus on saving money by reducing frontline nursing staff. It does not foster organisational loyalty and it does nothing to lift nursings' profile as a worthwhile profession.*

| | | |
|---|---|---|
| Workload | This included patient load, increased acuity, less down time, working long hours/extra hours. | 10 |

*Our resources bed numbers keep being trimmed (along with nursing FTE) but there is no discernible drop in actual patients and patient acuity seems to be increasing all the time.*

*I have worked hours in excess of 45-50 per week consistently for over 18 months and cannot achieve all KPI's that I am required to do; this is making me feel like I am failing and will have to leave the job I love eventually. This workload is ultimately unsustainable.*

*Over the last 12 months i have felt that management are pushing us more and more to achieve "targets"...with expectations being assumed that we will work regular overtime to finish elective theatre lists.*

*trend care is an absolute waste of time it does not work in real life.*

*it takes so long to complete every shift we are busy enough with out having this added stress the ward is stressful enough without adding to it .....it is a joke the management is really fast to remove staff when they feel that we are overstaffed but never seem to replace staff when we need it.*

*Work loads and complexity of cases managed are increasing.. staffing levels are decreasing nurses are being asked to provide quality care, yet the nurse: patient ratio is increasing, and often with poor skill mix.*

*unfortunately, there is a feeling of staff feeling undervalued lots of pressure from managers and no constructive solutions in areas of difficulty or when we are not reaching our numbers. Managerial efforts to cut costs impacts on nurses directly, recruitment friezes or recruitment "go slows" mean front line staff have to pick up the extra burden.*

*At present , find nursing stressful and documentation and expectations are huge pressures . I am planning to leave my job when I can find another and after I have completed my portfolio. My mental health is at risk and I want more work life balance even if it means a drop in pay.*

| | | |
|---|---|---|
| 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. | 29 |

*Nursing is now becoming a young person's job, it is more technical, and the care part of nursing has gone, more impersonal.*

*I feel the standard of graduate nurses' care is poor in NZ. Basic care is not given in hospitals today. Acute care is wonderful, but long term care is poor.*

*I have seen many changes to the nursing profession, some are of value, other are just doing a circle. I believe the hospital trained nurses produced a more compassionate well rounded bed side nurse, training today is more directed toward theory and less clinical learning, computers are taking time away from patient care.*

*I love my job, I always have, but the changes from Nursing as an Art to Nursing as a Science is very difficult to understand, people will always be people and if we do not care for them holistically we will not care for them properly. I have been a patient and I would prefer a Nurse who knows how to care*

*for me than one who can explain down to the minute cell what is wrong with me, they have no people skills and it will take them a very long time to learn this as they are not taught properly how to care for the person, instead they are taught how to care for and understand the disease first then the person. Many may argue that this is untrue, but I challenge them to be look after by a Nurse of Art and a Nurse of science and see who gives the better care!*

*However, I am also pleased I am getting closer to retirement age, as I can see changes creeping in that may not make the career as desirable in the future.*

*As I near retirement I reflect on the changes in nursing and medicine. Patients are much more acutely ill and require more knowledgeable nurses to observe and minister their care back to health.*

*Nursing has changed over the past three decades I have worked in healthcare. Some of the changes have been for the better, some not.*

*I feel clinical skills and experience are not as valued as academic courses - you can sit at the back and pick up a certificate - how does that improve patient care???*
*It sad to see nursing lose the essence of caring.*

*The Patient (client, consumer) has more complex needs, often more co-morbidities, and is put through a system that operates more like a conveyor belt than a healthcare facility.*
*I am at the end of my nursing career, I am concerned as to where nursing is heading in general. I don't think enough time is spent in a clinical setting. Performance reviews are very long winded and are only a reflection of your writing skills, doesn't really reflect how you practice.*

*Over the years I have nursed the trend seems to have gone from practical care to focus more on the academic. I fear that the profession is losing its way and has forgotten the main core of the job PATIENT CARE. Having to spend more time doing academic work rather than caring and observing the patients.*

*I firmly, & sadly, believe nursing is becoming to much about how good you look on paper & not about how good you actually are as a nurse. More focus needs to be placed on patient care, experience, & ethics.*

*Of particular concern to myself in my current area of work is the variance in practice standards of the LMC in the private midwifery arena. Requirements under section 88 are regularly discarded, and the core staff are left to cope with thier workload.*

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

*it is getting harder and harder to get enough education time to fulfil pdp requirements, pdrp is time consuming and not really applicable to ward nurse needs.*

*And add to the mountain of paperwork all the multitude of assessment forms ON EVERY PATIENT whether they need them or not.*

*Paperwork has become an issue and adds to an already busy workload.*

*i feel nursing is more about quantity than quality. more paperwork and computer work and less patient interactions.*

*Pressure therefore is constant to perform and one feels like it is a numbers game. Paperwork has be one a nightmare and yet no extra time is allowed for this.*

*I think the whole PDRP thing has got way out of hand. It has made me very despondent with nursing. It is very unrealistic to think in our busy lives as nurses with heavy work loads and a life apart from nursing that we can maintain portfolio requirements as well.*

*We spend a lot of time filling in paperwork that would not really make a difference to patients care if it was or was not filled in. It would be more beneficial spending that extra time with the patients rather than filling in the huge amounts of paperwork!*

*PDRP is causing much stress and grief to nurses and many staff are now choosing to not participate in this process.*

*I have done 5 PDRPs and have been expert in all of them but now can't be bothered, why should nurses have to continually do these personally time consuming documents when doctors don't have to!*

*I believe the tendency for paperwork to validate your nursing care has gone too far to the extreme, taking our 'hands on' time away from the patient.*

*Our current portfolio requirements are exhausting and assessed by nurses who cannot relate to the areas we work in. they are repetitive and far exceed the current council requirements.*
*PDRP process is a hassle that puts people off doing it.*

*Having achieved NZNO practice nurse accreditation ,I was very disappointed with the current professional portfolio. It is too similar to the previous tools, too long, wordy, repetitive and of no practical value to me.*

*There is far too much paper work and computer work to complete, taking time from the patient.*

*ACC is now an absolute disaster with the paper work involved- do they think that we are office workers????*

| | | |
|---|---|---|
| Poor management | Included bullying, remoteness, unsupportive, poor leadership, poor advocacy (32) | |

*Bullying is a big concern at XXX...*

*They are great employers who really look after their staff!*

*The only time I have been reluctant to go to work was in a work place where management used bullying and personal insults if a staff member stepped out of line in any way.*

*Generally poor managers with no idea how to make staff feel valued.*

*I retired gladly from a job I loved in XXX due to work stress and bullying.*

*Too much bullying and nepotism in DHB institutions. Nurses are often working in Victorian like arenas, "seen and not heard"!*

*I was unsupported in matters re bullying and harassment from a CNM and how the outcome was a conflict of personalities even though there was evidence this was not the case. I was not supported by management or the union.*

*I am near retirement my current manager is less than supportive.*

*There has been some level of bullying for me in the last year, which hopefully will not be happening as that person has left...I have felt humiliated, and put through some very unbelievable experiences over*

*the past year, ones that I wouldn't wish on any other nurse.*
*a morale boost every now and then would do amazing wonders. I find management to have a strong focus on blame and are never to be seen unless there is a complaint. A lot of compliments also are sent to the DHB but they never come to the ward to say you are doing a great job. When management do appear most staff have no idea who they are.*

| | | |
|---|---|---|
| Pay | Poor pay relative to other professions, levels of education and responsibility, and lack of promotional opportunities and the linked pay. | 22 |

*I have always felt nurses are undervalued in the responsibilities they hold compared to other professions and especially in regards to remuneration.*

*My friends think my wages are a joke, particularly as I basically work as both GP and nurse and get all the stress and none of the reward!*

*I think wages are dropping behind recently, nurses are called on more and more to be pro active in patient care and do "doctor work" etc which years ago we would never have touched ,therefore should be paid accordingly.*

*I plan to finish my Masters degree in the next 2 years. However, having this degree does not entitle me to a higher wage.*

*There is little to no quality support structures and or pathways in our DHB for nurses moving into management roles.*

*The pay for lower level management roles is not even as good as working as a nurse on the floor (once shift allowances are included). I have way more responsibility and the same pay!*
*I take personal pride in my work. I now understand the term "for the love of nursing".*

*Unfortunately this attitude doesn't and has never progressed nursing salaries-we continue to be in a weak position with salary negotiation.*

*We are a profession but we are not paid as such.*

*I find that once you hit the Staff Nurse 5 level of nursing it is difficult to progress or advance your career. Despite ongoing post graduate education and masters education, it is still extremely difficult to obtain Senior Nursing Roles in child health especially.*

*Nursing salaries need to be comparable to our professions e.g. teachers/police force. Nurses need to feel valued in order to stop skilled nurses leaving the country.*

## 10.3 Specific and separate themes

Table 23. Specific and separate themes

| Theme | Description | count |
|---|---|---|
| Unemployment | This included unemployment, job hunting, lack of new graduate positions, and job insecurity. | 12 |
| *I am currently unemployed and I am finding it hard to get employment as a RN. I will apply for support caring roles next .*<br><br>*I could lose my job if my employer adopts caregivers to do the role which I am currently filling and which is their policy in their other retirement villages in NZ.*<br><br>*I live in XXX few nursing career opportunities.*<br><br>*Lack of jobs is a real worry at the moment and it seems unfair that international nurses are being hired over kiwi nurses????*<br><br>*I feel very fortunate to have a job as i know several who graduated at the same time were not able to find one.*<br><br>*I was applying for positions but finding it difficult to attain due to the number of candidates with more experience.*<br><br>*Please only train enough nurses to match the NETP spots available to create a demand.*<br><br>*I find the lack of fulltime employment opportunities frustrating rotating shifts are hard enough but when you are dependent on picking up extra hours to survive recommended shift pattern are an impossible dream.* | | |
| 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 |
| *My career has taken a serious dip since coming to New Zealand. I have been studying for over 15 years and cannot use any of it currently.*<br><br>*If you haven't guessed by now I'm a very lucky immigrant nursing in your country. Nurses here need to be congratulated for their levels of kindness and their abilty to work hard uncomplaining.*<br><br>*Work is becoming more difficult due to high numbers of foreign staff with poor English skills and lack of understanding of the NZ health system and NZ cultures. Many are obviously here to earn money and have a job, there is no true interest in the people or the place.*<br><br>*Since I moved to New Zealand I have been totally supported in my current job.*<br><br>*Work life and work load easy compared to working in the UK. Feel unvalued and some negativity from one or 2 work colleagues, because I'm English and from the UK. Hurtful and unnecessary comments, making me question ever moving to New Zealand and Christchurch.*<br><br>*I still miss my old job and work conditions in mid-west Canada.* | | |

| | | |
|---|---|---|
| *We should be employing NZ registered nurses not foreign nurses as they have a much different work ethos and patient care that NZ nurses and it is very evident on the wards.*<br><br>*Its no wonder so many nurses are going to Australia, better pay and better work conditions and not so easy entry for international nurses, namely phillipino and indian that can't even speak proper English and have no concept of Māori culture and the Treaty of Waitangi* | | |
| Pay relative to Australia | This related to better opportunities, pay and conditions, came from those planning to go to Australia or having returned from Australia | 13 |
| *I am currently in the process of moving to Perth to work with an agency to choose my own shifts, avoid night shifts and still collect a liveable wage.*<br><br>*Having worked in Australia for 7 years and coming back to NZ to work has been a huge disappointment and made me aware of how much better off nurses are in most areas of Australia.*<br><br>*Moving to australia, no jobs available in Rotorua, too many international nurses.*<br><br>*NZ should increase the wages of people in the health sector so as to avoid brain drain overseas/Oz*<br><br>*I am returning to Australia in the next weeks to take up a permanent position with Qld Health. It is time NZ started to value its nurses and remunerated them more appropriately.*<br><br>*Significant pay cut returning to NZ nursing from Australia. Equally compounded by the increased cost of living, including basics such as groceries.*<br><br>*This lack of investment in NZ nurses is contributing to an exodus to Australia where pay and conditions are often better.*<br><br>*During this time I was offered work in two hospitals that I applied to in Australia. It seems that the New Zealand experienced nurse is not valued by our foreign nurse managers in New Zealand.* | | |
| Enrolled Nurses | Data from and about ENs has been captured separately and is reported elsewhere | 13 |

## 10.4 Summary

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

> New Zealand's nurses are most positive about the quality of care they deliver, nursing as a career, job security and job satisfaction.

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

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

> Compared to the responses from 2009 and 2011, New Zealand nurses' morale scores with most aspects of nursing as a career are very similar.

> Compared to the responses from 2009 and 2011, slight falls in confidence about career progression and job security were seen.

> There has been a slight improvement of perception of bullying and the quality of management.

# Chapter 11: Recommendations

> Comparative pay (especially relative to pay in Australia and 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 continuing professional development support and leave must be ensured.

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

> 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 hugely of concern.

> The changes to the EN scope of practice have impacted on their employment in some instances. Concerted effort must be exerted to ensure this group of workers (already adversely affected by changes and requirements for extra training) are not further disadvantaged by threats to their future employment.

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