RESEARCH

EMPLOYMENT SURVEY

NZNO Employment Survey 2017

Our Nursing Workforce: Resilience in Adversity

Dr Léonie Walker

NZNO Principal Researcher

Contents

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.

List of tables

List of figures

Executive summary

This is the fifth biennial employment survey of the New Zealand Nurses Organisation (NZNO) nurse membership. The web-based study of members was undertaken in late December 2016. Midwives were excluded from the 10 per cent random sample on this occasion, though dual registered nurse/midwife members could have been selected. This is because the employment situations of very many of the midwife members are very different from all other members than those employed by district health boards (DHBs) directly, and the decision was made to avoid skewing the results.

The questionnaire covered core employment issues (contracts, hours, pay, job changes), along with demographic details, and items related to plans for, and perceptions of, working life. The attitudinal rating scales were identical to those used since 2008/9, allowing change over time to be tracked, and kept as similar as possible to the standardised Royal College of Nursing set to allow international comparisons. New questions for 2017 included an exploration of burnout, additional questions about professional development and recognition programmes (PDRP), occupational health and safety, and progress with the introduction of care capacity demand nanagement (CCDM), a joint project being rolled out in DHBs designed to better match nursing resource with patient requirements.

Of the 4858 invitations sent out to a random 10 per cent of the membership, 23 were returned as not known at the address available. A reminder was sent two weeks later to the 2932 who had not opened the survey invitation e-mail. Invitations to take part were also sent to recipients of the NZNO e-newsletter. Seven hundred and thirty nine responses were returned. It is not possible to calculate a response rate, though the timing of responses relative to the e-mail invitations and the newsletter indicate e-mail was the main prompter to complete. Respondent profiles by age, gender, DHB area, health sector and fields of practice showed good concordance with workforce statistics from the New Zealand Nursing Council.

New Zealand's nurses show resilience and commitment to their profession in the face of continuing restructuring and resource restraint. The ageing profile of the workforce brings more urgency for changes to aid retention. This survey corroborates previous NZNO research (on late career nurses and flexible working practices) related to factors influencing nurses' retirement intentions. There is a steady decline in overall morale, along with specific concerns about staffing levels, workload and pay, and a loss of confidence in health sector leadership. This longitudinal survey has been running for nearly a decade and remarkable consistency in the patterns of steady decline are apparent over this time.

Significant and emerging themes

Profile of the nursing workforce

The Aotearoa New Zealand nursing workforce was well represented in the respondents to this survey. While other data about age, ethnicity, gender and qualifications exist, this survey also documents the proportions of such nurses, their employers and job titles. This allows comparisons with other items in the survey, such as pay, working patterns, second jobs, career plans, morale and perceptions of nursing roles and careers. The period from 2015 to 2017 was one of continued substantial structural and organisational change in the health system. The impact of changes over the previous two years have been captured, and are reported where significant.

Restructuring

Thirty two per cent (up from 27.4 per cent in 2015) of respondents had been affected by significant restructuring in their main employment within the previous two years. Of these, nearly half of the restructuring had involved reorganisation within the worksite, or across a wider employer such as an DHB; 24.4 per cent had involved the loss of senior nursing leadership positions; and 23 per cent involved a reduction of nursing skill mix (substitution of registered nurses (RNs) with enrolled nurses (ENs) or of RN/ENs with health care assistants (HCAs) or care givers). Other significant restructurings involved mergers of DHBs, primary health organisations (PHOs) or general practices, or the sale, privatisation or closing of facilities.

Workplace-acquired infections and injury

In the previous two years, 23.6 per cent (156) of respondents reported an occupationally-acquired infection or a workplace injury. This is an increase of two per cent compared to 2015, and over 100 per cent increase on 2013. Of the injuries, 16 per cent were related to heavy lifting. Seven respondents reported injury related to work place violence. Nearly 10 per cent required time off work with a workplace-related infection, and over half of the injuries were referred to the Accident Compensation Corporation (ACC). The commonest infections were flu or norovirus infections, four nurses reported injuries caused by assaults on staff by patients, and one reported a needle-stick injury.

Burnout

A modified version of the Abbreviated Maslach Inventory (McClafferty 2014) was used to examine the degree of burnout.
Nine items divided into three domains: emotional exhaustion, depersonalisation and personal accomplishment are scored using a seven point frequency scale ranging from every day to never. Analysis reveals that at the aggregated level at least, nurses have high personal accomplishment scores, moderate levels of emotional exhaustion, and low scores for depersonalisation. The inventory was designed for assessment at the individual level, and has not specifically been validated for use with New Zealand nurses, or in an embedded web-survey format, so some caution should be taken with putting too much emphasis on this aggregated analysis. Nevertheless, it does potentially reveal that despite emotional toll, nurses gain resilience from their sense of job satisfaction related to helping patients, and contrasts starkly with the considerable burnout reported by Association of Salaried Medical Specialists in a recent burnout-specific survey.

Morale

The morale of nurses has continued to steadily decline overall. Morale and satisfaction with staffing, hours and access to education were highest in the private surgical hospital sector. Those employed in aged care and DHBs frequently cited heavier workloads, higher patient acuity, restructuring and a perception of a decline in the capacity of nursing leadership and the quality of management. This was seen both in the answers given to questions about workload and restructuring, and in the free text general comments. While many expressed their love of nursing, many also expressed perceptions that increasingly unsafe practice environments, leadership unresponsive to nursing concerns and rigid management were causing them to question their future.

Access to, and use of, NZNO 2017 employment survey data

This report details 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 access to data for research purposes, or sub-set analyses for example by sector, field, DHB area or issue can be addressed to the nursing and professional services manager, Jane.MacGeorge@nzno.org.nz

Chapter 1: Introduction

1.1 The 2017 NZNO Employment Survey

NZNO is the leading professional and industrial organisation of nurses in Aotearoa New Zealand, representing over 48,000 nurses, midwives, students, kaimahi hauora and health workers on a range of employment-related and professional issues. NZNO commitment to te Tiriti o Waitangi is embedded in its constitution, and articulated through its partnership with Te Rūnanga 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 drawn by computer from across New Zealand.

The questionnaire was adapted for use in New Zealand from the United Kingdom Royal College of Nursing (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, 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 fifth biennial employment survey of NZNO nurse membership, and was undertaken in late December 2016, following continuing DHB restructuring, increasing health service reforms and budget constraints.

1.3 Method

A web-based survey of a random sample of NZNO members was undertaken in December 2016. Invitations to participate in the web-based survey were sent by e-mail link, along with a covering letter. A link was also inserted into the e-newsletter. Participants were 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

The questionnaire covers core employment issues (contracts, hours, pay, job changes) along with demographic details, and items related to plans for, and perceptions of, working life. The attitudinal rating scales mapping morale were identical to those used since 2008/9, allowing changes over time to be tracked, and kept as similar as possible to the standardised RCN set to allow international comparisons. New questions for 2017 included more detailed questions on health and safety (including burnout), and progress with the introduction of CCDM, a joint project being rolled out in DHBs designed to better match nursing resource with patient requirements. To avoid the survey becoming too long, a few previously used questions were not included this time.

1.3.2 Sample and response rate

Of the 4858 invitations sent out, 23 were returned as not known at the address available. Invitations to take part were also sent to recipients of the NZNO e-newsletter. Seven hundred and thirty five responses were returned. It is not possible to calculate an exact response rate, though the timing of responses relative to the e-mail invitation and the newsletter indicate the e-mail was the main prompter to complete. An approximate response rate from the random sample was 15 per cent, a reduction from previous surveys, but possibly related to recent increased survey requests from very many sources.

1.4 Report structure

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

Chapter 1	Introduces the context and methodology of the 2017 employment survey.
Chapter 2	Details the demographic and employment profiles of the respondents.
Chapter 3	Examines pay and employment agreements.
Chapter 4	Describes working and shift patterns.
Chapter 5	Captures workload and staffing issues, including CCDM.
Chapter 6	Summarises aspects important for workforce planning.
Chapter 7	Summarises the impact of restructuring and organisational change.
Chapter 8	Explores continuing professional development, education and qualifications.
Chapter 9	Examines perceptions of health, occupationally-acquired infections or injury and burnout.
Chapter 10	Utilises a combination of the attitudinal scales and analysis of qualitative comments to present a picture of the morale of the workforce.
Chapter 11	Overall summary
	Bibliography

Chapter 2: Respondent profiles

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

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

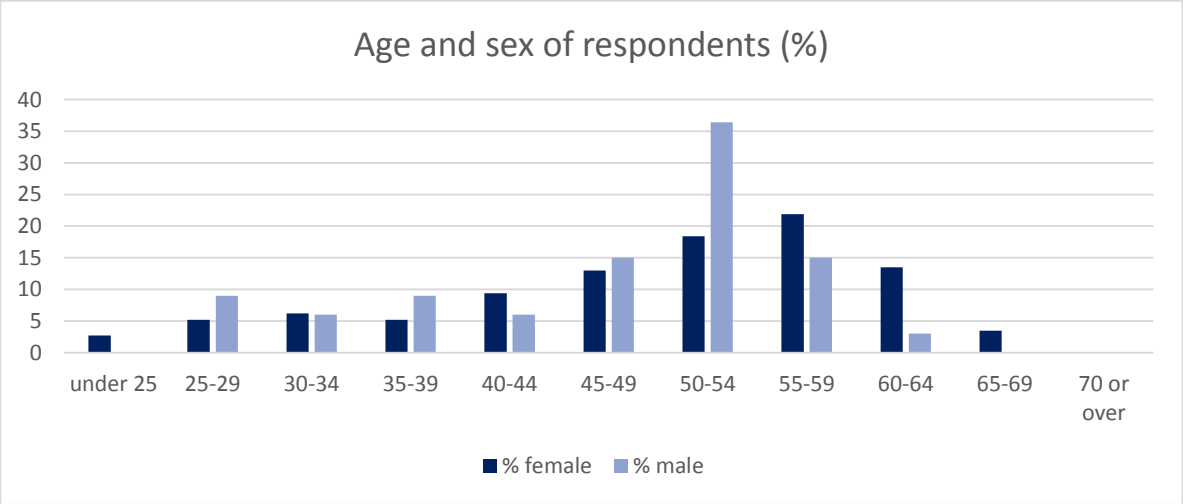
2.1 Age and gender profiles

The ages, percentages and comparative figures for the Nursing Council (March 2015) are shown in the tables below. The gender identity “other“ than male or female was also offered. No “other” responses were recorded.

Table 1. Respondent gender and age profile

Age group	Female	Male	% female	% female NC	% male	% male NC
under 25	17	0	2.70	5.3	0	3
25-29	33	3	5.20	9.6	9	19.6
30-34	39	2	6.20	8.9	6	12.3
35-39	33	3	5.20	8.3	9	8.4
40-44	59	2	9.40	11.7	6	11.6
45-49	82	5	13.00	12.3	15	11.7
50-54	116	12	18.40	15.1	36.4	12.2
55-59	138	5	21.90	14.3	15	11.8
60-64	85	1	13.50	9.3	3	7
65-69	22	0	3.50	5.3	0	2.4
70 or over	6	0	0.09	_	0	-
			answered question		663	

Figure 1. Age and gender profiles of respondents



2.2 Ethnicity

Table 2. Ethnicity

Ethnicity	Number	%	NC %	Ethnicity	Number	%	NC %
NZ European	499	74.9	64	Samoan	11	1.0	1
NZ Māori	70	10.5	6.9	Cook Island Māori	3	0.05	0.3
Other European	55	8.3	14.9	Tongan	4	0.6	0.05
South East Asian	19	2.8	6	Niuean	1	0.2	0.001
Other Asian	9	1.4	0.1	Tokelauan	1	0.1	0.001
Chinese	6	0.9	2.2	Other Pacific	11	1.7	0.003
Indian	11	1.7	6.5	Other	59	8.9	4.0
African	4	0.6	1.2				

Of all the respondents, 108 or 16.72 per cent FIRST trained as nurses outside New Zealand. They will be referred to in this report as internationally qualified nurses (IQNs). The Nursing Council workforce statistics (2015) show 25 per cent first qualified internationally.

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

Country of first training	Per cent	Count
Australia	3.7%	4
Pacific	2.8%	3
Philippines	12.0%	13
China	0.0%	0
India and Sri Lanka	5.6%	6
Other Asia	2.8%	3
Middle East	0.0%	0
South Africa	8.3%	9
Zimbabwe	0.9%	1
Other Africa	0.0%	0
United Kingdom	46.3%	50
Other Western Europe	3.7%	4
Central / Eastern Europe	0.9%	1
North America	0.9%	1
Central South America	0.0%	0
Other (please specify)	12.0%	13
	answered question	108

There is an under representation of Chinese and Indian respondents in particular compared to Nursing Council data.

2.3 Scope of practice

Table 4. Scopes of practice

Scope	Number	%
RN	646	88
EN	44	6.5
NP	1	0.09
Midwife	4	1.5
Unregulated	39	5.3

2.4 Employment situation

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

Table 5. Respondent profile by employment status

current employment status		
	Response Per cent	Response Count
Employed, working	93.9%	689
Employed, on parental leave	0.4%	3
Employed, on long term sick leave	0.3%	2
Student	0.7%	5
Unemployed, on career break	0.4%	3
Unemployed, looking for work	0.4%	3
Retired, still in paid employment	1.1%	8
Fully retired	0.3%	2
Other (please specify)	2.6%	19
	answered question	734

Of the five nursing students who responded, four were undergraduates, one a postgraduate, and none were doing return to nursing or overseas competency assessment courses.

Ninety seven per cent (673) held an APC, three were awaiting registration, and 16 were not seeking registration.

2.5 Job title

Table 6. Job title

Job title		
	Per cent	Count
Charge nurse/ manager	8.4%	54
Community nurse	4.0%	26
Enrolled nurse	3.6%	23
Nurse assistant	0.2%	1
Service manager	0.3%	2
Director of nursing	0.3%	2
Clinical nurse specialist	8.7%	56
Nurse practitioner	1.4%	9
District nurse	2.0%	13
Duly authorised officer	0.2%	1
Public health nurse	3.0%	19
Mental health nurse	3.9%	25
Registered nurse/ staff nurse	44.4%	286
Midwife	0.6%	4
Pacific Island nurse	0.0%	0
Māori and Iwi nurse	0.3%	2
Kaimahi hauora	0.2%	1
Pacific Island or Māori and Iwi care giver	0.0%	0
School nurse	0.8%	5
Practice nurse	10.7%	69
Educator/ researcher/ lecturer/ tutor	2.5%	16
Health care assistant	1.6%	10
Care giver	0.8%	5
Allied health professional	0.3%	2
Phlebotomist	0.2%	1
Social worker	0.0%	0
Medical receptionist	0.0%	0
Professional nurse adviser/consultant	1.9%	12
Other (please specify)		60
	answered question	**644**
	skipped question	**92**

2.6 Nursing field

Table 7. Field of practice

Field of practice		
	Response Per cent	Response Count
Emergency & trauma	5.7%	36
Assessment & rehabilitation	3.3%	21
Child health including neonatology	5.8%	37
Continuing care (elderly)	6.5%	41
Cancer nursing	2.8%	18
District nursing	4.1%	26
Familyplanning / sexual health	1.1%	7
Intellectually disabled	0.2%	1
Intensive or coronary care / HDU	3.3%	21
Mental health/ addictions	6.3%	40
Medical	7.7%	49
Nursing administration / management	1.6%	10
Nursing education	1.7%	11
Infection control	0.8%	5
Professional nursing advice	1.3%	8
Nursing research	0.3%	2
Obstetrics/ maternity	0.6%	4
Occupational health	1.3%	8
Palliative care	3.0%	19
Perioperative care/ theatre	5.8%	37
Primary health/ practice nursing	15.6%	99
Public health	3.1%	20
Prison nursing	1.3%	8
Surgical	10.1%	64
Other- nursing	5.7%	36
Other- non nursing	0.9%	6
Non-practicing	0.2%	1
Other (please specify)		102
	answered question	635
	skipped question	101

2.7 Employer

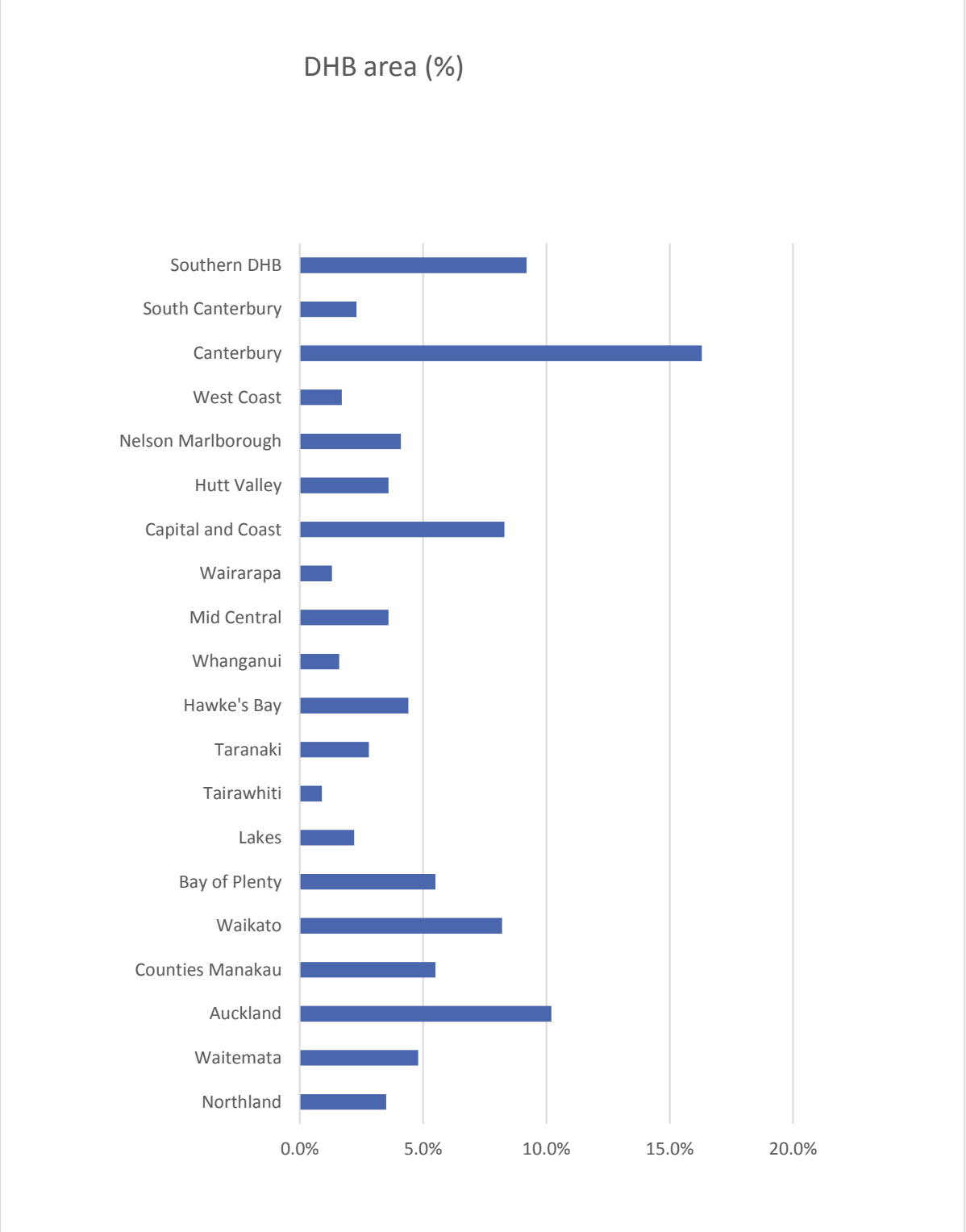
Table 8. Employer

Employer	Response Per cent	Response Count
DHB- in patient	41.8%	289
DHB- community	13.0%	90
Private surgical hospital	2.7%	19
Accident and medical centre	1.7%	12
Community hospital (rural)	0.6%	4
General Practitioner	8.2%	57
Aged care Pprovider	7.1%	49
Nursing agency	0.3%	2
Self-Employed	0.4%	3
Māori and Iwi health provider	1.6%	11
Pacific health provider	0.3%	2
Educational Institution	1.6%	11
Government agency (MOH, ACC, prisons, etc.)	2.0%	14
PHO provider	2.3%	16
NGO provider (e.g. Hospice, Plunket)	5.6%	39
Other, non-nursing work	0.6%	4
Other nursing work	1.3%	9
Other (please specify)	8.7%	60
	answered question	691
	skipped question	45

2.8 DHB area

A representative sample by DHB area was achieved.

Figure 2. DHB area



2.9 Employment contract status

This is shown in the table and graph below.

Table 9. Employment contract status

Employment agreement	% ES 2017	% ES 2015	% ES 2013	% ES 2011
Permanent	93.97	89.3	89.1	81
Secondment	0	0.29	0.4	-
Temporary or fixed term	2.79	3.61	4.4	5.3
Casual	2.65	5.61	4.5	11
Other	0.6	1.24	0.6	1.4

From this sample, it appears there has been a decrease in casualisation and use of temporary agreements since 2015.

2.10 Summary

> A smaller number of responses were received compared to 2015. This may relate to ongoing over-surveying of members or to recent events related to e-mail addresses.

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

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

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

> The permanent employment agreement status has increased in comparison to 2015.

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

Chapter 3: Pay and employment agreements

3.1 Pay

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

Figure 3. Salary band

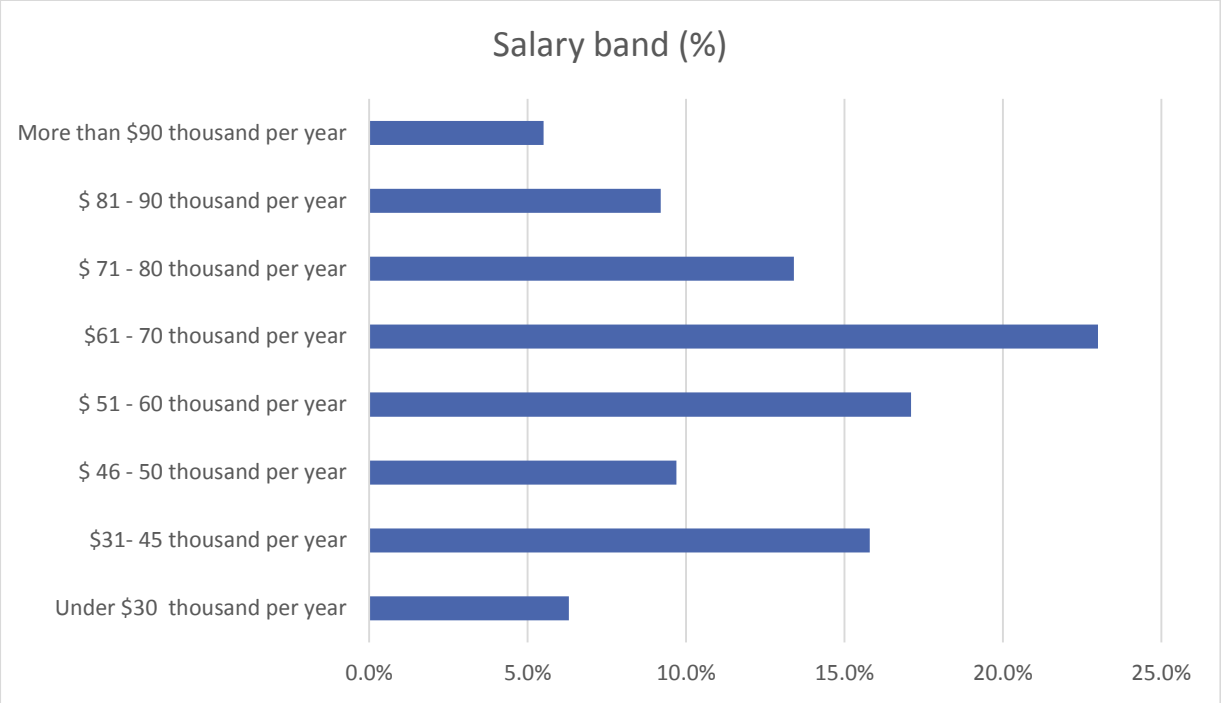


Table 9. Pay rates by employer (Number in each pay band, thousand dollars per year)

(Due to small numbers, both count and percentage of people employed in each settings by pay band are shown.)

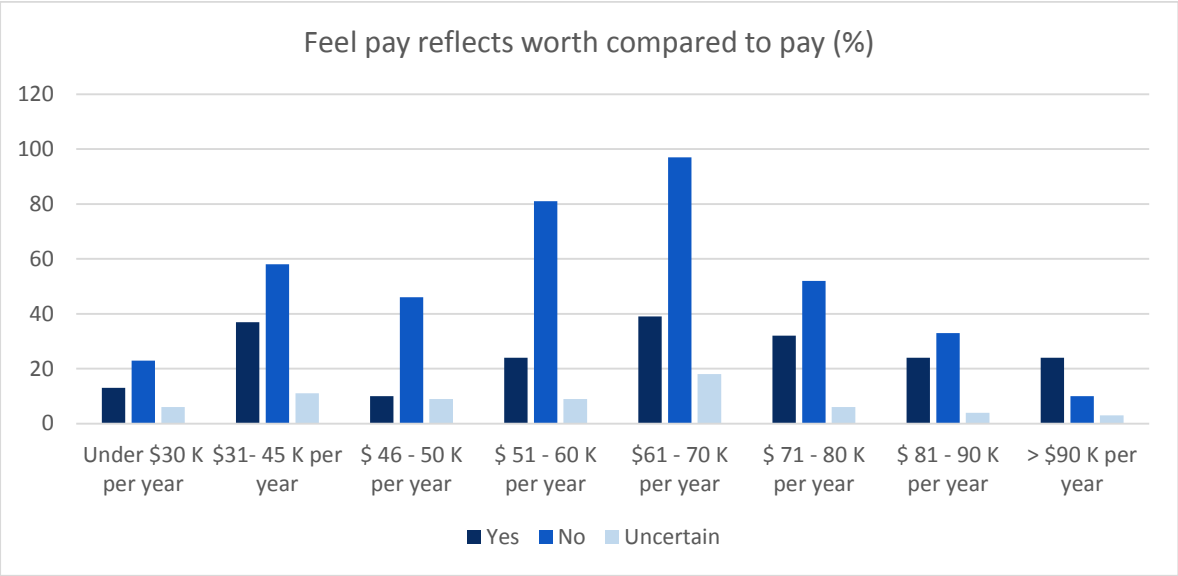
Employer	< $30K	$31-45 K	$ 46-50 K	$ 51 - 60 K	$61 - 70 K	$ 71 - 80 K	$ 81 - 90 K	> $90K
DHB- In patient	3.19% 9	9.93% 28	8.51% 24	22.34% 63	29.08% 82	11.35% 32	10.28% 29	5.32% 15
DHB- community	1.16% 1	12.79% 11	5.81% 5	13.95% 12	16.28% 14	30.23% 26	13.95% 12	5.81% 5
Private surgical hospital	10.00% 2	25.00% 5	30.00% 6	10.00% 2	5.00% 1	5.00% 1	10.00% 2	5.00% 1
Accident and medical centre	0.00% 0	41.67% 5	25.00% 3	16.67% 2	8.33% 1	8.33% 1	0.00% 0	0.00% 0
Community hospital (rural)	25.00% 1	50.00% 2	0.00% 0	0.00% 0	0.00% 0	25.00% 1	0.00% 0	0.00% 0
General Practitioner	25.00% 1	50.00% 2	0.00% 0	0.00% 0	0.00% 0	25.00% 1	0.00% 0	0.00% 0
Aged-care provider	18.75% 9	45.83% 22	16.67% 8	6.25% 3	4.17% 2	6.25% 3	2.08% 1	0.00% 0
Nursing agency	50.00% 1	0.00% 0	0.00% 0	50.00% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0
Self-Employed	0.00% 0	0.00% 0	0.00% 0	0.00% 0	33.33% 1	0.00% 0	0.00% 0	66.67% 2
Māori and Iwi health provider	0.00% 0	27.27% 3	9.09% 1	27.27% 3	18.18% 2	18.18% 2	0.00% 0	0.00% 0
Pacific health provider	50.00% 1	50.00% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0
Educational Institution	9.09% 1	18.18% 2	0.00% 0	9.09% 1	18.18% 2	45.45% 5	0.00% 0	0.00% 0
Government agency (MOH, ACC, prisons)	0.00% 0	0.00% 0	0.00% 0	8.33% 1	50.00% 6	8.33% 1	0.00% 0	33.33% 4
PHO provider	12.50% 2	18.75% 3	25.00% 4	6.25% 1	12.50% 2	18.75% 3	6.25% 1	0.00% 0
NGO provider	2.70% 1	10.81% 4	10.81% 4	18.92% 7	32.43% 12	10.81% 4	8.11% 3	5.41% 2
Other, non-nursing work	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 1	0.00% 0	0.00% 0	0.00% 0
Other nursing work	33.33% 3	11.11% 1	0.00% 0	0.00% 0	11.11% 1	11.11% 1	11.11% 1	22.22% 2

Table 11. Pay rate by job title (Number in each pay band, thousand dollars per year)

Job Title	< $30	$31-45	$ 46 - 50	$ 51 - 60	$61 – 70	$ 71 – 80	$ 81 – 90	>$90
Charge nurse/ manager	0	3	1	6	8	9	14	13
Community nurse	2	3	2	3	9	7	0	0
Enrolled nurse	2	8	8	3	0	0	0	0
Nurse assistant	0	1	0	0	0	0	0	0
Service manager	0	0	0	0	1	0	1	0
Director of nursing	0	0	0	0	0	0	0	2
Clinical nurse specialist	0	1	0	5	13	8	24	4
Nurse practitioner	0	0	0	0	2	1	0	4
District nurse	0	2	1	5	2	2	1	0
Duly authorised officer	0	0	0	0	0	0	1	0
Public health nurse	0	4	2	0	5	6	2	0
Mental health nurse	0	2	2	4	8	9	0	0
Registered nurse/ staff nurse	19	44	34	67	82	25	8	5
Midwife	0	1	1	0	0	0	0	0
Pacific Island nurse	0	0	0	0	0	0	0	0
Māori and iwi nurse	0	1	0	0	0	1	0	0
Kaimahi hauora	0	1	0	0	0	0	0	0
School nurse	0	1	0	2	1	1	0	0
Practice nurse	10	22	8	14	11	3	0	1
Educator/ researcher/ lecturer/ tutor	1	2	0	1	2	5	5	0
Health care assistant	3	4	0	0	0	0	0	0
Caregiver	2	3	0	0	0	0	0	0
Professional nurse adviser/consultant	0	1	0	0	1	1	3	5

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

Figure 4. Opinion on whether pay rate appropriate (per cent)



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

Table 12. Perception of pay by employer (%).

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

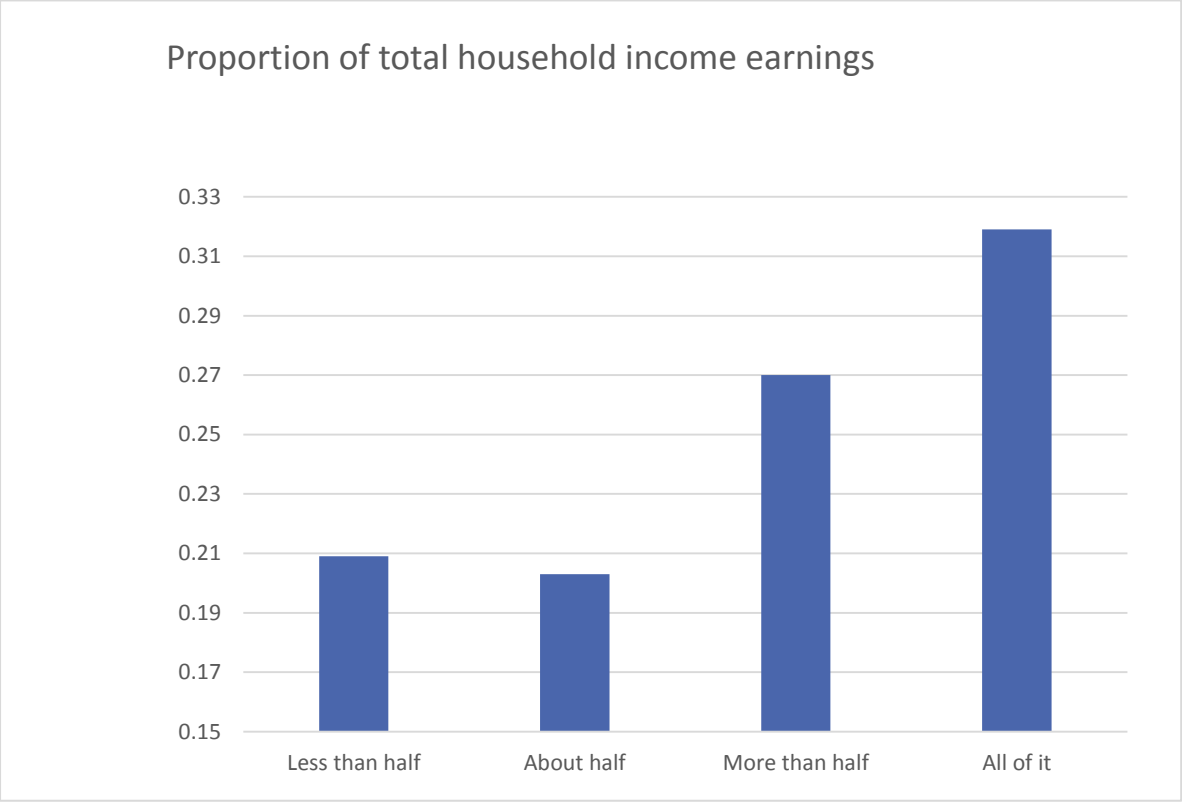
Employer	think current pay is appropriate given hours, role and responsibilities		
	Yes	No	Uncertain
DHB- in patient	72	181	32
DHB- community	40	42	4
Private surgical hospital	7	12	1
Accident and medical centre	3	8	1
Community hospital (rural)	3	1	0
General Practitioner	24	20	10
Aged care provider	6	38	4
Nursing gency	0	2	0
Self-employed	3	0	0
Māori and Iwi health provider	2	8	1
Pacific health provider	0	2	0
Educational institution	3	8	0
Government agency	6	5	1
PHO provider	5	8	2
NGO provider	8	26	3

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

3.2 Income and families

The following figure indicates that the perception held by some outside the sector that nurses' salaries are "nice to have, extra pin money" for households is *absolutely* not the case. Not only do salaries contribute significantly to households, but as shown in recent NZNO research (Walker and Clendon 2016, a, b, c), nearly half of all respondents had significant responsibilities for children, adults or both.

Figure 5. Proportion of income that contributes to household income

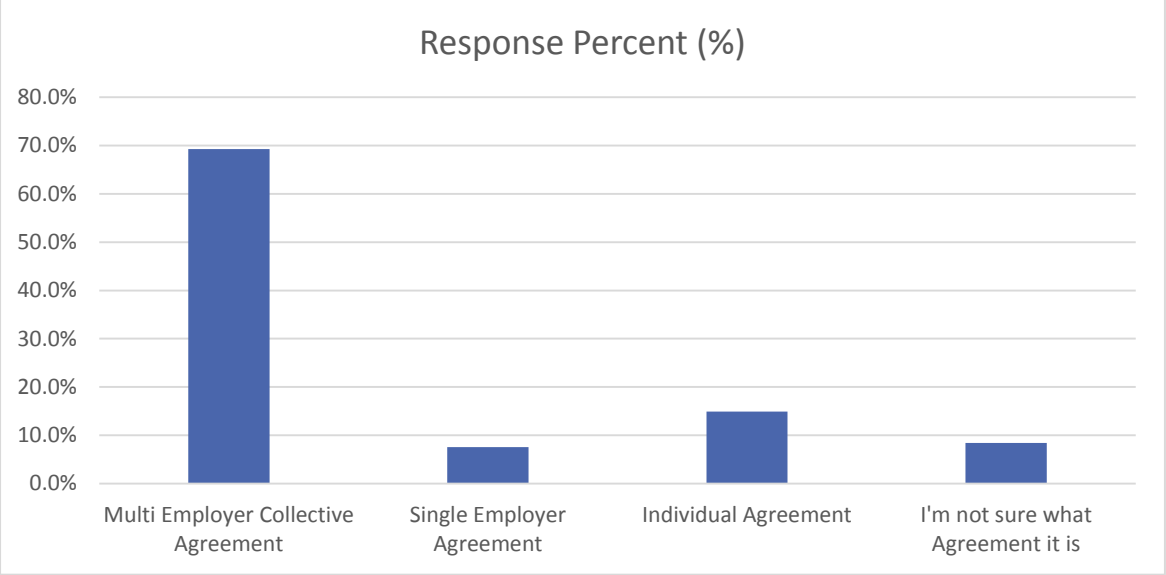


3.3 Māori respondents

Māori respondents who work for Māori and iwi providers (n=11) were the least happy with their pay – and many commented on the continuing unfairness of their pay relative to those employed doing the same work in DHBs.

3.4 Employment agreements

Figure 6. Percentage of respondents and type of employment agreement



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

3.5 SUMMARY

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

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

> The lowest rates of pay were for ENs and unregulated caregivers.

> Māori respondents working for Māori and iwi providers were not satisfied with ongoing pay disparity.

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

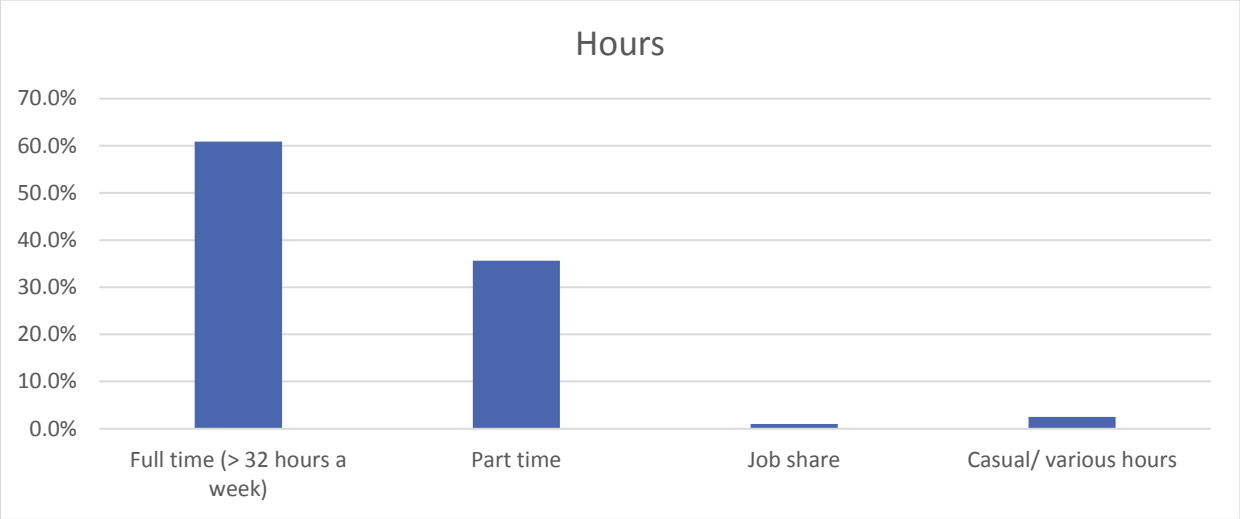
> Perceptions of the appropriateness of pay rates were, understandably, correlated with actual pay rates.

> Nurses' salaries make a significant contribution to the household budget, with around three quarters contributing half or more than half of all income to the total family income (a rise since 2013 and 2015).

Chapter 4: Working patterns

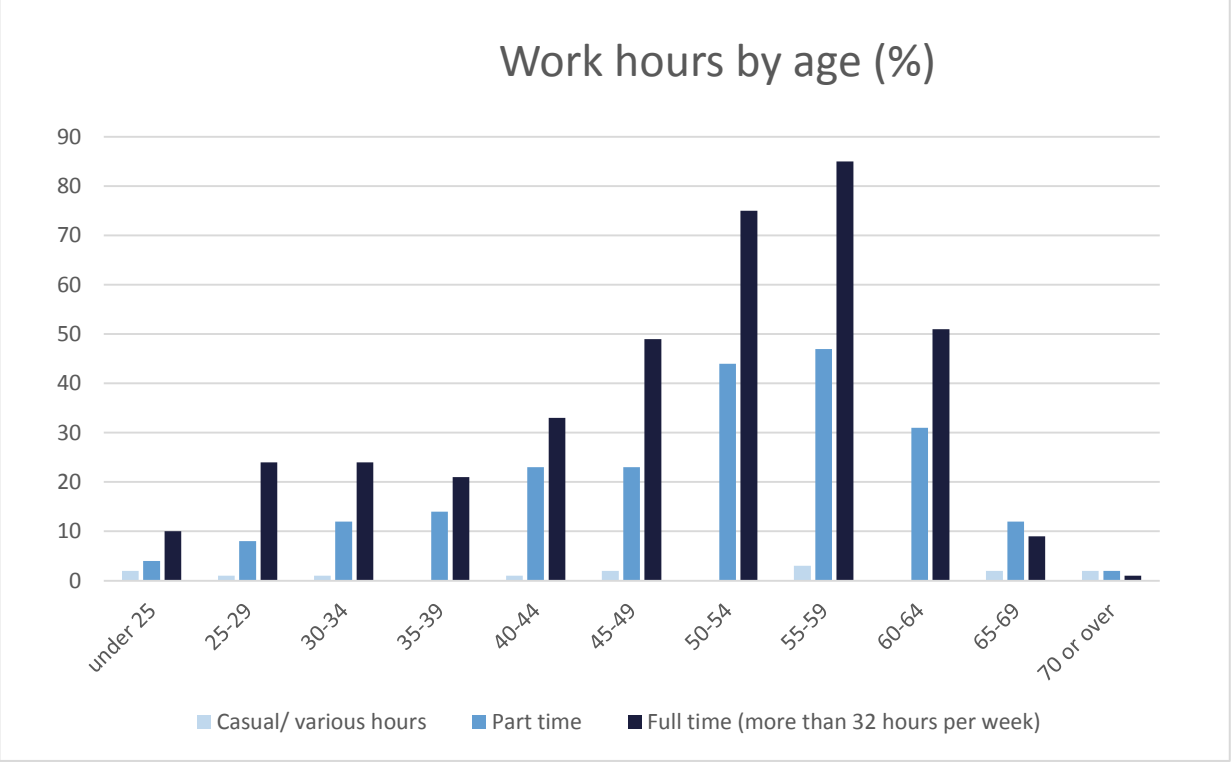
4.1 Contracts

Figure 7. Type of contract



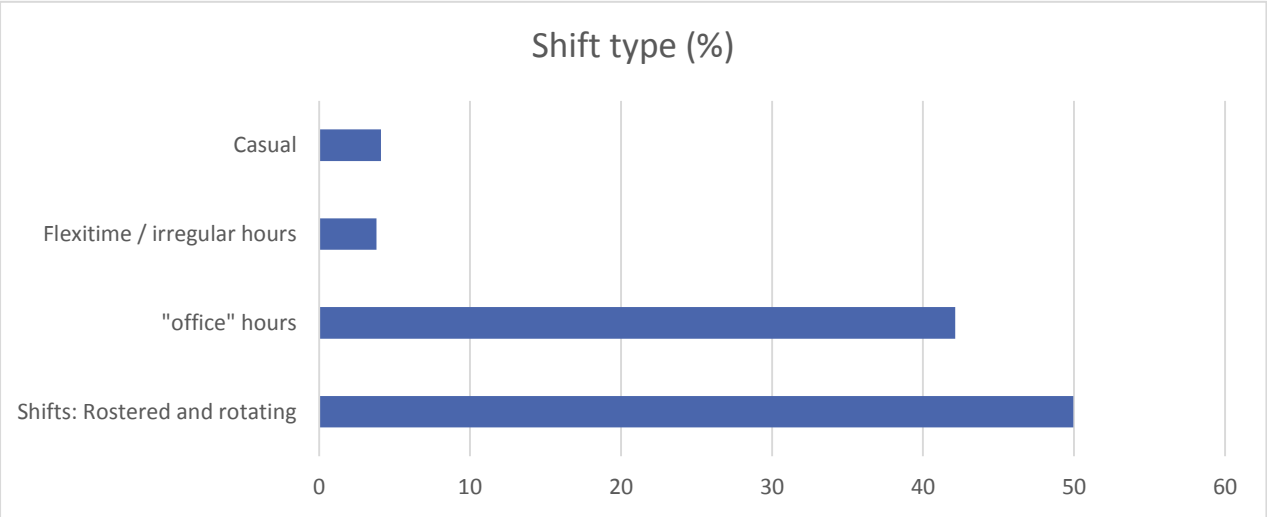
There has been another increase in the proportion of nurses working full time compared to 2015 (60.86% in 2017 vs 54% There were differences in the types of contracts in the various age groups, as shown in figure 8:

Figure 8. Types of work contract by age



4.2 Work pattern

Figure 9. Work pattern



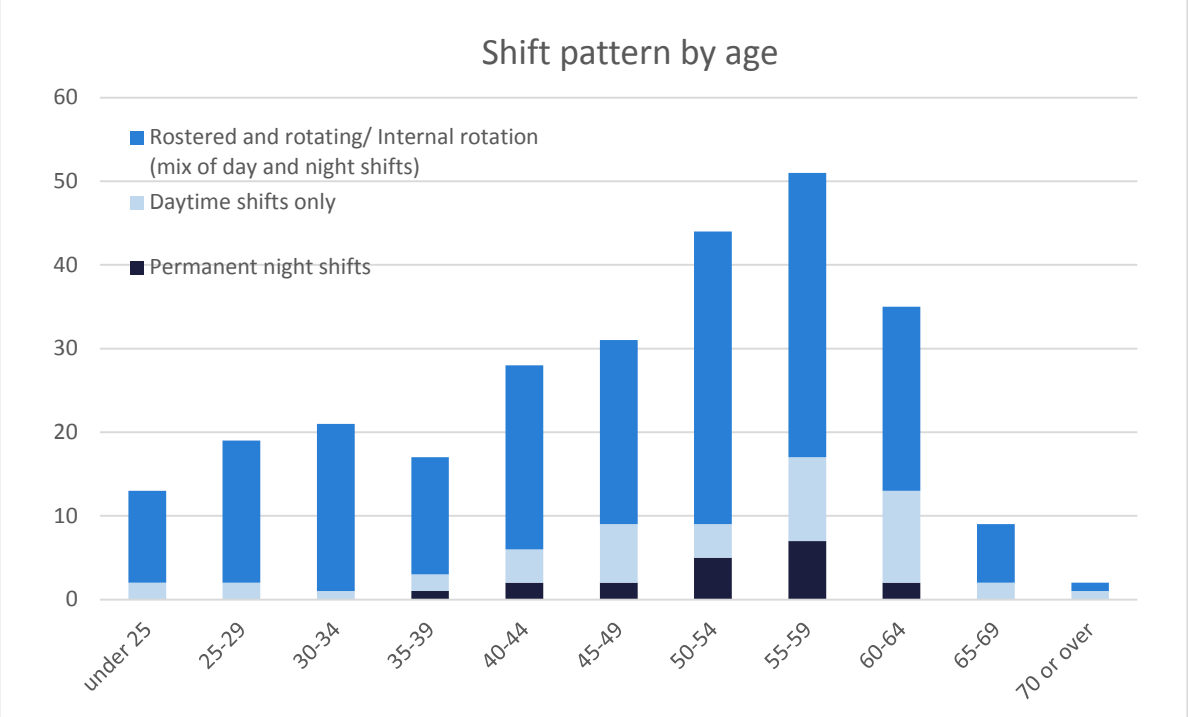
Work pattern also varied by age: with evidence of a change to work office hours for those between 51 and 60 year olds, while more 21-30 year olds work rostered and rotating (R&R) shift patterns. Older nurses were proportionately more commonly found in the group working permanent nights.

There were six respondents who specified they worked 10-hour shifts, some who specified hours on call, and very many who commented they worked extra if required, including extra unpaid hours.

4.3 Shifts

Of those (293) who worked shifts, 76 per cent worked rostered and rotating (R&R) shifts. This is unchanged from 2015, but 20 per cent higher than for the 2013 survey, and corroborates other evidence of a move by many employers to compel all staff to do R&R shifts. This move was particularly unpopular with older nurses, with those working in fields used to 12-hour shifts and with those previously happy with permanent night shift work.

Figure 10. Per cent of nurses in each age group working particular shifts



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

Figure 11. Shift length

The commonest shift length was eight hours.

Of the 10.6 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 high dependency unit/intensive care unit, followed by neonatology and surgical. The three DHBs with significant 12-hour shift options were Auckland, Capital and Coast and Counties Manukau. The impact of shift type, length and pattern are the subject of an ongoing Health Research Council funded study, led by Professor Philippa Gander of Massey University.

Figure 12. Shift lengths by DHB area

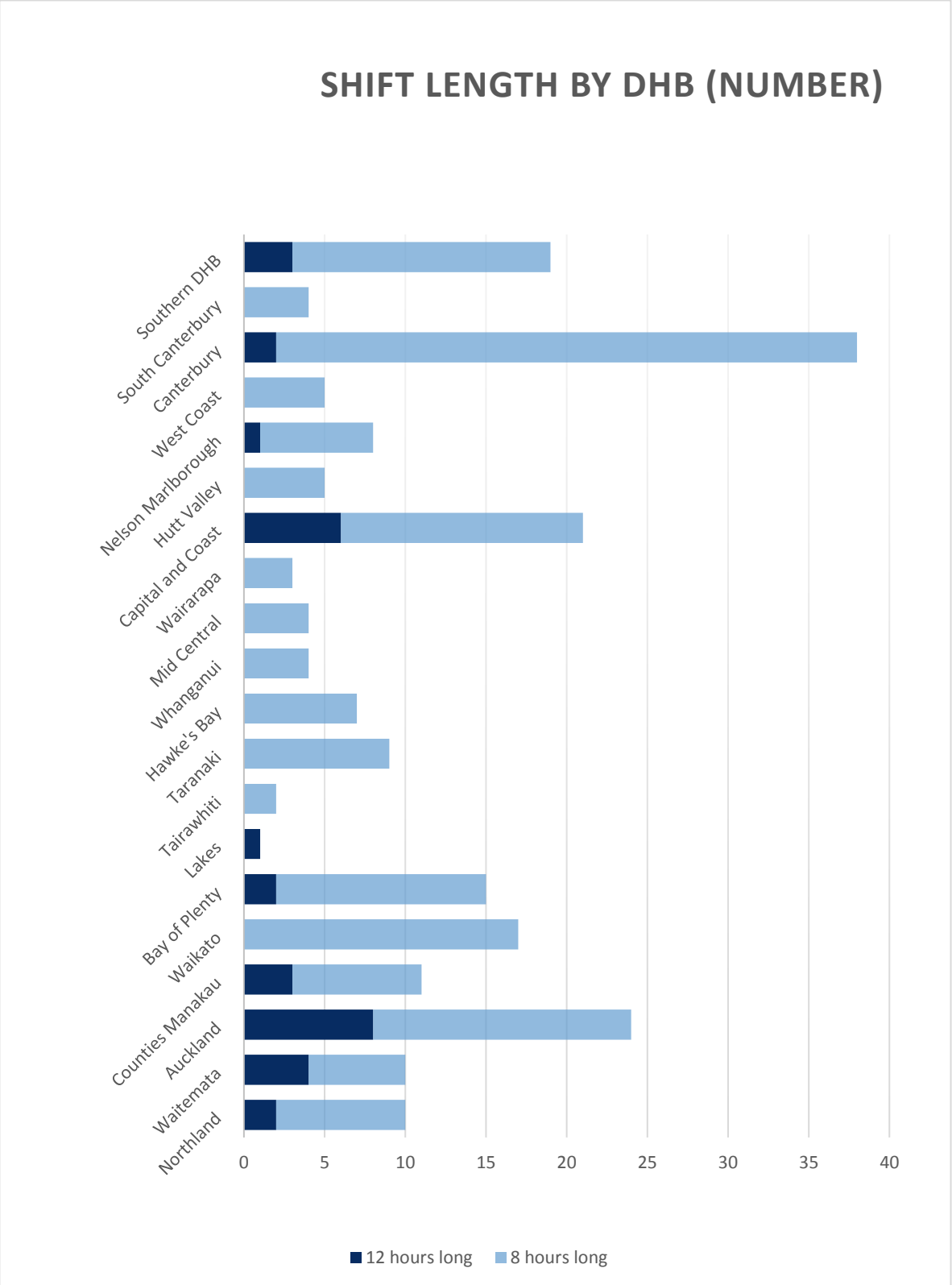
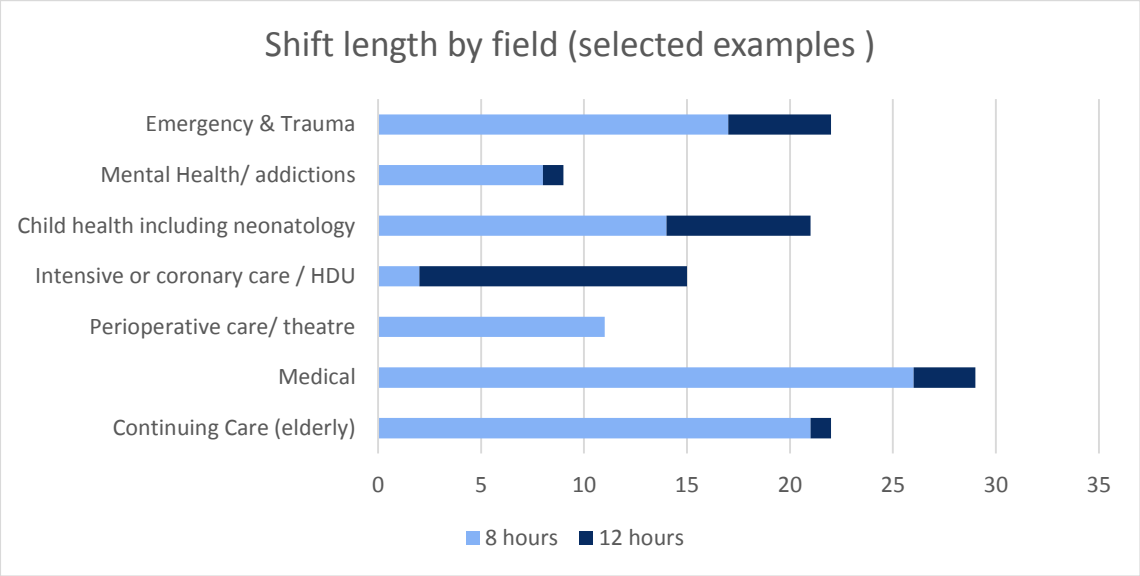


Figure 13. Shift length by field

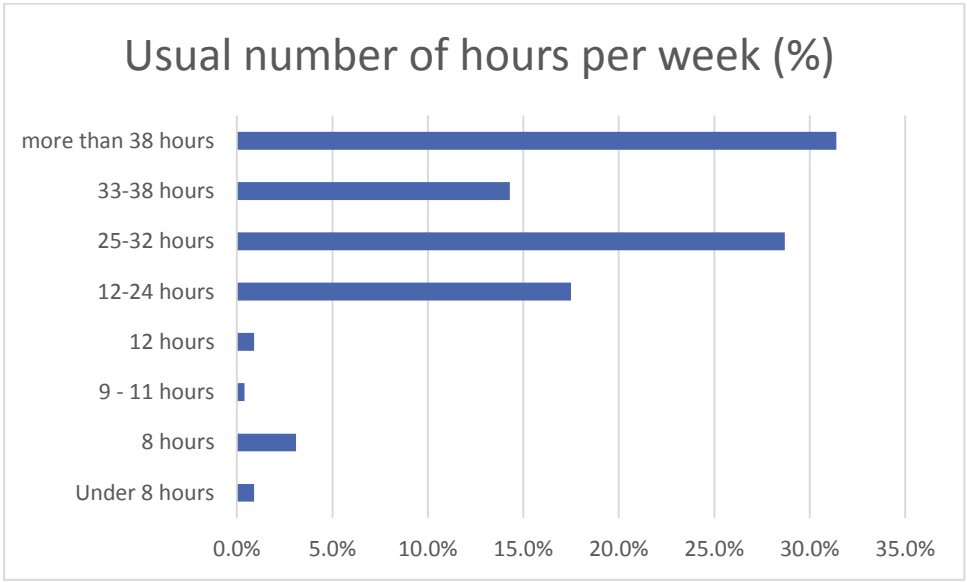


A shift length of eight hours is by far the most prevalent, but in some fields of practice a 12 hour shift is found.

4.4 Hours worked

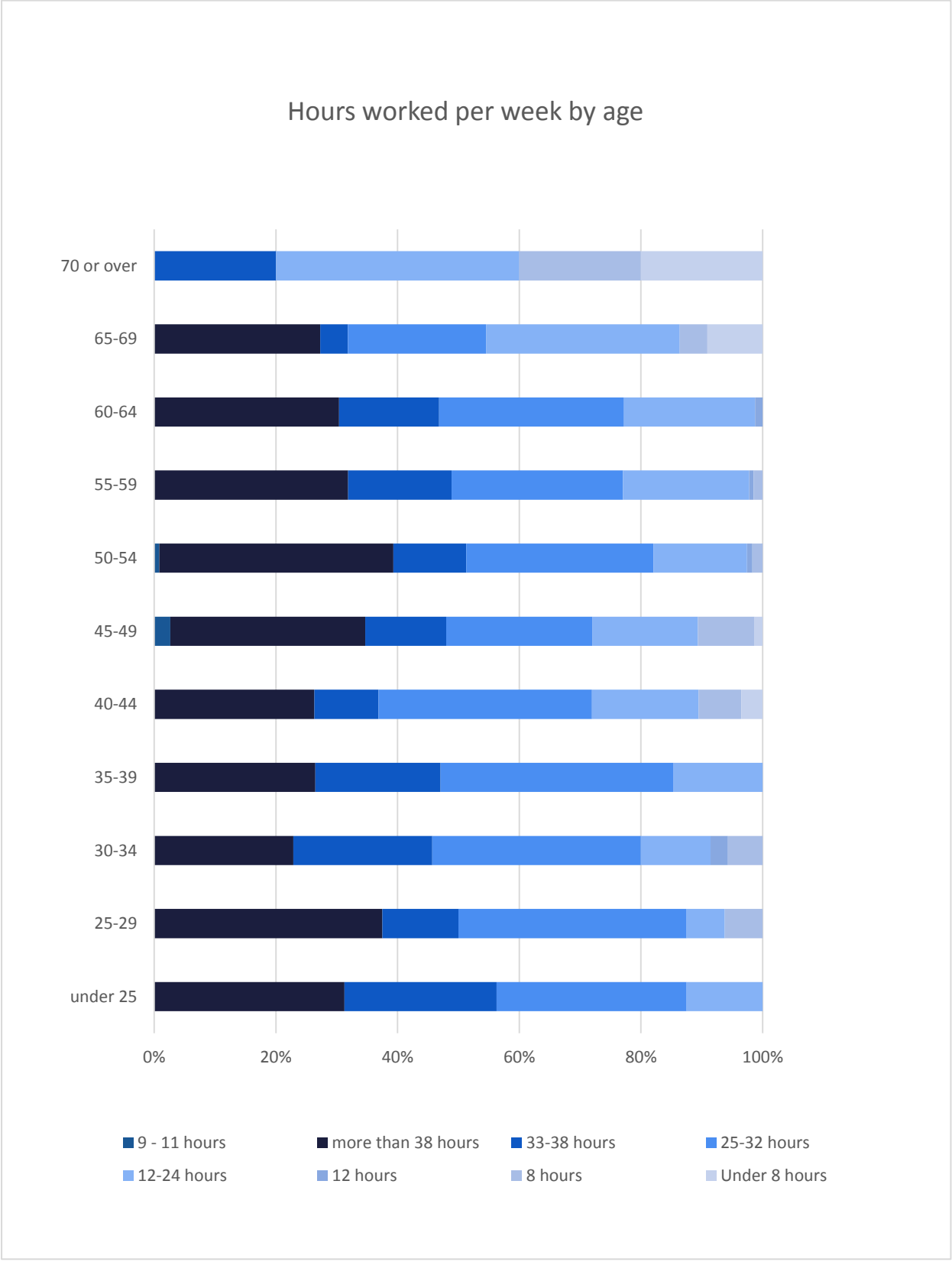
Only around a third of nurses are contracted to work more than 38 hours per week in their main job, with just under five per cent working the equivalent of one eigh-t or 12-hour shift per week. This has not changed significantly since 2011.

Figure 14. Percentage working different hours per week



Those working 12 hours per week or less were of all age groups, though the over 65 year olds are over represented.

Figure 15. Usual number of hours per week by age

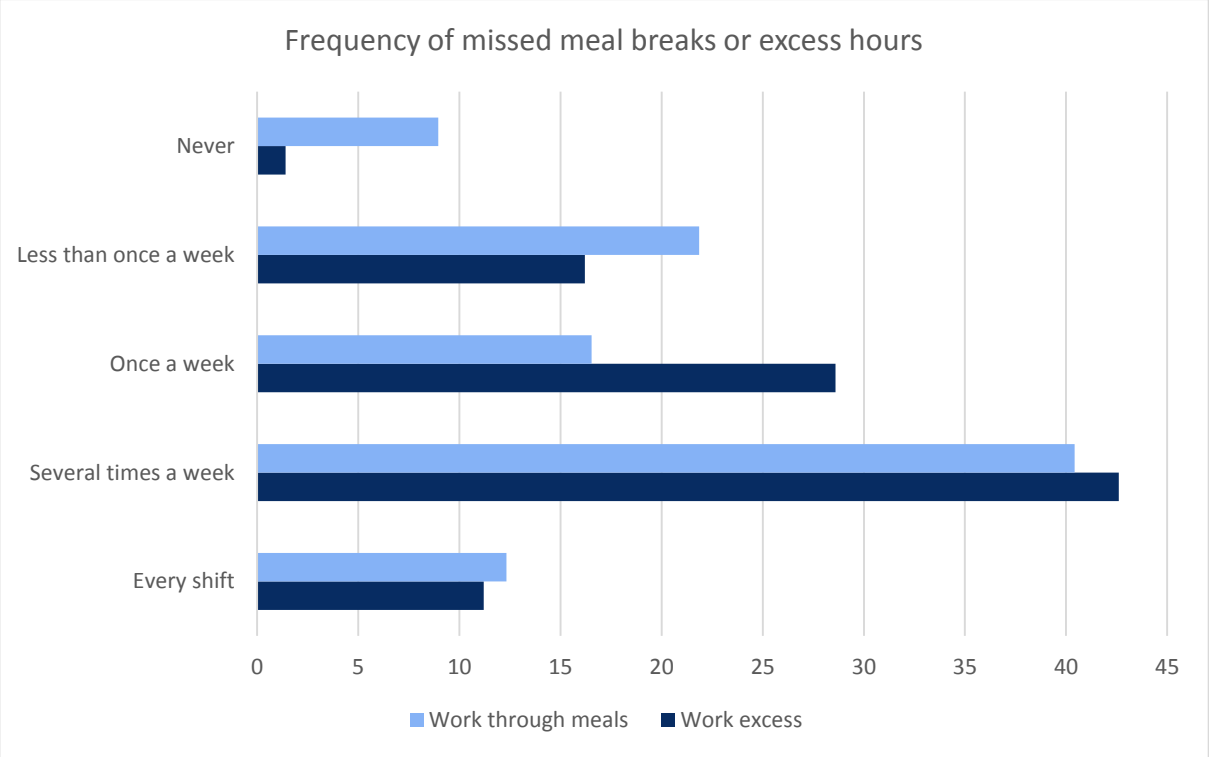


4.6 Extra hours

Fifty three per cent (up from 47 per cent in 2013, but down from 56 per cent in 2015) of nurses reported regularly working extra hours to provide cover. Fifty four per cent were paid at the normal pay rate, 17 per cent at a higher rate; nine per cent had time off in lieu, and 12 per cent (up from five per cent in 2013) received ***no*** financial reward for working extra to provide cover.

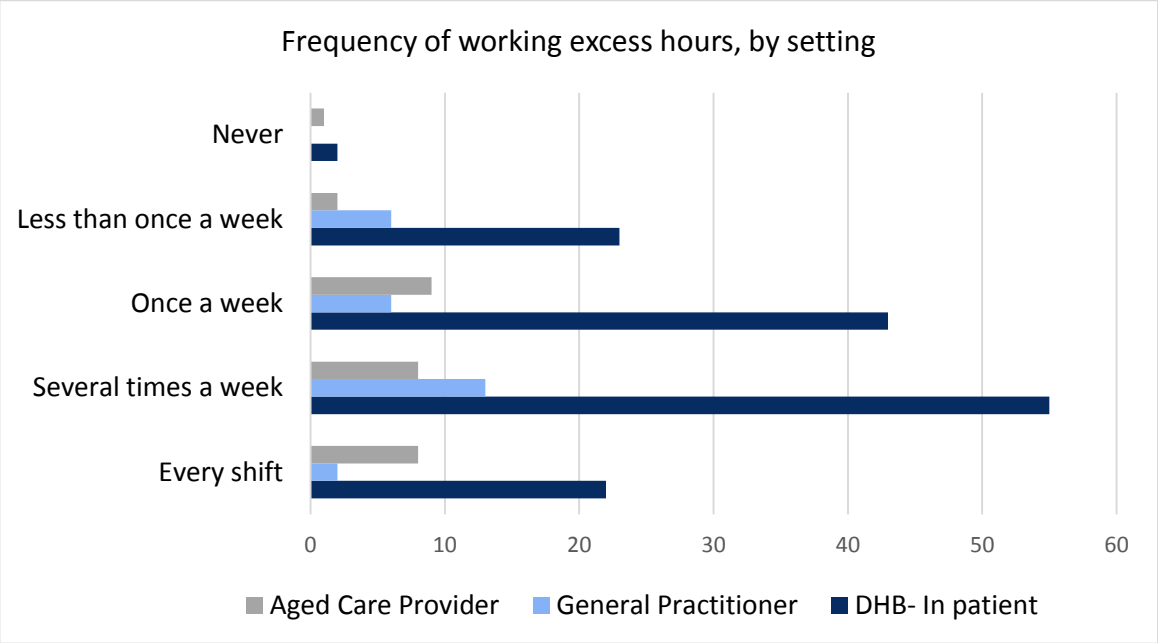
Asked specifically about the previous week, 47.3 per cent (490 nurses) had worked extra hours the previous week. Meal breaks were also commonly missed.

Figure 16. Frequency of missed meals or excess hours



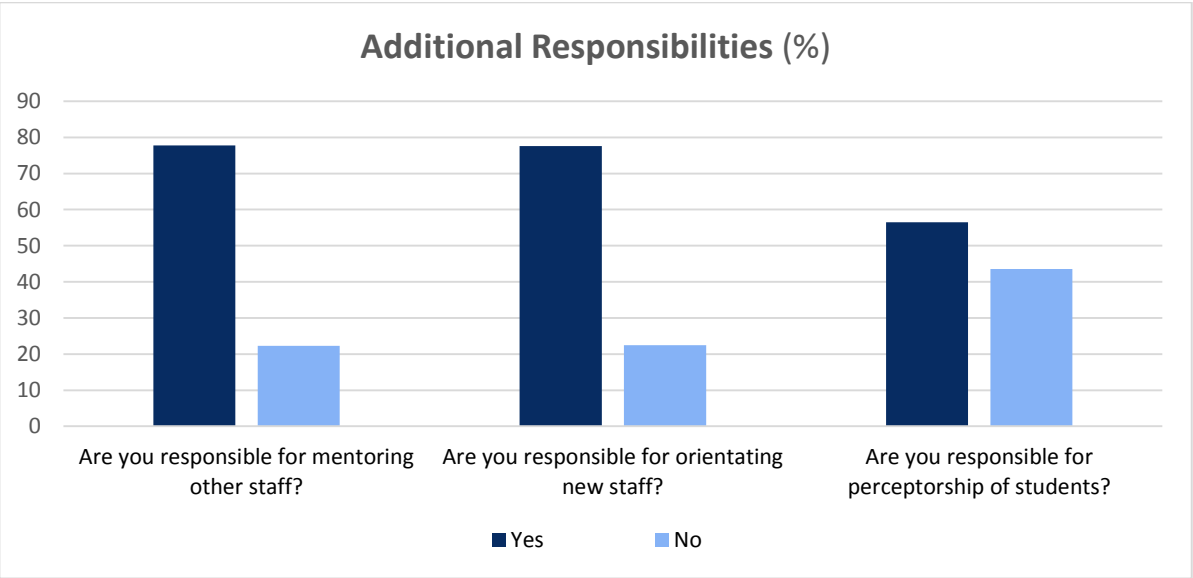
For illustration, differences can be further analysed by field. The percentage of those who worked excess hours in aged care, primary health / practice nursing and surgical (who each had similar numbers of respondents) are shown in figure 17.

Figure 17. Percentage of those who worked excess hours by work setting – DHB in patient, primary health/practice nursing, aged care.



4.7 Additional responsibilities

Figure 18. Additional responsibilities



Secondary work

Nearly 14 per cent of respondents had additional employment, almost identical to 2015. The likelihood of having additional work was proportionally higher in the NGO sector, PHO providers, and aged care. These are also the sectors with lower pay rates.

4.8 Summary

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

> The commonest shift length is 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 rostered and rotating shifts.

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

> 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.

> Fourteen per cent of all respondents had a second employer (no change since 2015). 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

Eighty one per cent of respondents worked in a clinical setting. Responses to a standardised set of factors related to good patient care, replicated since 2011, track perceptions over time. Of note, 45.2 per cent, (slightly down from 46 per cent in 2015), felt there were enough nurses where they worked to meet patient needs. This remains a concern. This varied by employer, with those who worked in in-patient DHB settings least likely to report enough nurses to provide safe care, aged-care nurses most likely to report too few *qualified* nurses to provide safe care, and private surgical nurses most likely to report satisfaction with the numbers and skills of nurses to provide safe care.

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

Figure 19. Respondent perspectives on whether there are sufficient nurses to provide safe care by employment sector

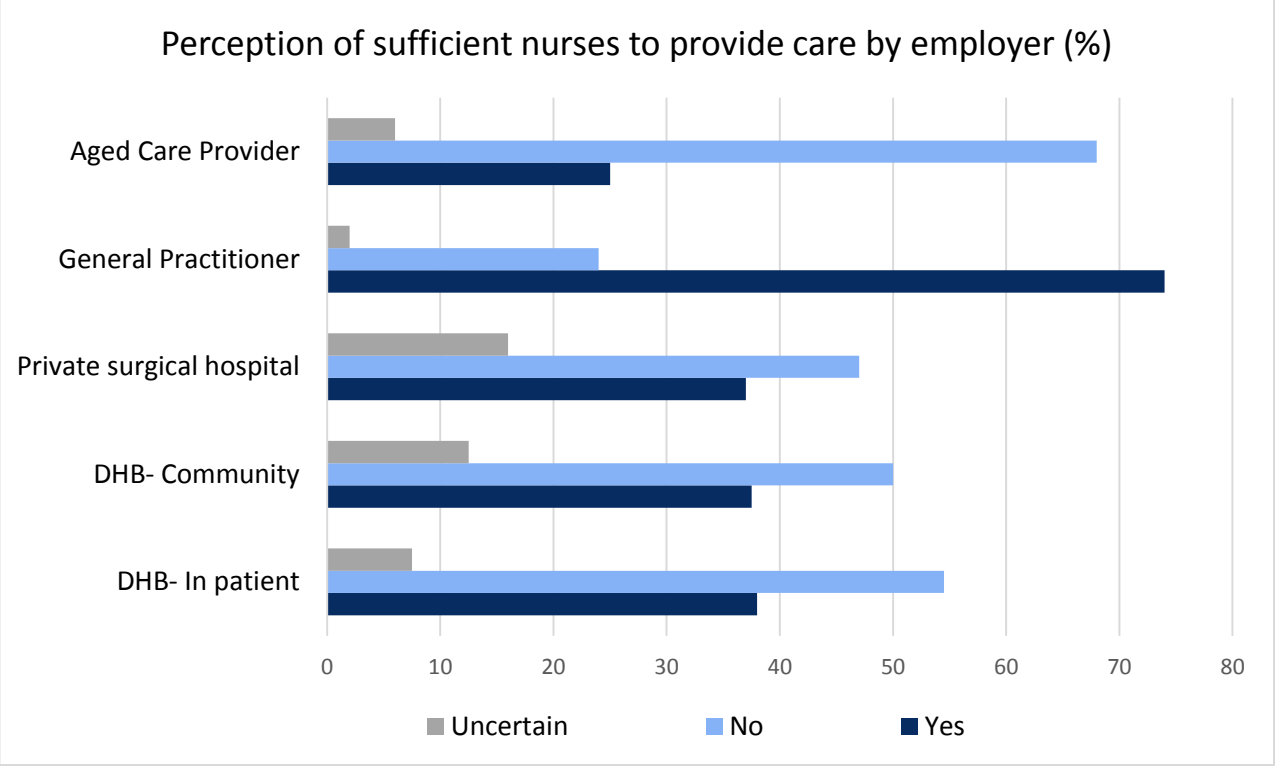
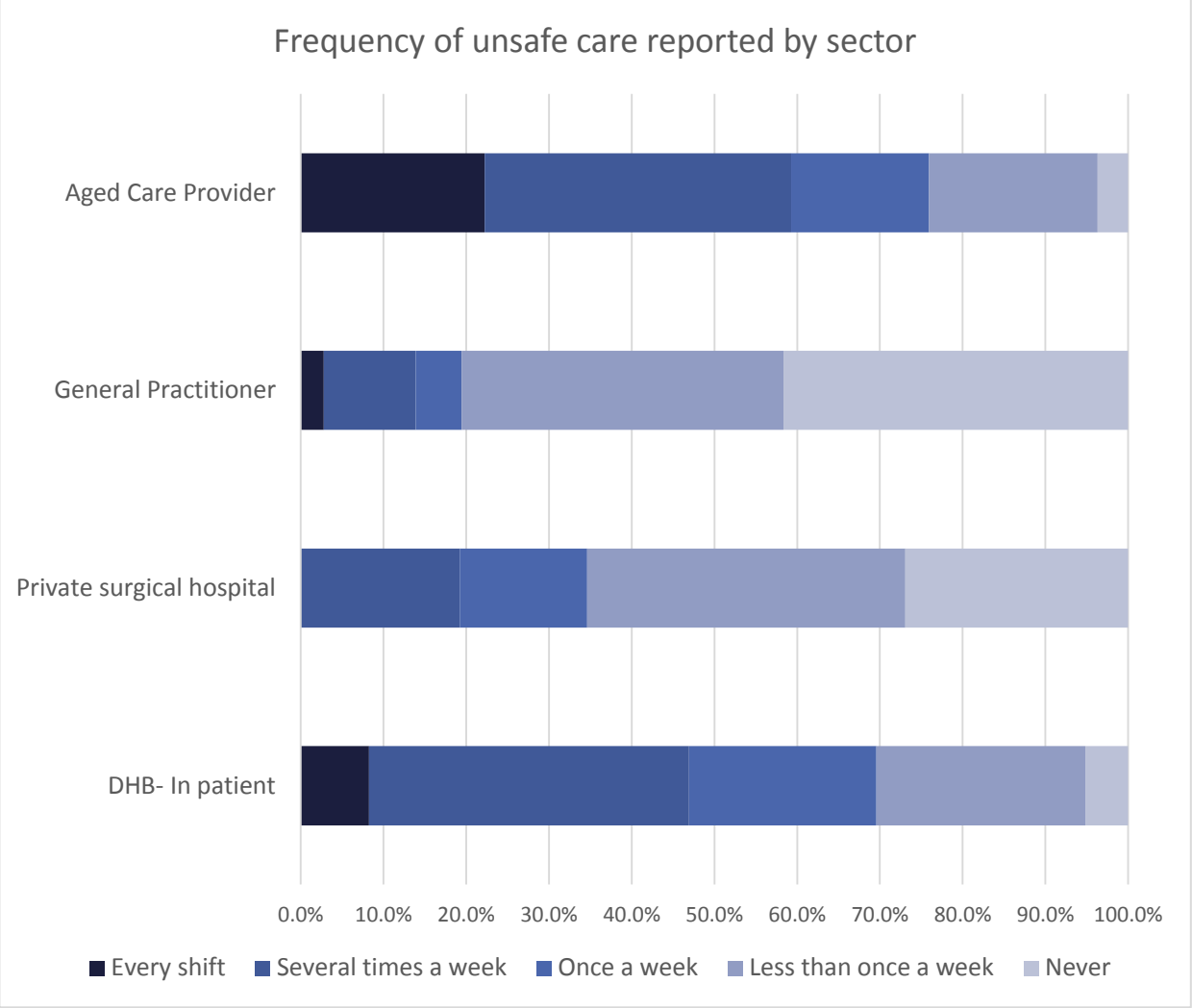
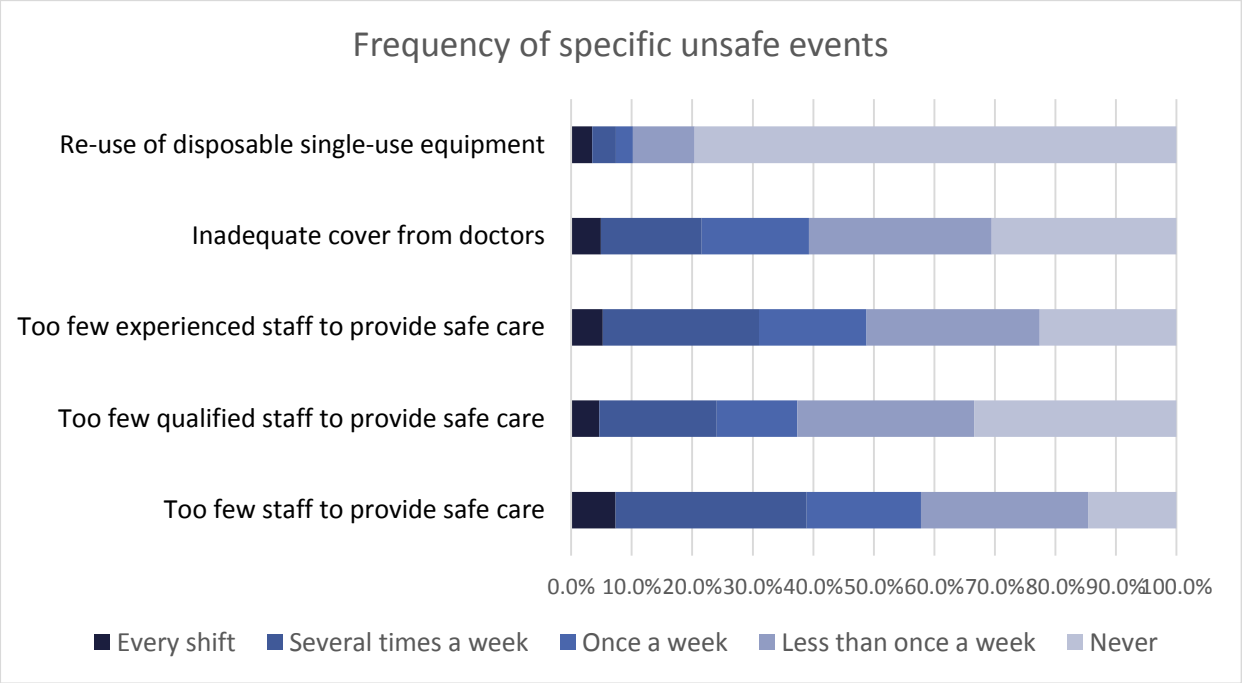


Figure 20. Frequency of unsafe care provide safe care by employment sector



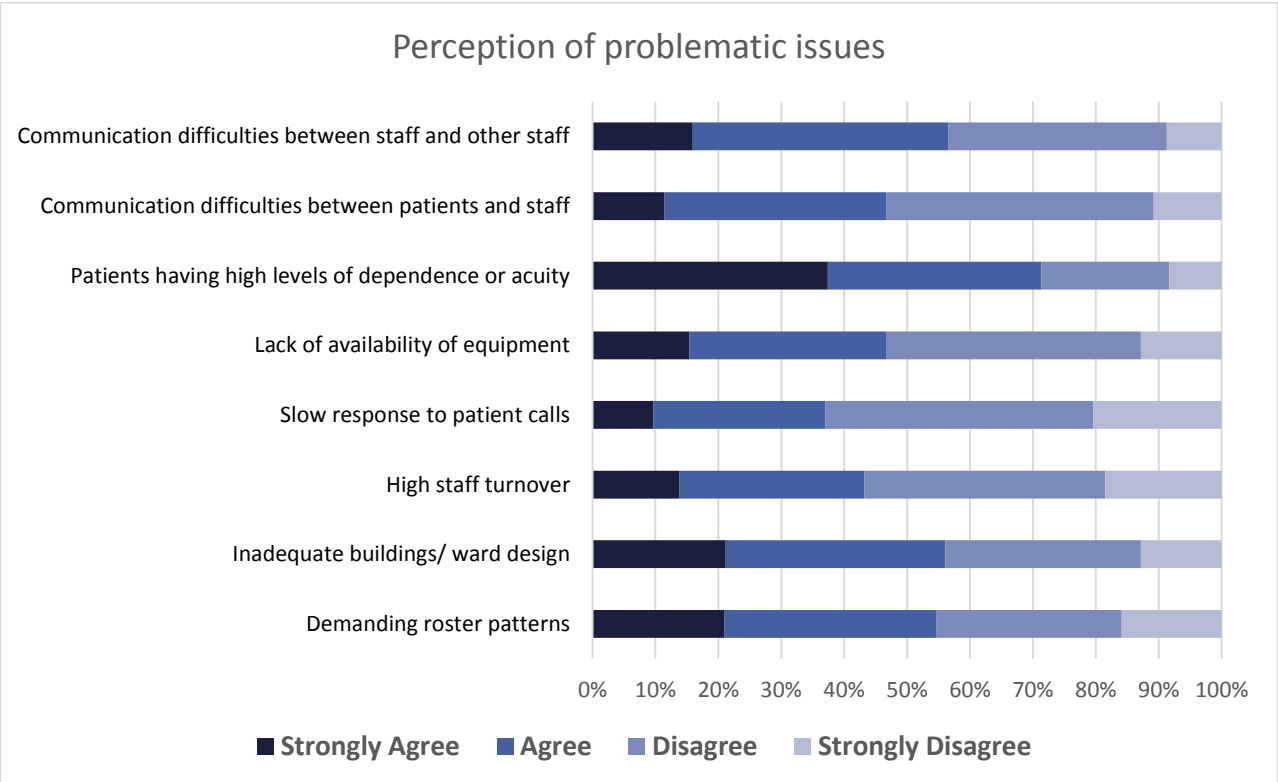
Asked about the frequency of unsafe events, the commonest event was too few nurses to provide safe care, which about two thirds of respondents reported. Thankfully, the reuse of single-use equipment was far rarer!

Figure 21. Frequency of specific unsafe events



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

Figure 22. Perception of issues impacting on patient safety



5.2 Care Capacity Demand Management

Three hundred and thirty one respondents who worked in the DHB sector were directed to a suite of questions related to CCDM. Thirty-eight-and-a-half per cent were aware their workplace had a CCDM system in place. This is an increase from 25 per cent in 2013, and 35.5 per cent in 2015. Questions related to the elements of CCDM show evidence of patchy implementation in different DHBs. These results are shown in figure 23 and 24.

Figure 23. Awareness of CCDM elements

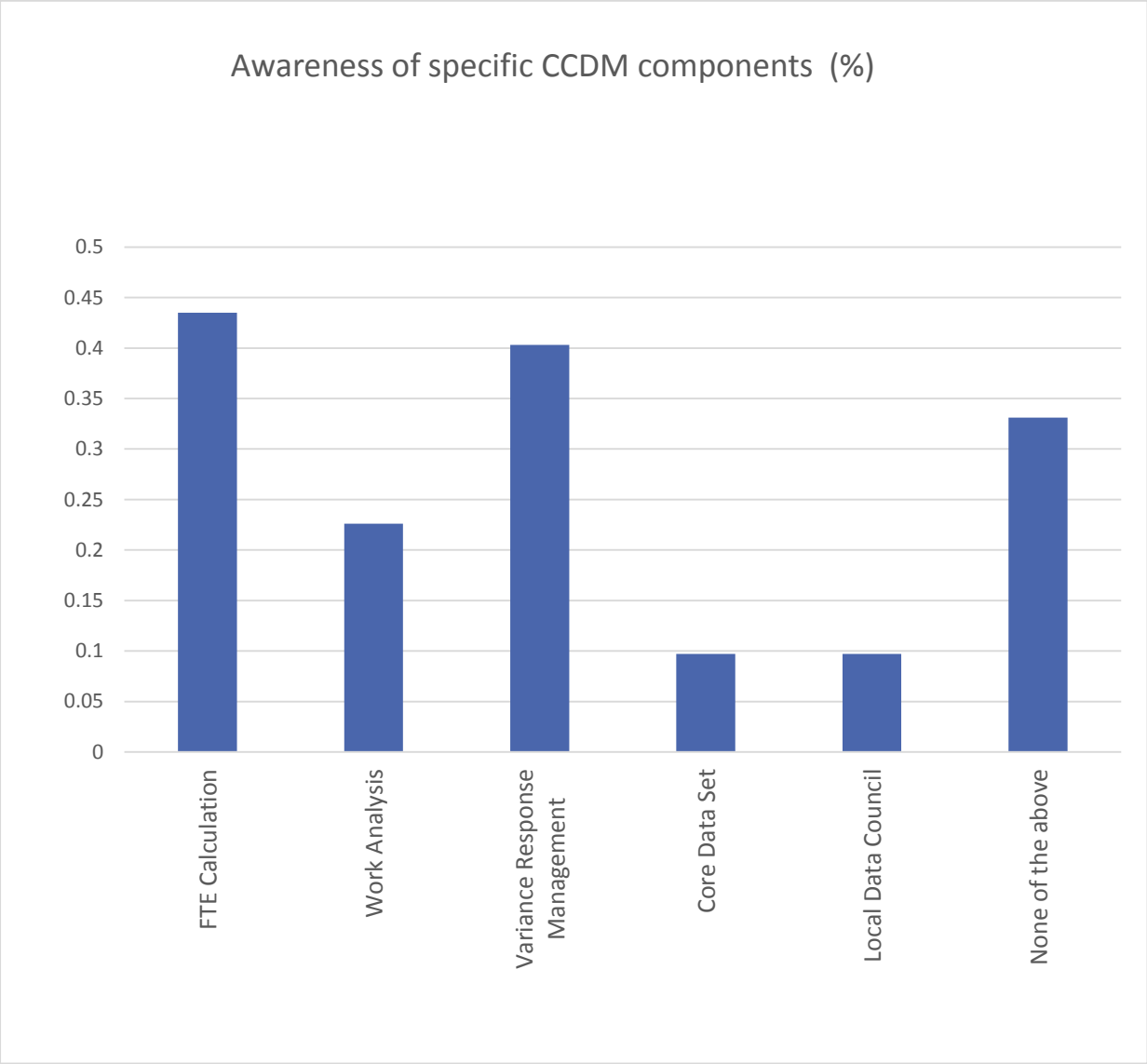
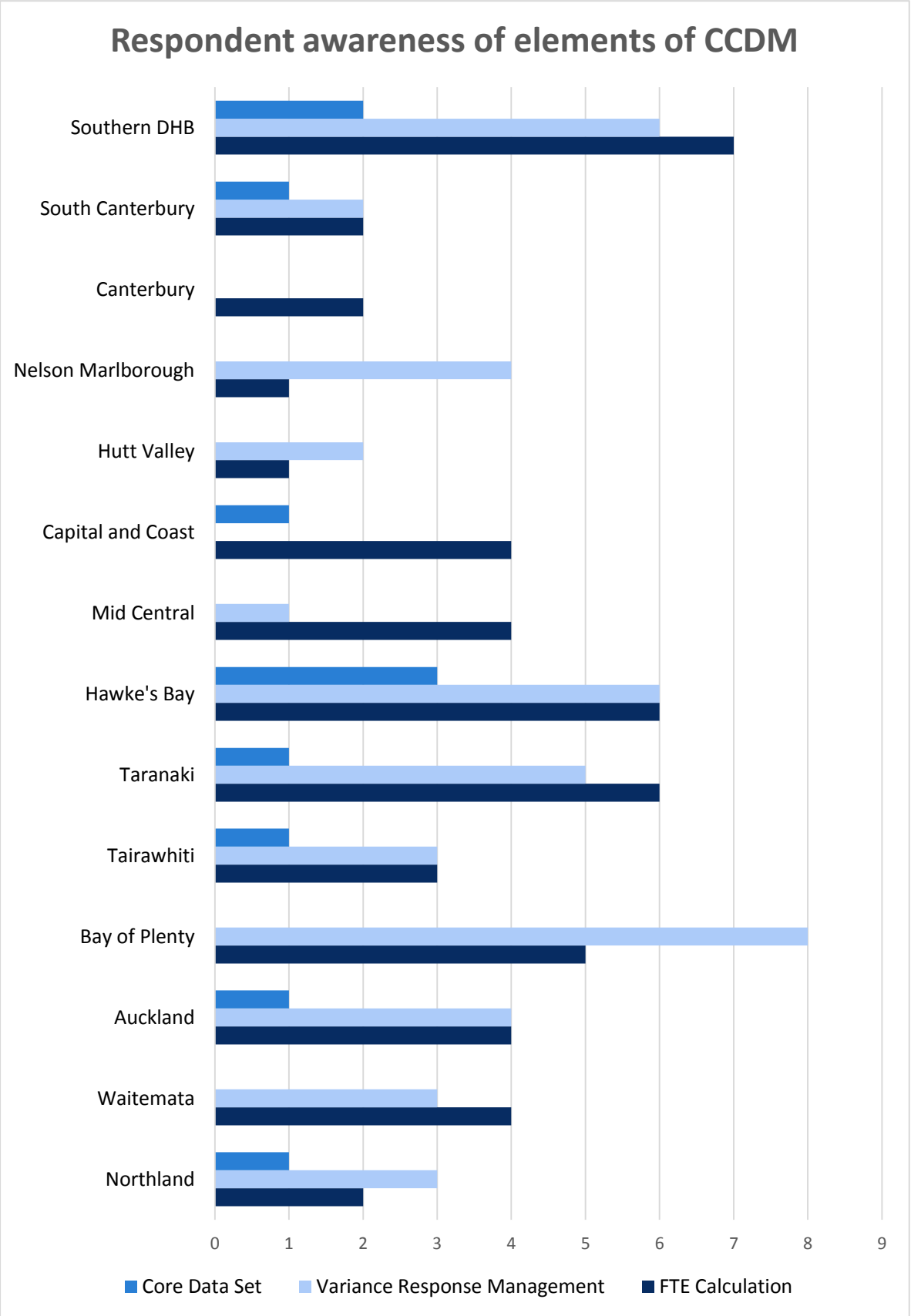


Figure 24. Comparison of CCDM implementation in DHBs (very low response DHBs excluded)



Different respondents also felt it had been of variable benefit. When asked to rate the impact on their workload since CCDM had been implemented, the responses were as shown below. Multiple choices means the percentage of each respondent who picked each option is shown, thus the sum does not equal 100.

Table 13. Impact of CCDM on workload

Statement	Per cent agreeing 2015	Per cent agreeing 2017
My workload has not changed	50.29	41.12
My workload is more even	3.43	4.67
Extra nurses are usually provided when needed	8	10.28
My workload is heavier	21.14	13.08
Extra nurses (when provided) usually have the required experience	10.86	7.48
Extra nurses (when provided) usually do NOT have the required experience	15.43	19.63
My workload is more erratic	13.71	10.28
CCDM has made no impact on my workload	46.29	55.14
Overall, CCDM is improving my workload management	1.17	2.8

Additional free text comments about CCDM were also made by 41 respondents, both connected with this question set, and in the final comments. There were **no** positive comments about CCDM. The following are representative of comments made about CCDM.

It is used mostly ineffectively, if I am moved to help in other areas it is more because staff in that area have asked than because CCDM has highlighted a shortfall

Fluctuating demand over a shift is still very difficult to manage and on extra busy days due to elective and acute surgery and variation in numbers of confused patients not always time to stop and update the system.

Feel more like a number to be shunted from pillar to post than a valued member of any nursing team

DHB rarely takes notice of recommended outcome of CCDM if that means more staff

It has little to no benefit for the amount of work that is going into it, or the cost. The acuity does not matter if there are no staff to work with. So patient care continues to suffer. I also do not like the automatic response that if you have feedback that is critical of CCDM the response is that you just don't know how it works.

It is a cumbersome tool, and if there are no extra staff available we don't get help regardless of predicted acuity. Little education provided on how to use Trendcare, and nurses not using the tool correctly also hamper any positive effects it may produce.

5.3 Summary

> As in 2015, fewer than half of all nurses working in a clinical area felt there were usually enough nurses to provide safe care.

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

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

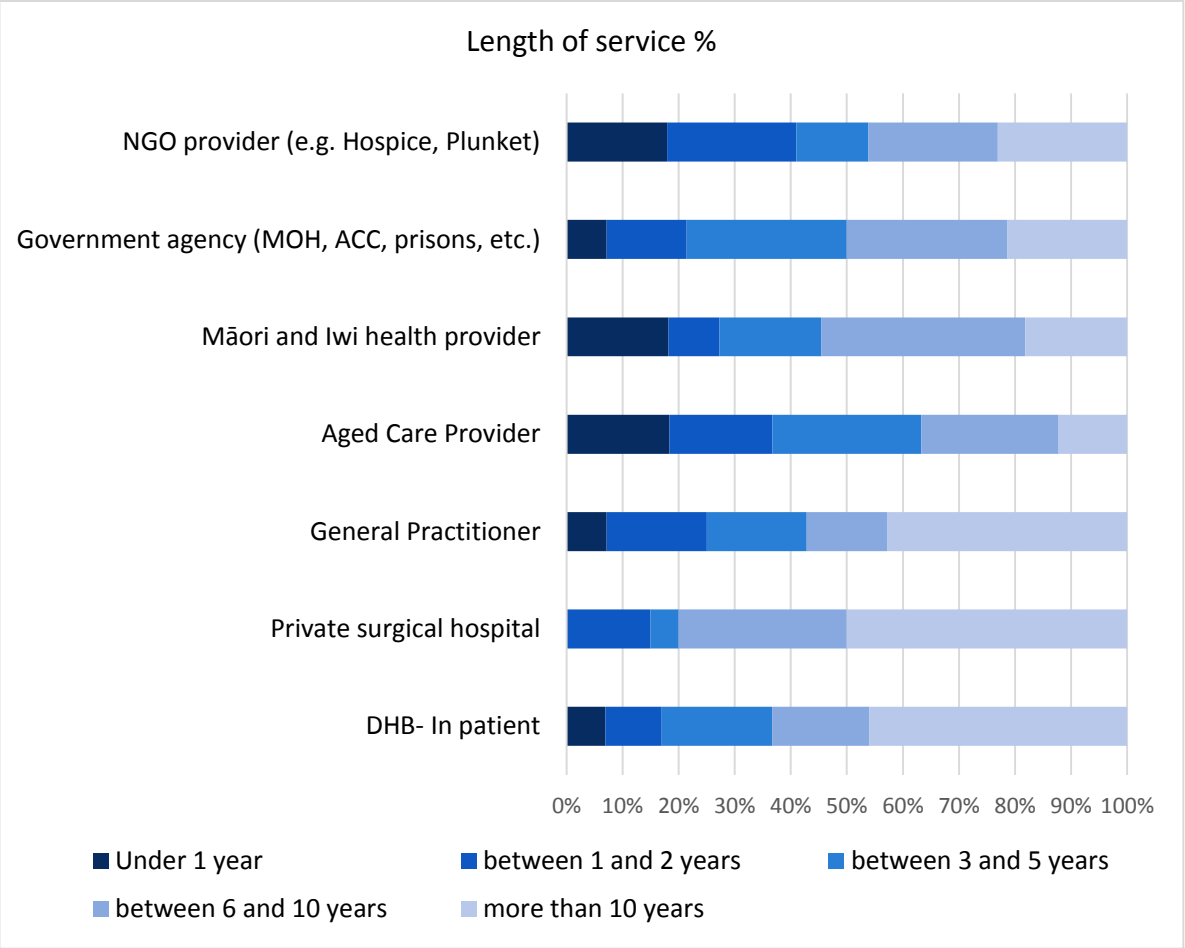
> There was evidence of the introduction of more of the components of CCDM into more DHBs, though the order and penetration of use and awareness were very variable. Knowledge of, and confidence in, the ability of CCDM to improve workload is still patchy, even in DHBs where it has been rolled out. Considerable scepticism about its purpose and effectiveness exists.

Chapter 6: Workforce planning

6.1 Length of service

Looking at length of service, there are some differences between employers, with private surgical hospitals having employees who have been with their employer the longest, and aged-care providers the shortest.

Figure 25. Length of service



For the purposes of nursing workforce planning, it is essential ***not*** to assume that nurses currently aged 50-60 years will be available to nurse in New Zealand. Many nurses aged 40-50 are contemplating a move to Australia, but even some 26-30 year-old nurses with up to 10 years' experience are thinking of leaving the profession altogether. Nurse attrition is the subject of a current NZNO research project which will be reported elsewhere.

Twenty five per cent of the 101 nurses who first trained as nurses outside New Zealand were currently job hunting. This compared to 22 per cent of those who first trained as nurses in New Zealand.

6.2 Retirement planning

As predicted by the age profile, and confirmed by other recent NZNO research on the retirement intentions of RNs, nearly a quarter of all nurses are planning retirement within the next few years. There is also a high level of signalling changes in hours, reduction in hours, and seeking more flexible work options. The coverage by enrolment in Kiwisaver has increased since 2015, as has the number who have accessed financial planning. This may also signal increased preparation to retire.

Table 14 Retirement intentions

options related to retirement planning		
	Response % 2017	**Response % 2015**
I intend to reduce my hours within the next two years or sooner	14.2%	14.8%
I intend to change to day time only work options within the next two years or sooner	4.92%	14.4%
I intend to apply for more flexible work options within the next two years or sooner	7.6%	15.2%
I intend to retire in the next two years or sooner	3.5%	2.7%
I intend to retire within the next two to five years	13.2%	5.8%
I intend to retire in the next five to ten years	26.3%	21.8%
I have had access to financial retirement planning	15.9%	12.8%
I am enrolled in Kiwisaver, or another retirement savings plan	85.6%	76.3%
Other: If you otherwise plan to change your working circumstances, please explain	9.4%	19.1%
	answered question	**628**

Of the many comments added, some signalled the financial need to continue to work past normal retirement age, and others to move to nursing in Australia specifically to earn towards their retirement. These findings echo those of the recent NZNO research on nurses over 50 – see bibliography. Many others signalled dissatisfaction with their current situation, a theme that was picked up in the later section on morale.

6.3 Māori nurses

There was a good response to the survey from Māori nurses. They are to be found employed in all settings and all DHB areas. Those employed in Māori and iwi providers unable or unwilling to pay equal rates to the DHBs were frequently dissatisfied with the inequality.

There is no equality of pay for Māori and iwi employed nurses despite years of negotiation……

Those in main-stream employment situations frequently cited a lack of cultural awareness or sensitivity as a source of stress and poor morale. This has also recently been more fully explored in other NZNO research, see bibliography.

Cultural component of nursing is often missed by staff and attitudes are often negative towards Maori & Pacific Islander patients.. e.g. that patient is a "typical Māori or typical islander"

Everyday I deal with derogatory and racial remarks. Not unusual to witness horizontal and vertical bullying by Manager and her 2IC towards staff. No cultural Competency is in place within the org I work for or in any of the polices.

My work place policies and procedures manual/s had no reference to the 3 P's until it was brought to their attention 2014. No information referencing te Tiriti O Waitangi in the resource folders Overall lack of SOPs for Māori and Pacifica

As evidence that these perceptions (in some quarters) are not merely subjective, there were three comments from non-Māori respondents (given in different sections of the survey free text sections) where “political correctness” or “cultural safety” has “gone too far”…….

6.4 Internationally Qualified nurses (IQN)

As signalled earlier, IQNs now make up around a quarter of the nursing workforce. For the purpose of workforce planning, it is important to know their intentions.

In this survey, of the 101 IQNs who answered the question, just over half intended to work as a nurse in New Zealand till they retire, while one in five were not sure of their plans. Having English as a first language was a strong predictor of intention to stay. Eighty eight per cent have citizenship or permanent residence. For those who don’t, gaining this would increase their likelihood of staying. These results are in accord with other NZNO research on IQNs and their intentions, see bibliography.

Summary

- While there is evidence of renewal in the workforce of many employers, with slightly higher numbers than in 2015 having worked for their current employers for less than two years, there are also staff who have been employed by the same employer for very many years.

- Workforce planning will be essential to compensate for intended emigration, retirement, reduced hours, reduced desire to work rostered and rotating shifts and the increased need for flexible work options to accommodate family care giving responsibilities especially of older nurses in the sandwich generation.

- Bi-culturalism in nursing clearly has some way to go in some quarters.

- It will also be essential to continue to ensure the appropriate acculturation of IQNs into the workforce, and to attend to some of the evident tensions that exist between nurses from different countries and cultures, if a revolving door and a gap between supply and demand is not to lead to workforce shortages.

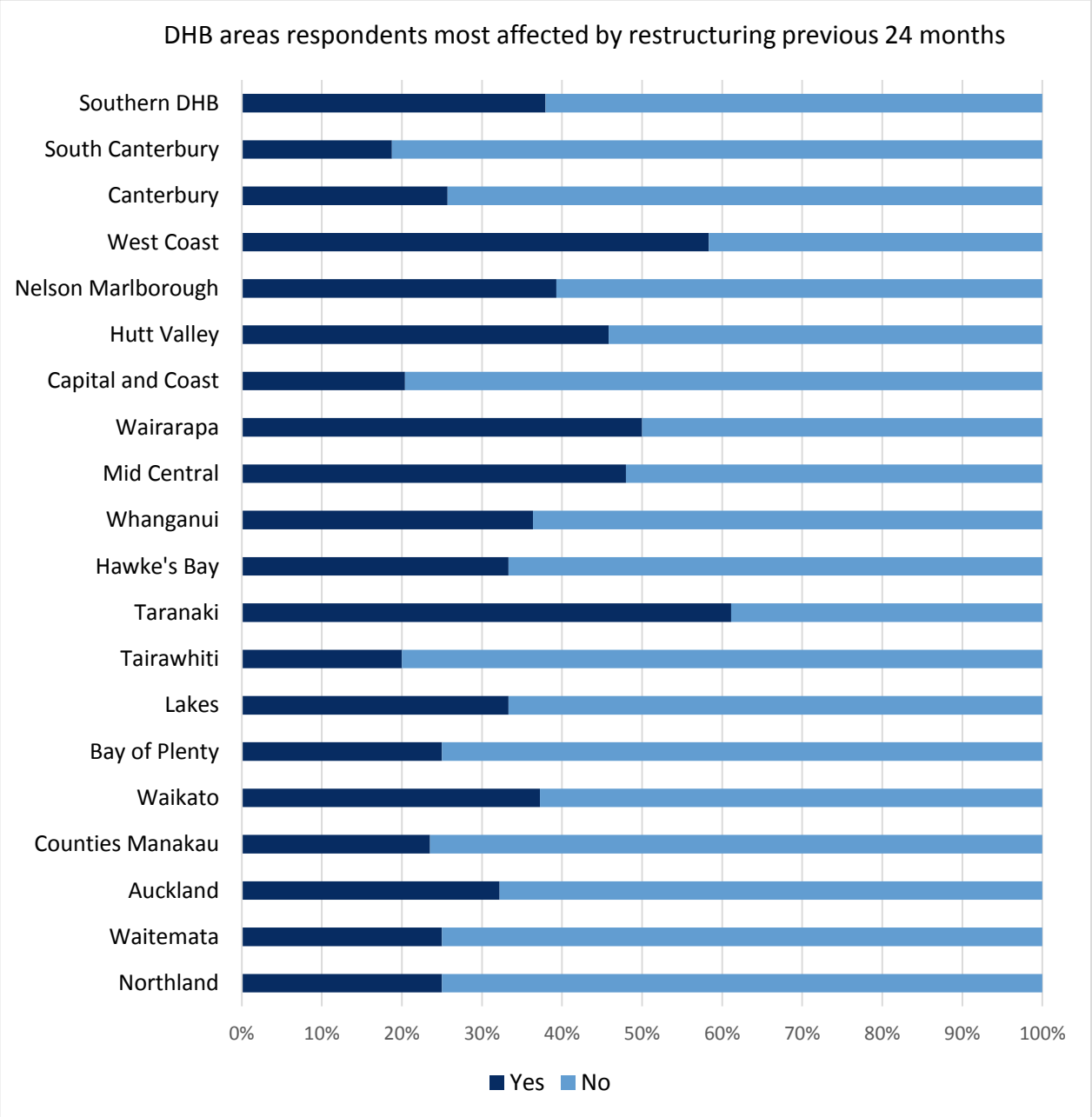
- NZNO has recently signed up to the ICNs and World Health Organization (WHO) commitments to a sustainable nursing workforce comprising no more than 10 per cent of new IQNs. Achieving this in the longer term will require specific policy direction and action, and careful balancing of competing requirements.

Chapter 7: Organisational change and restructuring

7.1 Organisational change and restructuring

Thirty two per cent (up from twenty-seven point four per cent in 2015) of respondents had been affected by significant restructuring in their main employment within the previous two years. Of these, nearly half of the restructuring had involved reorganisation within the worksite, or across a wider employer such as a DHB, 24.4 per cent had involved the loss of senior nursing leadership positions, and 23 per cent involved a reduction of nursing skill mix (substitution of RNs with ENs or of RN/ENs with health care assistants or care givers). Other significant restructurings involved mergers of DHBs, PHOs or general practices, or the sale, privatisation or closing of facilities.

Figure 26. DHB areas most affected by organisational change and restructuring



(n.b. Caution - some of the DHBs have small numbers of respondents)

Figure 27. Employment sectors most affected by restructuring

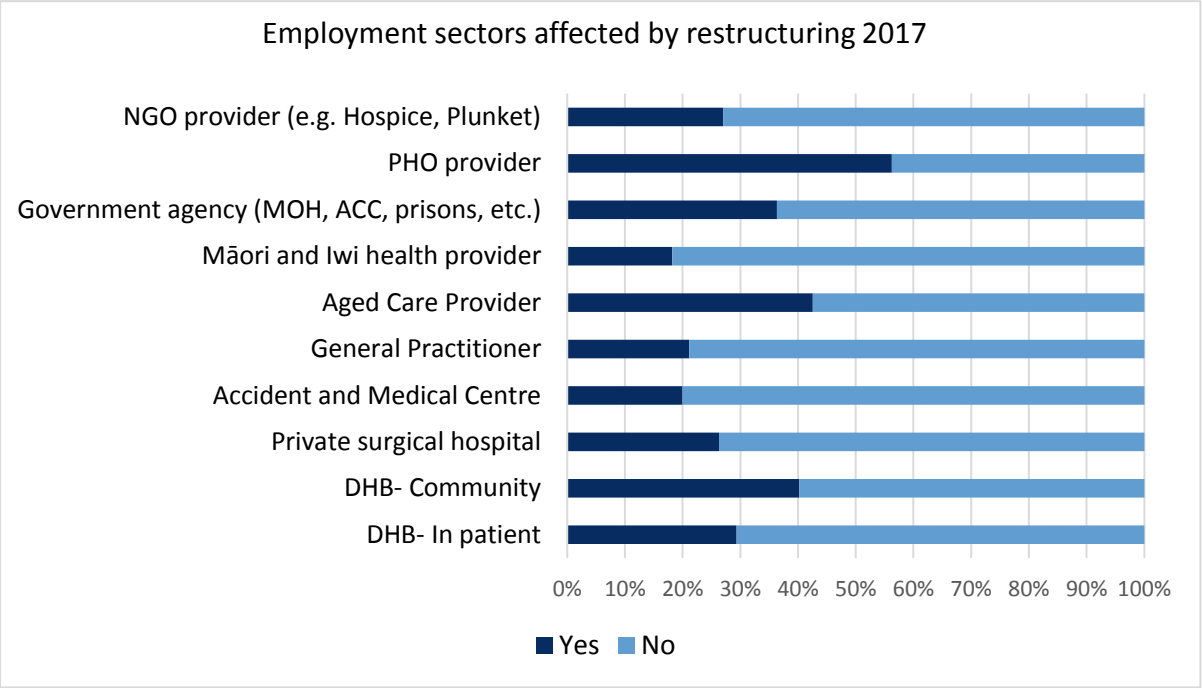


Table 15. Restructuring impact

Restructuring Impact		
	Response per cent	**Response count**
Reorganisation within your worksite only	46.9%	98
Restructuring across a wider employer (e.g. DHB)	39.2%	82
Merger of DHBs	4.3%	9
Merger of general practices	4.3%	9
Sale or closing of workplace (e.g. Aged Care Facility)	4.8%	10
Regionalisation of a specialist service	4.3%	9
Nationalisation of a specialist service	1.4%	3
Outsourcing of specialist service (e.g. DHB to PHO)	3.8%	8
Privatisation of specialist service (e.g. DHB to Private Hospital)	1.4%	3
Changing skill mix (e.g. replacing RN with EN or EN with HCA)	23.0%	48
Reduction of senior nursing leadership positions	24.4%	51
Reduction in nursing hours	12.0%	25
N/A	3.8%	8
Other (please specify)	18.2%	38
	answered question	**209**
	skipped question	**529**

7.2 Statements related to being affected by organisational change and restructuring

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

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

Management structure was changed after consultation with the whole team, who most were against for a number of reasons, but it happened anyway. We now no longer have a manager for outpatients but an umbrella manager, who covers two specialist areas and across two sites/districts.

Disestablished positions resulted in a lack of leadership for some time.

Lots of 'Acting' management positions, sometimes one person filling 3 management roles. A stalled mental health service review with no reports of progress. An informal hiring freeze.

I was previously a CNM and role disestablished with merger of two wards to make 46 bed ward with one overall CNM and ACNM role was introduced which I became.

Positive comments

Doctor shortage, nurses changing the way they work and working to the top of their scope to help with the shortfall.

Restructuring is giving me the opportunity to train as an NP.

Adding more services.

Less positive comments

Management structure was changed after consultation with the whole team, who most were against for a number of reasons, but it happened anyway. We now no longer have a manager for outpatients but an umbrella manager, who covers two specialist areas and across two sites/districts. This comment appears above as well.

Too many inexperienced staff employed as RN (preNesp) thrown into full RN roles, little support, in acute MH important. Management not listening to staff, bullying, and lots burnt out.

Closure of small necessary clinics across our team to one central office which is inadequate for the population that we care for. Nurses working out of their cars as there is no adequate office space provided. I have watched the health of those who have been forced to leave deteriorate to the point of danger due to their experience prior to resignation. Promises of new and wonderful technology that is not a part of the two basic Tenants of good nursing practice. Questionable nursing management practice.

Changes not related to the categories above included:

Being given an ultimatum by my then employer to manage two care homes (65 and 52 beds respectively) after the manager of one left, and a replacement was not sought. I resigned.

Push for patients to be discharged early to their home therefore requiring more support.

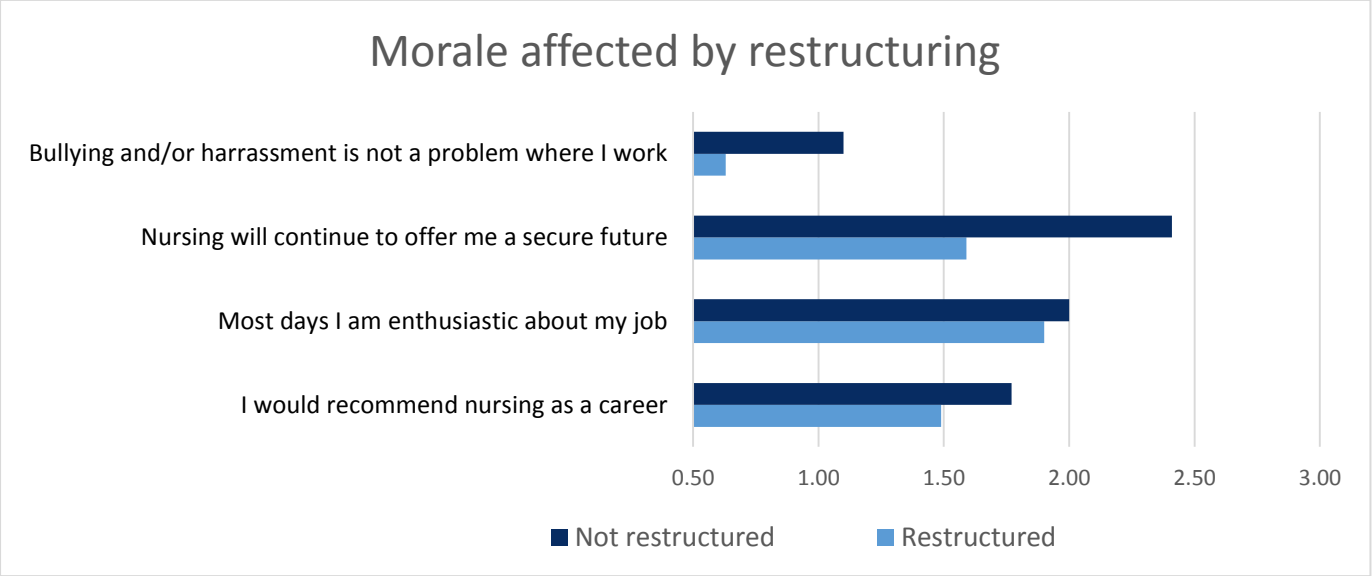
Moved to new hospital.

The items related to morale were examined for differences between those who had or hadn't experienced restructuring. A composite score for the items was generated, and a few key items chosen for display.

There was evidence that those who reported experiencing restructuring were less positive in their general morale and career confidence. Perceptions of bullying in areas that had been through (or were going through) restructuring were high. However, there were also some more contradictory differences in other morale items such as perceptions of workload, or fears of redundancy: this might relate to *fears* of impending restructuring, whereas those who had come through the process were more secure in their jobs.

These are displayed in figure 28 below.

Figure 28. Items related to morale and restructuring



(The larger the composite number, the more positively viewed the item was.)

7.3 Summary

> 32 per cent reported significant restructuring in their main employment within the previous two years.

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

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

> 24.4 per cent reported a reduction in the nursing skill mix (up from 18 per cent in 2013, but down from 25 per cent in 2015).

> Restructuring affected all sectors, and all DHB areas.

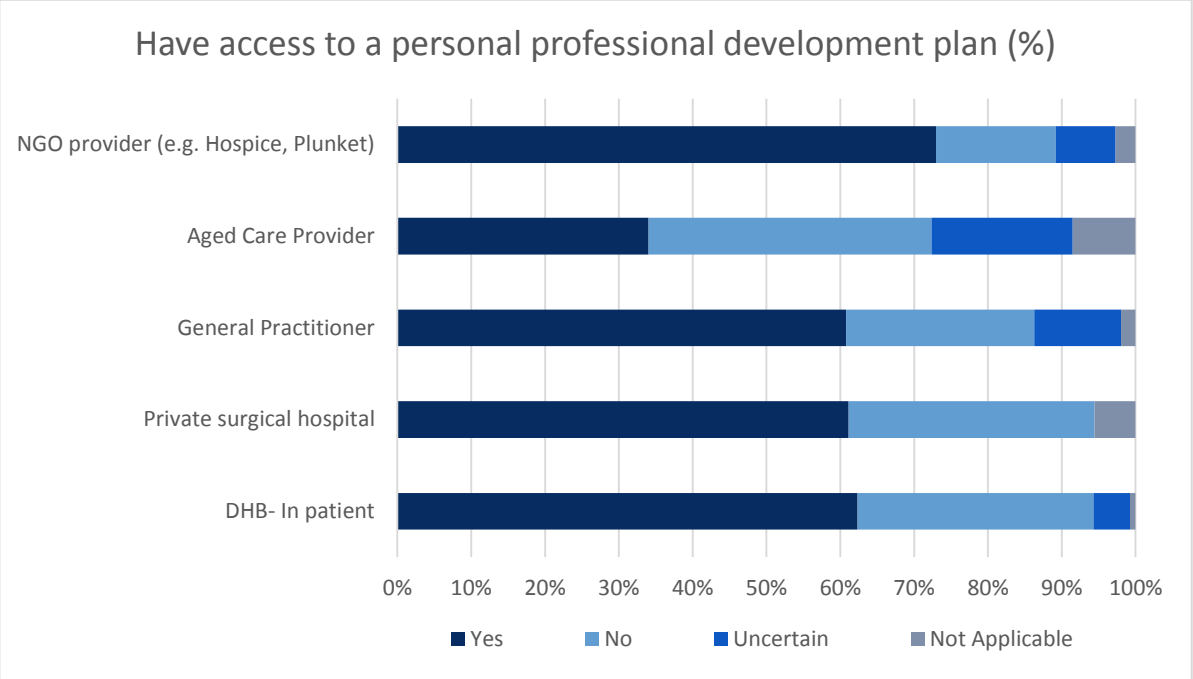
> Restructuring and reorganisation contributes to loss of morale and confidence in employment. It seems particularly linked to perceptions of bullying.

Chapter 8: Continuing professional development, education and qualifications

8.1 Continuing professional development

The majority of respondents (58.75%) had a current personal professional development plan. This varied by employment sector, as shown below.

Figure 29. Personal development plans



8.2 Professional development recognition programme (PDRP)

Forty two per cent also had timely access to a PDRP. A further 21.34 per cent had access to PDRP but timing was an issue, while a further 20 per cent needed one, and the remained either didn't need access to PDRP or were unsure.

When asked for any other comments related to PDRP, a huge response was obtained, with 260 respondents taking the opportunity. Representative quotes only are shown for each category.

The overwhelming majority of comments were very negative.

Negative

I don't feel that it is a good reflection of your skills and how well you practice. It is more about how well you can write and say what Nursing Council want to hear.

PDRP needs to be applicable to your professional work, not just a bunch of statements that you have to justify. Different specialities in nursing require their own frameworks.

Very frustrating experience with poor communication & "nit picking" from assessors. A lot of work for negligible remuneration, little motivation to resubmit.

Tedious, and morale sapping in the extreme!!! An important reason why I would leave nursing if able.

Far too much pressure to do postgraduate study, which is not how everybody wants to, or is able to learn. Another reason I would like to get out of nursing. I am a strong practical nurse, not an academic. I have had a guts load of having people try to ram tertiary study down my throat.

Particular issues included the time taken to complete, particularly for little or no personal benefit:

PDRP is just another thing to be done in nurses own time. I feel the job a nurse does at work does not need to be continually verified in writing. It shows in the care shown to his/her patients.

Far too much time commitment for little reward and very limited scope for advancement within CCDHB (hence have left employer).

It's too wordy, too long, way way too much input required. Takes up so very much of personal time to complete. The $ value is definitely not worth it.

Other issues included perceived inconsistencies as to how it was applied:

I struggle with the poor quality of some portfolios that are deemed acceptable.

I believe this is an unfair process.

I feel it is a bit of a tick box scenario and has no reflection on my practice as a nurse.

A poor nurse can create a great PDRP and a great nurse can create a poor PDRP.

The frequency, and the time it takes to find and get responses from assessors also caused problems:

Long wait for review of portfolio due to numbers within the organisation.

It's takes a whole year to assess my portfolio due to having staff changes (New charge nurse and new nurse educator) and it has been resubmitted 3times! On top of that, allowance has been stopped for the whole year it is now restarting.

Positive

There were a tiny number of positive comments though:

I am a PDRP assessor and have been in this role since 2006, I am a passionate believer that PDRP gives all nurses who participate an opportunity to illustrate what nurses do, the diversity of the roles nurses can undertake and promotes patient safety.

Love it, wish it could be used for career planning and my work encouraged promotion from within its own ranks.

All answers and comments will be submitted to the professional and education groups currently reviewing and examining PDRP.

8.3 Other professional development

Cancellation of education:

Thirty seven per cent of respondents had had education days withdrawn or cancelled in their workplace. This is identical to 2013, and a slight reduction from 39 per cent in 2015.

It varied by employment sector, as shown below.

Figure 30. Education withdrawn by employer

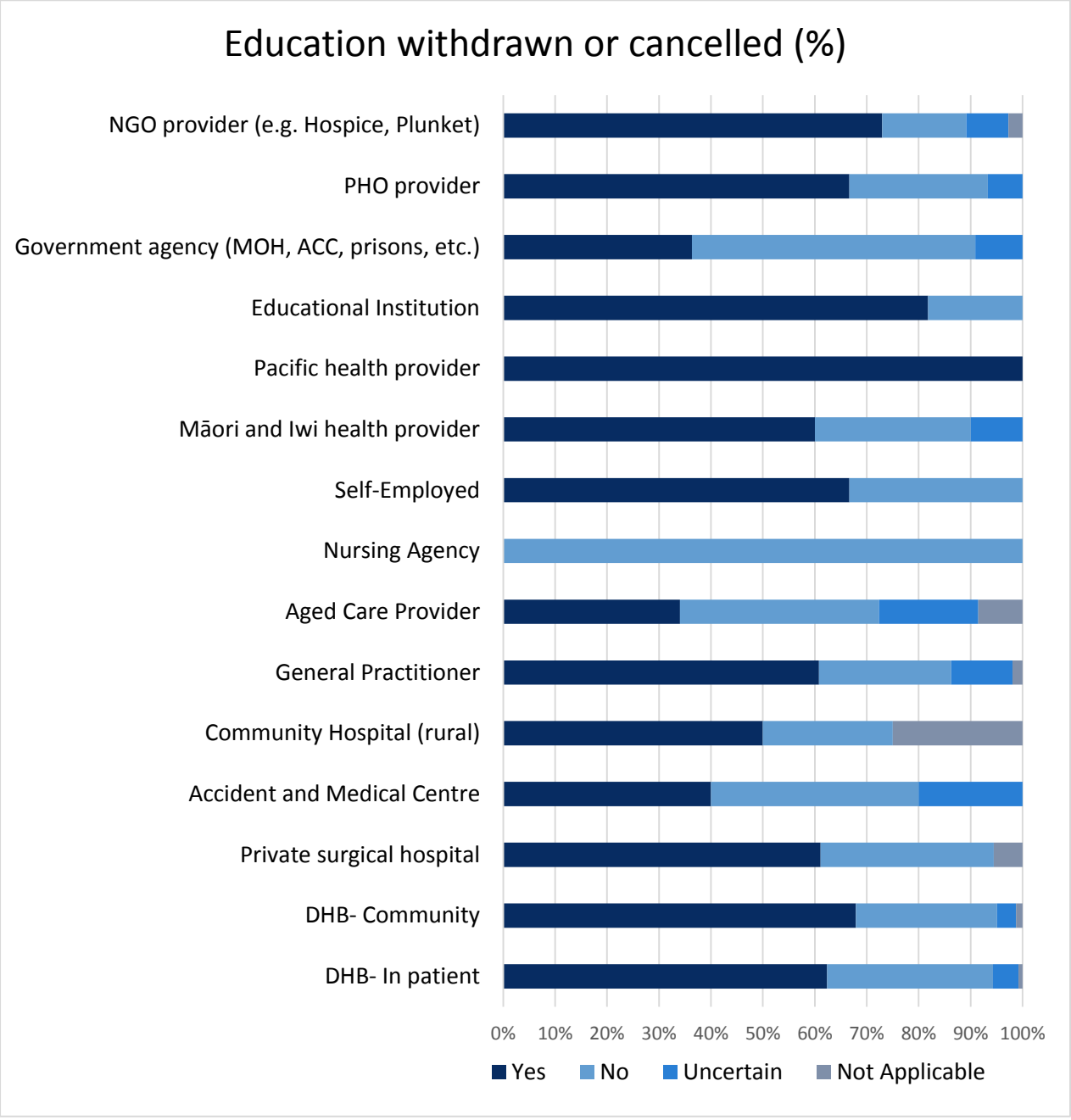
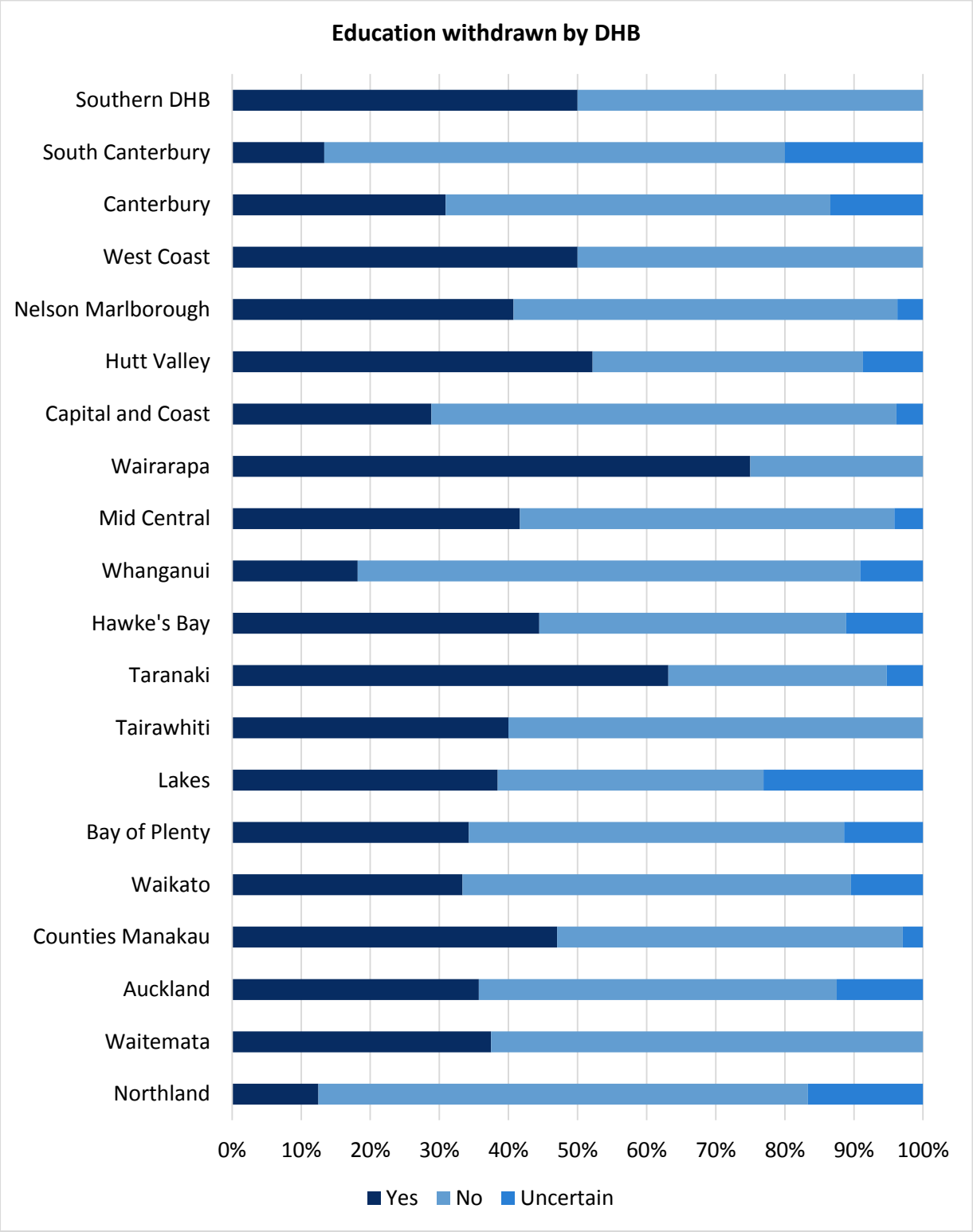


Figure 31. Respondents reporting that education had been withdrawn by DHB area



Knowledge Skills Frameworks (KSF):

Only 14 per cent of respondents were aware of KSF. Even where they had heard of them, respondents were unsure whether or how they were used.

Nurse entry to practice (NEtP):

Sixty one nurses had been enrolled in a NEtP programme within the previous two years. Forty eight provided comments specifically about their experience of NEtP.

The majority of comments were very positive about their experience with NEtP.

Great support/guidance for first year as a new graduate. Loved having the NETP co-ordinator visit each month. Never felt alone.

I was very fortunate in my NEtP year to work with a very supportive group of nurses who allowed me to find my feet and build up my confidence to work both autonomously and as part of a team.

I just completed my NETP year and I have found it beneficial. Good practical/theory to practice in my work place. This made me more confident in my nursing practice with acute and chronically ill patients.

One or two felt it contributed to their gaining employment:

Gained full time employment through it.

Only a few respondents reported a negative experience:

I had a terrible experience with no support in my first few months I then got the support but by then my passion for nursing was burnt out and I find nursing to be a bullying profession and not a place where I felt treated equally amongst other cultures I felt marginalised at times and abuse of power within health professionals disgusts me.

I worked hard to get a NEtP position. I completed the first paper with an overall B average. After finishing the NEtP year I have struggled to find a position long term. I went on the casual list for a couple of months post NEtP and then I picked up a temporary contract for 6 months which was extended for another two months. That contract finished end of November and I am now back on the casual list. I have applied for funding for study so I can complete the NEtP paper but it was declined because I haven't got a job which is temporary or permanent. I feel that all the hard work was not recognized or appreciated as I cannot complete the NEtP qualification or move forward with any certainty about my future as a nurse.

8.2 Qualifications

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

Table 16. Qualifications of respondents (per cent and number)

Nursing / care giving qualifications held		
	Response per cent	**Response count**
Enrolled nursing qualification	6.6%	44
Registered general obstetric nurse (Hospital trained)	25.9%	172
Registered psychiatric nurse	2.6%	17
Diploma in nursing	19.7%	131
Bachelor of nursing or equivalent nursing degree e.g. Bachelor of health science (Nursing)	52.3%	347
Masters (nursing related)	9.8%	65
PhD	0.2%	1
Postgraduate diploma	17.8%	118
Postgraduate certificate	27.0%	179
Plunket certificate	2.9%	19
Graduate certificate	2.7%	18
Diploma of advanced nursing	3.0%	20
Care giving qualification	3.5%	23
Other (please specify)	10.1%	67
	answered question	**664**

Other qualifications related to postgraduate midwifery study, and to non- nursing related qualifications.

8.3 Working overseas

Very large numbers (over half) have worked as nurses overseas, many in several countries. While 101 reported only having worked in New Zealand, 117 reported also having worked in Australia and 172 in the United Kingdom. Twenty-six had worked in the Middle East and 22 in the United States.

seventy-eight respondents described the benefits they had derived from working overseas.

While some had valued higher wages, or better conditions, many others felt they had benefitted from a wider understanding of working with other cultures, or different technologies or ways of doing things.

Yes. Cultural respect & sensitivity. Multicultural team nursing & support. Excellent educational courses & workshops to an American standard. Opportunity to learn to communicate to non-English speaking patients/families/staff.

Fosters open-mindedness and flexibility. Learning to live as total immersion within a strict cultural/religious society completely different to our own and how healthcare translates across all perceived barriers.

I had excellent exposure to London education departments and was exposed to some wonderful ideas.

Nursing is a fabulous profession in that it is transferrable across continents.

I think working overseas has allowed me greater experience with technologies and treatments not available in NZ. Working in other departments overseas has challenged my thinking about ways of doing things and I feel it has made me a better nurse.

8.4 Summary

- The New Zealand regulated nursing workforce is highly qualified, with over half having at least one postgraduate qualification, many having several.
- Over 37 per cent had had education days in their workplaces withdrawn or cancelled. This is a four per cent increase on 2013.
- Education days had been withdrawn by employers in all sectors, and all DHB areas. For some, workforce shortages mean that obtaining the study leave cover is a significant barrier.
- There is a high level of multi-national nursing experience, deriving not only technical but also social opportunities for educational experience. This may also help explain the (mostly) good integration of internationally qualified nurses into the workforce. See bibliography for previous NZNO research on this aspect of nursing in NZ.

Chapter 9:

Health

9.2 Occupational health and safety

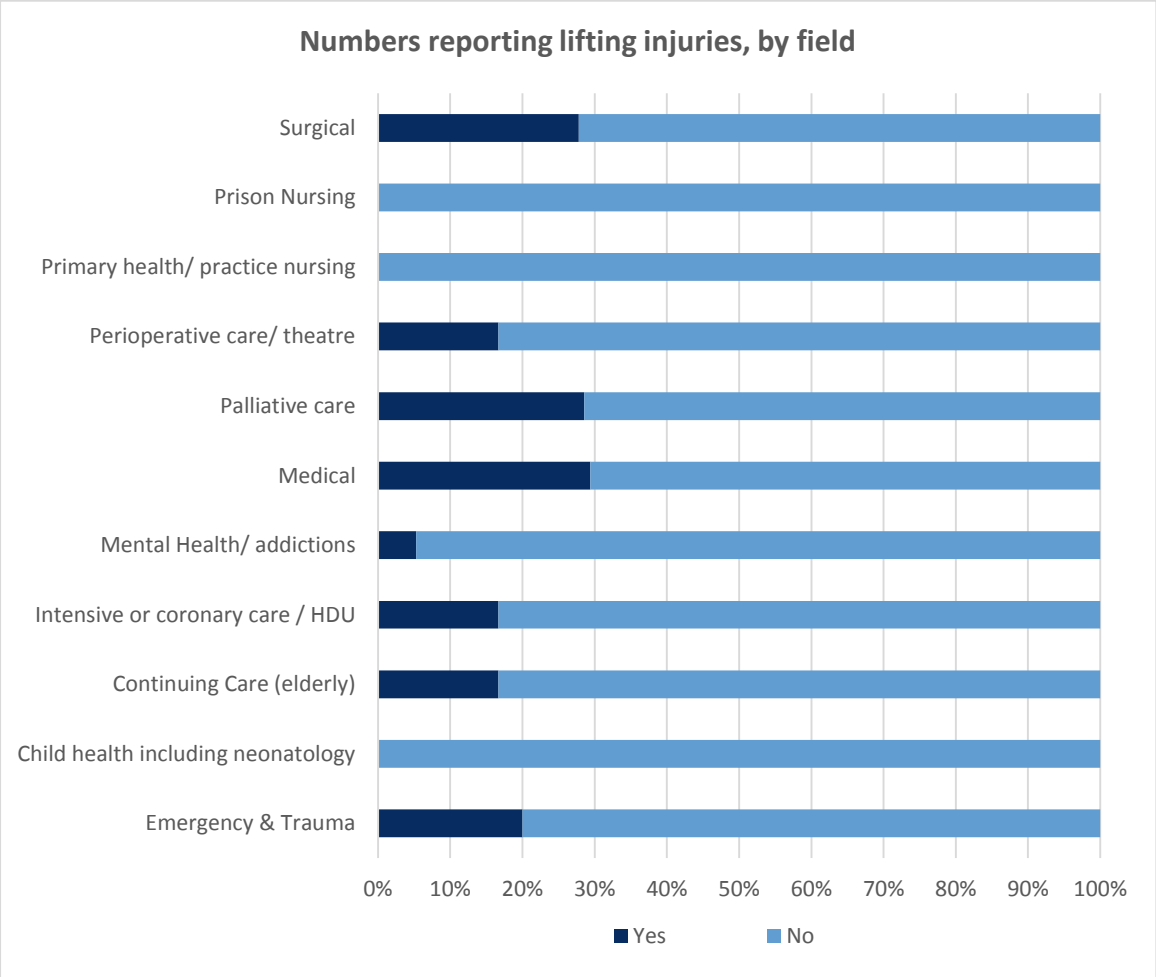
Summary

In the previous two years, 23.7 per cent (157) of respondents reported an occupationally-acquired infection or a workplace injury. This is an increase of two per cent compared to 2015 and an over 100 per cent increase on 2013. Of the injuries, 16 per cent were related to heavy lifting. Seven respondents reported injury related to work place violence. Nearly 10 per cent required time off work with a workplace-related infection, and over half of the injuries were referred to the ACC. The commonest infections were flu or norovirus infections, four reported injuries caused by assaults on staff by patients, and one reported a needle-stick injury.

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

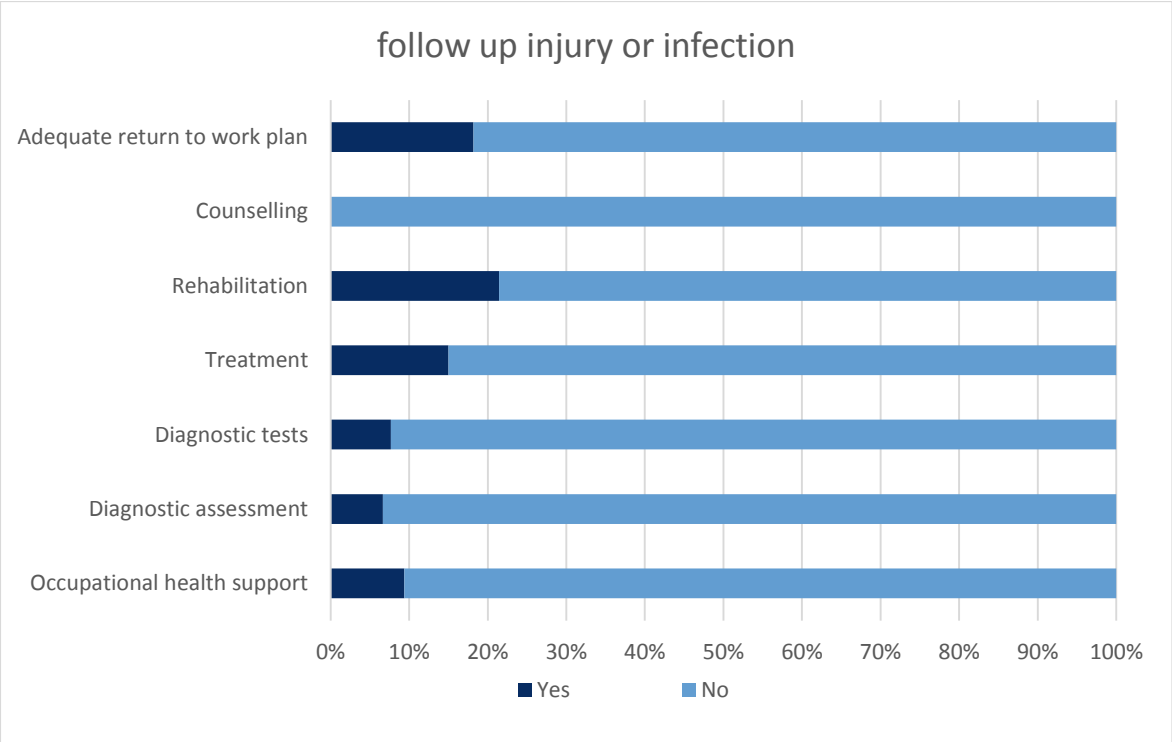
Lifting injuries:

Figure 32. Lifting injuries



For those reporting either injury or infection, the following responses were available.

Figure 33. Follow up to injury or infection



Domestic violence support

Asked if employers offered leave or assistance for domestic violence, 18 per cent were aware their employer did, while 75.65 per cent were uncertain, and six per cent thought not.

Employer responses to injury or infection

The responses from 69 people injured or infected at work covered the full range, from very satisfied to very unhappy. The following illustrate this.

Satisfied

Needle stick injury - covered by ACC, given time off work for testing, patient involved volunteered for testing as soon as he realised what had happened- very satisfied with a scary situation.

Current workplace health and safety team provided a car with special adaptation to reduce further irritation to my injuries sustained in an accident that occurred during my previous employment with another DHB. This was to allow me to continue in my new role was assist my driving only when they moved my workplace more than 40 minutes away from the original base where I was employed to work.

Excellent Occ Health support.

Dissatisfied

Once I officially reported a back strain and my Manager (after ascertaining it was a temporary injury) said that she would put on the event form that I would be more careful in the future. I felt unsupported/blamed - like it was my fault.

Having sustained a back injury some years ago and off work for several weeks, I did not feel supported by my then nurse manager and felt that the occupational health doctor had managements best interests at heart rather than mine as his diagnosis was very different (and less serious) than my GP and very experienced physiotherapist. As a result pressure was put on me to return to full duties before I had recovered enough and my job was threatened. This time when I injured my shoulder I elected to conceal my injury. I still have problems with my shoulder two years on.

Violence

Of the seven reporting assault, only two respondents provided more detail. Both had had further distress from the organisational response.

At times I felt overwhelmed by the amount of unhelpful input from senior staff I felt that they backed away from admitting liability. I had to claim on my personal insurance to get my glasses fixed and at times almost felt that the assault was my fault.

I went through hell during the disciplinary process, no support was offered to me for the fact that I was assaulted. The case eventually was closed at DHB level.

Time off work

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

Table 17. Days off work

Days off work past year	No	per cent
None	143	21.6
1-2	169	25.53
3-5	171	25.83
6 or more	152	22.96
Not applicable	27	4.08

There was little difference in this by age group. (Caution due to small numbers). See below.

Table 18. Days off work by age group

Answer Options	None	1 - 2 days	3-5 days	6 or more days
under 25	2	5	6	4
25-29	4	7	13	11
30-34	7	12	9	8
35-39	3	11	14	6
40-44	12	11	16	15
45-49	26	15	20	21
50-54	27	32	41	24
55-59	31	42	31	34
60-64	20	28	14	24
65-69	8	5	5	5
70 or over	3	0	0	0

Figure 34. Days of work by age group

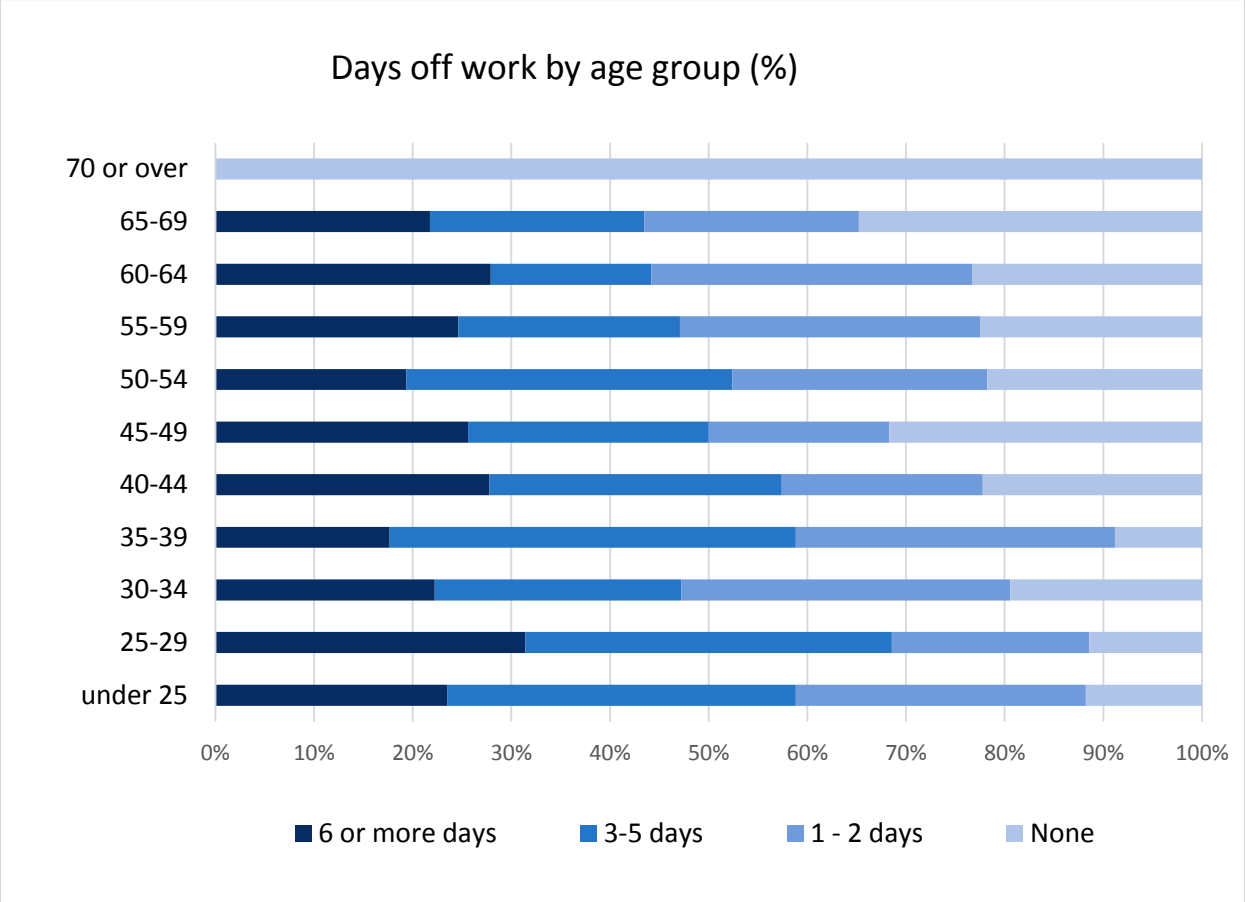


Table 22. Impact of illness or injury at work

Impact of illness or injury on work		
	Response per cent	Response count
None	20.03%	116
I have used some of my sick days	23.83%	138
I have used most of my sick days	5.35%	31
I have used all of my sick days	3.97%	23
I have used all of my sick days and some annual leave	5.87%	34
I have used all of my sick days and have taken leave without pay	4.66%	27
I have had to decrease the number of hours I work each week	2.59%	15
I have had to change jobs due to my illness or injury	2.25%	13
I have had to contemplate early retirement due to my illness or injury	1.04%	6
Not applicable	38.34%	222
	answered question	579

For all respondents answering the question (n= 579)

43.8 per cent had used none or some of their sick days, whereas, 5.4 per cent had used most of their sick days, per cent had used all their sick leave and some annual leave and 4.7 per cent had also used some leave without pay2.6per cent had had to decrease their hours due to illness, and 2.25 per cent changed their jobs. Six people, or one per cent had had to contemplate early retirement due to their illness or injury.

9.3 Burnout

A modified version of the Abbreviated Maslach Inventory was used. (McClafferty 2014). The scoring schedule is found at http://nbpsa.org/images/PRP/MaslachScoringAbbreviated.pdf

Nine items are offered, together with a seven point frequency scale ranging from every day to never. The items are divided into three domains: emotional exhaustion, depersonalisation and personal accomplishment.

The domain codes are colour coded into the three domains and depicted below:

Table 20. AMI coding

I deal very effectively with the problems of my patients
I feel I treat some patients as if they were impersonal objects
I feel emotionally drained from my work
I feel fatigued when I get up in the morning and have to face another day on the job
I've become more callous towards people since I took this job
I feel I'm positively influencing other people's lives through my work
Working with people all day is really a strain for me
I don't really care what happens to some patients
I feel exhilarated after working closely with my patients

Composite scores for the domains are shown below.

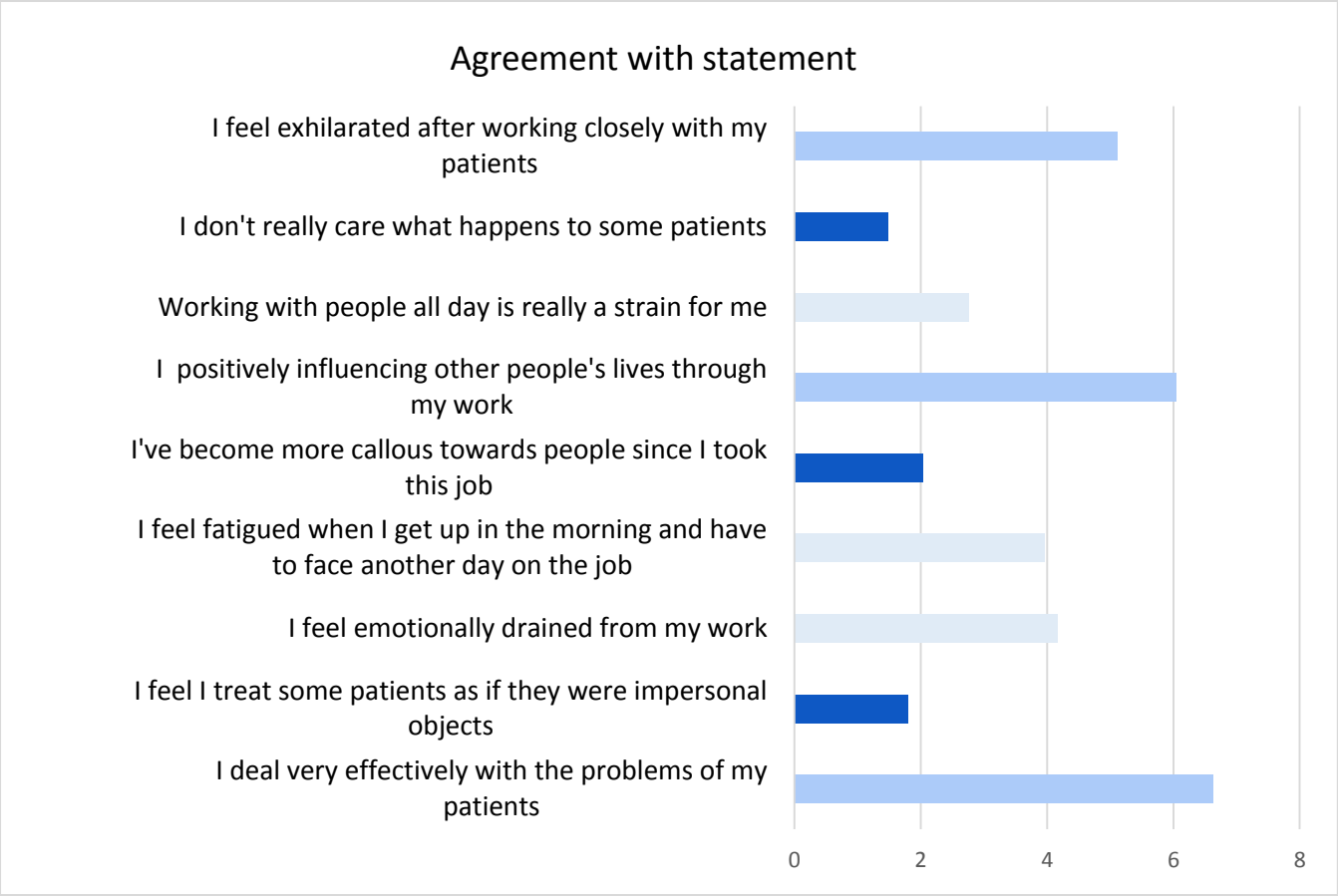
Emotional exhaustion	10.89 / 18	(High score = greater burnout)
Depersonalisation	5.33 / 18	(High score = greater burnout)
Personal Accomplishment	17.19 / 18	(High score = less burnout)

Relating the scores for this survey to the risk of burnout syndrome for scores as reported in the literature,

Domain	Low risk	Moderate risk	High risk
Emotional exhaustion	0-6	**7-12**	13-18
Depersonalisation	**0-6**	7-12	13-18
Personal Accomplishment	**13-18**	7-12	0-6

This is also shown for each item below.

Figure 35. Burnout inventory aggregate answers



Analysis reveals that at the aggregated level at least, nurses have high personal accomplishment scores, moderate levels of emotional exhaustion, but low scores for depersonalisation. The inventory was designed for assessment at the individual level, and has not specifically been validated for use with New Zealand nurses, or in an embedded web-survey format, so some caution should be taken with putting too much emphasis on this aggregated analysis. Nevertheless, it does potentially reveal that despite emotional toll, nurses gain resilience from their sense of job satisfaction related to helping patients.

Considerable scope exists outside this report for this data to be analysed in far more detail: to look at patterns related to age, education, employment sector, field of nursing or position in the hierarchy for example.

Comparison with the results from a burnout study on new Zealand doctors by ASMS, which was a survey specifically looking at burnout, using the Copenhagen Burnout Scale is also warranted. That study found high levels of burnout in the doctors, though the methodology and specific focus of that study, combined with timing related to bargaining and industrial action over excessive hours may have influenced those results.

Burnout is also related to fatigue, so the consecutive cumulative hours worked by doctors compared to nurses may be the defining difference.

9.4 Summary

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

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

- The commonest causes were norovirus and flu infections, and back and shoulder injuries relating mostly to lifting.

- Proportionately, 25 – 29 year olds had more days off work due to illness or injury than older nurses.

- Using the Abbreviated Maslach Inventory score for burnout, nurses at an aggregate level display high resilience in the face of moderate emotional exhaustion.

Chapter 10: Morale

10.1 Morale

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

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

Positivity scores are calculated from the percentage agreeing with statements in each theme block. Negatively-worded statements are reported in reverse to allow easy comparison. (For example, the percentage disagreeing with "*I would leave nursing if I could"* are reversed, showing instead as percentage agreeing with "*I would (NOT) leave nursing if I could, to allow comparison* with "*I would recommend nursing as a career").* Results from 2013 and 2015 are shown for comparison.

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

Compared to the responses from 2009, 2011, 2013 and 2015, New Zealand nurses' morale scores with most aspects of nursing as a career have continued to steadily decline across the board. Falls in satisfaction with pay and workload continue, and there has been a slight increase in perceptions of bullying.

Table 21. Weighted scores from the validated attitudinal question set

Themes / Statements	Per cent agreeing 2013	Per cent agreeing 2015	Per cent agreeing 2017
1. **Nursing as a career**			
I would recommend nursing as a career	82.9	77.09	75.22
I would (NOT) leave nursing if I could	75.2	69.34	66.88
I am (NOT) in a dead end job	88.3	83.28	82
Mean "positivity" score	**82.1**	**76.57**	**74.67**
2. **Career progression**			
It will (NOT) be difficult to progress from my current salary	26.8	21.12	20.66
Career prospects are (NOT) becoming less attractive	56.4	46.99	48.13
Mean "positivity" score	**41.6**	**34.05**	**34.39**
3**. Bullying/harassment**			
Bullying and harassment are not a problem where I work	55.2	50.2	48.84
I'd be treated fairly if I reported being harassed	67.1	62.04	59.21
Mean "positivity" score	**61.1**	**56.12**	**54.02**
4. **Working hours**			
I am happy with my choice of shifts	82.3	78.58	79.45
I feel able to balance home and work lives	73.6	72.9	71.2
Mean "positivity" score	**77.9**	**75.74**	**75.32**
5**. Job satisfaction**			
Most days I am enthusiastic about my job	88.9	87.4	86.87
I feel satisfied with my present job	77	72.73	73.62
I feel my work is valued	73	50.2	65.74
I feel part of a team	88.4	84.97	83.41
I am able to practise autonomously	87.3	84.49	85.36

My opinions about nursing are valued by my manager	75.6	70.78	70.25
Mean “positivity” score	**81.7**	**75.09**	**77.54**
6**. Pay**			
I am well paid considering the work I do	38.4	34.87	32.46
Nurses are paid well compared to other professionals	22.6	19.6	16.71
Mean “positivity” score	**30.5**	**27.23**	**24.58**
7. **Quality of care**			
The quality of care provided where I work is good	**92.8**	**90.62**	**90.18**
8**. Job security**			
Nursing will continue to offer me a secure future	85.7	82.67	82.68
I am (NOT) worried I may be made redundant	84.6	81.87	82.46
I would find it easy to get another job with my skills	69.2	64.34	63
Mean “positivity” score	**79.8**	**76.29**	**76.04**
9. **Training and education**			
I am (ABLE) to take time off for training	71	67.03	69.24
I am able to keep up with developments to do with my job	79.2	78.47	80.27
I have regular dialogue about my work with my manager	63.3	60.54	58.34
Mean “positivity” score	**71.6**	**68.68**	**69.28**
10**. Workload**			
My workload is (NOT) too heavy	50.5	41.56	43.06
I am (NOT) under too much pressure at work	54.4	47.48	42.05
(NOT) too much time is spent on non-nursing duties	57.5	54.71	46.34
There are sufficient staff to provide good care	57.8	50.46	52.35
Nurse staffing levels have improved over the last year	34.7	28.99	31.83
Mean “positivity” score	**50.98**	**44.64**	**43.13**

10.2 Qualitative results

The free text comments in response to the question: *Is 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. 272 separate respondents made comments in this section.

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

Table 22. 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.	56
I have always loved nursing - I have never wanted to do anything else - my daughter is now a wonderful nurse - it is a great profession. I love my role where I work - I have a great mix where I can work on the "floor", alongside patients in a diabetes and B4Sc clinic and also in a managerial role - with 14 other nurses to roster and manage. *I have been working in nursing for over fifty years on and off for that time. I am proud to have been nursing and I will love it to the day I die.* *I have enjoyed my nursing career. I have grasped opportunities for further studies with both hands and have seen myself grown in knowledge and confidence. I felt appreciated and am a valued team member whose knowledge and experience have often been sought out by my work colleagues and other health professionals.* *I have an amazing job, as part of an awesome nursing team, advocating and helping to empower our clients to improve their health and well-being.*		
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.	10
If you find the right job nursing can provide a flexibility to work while providing care for your children at home also. The catch is that you do inevitably compromise your career ambitions a bit to attain this balance. *I left my previous employment after taking maternity leave as they were unable to flex with working hours insisting that 20 hours was the minimum.(shift work also) I was lucky to find part time regular*		

hours. I think in a profession that is predominantly female that this rigid attitude does not work well with work/life balance and needs looking at. Job sharing would really work well with so many other nurses I have met. I did enjoy my previous job and feel my leaving was a shame and a waste of my skills/training. *As a nurse and now as a mother contemplating my return to work I feel the shifts and local day-care provider hours very difficult to combine. It's very stressful for me at the moment to think about what shift to do and the care for my son.*		
Support	This included supportive and empowering management, collegiality and encouragement/recognition for good work.	4
I'm lucky to be in a workplace with a very positive work culture and teamwork. My answers would have been quite different if I was in previous jobs. The main reason I see for negative when culture is the stress that comes from under resourcing. Nursing is a great career and will be my career for my life but there needs to be more job opportunities for be graduates. *Very fortunate to have a very supportive and approachable ACNM.* *I love my job and have a great relationship with colleagues and management*		

Table 23. Negative themes

Theme	Description	count
Low morale	This included low morale, leaving nursing, pressure, stress, burnout and exhaustion/fatigue.	44
I have loved my nursing career but recently I have lost the enthusiasm to continue nursing. The lack of autonomy/ communication/involvement and drive for money by my employers has made my working day miserable. *Aged care is underfunded under staffed and forgotten about. It is treated by anyone not in the aged care sector as where nurses go to retire or the ones that can't get a job at the hospital. I am passionate about age care and don't want to do anything else however am disheartened by the public and other health professionals disregarding the skill and knowledge required to do the job. We don't get the funding for quality and quantity of staff and resources to do right by the residents.* *I would never work in a DHB again as conditions are so poor and job satisfaction was very low. I think it's got worse since I first started nursing. Working in the private sector is much more enjoyable and I have never loved nursing so much since I started working in this area.* *Nurses continue to feel they are not recognised for the long hours and missed meal breaks. Getting that recognised is a mission and then being paid is arbitrary. Up to managers who more often than not choose not to pay you. Most recently a cost saving exercise has been to stop*		

providing one dollar a loaf bread to the ward...but Dr's still receive allowances for meals, which I applaud but we are not worth a loaf of Bread! I could go on....

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

The overloading we experience every day is draining and dangerous for the nurses and the patients. We are short one or more RN daily. Trendcare shows I have a workload of 11.45 hours to accomplish in 8 hours. No one and nothing happens to help me and my patients. Is it any wonder I am beside myself and crying as I try to write my notes? Another day another ward. One of us has 15 hours work, one 12 one 10.5 according to Trendcare. But we have only 8 hours to do it in. No one and nothing happens to help us and our patients. The floor manager says it is what it is. I find myself crying as I write this.

Highly stressful and political professional that I never intended to work like in like this. The burden is very heavy with current policies and health issues. I would change my career if I have a good opportunity present. Being a Maori nurse is a lot more stressful and the burden is heavier.

I work for the Older Adult Mental Health team, we have recently combined with Mental Health, and in the past we were part of the Elder Health Team. This change has been made with little fore thought, currently we are working in chaos, we are short staffed, have no administration support, no Psychologist, no community Social Worker. We have wait lists of people needing to be seen by a Psychiatrist which makes our job high risk, carrying high case load numbers is unsafe. Sick leave for my colleagues is high, which means my work load increases considerably.

It's a job that is getting harder and harder in that more demands are being placed on the nurse. e.g.; in aged care, residents are being admitted closer to their end of life and with very complex co-morbidities. Staffing levels are not increasing to match this, sometimes shifts are being run on less staff than is good for the duties required.

Theme	Description	count
Changing nature of nursing	This included perceptions that nursing was changing, losing its way, becoming overly technical and remote, and of changes to nurse education not having delivered better nursing care. Also restructuring.	10

We are undergoing huge change and there is NO support. The feeling is if you don't like it leave. This attitude is apparent from senior management. The lack of consultation is a major concern. The papers for consultation are emailed say Thursday and close to comment on Monday and that is consultation!! Give me a break. They have no respect for our opinion. That says it all.

Nursing is changing all the time with expectations work pressure and IT involvement but I am continually reminded a nurse has to have compassion, respect, a smile and common sense based on experience with the joy of interacting with diverse people.

I have been privileged to be able to continue practicing as registered nurse for over 50 years, & am now semi-retired, but employed on a in a private practice where my background & experience is obviously very much appreciated.

Nursing has been a wonderful career for me, but I am concerned that the pressures on nurses working in the public sector are under an unreasonable amount of pressure given the financial constraints which affect staffing levels & reduce opportunities for staff educational opportunities.

I work in aged care. Gone are the days of job satisfaction and making a difference, increasingly we are at the mercy of a profit driven corporate. Any warm body in a bed seems to be the focus now. We are expected increasingly to nurse palliative patients in a revolving door manner, we have just become a mini hospice without the training and emotional skills, that they, the hospice have. We give a reasonably competent medication journey for end of life cares but are woefully short changing our patients and families by not meeting their emotional needs. Time poor, massive amounts of documentation, not being paid for numerous hours overtime, doing care plans in our own time, bulling management. I do not see any improvement on the horizon in this environment of profiteering. So when asked why am I retiring early, the above synopsis gives a good reason why, I grieve for the nurse I once was allowed to be in a vocation I loved and was so proud of.

Paperwork	This included patient paperwork, incident reporting, Key Performance Indicators, targets, and over-onerous/repetitive nature of PDRP.	19

Love my job but certainly the paper work is taking over. There is a shortage of younger nurses to help take over our jobs in the future.

It seems to me that nurses are pushed to their limit due to poor staffing levels, more paper/computer work and getting less and less support from their overworked managers.

I find the 3 yearly nursing portfolio paper work requirements excessive. I sometimes think it would be easier to let my portfolio lapse and wait for the nursing council to catch up with me. The nursing council portfolio requirements are much more realistic for working nurses to complete.

I enjoy the patient contact, I don't enjoy the ever increasing paperwork.

I became a nurse to help people, and my passion is older people's health. However so much of my day is taken up with paperwork, that I find I don't have time for the people.

Theme	Description	count

Poor management	Included bullying, remoteness, unsupportive, poor leadership, poor advocacy	27

Bad management cause some good staff to find other jobs and leave the rest wondering why they are still there.

I have an extremely incompetent manager which has a big impact on my work performance, professional development and service development as well as the functionality of the team. I have tried to complain about this and received little union support and little support from my employer. I cannot see improvement happening until this manager retires and because I have spoken out against this I cannot see myself being employable for other positions in this very small DHB.

I love my work with patients and most of my colleagues it is the internal politics plus entrenched behaviours by some staff that lead to an ugly culture and it appears that definitive action is not always taken to address these issues. I feel that the culture underlying the department is not healthy and a level of bullying is present. It is this stuff that is tiring to work with and deal with.

Nearing the end of my career feeling sad, working with a difficult manager. Little support, bullying behaviour etc. Feel I'm too old to get anything else, and am just hanging in there as long as I can.

I have been working at the same DHB for 30 years. I truly love my position as a District Nurse, consider it a privilege to visit patients in their home. Management in this DHB is poor, rating of 3 out of 10.

It is unbelievable that these people can get away with this negligence. The bullying and harassment needs to be halted. The expectation on nurses is unrealistic. The shifts are horrendous. The rostering is unethical and possibly illegal.

Pay	Poor pay relative to other professions, levels of education and responsibility, and lack of promotional opportunities and the linked pay.	28

Can be very stressful. Don't always feel appreciated and don't feel our salary reflects how hard we work.as work full time have been told at times will have to take annual leave to do professional development outside of work development days which I feel is very unfair.

While financial benefit isn't everything in a job, it would be great if nurses were paid more for their contributions to society.

I feel nurses are well underpaid especially in comparison to police and teachers. My current employer gave me a pay rise of .57 cents. The new graduate who works part time who I still support now gets the same pay as me. Her pay rise was over $2.50. But this is also another reason I do not enjoy my work as a nurse and feel undervalued. I have been nursing ten years just to get $31 dollars an hour. I started on about $23 or so.

I feel our salaries are not keeping up with the increased costs of living. Especially in Auckland. It is getting harder and harder to get ahead (in life) with nursing as a career and it will put people off in the future. We are health professionals with post graduate qualifications and we are still struggling

Nursing does not reward me financially for my advanced academic qualifications and experience. nursing does not support a young family financially well, especially on one income

I enjoy the ethics of nursing but in a world of massive mortgages I regret choosing nursing as my career

Aged care needs to be better recognised for the work load, the passion staff have towards people, and pay parity with all providers!

11.3 Specific and separate themes

Table 24. Specific and separate themes

Theme	Description	count
Unemployment	This included unemployment, job hunting, lack of new graduate positions, and job insecurity.	3

It took me nearly a year to find employment and had to move out of my home town away from my family. I found as a new grad it was difficult to get employment if you didn't get into NEtP/NEsP programs or have 2 years post grad experience. I had more luck getting employment in Auckland after cold calling and submitting my cv to agencies. I am grateful that the employer gave me a chance and a foot in the door.

I was not able to receive a NEtP place from ACE, like many of my fellow graduates. However, I have luckily received an offer from my current workplace. This was from all my hard work, and support from my manager and colleagues. I, like many other graduates feel let down. We were told that there was a significant shortage of nurses and we'd all get jobs. The problem is skill mix, yes we need nurses but areas can't operate solely on junior staff. The schools seem to be pumping nurses through, but if they don't get jobs in a timely manner people will leave New Zealand or simply abandon a profession they never got a start in.

Bullying

I began my nursing life as a young 16 1/2 year old girl in 1973 full of an inbuilt instinct to care. Eager to care and learn. Over the past 40 odd years as an Nursing assistant, EN and now a RMHN I have watched nurses being bullied by senior staff and management to the point that it shames me to be part of the caring profession "if we can't care for ourselves and our colleagues who can we honestly care for" I've stood up to the bullies and they continue to try to find chinks in our professional practice and status to chip away at us, using the national nursing guidelines as their way to erode our ability to care, our inbuilt humanity and good practice as a show board of what they think they can prove against us as our inability to do the best for our patients, and months after they have been our patients

Bullying is a major issue that's accepted in nursing. Especially from Senior nurses or CNLs. From what I can tell most organisations only pay lip service to anti bullying statements. But, ultimately I love my job because I feel I make a real difference.

Every day I deal with derogatory and racial remarks. Not unusual to witness horizontal and vertical bullying by Manager and her 2IC towards staff. No cultural Competency is in place within the org I work for, nor in any of the polices.

Since entering the workforce I have found it to be very different from what we got taught at CPIT. Although we were told that workplace bullying doesn't happen, I have found it to be rampant throughout the workforce. There is a real hierarchical system and some senior nurses have little to no respect for junior nurses. You get constantly told that doing my training through CPIT does not give us any skills and we should be trained the old way.

There is no mention or programmes that I have come across to ensure we keep our backs in good health to prevent injury. Little support when struggling with workplace pressures and bullying.

When will something ever be done to deal with toxic bullies in our profession? At the very least they undermine the whole team dynamic, which impacts on the patients and undermines nurses as individuals.

Enrolled Nurses	Specific comments from Enrolled nurses about their career opportunities	4

It is very discouraging when it comes to nursing jobs for enrolled nurse. I sometimes feel as if the whole qualification is wasted.

I think as an Enrolled Nurse (EN) I am underpaid for the amount of work responsibility I do. It's disgusting the great wide gap between EN/RN. My patient caseload is that of a registered nurse (RN). Although I don't get the most difficult-hard-complex patients but where I work they all have some degree of complexity.

I think for me it's about pay equity and for this reason I'll be doing Bachelor of Nursing. They get paid way more than EN. You can advance yourself in management roles and have more/better PDRP.

I am disappointed that with the DHB's getting rid of enrolled nurses and replacing us with caregivers the

standard of care has deteriorated. This I have observed from personal experiences. Enrolled nurses and Registered Community nurses have a wealth of knowledge and are a great support to the Registered nurses.

11.4 Summary

- Nurses are mostly positive about the quality of care they deliver, nursing as a career and job satisfaction.
- There is ongoing concern about staffing levels and increased patient workloads.
- They are least positive about workload and pay, especially in comparison with other professionals.
- They are concerned about access to training, career progression, restructuring and bullying.
- Compared to the responses from 2013 and 2015, New Zealand nurses' morale scores with most aspects of nursing have continued to decline slightly.

Overall Summary:

> Comparative pay, and pay progression (especially a perception of poor pay relative to other professions such as teaching and the police) remains a source of dissatisfaction for many. 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, increasing patient acuity, stress and lack of job satisfaction also contribute to staff turnover and to lower morale, and must be better managed. Safe levels of staffing, better shift rostering, and appropriate access to continuing professional development support and study leave must be ensured.

> The CCDM project, with its aim of better managing nurse workload and patient safety should be given greater support, visibility and resourcing, if the potential of the project is to be realised. Staff buy–in for the project is poor where there are perceptions that the methodology is not working, or where it is not acted on appropriately.

> Access to flexible working options, especially for nurses over 50 and those with care giving responsibilities (including looking at the requirement to do night shifts, and more flexibility about the minimum hours required) must be addressed to ensure workforce supply and continuity.

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

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

Bibliography

Ball, J., & Pike, G. (2009). *"Past imperfect, future tense".* London: Royal College of Nurses.

Clendon, J., & Walker, L. (2013) *The impact of shift work on nurses aged over fifty; implications for retention* Journal of Nursing Management DOI: 10.1111/jonm.12157

Clendon, J., & Walker, L. (2013). *The health of nurses aged over 50 in New Zealand*. Contemporary Nurse, *45*(1), 90–99.

Clendon, J., & Walker, L. (2015) The juxtaposition of ageing and nursing: the challenges and enablers of continuing to work in the latter stages of a nursing career *Journal of Advanced Nursing. 72*(5), 1065-1074. doi: 10.1111/jan.12896

McClafferty, H. (2014) Physician health and well being: the art and science of self-care in medicine.

Nursing Council of New Zealand. (2016). Annual report. Wellington: Nursing Council New Zealand. Available from: http://nursingcouncil.org.nz/Publications/Reports

Walker, L., (2009). NZNO Employment Survey, *"Holding up"* Wellington: New Zealand Nurses Organisation.

Walker, L., (2011). NZNO Employment Survey*, "Vital Signs"* Wellington: New Zealand Nurses Organisation.

Walker, L., & Clendon, J. (2013). NZNO Employment Survey, "*Our nursing workforce: for close observation".* Wellington: New Zealand Nurses Organisation.

Walker, L., (2015) NZNO Employment Survey; "*Our Nursing workforce; condition deteriorating"* NZNO Wellington: New Zealand Nurses Organisation.

Walker, L., & Clendon, J. (2012). *Ageing in place: retirement intentions of New Zealand nurses aged 50+.* Proceedings of the New Zealand Labour and Employment Conference, Wellington, New Zealand.

Walker, L., & Clendon, J. (2012). *A multi-cultural nursing workforce: views of New Zealand and internationally qualified nurses.* Kai Tiaki Nursing Research, 3(1), 4-11.

Walker, L., Clendon J. & Cheung, V. (2016) Family responsibilities of Asian nurses in New Zealand: implications for retention. *Kai Tiaki Nursing Research* 7(1) 4-10

Walker, L., Clendon, J., Nuku K., & Manson, L. (2016) Ngā Reanga o ngā Tapuhi Generations of Māori nurses. *AlterNative* 12(4) 356-368

Walker L. & Clendon, J. (2016) Nurses as family caregivers - Barriers and enablers facing nurses caring for children, parents or both. *JONM* DOI: 10.1111/jonm.12445

Endorsed by Board of Directors: April 2017
Principal author: Dr Léonie Walker
Correspondence to: researchers@nzno.org.nz

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

ISBN: 978-1-877461-86-6