Degree of Value Alignment – Why NSW Rural Nurses Resign: A Grounded Theory Study of Rural Nurse Resignations

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Table of Contents

Abbreviations ........................................................................................................... v
Certificate of Authorship .......................................................................................... vi
Acknowledgments ..................................................................................................... vii
Ethics Approval ......................................................................................................... viii
Professional Editorial Assistance ............................................................................. viii
Dedication ................................................................................................................... ix
Abstract ..................................................................................................................... x

CHAPTER ONE. INTRODUCTION TO THE STUDY ......................................................... 1
1.1 Introduction ......................................................................................................... 1
1.2 Overview of the Australian Nursing Workforce ................................................ 2
1.3 Australian Rural Communities ........................................................................ 4
1.4 The Context of the Nursing Shortage ................................................................ 13
1.5 Aim of the Study ............................................................................................... 16
1.6 Methodology Overview .................................................................................... 17
1.7 Overview of the Thesis ...................................................................................... 17
1.8 Chapter Summary ............................................................................................... 19

CHAPTER TWO. LITERATURE REVIEW ..................................................................... 20
2.1 Introduction ......................................................................................................... 20
2.2 Nurse Retention ................................................................................................ 22
2.3 Nurse Education ................................................................................................ 43
2.4 Seminal Australian Research into the Nursing Shortage ...................................... 49
2.5 Literature Review Discussion ............................................................................ 66
2.6 Chapter Summary ............................................................................................... 69

CHAPTER THREE. METHODOLOGY ........................................................................ 72
3.1 Introduction ......................................................................................................... 72
3.2 Grounded Theory – An Overview ...................................................................... 72
3.3 Methodology ....................................................................................................... 79
3.4 The Components of Grounded Theory .............................................................. 88
3.5 Researcher Reflexivity ....................................................................................... 99
3.6 Relevance of Grounded Theory to this Research ............................................. 100
3.7 Chapter Summary ............................................................................................... 102

CHAPTER FOUR. RESEARCH METHOD, DATA COLLECTION AND ANALYSIS ........ 104
4.1 Introduction ......................................................................................................... 104
4.2 Sample and Recruitment ................................................................................... 105
4.3 Ethical Considerations ...................................................................................... 111
4.4 Data Collection .................................................................................................. 114
4.5 Data Analysis ..................................................................................................... 117
4.6 The Process of Theory Building ........................................................................ 129
4.7 Data Management ............................................................................................. 134
4.8 Rigour, Trustworthiness and Evaluation Criteria ............................................... 135
4.9 Chapter Summary ............................................................................................... 138
CHAPTER FIVE. THE CORE CATEGORY OF CONFLICTING VALUES (THE FIRST CATEGORY – ORGANISATIONAL VALUES) .................................. 140
5.1 Introduction .................................................................................................................. 140
5.2 Conflicting Values ......................................................................................................... 140
5.3 Organisational Values ................................................................................................. 143
5.4 Chapter Summary ........................................................................................................ 167

CHAPTER SIX. THE CORE CATEGORY OF CONFLICTING VALUES (THE SECOND CATEGORY – PERSONAL VALUES) .................................. 169
6.1 Introduction .................................................................................................................. 169
6.2 Personal Values ............................................................................................................ 169
6.3 Chapter Summary ........................................................................................................ 188

CHAPTER SEVEN. A GROUNDED THEORY OF RURAL NURSE RESIGNATIONS .......... 190
7.1 Introduction .................................................................................................................. 190
7.2 Theory Building .......................................................................................................... 191
7.3 The Basic Social Process of Conflicting Values .......................................................... 197
7.4 Degree of Value Alignment – Why NSW Rural Nurses Resign .................................. 207
7.5 Chapter Summary ........................................................................................................ 215

CHAPTER EIGHT. DISCUSSION .................................................................................. 216
8.1 Introduction .................................................................................................................. 216
8.2 Conflicting Values ......................................................................................................... 216
8.3 Degree of Value Alignment ......................................................................................... 232
8.4 Job Satisfaction ............................................................................................................ 239
8.5 Retention of Nurses in the Australian Workforce ...................................................... 240
8.6 Chapter Summary ........................................................................................................ 242

CHAPTER NINE. IMPLICATIONS, RECOMMENDATIONS AND CONCLUSION .......... 244
9.1 Introduction .................................................................................................................. 244
9.2 Implications ................................................................................................................ 244
9.3 Recommendations ...................................................................................................... 254
9.4 Strengths and Limitations of the Study ..................................................................... 265
9.5 Conclusion ................................................................................................................... 268

REFERENCE LIST ........................................................................................................ 276
Appendix A: Information Statement ................................................................................ 295
Appendix B: Consent Form ............................................................................................... 298
Appendix C: Initial Open Codes and Preliminary Categories ........................................ 299
Tables

Table 1: Overview of the Area Health Services of NSW ........................................... 8
Table 2: Inclusion Criteria for Research and Non-research Based Literature .......... 22
Table 3: Factors Influential in Leaving or Staying ................................................. 51
Table 4: Summary of NSW Investigations into the NSW Nursing Shortage .......... 64
Table 5: The Different Ontologies, Epistemologies and Methodologies .............. 82
Table 6: Characteristics of Participants .................................................................. 109
Table 7: Sampling Methods, Data Analysis, Coding and the Core Category ........ 128
Table 8: Coding Families Utilised in this Study ..................................................... 130
Table 9: Comparison of Recommendations .......................................................... 262

Figures

Figure 1: NSW Area Health Services ...................................................................... 6
Figure 2: The Constant Comparative Method of Data Analysis Employed ............ 119
Figure 3: Emergence of the Core Category ............................................................ 126
Figure 4: The Core Category of Conflicting Values .............................................. 142
Figure 5: The Sub-category Organisational Structure .......................................... 144
Figure 6: The Sub-category Organisational Attitudes .......................................... 158
Figure 7: The Sub-category Compromising Care ............................................... 171
Figure 8: The Sub-category Compromising Self .................................................. 182
Figure 9: The Three Stages of the Basic Social Process of Conflicting Values ....... 198
Figure 10: Value Alignment Scales ...................................................................... 214
## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AACN</td>
<td>American Association of Critical-Care Nurses</td>
</tr>
<tr>
<td>ACIRRT</td>
<td>Australian Centre for Industrial Relations Research and Training</td>
</tr>
<tr>
<td>AHS</td>
<td>Area Health Service</td>
</tr>
<tr>
<td>AHWAC</td>
<td>Australian Health Workforce Advisory Committee</td>
</tr>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>AIN</td>
<td>Assistant in Nursing</td>
</tr>
<tr>
<td>ANF</td>
<td>Australian Nursing Federation</td>
</tr>
<tr>
<td>ARIA</td>
<td>Accessibility/Remoteness Index of Australia</td>
</tr>
<tr>
<td>ASGC</td>
<td>Australian Standard Geographical Classification</td>
</tr>
<tr>
<td>CAQDAS</td>
<td>Computer Assisted Qualitative Data Analysis Software</td>
</tr>
<tr>
<td>CNC</td>
<td>Clinical Nurse Consultant</td>
</tr>
<tr>
<td>CSU</td>
<td>Charles Sturt University</td>
</tr>
<tr>
<td>DEEWR</td>
<td>Department of Education, Employment and Workplace Relations</td>
</tr>
<tr>
<td>DEST</td>
<td>Department of Education, Science and Training</td>
</tr>
<tr>
<td>DoHA</td>
<td>Department of Health and Ageing</td>
</tr>
<tr>
<td>EN</td>
<td>Enrolled Nurse</td>
</tr>
<tr>
<td>FTE</td>
<td>Full Time Equivalent</td>
</tr>
<tr>
<td>GSAHS</td>
<td>Greater Southern Area Health Service</td>
</tr>
<tr>
<td>GWAHS</td>
<td>Greater Western Area Health Service</td>
</tr>
<tr>
<td>HNEAHS</td>
<td>Hunter New England Area Health Service</td>
</tr>
<tr>
<td>ICN</td>
<td>International Council of Nurses</td>
</tr>
<tr>
<td>LGA</td>
<td>Local Government Area</td>
</tr>
<tr>
<td>LHN</td>
<td>Local Health Network</td>
</tr>
<tr>
<td>MPS</td>
<td>Multi-purpose Service</td>
</tr>
<tr>
<td>NCAHS</td>
<td>North Coast Area Health Service</td>
</tr>
<tr>
<td>NHSRC</td>
<td>Nursing and Health Services Research Consortium</td>
</tr>
<tr>
<td>NMB</td>
<td>Nurses and Midwives Board</td>
</tr>
<tr>
<td>NMBA</td>
<td>Nursing and Midwifery Board of Australia</td>
</tr>
<tr>
<td>NSWNA</td>
<td>NSW Nurses’ Association</td>
</tr>
<tr>
<td>NUM</td>
<td>Nursing Unit Manager</td>
</tr>
<tr>
<td>QDA</td>
<td>Qualitative Data Analysis</td>
</tr>
<tr>
<td>RRMA</td>
<td>Rural, Remote and Metropolitan Areas</td>
</tr>
<tr>
<td>RVS</td>
<td>Rokeach Value Survey</td>
</tr>
<tr>
<td>TAFE</td>
<td>Technical and Further Education</td>
</tr>
</tbody>
</table>
Certificate of Authorship

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the award of any other degree or diploma at Charles Sturt University or any other educational institution, except where due acknowledgment is made in the thesis. Any contribution made to the research by colleagues with whom I have worked at Charles Sturt University or elsewhere during my candidature is fully acknowledged.

I agree that this thesis be accessible for the purpose of study and research in accordance with the normal conditions established by the Executive Director, Library Services or nominee, for the care, loan and reproduction of theses.”

Signature.........................................................Date.................................
Acknowledgments

This thesis would not be possible without the wonderful stories of the participants who kindly gave of their time and shared their stories with me. For this I am extremely grateful. Their stories are wonderful insights into the world of nursing and I have great respect and admiration for the participants’ work.

Acknowledgment is given to the three women who illuminated and guided the way. To Professor Elaine Duffy whose valuable support assisted this thesis greatly, to Associate Professor Jan Allan, who was there from day one and never gave up on me and, finally, to Associate Professor Ann Bonner, who made the journey memorable, shared her infinite knowledge of grounded theory methodology with me and taught me so much about myself – this thesis would not have been possible without her wise and patient teaching.

Special thanks to Dr Judith Anderson, my fellow PhD student, who kept my coffee cup filled and shared many an afternoon discussing grounded theory with me. Thank you.
Ethics Approval

Ethics approval was sought and granted from Charles Sturt University Ethics in Human Research Committee, approval number 2004/228.

Professional Editorial Assistance

Professional editing was limited to formatting, grammar and style (Australian Standard for Editing Practice – ASEP Standard D – Language and Illustrations, ASEP Standard E – Completeness and Consistency) and did not alter or improve the substantive content or conceptual organisation of the thesis. This assistance was provided by Ms Di Davies. A fee was paid for this service from personal funds.
Dedication

This thesis is dedicated to my maternal grandmother, Sister Connie Simms, and my maternal great aunt, Sister Daphne Simms, pioneers of rural nursing in 1920s NSW

… and to those who share my love of nursing.
Abstract

Currently in Australia nursing is continuing to face workforce shortages due to the challenge of retaining staff; this is especially true for rural areas. Current research indicates that job dissatisfaction is implicit in nurse resignations however the identification of the underlying reasons that contribute to job dissatisfaction remains elusive. This grounded theory study explores the reasons why NSW registered nurses resign from rural hospitals. Twelve registered nurses who had resigned from rural hospitals were interviewed in fourteen face-to-face, semi-structured interviews.

The substantive theory that emerges from this study to explain rural nurse resignations is titled ‘degree of value alignment’. Findings indicate that nurses resign from NSW rural hospitals when hospital values change and nurses are unable to realign their values to the hospitals. A decreased degree of value alignment between nurse and hospital is paramount in rural nurse resignations; the greater the degree of value alignment the greater the possibility of nurse retention. The theory emerges around the core category of ‘conflicting values’ which explains the conflict between nurses’ personal values – how nurses perceive nursing should occur – and organisational values – how the hospital enables nurses to carry out nursing. The conflict in values between nurse and hospital arises because of a number of reasons. These include rural area health service restructures, centralisation of budgets and resources, cumbersome hierarchies and management structures that inhibit communication and decision making, outdated
and ineffective operating systems, insufficient and inexperienced staff, bullying, and a lack of connectedness and shared vision between nurse and hospital.

Conflicting values emerge as a basic social process that encompasses three stages which nurses move through prior to their resignation. The first stage is sharing values, a time when nurse and organisation share similar values. The second stage is conceding values where, due to changes in the organisation’s values, nurses perceive that patient care becomes compromised and values diverge between the nurse and the hospital. The final stage is resigning, a stage where nurses ‘give up’ and feel that they compromise their professional integrity, that their values are conflicted and that they are unable to realign their values to the hospital’s. In this stage the nurse eventually resigns. The findings indicate that, unless nurses’ values and hospitals’ values are in alignment, nurses will continue to resign. Effective retention strategies must address contributors to the decrease in value alignment, enhance shared values between nurse and hospital, give nurses back control of nursing, and create an environment that is patient focused and conducive to nursing.
It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm.

(Florence Nightingale, 1859).
CHAPTER ONE

Introduction to the Study

1.1 Introduction

Worldwide, nursing is facing a significant challenge in recruiting people into the profession and then retaining nurses in the workforce. This is especially true for Australian rural areas which are experiencing one of the greatest nursing shortages of all times (Australian Nursing Federation [ANF], 2008a; Hegney, McCarthy, Rogers-Clark, & Gorman, 2002a; Kenny, 2009; Kenny & Duckett, 2003; Mills, Francis, & Bonner, 2007a; Pearson, 2008). Simultaneously, the current Australian nursing workforce is ageing with large numbers of nurses due to retire and one-third of new graduate nurses leave within the first five years of graduating (Levett-Jones & FitzGerald, 2005). Together, the problems of recruitment, retention and retirement are exacerbating the difficulties of sustaining an adequate nursing workforce (Duffield, Roche, et al., 2007; Graham & Duffield, 2010; Kenny, 2009; NSW Nurses’ Association [NSWNA], 2006).

Nursing shortages are spread across all fields of nursing including mental health, emergency, midwifery, intensive care and general nursing (Australian Institute of Health and Welfare [AIHW], 2008, 2010). Poor retention of health workers is a significant problem in rural and remote areas and subsequently results in negative consequences for both health services and patient care (Bukyx, Humphreys, Wakerman, & Pashen, 2010). Australian rural areas have a lower retention rate of nurses than their metropolitan counterparts, with more remote communities
experiencing an even higher turnover of nursing staff (Hegney, Plank, Buikstra, Parker, & Eley, 2005).

This thesis is a study of rural registered nurses and will explore the reasons why nurses resign from NSW rural hospitals. NSW Health indicates that nursing shortages for NSW were between 10,000 and 12,000 in 2010, threatening the entire public health system in NSW with a major crisis (Garling, 2008). Adding to this, approximately one-quarter of the NSW registered nurse population is due to retire in 2011 (Garling, 2008). In NSW alone, there are 1,196 nursing vacancies in the NSW Health Department (NSW Health, 2010c) and yet there are 12,847 registered nurses in NSW who are not currently working in nursing and not looking for work in nursing (AIHW, 2008, p. 8). Theoretically, there are ten registered nurses available in NSW for each vacant nursing position. In addition, there is a high percentage of mature-aged nursing students entering the nursing workforce which may aggravate the ageing nursing workforce. It will be essential that succession planning and workplace conditions are addressed to ensure that nursing has a sustainable future as large numbers of nurses (particularly the baby boomers) prepare to retire (Drury, Francis, & Chapman, 2009).

1.2 Overview of the Australian Nursing Workforce

In Australia, nurses are required to be registered with the Nursing and Midwifery Board of Australia (NMBA) to practise. To approve registration, the Board must be satisfied that the applicant has completed an appropriate nursing or midwifery course, is fit and competent to practise, has a state of health such that they can practise safely and has sufficient command of the English language to ensure safe
practice (NMBA, 2010). Once a nurse is registered, they may choose to work in a metropolitan, rural or remote area. Most registered nurses are clinicians and, in the Nursing and Midwifery Labour Force Census, are defined as providing direct patient care, treatment, diagnosis or advice. Other nurses work as administrators, teachers/educators or researchers (AIHW, 2010).

The most recent figures on the Australian nursing workforce are from 2008 and show that, from a total of 253,616 registered nurses, approximately 87% are employed as nurses (AIHW, 2010). Approximately 36% of the Australian nursing workforce are rural nurses (AIHW, 2008). The nursing labour force continues to age with the average age of employed registered nurses increasing from 42.1 years in 2005 to 44.1 years in 2008 (AIHW, 2010). Nursing continues to be a female-dominated profession, with males comprising 9.4% of employed registered nurses (AIHW, 2010). In NSW in 2008, there was a total of 85,587 registered nurses with 65,469 employed in nursing (76.5%) and 11,185 (13%) not looking for work in nursing (AHIW, 2010). The largest proportion of NSW nurses work in the clinical area of medical/surgical nursing followed by critical care and aged care (AIHW, 2010).

In August 2004, there were 1,261 registered nurse vacancies being actively recruited\(^1\) in NSW public hospitals with 21% of these being rural nursing vacancies (NSW Health, 2004a, 2004b). The rural vacancy rate is consistent with

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\(^1\) It should be noted that actively recruited refers to how many positions are being recruited, and not how many vacant nursing positions there are. For example, for every twenty nursing positions vacant, NSW Health may choose to fill fifteen permanently and fill the remaining five with casual staff (NSW Health, 2001).
the ratios of rural to metropolitan nurses in NSW (23.4% of NSW nurses work in rural NSW) (NSW Health, 2001). Four years later in September 2008, the Department of Health Reporting System actively recruited a similar number of nursing vacancies to 2004 (1,236); however, the percentage of rural nursing vacancies had nearly doubled from 21% to 41%. Even though the 2004 figure was prior to the 2005 area health service (AHS) restructures, the rurality classification remains the same when the previous AHSs are compared to the current (NSW Health, 2008c). It is unclear why rural nursing positions increased with metropolitan nursing positions decreasing. These nursing vacancy figures only reflect what is currently vacant within the NSW public sector workforce and do not include private nursing vacancies.

1.3 Australian Rural Communities

As this thesis explores NSW rural nurse resignations, this section will assist to locate the study by providing an overview of the setting in which rural nurses work. This will include a discussion of NSW rural classifications, rural NSW AHSs and an overview of rural communities and rural nursing.

**Rural classification**

Most literature on rural nursing in Australia uses terms such as ‘rural’ and ‘remote’. In Australia, there are three main classification systems used to define ‘rural’ and ‘remote’ areas and populations. These classification systems define rurality and remoteness using indicators such as population numbers and distance from larger towns. Classification systems include the Rural, Remote and Metropolitan Areas (RRMA) classification, the Accessibility/Remoteness Index
of Australia (ARIA) and the Australian Standard Geographical Classification (ASGC) Remoteness Areas (Department of Health and Ageing [DoHA], 2008). As the Department of Health and Ageing use the RRMA classification system for health statistics, research and health publications (DoHA, 2008) this classification system will be used throughout the thesis.

According to the RRMA classification system, the term ‘rural’ refers to towns with a population between 10,000 and 99,000 people whereas the term ‘remote’ refers to towns with a population of less than 10,000 people (DoHA, 2008). For the purpose of this study, rural nurse participants are defined as registered nurses who had worked in and resigned from a hospital that was within a NSW rural AHS and includes both rural and remote nurse participants. NSW Health uses the RRMA definition to define rural AHSs (NSW Health, 2008a). An overview of the geographical size and location of these rural AHSs within NSW follows.

**NSW Area Health Services**

NSW Health has the main responsibility for public health care delivery to the people of NSW. In order to manage delivery of health care in the large geographic area of NSW, NSW Health has divided the state into AHSs. In 1986, twenty-three AHSs were established and then in 1988 this was reduced to seventeen. On 1 January 2005, NSW Health restructured health services within NSW to merge from seventeen to eight in an attempt by the state government to save over $100 million. This money would then be redirected to front-line health services (NSW Health, 2005a). These eight AHSs comprise four metropolitan and four rural AHSs and the following figure, Figure 1, shows these eight AHSs spanning NSW.
The following information provides a brief overview of the four rural AHSs which are relevant to this study. Three of the AHSs (Greater Western, Greater Southern and Hunter New England) are relevant to this study as they encompass the areas the participants had resigned from. In January 2011, the current eight NSW AHSs were restructured to form eighteen Local Health Networks (LHNs) (NSW Health, 2010a); this will be discussed further in Chapter Eight.

Figure 1: NSW Area Health Services

Source: NSW Health, 2008a
Greater Southern Area Health Service

The Greater Southern Area Health Service (GSAHS) provides health care to approximately 468,000 persons spread across 166,000 square kilometres of NSW and employs 6.03% of the NSW nursing workforce. There are six main areas of population density: Albury, Deniliquin, Goulburn, Griffith, Queanbeyan and Wagga Wagga. The GSAHS contributes significantly to communities as one of the major employers in the region, employing over 5,222 (Full Time Equivalent [FTE]) staff in a range of clinical and non-clinical roles (NSW Health, 2008b).

North Coast Area Health Service

Of the total number of NSW nurses, 7.7% are employed in the North Coast Area Health Service (NCAHS) which covers an area of 25,570 square kilometres extending from Port Macquarie in the south, to Queensland in the north and westward to the Great Dividing Range. NCAHS shares a state border with Queensland. Residents of the southern Gold Coast and Tweed Valley share primary, secondary and tertiary health services provided by both Queensland and NSW health services. NCAHS includes twelve Local Government Areas (LGAs), with an estimated population in 2006 of 480,675 (NSW Health, 2007a).

Greater Western Area Health Service

Greater Western Area Health Service (GWAHS) services approximately 287,481 people across a huge geographic area of 445,196.9 square kilometres, an area representing over 55 per cent of NSW. This AHS employs 4.79% of the NSW nursing workforce. The population is dispersed, extending from Bathurst in the east to Broken Hill in the west. The area shares its borders with South Australia,
Victoria and Queensland (NSW Health, 2007b). GWAHS is unique in that, of all the AHSs, it has the largest geographic area but the least number of nurses (NSW Health, 2010b).

**Hunter New England Area Health Service**

Of all registered nurses working within NSW, 13.77% work in the Hunter New England Area Health Service (HNEAHS) which was created following the merger between Hunter, New England and the Lower Mid North Coast LGAs of Gloucester, Greater Taree City and Great Lakes. It covers a geographical area of 130,000 square kilometres (the size of England) and provides health care services to 840,000 people and employs 10,500 FTE staff (NSW Health, 2005b). The following table provides an overview of the NSW AHSs discussed in this section of the chapter.

<table>
<thead>
<tr>
<th>AHS</th>
<th>AHS size in kilometres square</th>
<th>Percentage of NSW nursing workforce employed</th>
<th>AHS population</th>
</tr>
</thead>
<tbody>
<tr>
<td>GSHAS</td>
<td>166,000</td>
<td>6.03%</td>
<td>468,000</td>
</tr>
<tr>
<td>NCAHS</td>
<td>25,570</td>
<td>7.7%</td>
<td>480,675</td>
</tr>
<tr>
<td>GWAHS</td>
<td>445,196.9</td>
<td>4.7%</td>
<td>287,481</td>
</tr>
<tr>
<td>HNEAHS</td>
<td>130,000</td>
<td>13.77%</td>
<td>840,000</td>
</tr>
</tbody>
</table>

This overview of rural health services has assisted in locating the study by describing the rural areas in which NSW rural nurses work. Nurses working in these rural AHSs are often over 1,000 kilometres from cities. A brief description of rural communities and rural nursing now follows.
Fundamental to the viability of Australian rural communities is access to both a reliable health service and educational opportunities for health care workers (Daly, Speedy, & Jackson, 2010; Gibb, Jones, Molloy, & Hamilton, 2002; NSW Health, 2006). Rural and remote Australians continue to be disadvantaged in their access to health professionals compared to their metropolitan counterparts (AIHW, 2008). Rurality in itself impacts on the health of the community and has its own implications as people living in rural areas of Australia usually have a lower health status as well as lower life expectancy (Daly et al., 2010; Gibb et al., 2002; NSW Health, 2006). Mortality from trauma is higher (Daly et al., 2010; Gibb et al., 2002), rural populations have higher hospitalisation rates (Daly et al., 2010), road accidents occur twice as often (AIHW, 2008), and death rates from coronary artery disease, diabetes and asthma increase with remoteness because of a lack of health services (AIHW, 2008, 2010; Daly et al., 2010; Phillips, 2009).

The Australian rural population often needs to travel greater distances in order to access these services; this is particularly so in remote communities. This places additional expense on health care as a result of travel and sometimes accommodation costs (Daly et al., 2010; DoHA, 2008; Pearson, 2008). Sustaining hospitals, nursing homes and other services for rural people poses a financial as well as a logistical problem and there is less investment in maintaining and developing small rural hospitals as a base for health care to small rural communities (Pearson, 2008).
The picture of health inequity within the rural sector is complicated by the growing perception that the only reliable health care workforce in these rural areas comprises the permanent members of these communities (Gibb et al., 2002). The issue of a shortage of rural health care workers is compounded by the lack of local nursing educational facilities, as those rural people who wish to pursue nursing must leave their rural homes to gain a university education. At the time of this study the NSW Nurses and Midwives Board did not allow first year nursing students to study by distance education, and this necessitated that students needed to relocate to the university town. According to Gibb et al. (2002), the lack of educational opportunities in smaller rural areas places a fourfold burden on the community: cost, lack of cultural familiarity with higher education, higher competition for scarce educational resources and restricted employment opportunities. Rural nursing also has its own uniqueness and disadvantages and a discussion of these now follows.

In rural communities, nurses make up a greater proportion of the health workforce than in metropolitan settings, which makes their role in service provision even more significant (Francis & Mills, 2010). There is an acknowledgment that rural nursing practice is different from nursing practice in metropolitan areas (Francis & Mills, 2010). First, by necessity, rural nurses tend to be more generalist practitioners than specialists (Daly et al., 2010; Francis & Mills, 2010); in other words, rural nurses often work in small hospitals that provide a wide variety of nursing care with the scope of practice covering prevention, intervention and rehabilitation and is lifespan inclusive (Francis & Mills, 2010). Second, rural nurses provide multiple services that metropolitan nurses do not provide. For
example, in an inner city hospital in Australia, there are specialised teams to deal with all aspects of patient care; however, in a small rural hospital, nurses will deal with all aspects of health care from a cardiac arrest or major car accident through to aged care (Daly et al., 2010; Department of Education, Science and Training [DEST], 2001).

The role of rural nursing differs from that of metropolitan nursing and many metropolitan nurses lack an understanding of these differences. This is particularly so in relation to rural isolation as this isolation impacts on both clinical issues and clinical decisions therefore making rural nursing unique (Drury, Francis, & Dulhunty, 2005). There are several issues that compound and impact on rural nursing. These are a lack of access to further nurse education and professional development, personal and professional isolation (Daly et al., 2010; Drury et al., 2005; Francis & Mills, 2010), and a lack of anonymity in small communities which can compound issues such as mandatory reporting, dealing with disclosures and reporting abuse (Daly et al., 2010; Drury et al., 2005; Hegney et al., 2005).

In addition, there are also implications of living and working in the same community (Mills, Francis, & Bonner, 2007b), a concept unique to rural nursing. Not only do rural nurses have to understand the culture of the wider rural community, but also they need to understand and manage their local workplace culture. This includes understanding and communicating to others the peculiarities and work patterns of general practitioners and other allied health practitioners with whom they work (Mills et al., 2007b). Combined with a lack of mentoring and debriefing (Mills et al., 2007b), as well as the difficulties of being managed
from a distant geographical location often several hundred kilometres away (Drury et al., 2005), rural nursing is a complex practice. In addition, workplace inflexibility and limited access to acceptable housing contribute to the difficulties of attracting nurses to the rural workforce (Francis & Mills, 2010).

Rural nurses may work in a variety of community and hospital settings. Within rural areas of NSW, depending on the size of the town, nurses may work in a large rural hospital where doctors are always present, or small rural hospitals where doctors are not present but available in town. Many small rural communities have a Multi-purpose Service (MPS) which provides all aspects of hospital care from emergency to aged care facilities, community nursing, domestic assistance and meals on wheels, respite care, acute care, emergency services, mental health services, and a range of allied health services including physiotherapy and podiatry (Daly et al., 2010).

Remote Area Clinics or Remote Area Health Centres care for the health needs of community members in a non-hospital situation in remote areas. In this environment, rural nurses work closely with Aboriginal Health Workers, and often there is no Medical Officer present at the Clinic. Medical Officers are available via phone consults, and evacuations to hospital are by small plane or road ambulance, potentially leaving a nurse with a critical patient to manage for a considerable length of time. These rural nurses often have a background in emergency care and midwifery but they must also have a strong focus on primary health care and are also required to share on-call rosters with another nurse (Daly et al., 2010).
In summary, rural communities often lack health services and community members have poorer health outcomes than their metropolitan counterparts. Rural nursing encompasses unique features with health service delivery often occurring in isolation from other nurses and support services because of the vast geographical areas nurses work in; this is an everyday part of rural nursing.

1.4  The Context of the Nursing Shortage

The current nursing shortage is impacting globally with many nations experiencing difficulty in retaining a sufficient nursing workforce. The global shortage is not just a problem for nursing, but an issue for all health systems nationally and internationally (International Council of Nurses [ICN], 2004). This section will provide an overview of the nursing shortage and will include a brief synopsis of the international, national and local nursing shortage. The reason why the Australian nursing shortage continues to escalate is unclear, although the reasons are most likely multifaceted and complex. Chapter Two examines the nursing shortage literature in more detail.

International literature on the subject indicates that the nursing shortage is endemic and that, since 2002, the worldwide nursing shortage has been labelled a global crisis (ICN, 2004; Oulton, 2006). Adequate nurse staff numbers are equated to positive health outcomes and failure to deal with a nursing shortage, be it local, regional, national or global, is likely to impact detrimentally on maintaining or improving health care (ICN, 2004).
From a global perspective, the nursing shortage appears widespread in both Westernised and non-Westernised nations and is noted in countries such as the United States of America (USA), the United Kingdom (UK), France, Germany, Ireland, Denmark, Norway, Canada, the Middle East, Japan and Africa (ICN, 2004; Kline 2003; NSWNA, 2008; Oulton, 2006). Globally the rural nursing shortage is endemic with developed countries experiencing a shortage of nurses in both rural and metropolitan areas whereas developing countries are experiencing a critical shortage in rural areas. This problem is exacerbated by the tendency of nurses preferring to work in large metropolitan areas as career opportunities are greater. Rural areas in developing countries tend to be the most underserved areas in terms of availability of nurses (ICN, 2004). Furthermore the ICN estimates a global deficit of 2·4 million doctors, nurses and midwives (ICN, 2004).

In the USA in 2000, the national supply of FTE registered nurses was estimated at 1.89 million, while the demand was estimated at two million, a shortage of 110,000 nurses or 6%. By 2020, the shortage is projected to grow to an estimated 808,400 nurses or 29% (Lavoie-Tremblay, O’Brien-Pallas, Genlinas, Desforges, & Marchionni, 2008). In Canada, the projected shortfall of registered nurses is estimated to be 78,000 nurses by 2011 (Canadian Nurses’ Association, 2002). The UK has experienced a shortage of nurses since the mid-1980s. Some twenty years later this has worsened with nurse registrations declining by 6,000 nurses between 1990 and 1998. Germany and the Netherlands are suffering stress to their health care systems with a shortage of 13,000 nurses (Oulton, 2006) and the New Zealand health system, similar in structure to the Australian system, is also facing chronic nursing shortages (Department of Human Services, Victoria, 2001).
Current projections for Australia indicate that 90,000 nurses will be retiring by 2020. At the present time, all states and territories report nursing shortages (NSWNA, 2008).

Comparisons of the international rural nursing shortage figures to current Australian rural nursing shortages are difficult to compare as countries measure their rurality by different terms. For example the USA measures nurses as working in ‘frontier community’, ‘county’, ‘rural’ and ‘mountainous’ therefore the data prevents a comparison of the Australian rural shortage.

**The implications of the nursing shortage in Australia**

The nursing shortage in Australia has many implications; these include an increase in nurse workloads, increased risk of errors, increased infection rates, increased patient deaths, an increase in nurse turnover (Stone, Clarke, Cimiotti, & Correa-de-Araujo, 2004), increased hospital bed closures as well as an exacerbation in waiting lists for elective surgery (NSWNA, 2007). In addition, there are financial consequences. The cost of replacing a registered nurse employed in the public sector of Australia ranges from $20,000 to $92,115, excluding penalty rates, overtime and leave loading (Hegney et al., 2005). NSW Health reports that it takes approximately 61 days to recruit into a vacant position that is advertised externally with a cost for the recruitment process alone estimated at between $4,000–5,000 per position (NSW Health, 2005a). If the conservative figure of $4,000 is used, then NSW Health spent just under $5 million on the recruitment process for NSW’s September 2010 vacant nursing positions (NSW Health, 2010c).
The nursing shortage also affects support structures for nurses. This includes the mentoring of nurses (Mills et al., 2007a, 2007b) and decreased support and education within the hospital for newly graduated registered nurses (Daly et al., 2010). The shortage also extends to impacting on undergraduate nursing students who attend clinical placements and are supervised by registered nurses who are stretched for time and have little time to take on professional roles with these students (DEST, 2002). The current nursing shortage paints a grim picture for the health and welfare of both nursing and communities.

This section has provided a synopsis and overview of the current nursing shortage. The aim of the study as well as the research objectives will be discussed and this will include an overview of the thesis.

1.5 Aim of the Study

The aim of this study is to understand the reasons why registered nurses resign from NSW rural hospitals. Through having a better understanding of why rural nurses resign, more appropriate retention strategies can be implemented. In this study five research objectives emerged:

1. identify why registered nurses resign from rural NSW hospitals;

2. identify and describe particular issues of rurality in the current light of the nursing shortage;

3. discover the basic social process of nurse resignations;

4. develop a substantive grounded theory that accounts for rural nurse resignations; and

5. provide a knowledge base on which to structure recommendations and appropriate retention strategies for rural nurses.
1.6 Methodology Overview

The research is conducted using qualitative methods and a methodology of grounded theory. Grounded theory is the generation or discovery of theory that emerges from the data (Glaser, 1978, 1992, 1998; Glaser & Strauss, 1967). While grounded theory can be used to study areas of minimal research it also opens up areas that have been heavily studied; this is relevant to the nursing shortage. Grounded theory in this study will allow for nurses’ thoughts, feelings and identified reasons for resignation to be the basis of understanding of retention issues that must be addressed in order to partly resolve this nursing shortage. Grounded theory is the relevant methodology for a study of this type as it is anticipated that the theory of why rural nurses resign needs to emerge during data collection. Grounded theory is needed to address the aim of this study; this is discussed further in Chapter Three.

1.7 Overview of the Thesis

The thesis is structured into nine chapters and reports the study that explains rural nurse resignations. The first chapter has provided an overview of rurality, NSW AHSs, rural communities and rural nursing. It has also described briefly the context of the international and national nursing shortage including the implications of the nursing shortage in Australia and has set the tone of the thesis. The research aim and objectives were outlined as well as an overview of the methodology used in this study.

Chapter Two will examine and critique the relevant literature on the current nursing shortage from an international and Australian perspective. This will
include an analysis of the literature pertaining to nurse retention and nurse education. The literature review will also critique Australian research and NSW inquiries into the nursing shortage.

Chapter Three examines the grounded theory methodology used for this study. This includes an historical overview of grounded theory, a discussion of the differences between traditional Glaserian grounded theory, Strauss grounded theory and contemporary grounded theories such as that advocated by Charmaz (2000, 2005, 2006) and Clarke (2005). A discussion on research paradigms and how they impact on grounded theory will be included. The chapter will defend why the Glaserian grounded theory method was used as well as explain the implications this has on the method.

Chapter Four will describe the method and data analysis of the study. Details of the participants and their recruitment, ethical considerations and data collection through interviews will be discussed as well as a detailed account of the data analysis. The analysis will reveal the development of categories and the emergence of a substantive grounded theory on rural nurse resignations; details of substantive and theoretical coding; theoretical saturation; and finally the emergence of the core category. Data management and issues of rigour and trustworthiness will also be discussed.

The findings from this study have been placed into three chapters. The first two chapters (Chapters Five and Six) will discuss the substantive codes and findings at length. These findings encompass the core category. In grounded theory the core
category conceptualises the main theme emerging, that is, the main concern for the participants (Glaser, 1978). Chapter Seven, the third chapter of findings, will discuss the theoretical codes that conceptually link the substantive codes discussed in Chapters Five and Six to reveal a basic social process and a substantive grounded theory of rural nurse resignations.

Chapter Eight provides a discussion on the findings of the research in light of current literature. The chapter will explore literature relevant to the findings of this study as well as summarise the study.

Chapter Nine is the final chapter and concludes the thesis by discussing the implications of the study. The chapter then discusses the strengths and limitations of the study as well as identifies future research. This chapter will also include recommendations and/or implications for policy, management, practice, education and research.

1.8 Chapter Summary
This chapter has set the context for this study of NSW rural nurse resignations and has provided an overview of rurality, nursing and the implications of the nursing shortage. Following is a discussion of the current literature pertaining to the nursing shortage. This will include a critique of the seminal international and national literature on nurse retention and will include emerging issues of the work environment, violence in the workplace, job satisfaction and dissatisfaction, nursing management and leadership, magnet hospitals, generational issues, exit interviews and nurse education.
CHAPTER TWO

Literature Review

2.1 Introduction

This chapter is a review of the literature pertaining to nurse retention and is comprised of four main sections: nurse retention, nurse education, seminal Australian research and inquiries into the NSW nursing shortage. International and national research relating to nurse retention and education will be critiqued. Australian research and inquiries into the NSW nursing shortage will be critically examined. A summary of the literature review and identified gaps in knowledge will then be discussed.

This literature review was undertaken continuously over a six year period (i.e. candidacy period) using several databases and government websites. These include Ebsco Host, CINAHL Plus, SmartSearch, Medline and Google Scholar. The keywords used in searching the literature in these databases included nursing retention, rural, job satisfaction, job dissatisfaction, nurse education, nurse leadership, nurse management, nurse graduates, nursing generational factors, magnet hospitals, recruitment, nurse workforce, nurse shortage, staffing, NSW retention. Other websites included NSW Health; the Department of Education, Employment and Workplace Relations (DEEWR); and DEEWR’s previous website DEST.
Research reports and non-research based literature were retrieved and, owing to the large quantity of available literature on nurse retention issues, specific inclusion and exclusion criteria were developed to focus the review. Research literature was included if published between 1995 and 2010 and included those authors who frequently published in the field of nurse retention. For non-research based literature, inclusion criteria included a time frame from 2000 to 2010. This was to ensure that relevant literature related to investigations into the NSW nursing shortage over the past decade was reviewed. This literature includes both Australian and NSW specific data owing to the interpretation that some investigations only examined the nursing shortage from a national perspective while some were NSW specific. Non-research based literature included Australian government reports, reports from peak nursing bodies, Senate inquiry papers and reports as well as Senate Hansard reports as these contained relevant information on the NSW nursing shortage. The following table, Table 2, details the inclusion and exclusion criteria.
Table 2: Inclusion Criteria for Research and Non-research Based Literature

<table>
<thead>
<tr>
<th>Research based literature</th>
<th>Inclusion exclusion criteria</th>
<th>Rationale</th>
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<tr>
<td>International and national research reports</td>
<td>Time frame</td>
<td>1995–2010</td>
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<td></td>
<td>Authors</td>
<td>Frequently published in the field of nurse retention</td>
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<table>
<thead>
<tr>
<th>Non-research based literature</th>
<th>Inclusion exclusion criteria</th>
<th>Rationale</th>
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</thead>
<tbody>
<tr>
<td>Restricted to Australia</td>
<td>Time frame</td>
<td>2000–2010</td>
</tr>
<tr>
<td></td>
<td>Authors</td>
<td>1. NSW Health 2. NSW Parliament 3. DEST 4. DEEWR 5. NSWNA 6. Senate papers 7. Independent inquiries</td>
</tr>
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* seminal authors refers to those authors who contributed extensively to the area of the nursing shortage, were frequent publishers on this topic, appeared frequently in the databases using the key words detailed in Section 2.1 and were cited by other authors.

### 2.2 Nurse Retention

The first section of the literature review will provide a critical analysis of both international and national research related to nurse retention. This will include research on the work environment, violence in the workplace, job satisfaction and dissatisfaction, nursing management and leadership, magnet hospitals, generational factors and nurse exit interviews.
Work environment of the nursing workforce

The environment in which nurses work has a significant role in retention (Aiken, Clarke, Sloan, & Sochalski, 2001; Duffield, Roche, et al., 2007; Hegney et al., 2002a; Hegney, McCarthy, Rogers-Clark, & Gorman 2002b; Upenieks, 2003, 2005). Research indicates that the ideal work environment that enhances nurse retention is one that minimises stress, ensures team cohesion, fosters nurses’ ownership of work and promotes nurse autonomy, all under supportive nurse managers (Christmas, 2008; Duffield, Roche, et al., 2007; Hayhurst, Saylor, & Stuenkel, 2005). Understanding this complex and varied work environment in which nursing occurs is vital in understanding the issue of nurse retention (Duffield, Roche, et al., 2007). International research over the past decade and a half suggests that, apart from staffing levels, the quality of nurses’ working environments, nurse leadership, sufficient resources and nursing autonomy predict nursing job satisfaction, retention and intention to leave (Aiken et al., 2001; Duffield, Roche, et al., 2007; Gullo & Gerstle, 2004; Havens & Aiken, 1999; Hegney et al., 2002a, 2002b; Upenieks, 2003, 2005).

Australian research indicates that nurses’ work environment and job satisfaction are intrinsically linked. This is because the provision of basic nursing interventions that provide patients with comfort measures (e.g. talking with patients, back rubs and skin care, oral hygiene and patient/family teaching) gives nurses job satisfaction; these nursing interventions are often dependent upon the work environment (Duffield, Roche, et al., 2007; Hegney et al., 2002a; Hegney, Rogers-Clark, Gorman, Baker, & McCarthy, 2001). While nurses aim to carry out comfort measures for patients, recent research (Duffield, Roche, et al., 2007)
indicates that 37% of nurses working at the ward level feel they do not have enough time to provide adequate patient care in a given shift; they require at least an extra thirty minutes per shift in order to carry out comfort measures that increase nurse job satisfaction. In addition, 63% of nurses did not take required breaks on their shift (morning tea or lunch) because of time constraints (Duffield, Roche, et al., 2007).

**Violence in the workplace**

Violence in the work environment also impacts on nurse retention. Violence may be verbal, physical or emotional. Often referred to as bullying or horizontal violence, bullying in nursing is frequently described in terms of oppressed group behaviour and causes trauma resulting in considerable harm to nurses and organisations. Violence in nursing is both an international and national issue related to nurse retention (Edwards & O’Connell, 2007; Farrell, 2001; Farrell, Bobrowoski, & Bobrowski, 2006; Hegney, Eley, Plank, Buikstra, & Parker, 2006; Hutchinson, Vickers, Jackson, & Wilkes, 2006; Jones & Lynham, 2000; Roche, Diers, Duffield, & Catling-Paull, 2010; Wickett, McCutcheon, & Long, 2003).

Australian research indicates that 11–20% of nurse resignations are due to workplace violence (Farrell et al., 2006; Hegney et al., 2005). Nearly 85% of nurses have experienced some form of aggression from patients (Moait, 2001) and nurses frequently blame themselves for the episodes (O’Connell, Young, Brooks, Hutchings, & Lofthouse, 2000).
Currently, NSW Health has a ‘zero tolerance’ approach to bullying with policies and guidelines that reflect this. However, despite these policies and guidelines bullying is still apparent at every level with a culture of bullying endemic in NSW Health (Garling, 2008). In Garling’s 2008 investigation into NSW Health hospitals he found a plethora of workplace behaviours that could be characterised as bullying. These included verbal abuse, damage to personal property, teasing, threats of dismissal, blocking reasonable access to further education and the malicious and deliberate attempts by co-workers to force a person out of the workforce. These acts of bullying were compounded by a lack of respect amongst staff which Garling (2008) believes may be the missing element contributing to this culture.

The level of education a nurse has also impacts on their experience of violence in the workplace (Duffield, Roche, et al., 2007). The proportion of nurses on the ward with a bachelor’s degree or higher decreased the perception of physical violence and the threat of violence. This result could indicate that the higher the level of nurse education, the greater the communication skills the nurse has for interacting with patients and families. This may result in nurses feeling they have greater control which subsequently lowers the nurses’ perception of violence (Duffield, Roche, et al., 2007).

Australian research indicates that up to 50% of aged care nurses experience some form of violence in the workplace, as do 47% of public sector nurses and 29% of private sector nurses (Hegney, 2003). This violence occurs both within the workplace and external to the workplace. Research performed in 2003 by Hegney
revealed that violence in the workplace was a problem, and three years later the incidence of violence had increased (Hegney et al., 2006). While work environment violence is linked to decreased nurse retention (Hegney, 2003; Hegney et al., 2006; Jackson, Clare, & Mannix, 2002; Moait, 2001; Wickett et al., 2003), research indicates that workplace security, policies and procedures on violence management are inadequate (Hegney, 2003; Jones & Cheek, 2003). Policies and procedures for workplace violence in some rural and remotes areas are nonexistent (Hegney, 2003). In spite of extensive research on bullying in the health care sector and how it is perceived, there has been no significant reduction in its occurrence (Duffield, Roche et al., 2007).

The next section of the literature relating to nurse retention is job satisfaction and job dissatisfaction. These will be discussed separately.

**Job satisfaction**

Job satisfaction is important for how people feel about their work. Job satisfaction could be described as an individual’s evaluation of how well the job meets their personal expectations and needs or as their feelings and emotions towards work experiences (Cowin, 2002). Increased job satisfaction is linked to increased nurse retention (Cowin, 2002; Duffield, Roche, et al., 2007; Hegney et al., 2001; Hegney et al., 2002a) and research suggests that job satisfaction is a complex, subjective and multi-factorial phenomenon (Hayes, Bonner, & Pryor, 2010). International research has been instigated to measure nurse job satisfaction and several tools have been created in order to quantify job satisfaction and to assist in gaining a clearer understanding of the issues associated with it (Yatkin, Azoury, &
Doumit, 2003). Yatkin et al. (2003) surveyed 421 registered nurses and found that nurses with greater levels of job satisfaction include nurses with more than ten years experience as well as those working in nurse management. Australian research also supports this finding (Duffield, Roche, et al., 2007).

International and national research indicate that the major contributors that enhance job satisfaction for nurses include positive anticipation of going to work; viewing work environments as empowering, autonomous and supportive (Baernholdt & Mark, 2009; Ning, Zhong, Libo, & Qiujie, 2009; Tourangeau & Cranley, 2006; Tourangeau, Cummings, Cranley, Ferron, & Harvey, 2009); a safe environment (Tallman & Bruning, 2005); utilisation of nursing knowledge; positive attitudes from management (Tourangeau et al., 2009; Utriainen & Kyngas, 2009); a sense of belonging with peer groups (Tourangeau et al., 2009); and the provision of high quality care that is satisfying to both nurse and patient (Duffield, Roche, et al., 2007; Hegney et al., 2001; Hegney et al., 2002a). Nurse job satisfaction is also linked to autonomy and control over practice with good nursing leadership at the ward level being a predictor of satisfaction with nursing, job satisfaction and lower rates of intention to leave (Duffield, Roche, et al., 2007).

Hospital-educated nurses are significantly more satisfied in their work than university-educated nurses (Yatkin et al., 2003) while older nurses seem to be more satisfied with their nursing work (Best & Thurston, 2004; Hayes et al., 2010; Yatkin et al., 2003) which may help to explain why over one-third of the
Australian nursing workforce are aged over 50 years (AIHW, 2008). This fits with theories on generational factors which will be discussed below.

Research also indicates that factors related to nurse job satisfaction include personal factors such as work being located close to home, time off if needed, facilitation of personal goals, a sense of belonging to the community in which nurses work; and professionalism issues such as opportunities for independent thinking, educational opportunities, opportunity for input into the organisation the nurse works for, and opportunity for professional growth (Hegney et al., 2001; Hegney et al., 2005; McNeese-Smith, 1999).

Hayes et al. (2010) expand this view of personal factors which have an influence on job satisfaction and identify that factors relating to job satisfaction can be grouped into three categories. These are identified as intra-personal, inter-personal or extra-personal factors. Intra-personal factors describe those characteristics of the nurse that they bring as a person to the job. Inter-personal factors are those factors which relate to interactions between the nurse and others. Extra-personal factors are beyond nurses’ direct interactions with others and are influenced by institutional or governmental policies (Hayes et al., 2010). While a single factor at a given point in time may lead a nurse to consider the job satisfying or not, it seems more likely that a combination of factors will be involved. While factors such as age, gender, culture, educational preparation and previous work experience cannot be changed, the three clusters (intra-, inter- and extra-personal) may assist nurse managers to identify specific types of factors which may lead to
job dissatisfaction, and then implement strategies to improve nurse job satisfaction (Hayes et al., 2010).

The effectiveness of strategies to address the issues of retention in the nursing workforce will partly depend upon understanding how job satisfaction relates to retention (Cowin, 2002). Research by Hegney and colleagues (Hegney et al., 2001; Hegney et al., 2002a, 2002b) indicates that the retention of the Australian nursing workforce is allied to job satisfaction and that job satisfaction for rural nurses is also linked to a sense of relationship with the community within which nurses work. Cowin and Jacobsson (2003a) concur; job satisfaction is linked to intangible factors such as providing holistic care, pride in work, closer relationships with patients and workmates rather than factors such as financial incentives. Yet, these very issues are not being addressed as answers to the current nursing shortage as evidenced by NSW Health’s (2002) Recruitment and Retention of Nurses – Progress Report (discussed in the next section). In this publication, NSW Health lists only tangible initiatives such as wage increases, scholarships, overseas recruitment, funding for postgraduate education and child care (NSW Health, 2002). Research in job satisfaction has shown repeatedly that if working conditions are reasonable and relationships between staff are harmonious and positive, the issues of wages become less significant (Hegney et al., 2002a).

Job satisfaction is the most important yet elusive characteristic in understanding motivation and performance. Nurses who have left the profession as a result of low job satisfaction may not be enticed back to the profession no matter how
attractive the governments’ recruitment strategies may be (Cowin, 2002). Cowin’s (2002) research is insightful when examining NSW Health’s current recruitment and retention scheme, *Nurse Re-Connect*, which is designed to entice registered nurses back into the workforce. The scheme began in 2002 and by 2007 had attracted 1,647 nurses back into NSW public hospitals but one-third of these recruited nurses have since resigned. The *Nurse Re-Connect Scheme* has cost $6.5 million, meaning each returning nurse cost more than $4,000 in refresher training and administration (Carty, 2008).

**Job dissatisfaction**

Job dissatisfaction is a major indicator for nurse resignation (Duffield, Roche, et al., 2007; Gullatte & Jirasakhiren, 2005). Comparative international research has shown that countries similar to Australia such as the US, Canada and England have 30–40% of their nurses dissatisfied with their job (DEST, 2001; Montgomery Dossey & Keegan, 2009).

For nurses, job dissatisfaction is related to many factors. Among these are abuse from patients; poor patient outcomes; lack of patient response to care; not being able to provide adequate patient care; inadequate staffing levels; and lack of time. In addition, relationships with co-workers impact on nurse job dissatisfaction. These include negative attitudes by co-workers, co-workers not following policy, rude doctors who blame nurses for errors and a perceived lack of ethics. Organisational factors such as threats to personal safety, poor leadership, not being heard by management, low morale and having no say in organisational
matters decrease job satisfaction for nurses (Best & Thurston, 2004; Hegney et al., 2002a, 2002b; Hegney et al., 2005; Lei, Hee, & Dong, 2010).

Job dissatisfaction also occurs when resources required for patient care are limited or reduced. This results in nurses becoming frustrated when they cannot provide the care they were educated to deliver (Morgan & Lynn, 2009). Emotional exhaustion and depersonalisation of nursing are linked to psychosomatic complaints and decreased professional commitment; these then are associated with the intention to leave nursing (Jourdain & Chênevert, 2010). Nurses are less satisfied with their work if they are in an environment that has increasing stress levels and prolonged tension as well as uncertainty and inconsistency within the role (Tran, Johnson, Fernandez, & Jones, 2010).

In a 2005 study, Australian nurse work dissatisfaction was compared to a previous study of twenty years ago. While there is still a high level of discontent amongst today’s nurses, the focus of their complaints and their responses to them have changed (Forsyth & McKenzie, 2006). Twenty years ago, medical dominance was the major cause of dissatisfaction for nurses and this discontent led to a sense of solidarity amongst practising nurses, defusing their frustrations rather than channelling them into demands for workplace reform. The 2005 study shows that, rather than contributing to a sense of solidarity, contemporary nurse discontent reflects intense personal frustration and underpins individual nurses’ decisions to leave, or plans to leave, the workforce (Forsyth & McKenzie, 2006).
The literature identifies that nurse job dissatisfaction is an imperative factor in nurse retention. Job dissatisfaction is linked to high rates of nurse resignations and identifying the factors that contribute to increased nurse job satisfaction is a key to retaining the nursing workforce.

**Nursing management and leadership**

Nurse managers seek to produce order by setting operational goals, establishing action plans, allocating resources, organising staffing, solving problems and monitoring patient care and results. Nurse leadership on the other hand seeks to produce necessary changes by developing a vision of the future and strategies to reach that vision. This includes communicating the vision and motivating and inspiring staff to attain the vision. The manager’s ability to lead affects the staff’s ability to achieve stated visions and goals. Research indicates that leading and managing are distinct processes but the research does not assume that leaders and managers are different types of people (Sellgren, Ekvall, & Tomson, 2007).

The importance of nursing leadership at the ward level in relation to nurse job satisfaction and intention to leave cannot be overstated (Duffield, Roche, et al., 2007; Sellgren et al., 2007). Effective nurse leadership characteristics include being able to articulate a shared vision of the future of the organisation and encourage creative problem-solving that demonstrates support and encouragement of staff (Kleinman, 2004b). A nurturing leadership style, physical presence and the ability to resolve nurses’ issues were seen as values that nurses looked for in nursing leadership (Hayhurst et al., 2005).
From both an international and national perspective, one of the greatest factors that nurses cite for being dissatisfied in nursing or for resigning from a nursing position is that of nurse management style. When managers demonstrate strong leadership, job satisfaction is enhanced, while poor leadership is linked to job dissatisfaction (Aiken et al., 2001; Duffield, Roche, et al., 2007; Hegney et al., 2002a, 2002b; Upenieks, 2005). Ribelin (2003) believes that nurses do not leave hospitals; they leave managers. A part of the role of nurse managers is to provide leadership to clinical nurses. The issues within management style that are linked to job dissatisfaction are noted as poor leadership, nurses not being heard by management and having no say in organisational matters (Best & Thurston, 2004; Cline, Reilly, & Moore, 2004; Hegney et al., 2005; Hegney & McCarthy, 2000; Shader, Broome, Broome, West, & Nash, 2001), lack of support from management (Cline et al., 2004; Jones & Cheek, 2003), inadequate management techniques, failure to follow through with responsibilities (Cline et al., 2004), and lack of respect from management (Khowaja, Merchant, & Hirania, 2005). Respect from nurse managers has been associated with a decrease in short-term sick leave while respect from co-workers has been associated with less long-term sick leave (Schreuder, Roelen, Koopmans, Moen, & Groothoff, 2010).

Shared governance within hospital management is an organisational structure through which nurses control their practice and are allowed and expected to participate in decision-making processes. Shared governance promotes control over nursing practice previously controlled by management and allows nurses to be more autonomous in their practice (Kramer, Schmalenberg, Maguire, Brewerm, Burke & Chmielewski, 2009). The concept of shared governance in
nursing first emerged in the 1980s and was associated with increased nurse retention in the American Magnet hospitals (Malleo & Fusilero, 2009).

While it has been demonstrated that shared governance may enhance nurse job satisfaction and retention (Malleo & Fusilero, 2008; Newcombe, Smith & Webb, 2008; Kramer, Schmalenberg, Maguire, Brewerm, Burke & Chmielewski, 2009) research indicates that many nurses have become frustrated about the true involvement in the decision making process with hospitals varying on what they classify as shared governance (Newcomb, Smith, & Webb, 2008).

International literature reveals that the opinions of nurses’ immediate managers carried more impact on the employee than overall company policies or procedures. Nurse managers are critical components of building a strong workforce and assist greatly in retaining nursing staff (Duffield, Roche, et al., 2007; Khowaja et al., 2005; Ribelin, 2003). USA research by Kleinman (2004a) indicates that nurse managers perceived that they demonstrated a high frequency of predominantly transformational leadership behaviours, but staff nurse perceptions did not concur. Australian research also supports a similar pattern among nurse executives, nurse managers and staff nurses with disparity between what nurse managers perceived as important factors in nurse retention and the perceptions of those who have left (O’Brien-Pallas, Duffield, & Hayes, 2006).

Australian rural research has also been conducted on rural nurses and found that 43% of Queensland rural registered nurses resign as a result of management practices within the health facility. Management practices such as ineffective
communication between management and staff, poor conflict resolution skills, failure to deal with low workplace morale and bullying were the main contributors to nurses resigning (Hegney et al., 2001).

In contrast to Hegney et al.’s (2002b) findings on why registered nurses resign, Johnstone’s (2003) research on why nurse managers resign shows different results. For example, Hegney et al.’s (2002b) research on the retention of Queensland rural nurses highlights the importance of differentiating between nurses’ specific roles and practice areas in order to fully understand issues for nurses related to retention. Johnstone’s (2003) research of 803 NSW nurse managers found that, unlike Hegney et al.’s (2002b) study of rural nurses (where nurses cited poor management practices, emotional demands of work, family responsibilities, physical demands of work and lack of support as reasons for leaving), nurse managers cited the top five reasons for resigning as changing to another management job in the same organisation (more prevalent in the public sector); left of their own free will for personal or professional reasons (more prevalent in the private sector); left of their own free will as a result of dissatisfying aspects of the job (more prevalent in private sector); organisational politics – pressure on them to leave (more prevalent in the private sector); and ‘other reasons’. These ‘other reasons’ were analysed by qualitative methods and revealed that the main reason for leaving in this category was secondment to an acting or relieving position, followed by retirement, partner relocation, personal/family reasons and faculty closure (Johnstone, 2003).
It is interesting to note that, in Johnstone’s (2003) nurse manager turnover research, none of the nurse managers cited higher management issues as a reason for resignation. This may be because the nurse managers in this study moved to another management job in the same organisation. In comparison to Hegney et al.’s (2002b) research, it is evident that clinical registered nurses resign for different reasons than nurse managers and the reasons why they differ have not yet been identified, but may provide some further insight into the reasons for the nursing shortage.

*Magnet hospitals*

In the 1980s, it was recognised in the USA that certain hospitals were more likely to attract and retain nurses than other hospitals and the term ‘magnet hospital’ was created (Chen & Johantgen, 2010; Havens & Aiken, 1999; Kramer & Schmalenberg, 2005; Upenieks, 2003, 2005). Not only did these hospitals attract and retain nurses but also provided exceptional patient care (Chen & Johantgen, 2010; Havens & Aiken, 1999; King, 2009; Ridley, Wilson, Harwood, & Laschinger, 2009; Upenieks, 2005). Magnet hospitals are certified by the American Nurses’ Credentialing Center (Upenieks, 2003) and share common attributes. The attributes that are identified in these hospitals are autonomy of nursing practice, accessible nurse leadership (seen as advocates for staff), and strong interdisciplinary relationships which linked working relationships and communication. These attributes have also been reported elsewhere as highly conducive to nurse retention (Chen & Johantgen, 2010; Department of Human Services, Victoria, 2001; Havens & Aiken, 1999; Upenieks, 2003, 2005).
Germany and Belgium have also recently implemented magnet hospitals with similar success in increased retention as the USA (Chen & Johantgen, 2010).

Havens and Aiken (1999) noted that a number of strategies were common in all sixteen original magnet hospitals. First, a move towards all registered nurse staffing (as opposed to traditional models of a staff mix of registered nurses and enrolled nurses or assistant nurses). Second, increasing the ratio of nurses to patients – this was a key feature. These two factors have been found to be instrumental in nurse retention as nurses have the time and resources to provide a standard of patient care that creates job satisfaction for the nurse (Chen & Johantgen, 2010; Duffield, Roche, et al., 2007; Haven & Aiken, 1999; Hegney et al., 2002b).

Studies of nursing leadership in American magnet hospitals reveal that nurse leaders display attributes such as being supportive, honest, visible, accessible, good listeners, good communicators, positive, collaborative and influential (King, 2009; Kramer & Schmalenberg, 2005). Upenieks (2003) categorises the attributes of effective leadership as the ability to empower staff and to have effective people-orientated skills. This may indicate that the magnet hospitals attract nurse leaders with strong people attributes who are a visible presence and provide a supportive culture. The leadership attributes are relevant to the Australian nursing shortage. In recent studies, Australian nurses have cited ineffective communication between nurse leaders and staff, poor conflict resolution skills of managers, failure by managers to deal with low workplace morale, bullying and quality care being compromised by unrealistic workloads as reasons for job
dissatisfaction (Australian Centre for Industrial Relations Research and Training [ACIRRT], 2002; Duffield, Roche, et al., 2007; Hegney et al., 2002b).

In light of the success of American magnet hospitals to increase nurse retention, some hospitals in Australia implemented strategies to acquire magnet hospital status. The Princess Alexandria Hospital in Brisbane in 2005 was the first to receive magnet hospital status from the American Nurses Credentialing Center Magnet Recognition Program (Queensland Health, 2009). Cowin and Jacobsson (2003b), in responding to Australian health departments implementing strategies for Australian hospitals to take up magnet hospital status, stated that Australian organisations have failed to take into account the differences between the American and Australian health care systems. Magnet hospitals in America are part of the private health system whereas Australia has a predominantly public health system. Cowin and Jacobsson (2003b) believe that, until a major paradigmatic shift occurs in public health care management in Australia, a magnet hospital system is unlikely to heal falling nurse retention rates.

**Generational factors**

International and national research indicate that the ageing workforce is a key contributor to the nursing shortage as much of the existing workforce will soon retire (Cohen, 2006; Cowin & Jacobsson, 2003a; Doiron, Hall, & Jones, 2008; Fitzgerald, 2007; Garling, 2008; Graham & Duffield, 2010; Hegney et al., 2005; Janiszewski Goodin, 2003). Zemke, Raines, and Filipczak (2000) describe generational cohorts as groups of people who share birth years, history and a collective personality as a result of their defining experiences. Each generation
has differing attributes that impact on their attitudes towards work (Cowin 2002; Cowin & Jacobsson, 2003a; Sherman, 2006; Watson, 2002; Zemke et al., 2000).

Baby boomers, those born between 1946 and 1963 and aged between 65 and 48 years, are the largest group of nurses currently in the hospital workforce and the easiest to retain. This is attributed to the idea that baby boomers are steadfast and loyal, and place increased value on having one employer (Cowin & Jacobsson, 2003a; Watson, 2002). In contrast, Generation X, those born from 1963 to 1980 and currently aged 31 to 49 years, is the most difficult group to retain in nursing. This is attributed to an excessive need amongst Generation Xers for independence coupled with a willingness to change jobs frequently and a lack of respect for seniority and the corporate culture (Cowin & Jacobsson, 2003a; Sherman, 2006; Watson, 2002).

Generation Y (also known as the Millennials), the new generation of nurses, is now emerging as they were born between 1980 and 2000. Generation Yers were raised at a time when violence, terrorism and drugs became realities of life. Raised by parents who nurtured and structured their lives, they are drawn to their families for safety and security. They are a global generation and accept multiculturalism as a way of life. Technology and instant communication made possible by cellular phones have always been part of their lives (Sherman, 2006).

There are suggestions that different generations of nurses do not work well together (Cowin & Jacobsson, 2003a; Hicks et al., 2010; Watson, 2002). This may not be due to their interactions, but rather that younger generations of nurses will
Chapter 2: Literature Review

not tolerate a patriarchal and outdated hierarchical dominant health system (Cowin & Jacobsson, 2003a). International research on generational factors replicates Australian data that show that these factors are an issue in the nursing shortage (Watson, 2002). The generational factor theory is one of many theories emerging in the Australian nursing shortage that attempts to explain why it is difficult to retain nurses and why the current workforce is middle aged (NSW Health Ministerial Standing Committee on the Nursing Workforce, 2001). Differences in generational work attitudes present challenges for the nursing workforce. How work is viewed and experienced, what is expected from managers, and the commitment of the employee have changed over the last decade (Crowther & Kemp, 2009; Sherman, 2006). The latter generations of X and Y are more flexible, attach little value to remaining with one employer for a period of time, and may view doing so as a negative (Sherman, 2006). Baby boomers are more content with limited opportunities at work than are Xers or Yers (Crowther & Kemp, 2009). Taking this into account, job descriptions and management styles within nursing may need to be flexible to better reflect the changing generational workforce. Issues such as job descriptions and management styles in nursing also need to reflect generational changes with Crowther and Kemp’s (2009) research indicating that the threat of using job descriptions to pressure nurses into compliance is not effective with Generations X and Y.

Rather than generational factors being an issue in the nursing shortage, it could be argued that a health system that is patriarchal and has not updated its way of thinking or invited its younger generation of nurses to provide input into the way in which hospitals are run may be a more relevant factor in nurse retention (Cowin
& Jacobsson, 2003a). As younger nurses leave the hospital system as a result of a patriarchal and outdated hierarchal system (Cowin & Jacobsson 2003a; Perry 2002; Watson, 2002), merely understanding the differences between generations fails to clearly explain nursing retention issues. For instance, generational factors do not explain why newly graduated registered nurses who are also baby boomers leave the hospital system, and why Generation X nurses stay; rather, the issue appears to be why nurses, who choose to stay in the hospital system and become entrenched in its hierarchical way, are either failing to invite or create change in an antiquated hospital system.

**Exit interviews**

An exit interview is an interview with an employee who has decided to resign from their place of employment. This interview allows employees to provide an insight into their experience of working in that organisation and identifies the strengths and weaknesses of the organisation from the staff’s perspective (Brookes, 2007). Information from exit interviews can allow organisations to assess current retention, training and management processes and highlight organisation deficits (Department of Health, Western Australia, 2008; Flint & Webster, 2007), as well as identify important indicators of organisational culture, staff skills and development, and conditions and resources (NSW Health, 2005c).

While 90% of American hospitals conduct nursing exit interviews (HSM Group, Ltd, 2002), American nurses feel that exit interviews fail to address the real issue of why nurses leave and some nurses have reported that they did not want to tell the true reason for resigning in case they burnt their bridges (Cline et al., 2004).
Vernaglia, Bosek, and Flarey (2002) also cite the ‘burning your bridges’ theory and claim that nurses may use the reason of better pay as a reason for resigning as it is non-threatening.

The real reasons employees resign have been shown to be inconsistent with the information given at exit interviews (Brookes, 2007; Franckeiss, 2010). Resigning employees may not give honest responses for many reasons. The employee may fear retribution for either themselves or other employees; they may not choose to discuss difficult or painful events that led to the resignation as the outcome has already resulted in them resigning; or they may fear that issues raised could jeopardise job security for other workers (Brookes, 2007). Staff conducting the exit interview may also be personally involved in the factors surrounding the employee’s decision to leave. As a result, there may be defensiveness, and a selective perception is inevitable (Brookes, 2007; Fottler, Crawford, Quintana, & White, 1995). Fottler et al. (1995) caution against the use of exit interviews of nurses as they are likely to identify non-job related factors as reasons for leaving because of their reluctance to criticise the organisation for fear of alienating the interviewer and jeopardising future job references.

Giacalone, Knouse, and Montagliani (1997) identified that resigning employees will give honest responses to exit interviews if they have been treated fairly and honestly and share a belief that the good of the company is intertwined with the good of the individual. Employees will be dishonest at exit interviews if they believe there will be serious repercussions for themselves or other employees or if they will be personally identified with the complaint.
Australian research into the exit interview process for nurses, in particular as a retention strategy, is minimal. In 1990, Mathews and Campbell from St Vincent’s Hospital in Sydney researched the reason why the Intensive Care Unit had a high turnover of registered nurses. While the research identified many factors as to why nurses may resign – night duty, job dissatisfaction, career structure – of significance was the recommendation from the research that to truly examine and gain reliable information on why nurses resign ‘it would be beneficial to have someone who is seen to be outside the main stream of nursing management to conduct exit interviews in order to obtain honest answers from nurses as to why they resign’ (Mathews & Campbell, 1990, p. 24). Again, the same response was found thirteen years later in research at a Melbourne public hospital that employed 900 registered nurses. Despite government and internal initiatives to retain nursing staff, 200 nurses resigned from the hospital in a twelve-month period. The hospital still had not identified why these nurses resigned so they chose to employ an exit policy. Feedback from the nurses surveyed strongly recommended that the exit process be administered by staff who were not the staff members’ managers and also recommended that an online survey may elicit more honest responses because of the ability to structure the online site to protect anonymity (Hawkins, O’Connor, & Potter, 2003).

\[2.3\] Nurse Education

Prior to the 1990s, Australian registered nurses were educated in a hospital-based apprenticeship system. Depending on state requirements, nurse education was transferred to the tertiary education system throughout the 1980s and 1990s with Queensland being the last state to transfer. Since that time and across the entire
country, the minimum requirement for registration as a nurse has become a Bachelor of Nursing degree (Rella, Winwood, & Lushington, 2009). Given the current nursing shortage in Australia there have been claims that this transfer of education to universities is one of the leading causative factors of the nursing shortage. However, there is research to indicate that this is not the case (Cowin & Jacobsson, 2003a; Hegney et al., 2002a; Johnson & Preston, 2001). Cowin and Jacobsson (2003a) label the notion of blaming nurse education for the current nursing shortage as the ‘educational scapegoat’ (p. 34). Cowin and Jacobsson (2003a) believe that universities teach nurses patient care based on a philosophy that does not exist in the hospital system and state that ‘it is easier to direct attention towards nursing preparation than to investigate the organisation and management practices of the health care workplace that has led to this shortage’ (Cowin & Jacobsson, 2003a, p. 34). Feedback from graduates entering the nursing workforce indicates that they encounter an entrenched military-type hierarchy, an insistence on routine and regressive managerial practices which are disempowering and dehumanising (Cowin & Jacobsson, 2003a; Hegney et al., 2001; Moait, 2000).

On the basis of historical data, attrition rates from nursing courses have declined since the implementation of university-based nursing education. Current attrition rates in undergraduate nursing courses are reported as being approximately 25–27% (Gaynor, Gallasch, Yorkston, Stewart, & Turner, 2006) which compares favourably with historical hospital training attrition rates for the period 1962–1968 of over 50% (Gilmore, 2001). What has changed since the sixties is that nursing has lost its competitive recruitment advantage and is unable to attract the
same high number of women to the profession, considering that women make up 92% of the nursing workforce (AIHW, 2008). Women today virtually have unlimited access to many career options and this is also true in the health arena (Hegney et al., 2001; Hegney et al., 2005).

In order to supply new nursing graduates to meet the demand in the nursing workforce, between 10,712 and 13,483 new graduate nurses were required to enter the workforce in 2010 (Australian Health Workforce Advisory Committee [AHWAC], 2004). In 2007, a total of 7,924 students completed a pre-registration nursing course at Australian universities (DEST, 2007). This correlates with the AHWAC predictions that there will be a shortfall of 4,000 graduates per year to meet current demand. While there are attempts to increase graduate numbers by increasing university places, there will still be a significant shortfall in the nursing supply (AHWAC, 2004). Even if demand is met, an over-simplistic analysis of the nursing shortage could lead to the incorrect assumption that if enough nurses are ‘produced’, then the shortage of nurses will be over. Increasing nurse education enrolments cannot stop the insidious erosion of the nursing workforce which also includes the retirement of the baby boomers. Caution is given that the issue of retention must be addressed instead of relying on a finite pool of nurses through increased enrolments (Cowin & Jacobsson, 2003a).

In rural Australia, the situation of providing educated nurses is problematic. For instance, in NSW an inter-sectoral partnership was established between rural Technical and Further Education (TAFE) facilities, rural AHSs and the university sector to bring nurse education closer to these rural communities (Gibb, Anderson,
& Forsyth, 2004). This partnership resulted in a program which allowed local community members to work in a rural MPS and train as an Assistant in Nursing (AIN), then move to the surgical area of the MPS and train locally to become an Enrolled Nurse (EN), and then enrol in a nursing degree at a rural university, all the time remaining working in the local rural community. This educational career-orientated model is recognised as important in attracting rural and remote people to access nurse education without the expense and stress related to leaving their local community (Gibb, Forsyth, & Anderson, 2005). An analysis of this model revealed that barriers to learning included a nurse’s lack of confidence in themselves and inconsistent and variable levels of support within the hospital. Organisational support was found to be crucial for the support of this nurse education program with mentoring identified as one of the key issues to retention (Gibb et al., 2004).

**Expectations of new graduate nurses entering the workforce**

Australian universities prepare graduates to practise in a variety of settings as a beginner-level registered nurse. The literature suggests that there is a marked difference between the expectations of new graduates and the nursing workforce (Heslop, McIntyre, & Bapp, 2001). While Australian researchers such as Stevens and Dulhunty (1994) and Happell (1999) have identified the areas of nursing that undergraduates would prefer to work in, Heslop et al.’s (2001) research expands on this and explores what nurses also expect of nursing as a career. Heslop et al.’s (2001) survey of 105 undergraduate nursing students reported that the majority of students expected the graduate year to be alienating, democratic, frustrating and disordered but also stable and productive. None of the respondents expected the
organisational climate to be a major concern; instead, they anticipated that the organisation would foster and nurture them. The respondents also felt that relationships with nursing colleagues would be supportive and welcoming (Heslop et al., 2001). These expectations of nursing as a career from undergraduate students become significant when compared with Hegney et al.’s (2001) study of why nurses resign. As previously mentioned, Hegney et al. cite management practices within the health facility as the reason why 43% of Queensland registered nurses resigned; the very issues undergraduates do not perceive will be a problem. Thus, the profession is now witnessing a marked difference in what nurses expect will or will not be an issue in their nursing career, and what really eventuates.

New graduate nurses have reported that a lack of graduate programs and support in hospitals results in low retention rates of new graduates (Scott, Engelke, & Swanson, 2008). Mentors and preceptors found this disappointing when they had invested so much time in the new graduates who soon left the workforce (Hegney et al., 2005). In addition, 50% of new graduates had either changed their job in the first year or wanted to change. Twenty-five per cent found it difficult or impossible to do their jobs at least once a week because of inadequate resources (Kovner et al., 2007). Recent research indicates that the most important aspect to promote new graduate nurse job satisfaction and retention is an orientation to the ward that is comprehensive and provides adequate information for new graduates to commence work on the ward (Scott et al., 2008).
There are also concerns that registered nurse graduate programs are not delivering what they offer. Anecdotal evidence suggests some Australian hospitals offer registered nurse graduate programs with high levels of support, a wide choice of clinical rotations, education and guidance, but these unfortunately are often not delivered and nurses are left feeling cheated, disillusioned and dissatisfied (Johnstone & Stewart, 2003). Research by DeBellis, Longson, Glover, and Hutton (2001) has also shown that registered nurse graduate programs are based solely on expenditure and outcomes and that there is little collaboration between organisations and nurse education institutions in providing appropriate programs according to the needs of the new graduates. In NSW, government funding for new graduate nurses is $900 per nurse while Victoria is funded at $12,600 per nurse and the Northern Territory at $4,000 per nurse. This clearly demonstrates inconsistencies across state and territory governments with the level of funding provided to support graduate transition (Levett-Jones & FitzGerald, 2005).

For new graduate programs to ensure a useful transition for new graduates, they need to encompass teaching and learning activities grounded in practice experience, strong program coordination, skilled and well-supported clinical educators and preceptors and a structured learning framework (Adlam, Dotchin, & Hayward, 2009). When Australian new graduate nurses felt accepted and valued, they experienced greater job satisfaction and were less likely to leave their place of work (Evans, Boxer, & Sanber, 2008). Many registered nurse graduates found that graduate programs failed to address issues such as the provision of a high standard of patient care which is consistent with Cowin’s (2002) view, that nurses are taught a standard of nursing care in the tertiary institutions that does not exist.
in the hospital system (Cowin, 2002; DeBellis et al., 2001). Nurses also complained of feeling rushed, overworked, alone and unsupported which is contrary to the aims and objectives of graduate nursing programs (Evans et al., 2008). DeBellis et al. (2001) suggest that the nursing profession as a whole must support a culture that is nurturing and supportive of new graduates in order to retain them. Research indicates that the most effective process for graduate nurse transition, including the transition into the health care system, is best provided in the first four weeks of a graduate nurse transition program and thereafter at the beginning of each ward rotation (Johnstone, Kanitsaki, & Currie, 2008). Identified barriers to new graduate support have been identified as lack of staff, lack of consistency amongst preceptors, the general reality of ward nursing and inappropriate behaviours or attitudes from staff (Johnstone et al., 2008).

This literature review so far has explored and critiqued nurse retention and nurse education using international and national literature. The literature review will now narrow its focus to explore the literature related specifically to Australian and NSW research on the nursing shortage. This will include data on the current nursing shortage in Australia, seminal Australian research on nurse retention as well as NSW government inquiries, reports and recommended nurse retention strategies.

2.4 Seminal Australian Research into the Nursing Shortage

Rural, remote and metropolitan areas of Australia are experiencing a critical nursing shortage across all states and territories as there are more nurses leaving the profession each year than are being recruited (Duffield & O’Brien-Pallas,
2003). In 2001, Hegney et al. published the first Australian research on rural nurse retention. This research identified the factors that were important in rural nurses’ decisions to leave or stay in nursing in Queensland. Participants were asked to indicate the importance they placed on a list of ninety-one factors which may have influenced their decision to leave or stay. The questionnaire was posted to 368 nurses with 40% responding (n = 146). Qualitative data were also collected as participants could give further written information. Two limitations were identified:

1. The sample was only representative of those nurses who left Queensland Health in the period February 1999 – May 2000 and did not include nurses who left in that time frame but remained employees of Queensland Health.
2. The research did not include nurses who had left from the private health sector.

As well as identifying that the first twelve months of a rural nurse’s employment was a critical time in relation to the retention of that nurse in rural practice, the following table, Table 3, shows the identified factors for leaving or staying in nursing.
Table 3: Factors Influential in Leaving or Staying

| Five most important factors for staying | 1. Being part of a team (47%)  
|                                         | 2. Job satisfaction (47%)  
|                                         | 3. Rural lifestyle (45%)  
|                                         | 4. Relationships with other nursing colleagues in the health facility (40%)  
|                                         | 5. Sense of belonging to the community (39%)  
| Five least important factors for staying | 1. Transfer of partner (4%)  
|                                         | 2. On-call work (6%)  
|                                         | 3. Research opportunities (8%)  
|                                         | 4. Availability of appropriate child minding (8%)  
|                                         | 5. Personal health reasons (8%)  
| Five most important factors for leaving | 1. Management practices within the health facility (43%)  
|                                         | 2. Emotional demands of work (36%)  
|                                         | 3. Family responsibilities (34%)  
|                                         | 4. Physical demands of work (34%)  
|                                         | 5. Workplace support (33%)  

Source: Hegney et al., 2001

The strength of Hegney et al.’s (2001) research is that it elicited data from nurses who were currently in or had recently left the rural health system. The weakness of this rural study is that the factors that participants could identify for leaving needed to be selected from a limited list of pre-determined responses and may not have captured the entirety of why nurses leave. While these identified reasons give a valuable insight into rural nursing, the research was never designed to provide a theory for rural nurse resignations.

Other seminal Australian research into the NSW nursing shortage is Duffield, Roche, et al.’s (2007) Glueing it Together report on NSW hospitals. The research was commissioned and funded by NSW Health to inform future policy development on nursing workforce issues. This was the first study in Australia undertaken at the ward level. While the study confirmed well-known findings related to nurse retention – such as the importance of job satisfaction, nurse
autonomy, strong leadership, nurse/patient ratios and work environment – it also revealed new findings, one of which – identified as ‘churn’ – is particularly relevant to nurse retention. Churn describes the constant moving of patients within the ward, and to and from the ward, for the purpose of care. This includes taking patients to operating theatres, x-ray departments, diagnostic departments and facilities for treatment. Duffield, Roche, et al.’s (2007) research indicates that, due to churn, 40% of nurses report that they are unable to provide patients with basic nursing care, thus reducing the level of job satisfaction for nurses.

While the research is timely and relevant and provides valuable data to drive policy reform in NSW Health, Duffield, Roche, et al.’s (2007) research does not collect data from nurses who have already resigned from NSW hospitals; this was not the aim of the research. However, Duffield, Roche, et al.’s (2007) research found that 67% of participants were satisfied with their work and 71% were not planning to change jobs during the next twelve months. The issues that impact on nurses who have resigned may differ from those that choose to stay, but this remains unclear.

Two studies were conducted in NSW to examine the behaviour and characteristics of registered nurses in an attempt to identify characteristics that may explain reasons for nurse resignations (Cunich & Whelan 2006; Doiron & Jones, 2006). The aim of both studies was to identify trends in nurse characteristics to see if they correlated with nurse retention. Characteristics included registered nurse education, postcode, age, main employer, postgraduate qualifications, area of work and gender.
Findings from the two studies indicate that male registered nurses are eight times more likely to exit from the registered nurse workforce than females; and younger registered nurses are more likely to exit the registered nurse workforce than older nurses. Registered nurses are more likely to exit the workforce between the ages of 25 and 29. This may be linked to child-bearing years but it was not clear. The main place of work for NSW registered nurses was not a determinant in resigning; however, the type of specialty did have a significant impact on exiting. Registered nurses working in surgical or mixed medical/surgical are less likely to exit the workforce while registered nurses working with psychiatric patients are more likely to stay in a private facility than a public one. Registered nurses educated in a NSW educational facility (i.e. university) are 12% more likely to exit the nursing workforce. This is explained by two factors. First, university-educated registered nurses have greater outside labour market opportunities than hospital-trained nurses; and second, university students are using the nursing degree as a stepping-stone for undertaking other university studies and/or work opportunities. This may be explained by the interpretation that university-educated registered nurses may have different expectations of nursing and are less satisfied with the workplace environment (Cunich & Whelan, 2006; Doiron & Jones, 2006).

While the aim of Cunich and Whelan’s (2006) research was to identify trends in nurse characteristics to see if they correlated with nurse retention, the research fails to demonstrate a link between identified characteristics and retention. It does, however, shed light on trends such as gender, age and type of employment the nurse exited from but fails to explain why this may have occurred. In comparison,
Hegney et al.’s (2001) research identifies the issues that are relevant for staying or leaving which provide the most valuable data to date for nurse retention strategies.

The findings from Hegney et al.’s (2001) seminal research will now be used to explore and contrast findings from NSW Health reports. The next section will firstly critique the NSW Health reports and then compare the findings with Hegney et al.’s (2001) research that provides data on reasons important for leaving or staying in rural nursing.

**NSW retention strategies and reports into the nursing shortage**

Over the past decade, numerous reports and inquiries (e.g. *NSW Nursing Workforce Research Project 2000; Recruitment and Retention of Nurses – Progress Report* (2002); the 2002 Senate Inquiry into Nursing (*The Patient Profession: Time for Action*)) have been undertaken in NSW in an effort to identify the key issues for nurse retention and to implement policy solutions for the current nursing shortage. Some federal inquiries have been included in this section due to their relevance to the NSW nursing shortage. This section of the review will critique these reports in an attempt to better understand the issues related to NSW rural nurse retention.

In 2000, NSW Health commissioned the Nursing and Health Services Research Consortium (NHSRC) to conduct an analysis of the reasons why nurses who were currently enrolled or registered with the then NSW Nurses and Midwives Board (NMB) were not in the nursing workforce. The analysis was to also identify what
may encourage their return to the workforce (NHSRC, 2000, p. 7). This research was titled the *NSW Nursing Workforce Research Project 2000*.

While valuable data were gained from this survey as to what would attract nurses back into nursing and the areas where nurses would like to work, the results were misreported. The aim of the research was to identify what would entice nurses back to the workforce. According to the results and conclusion of the research project, 1,410 nurses gave the main reason for leaving nursing as ‘family responsibilities’ and 513 nurses gave their reason for leaving nursing as ‘to move into a role that was more suited to my lifestyle’ (NHSRC, 2000, pp. 8–9) yet the survey tool, when examined, never asked the question ‘Why did you leave nursing?’ When examining the survey tool, the question asked was ‘What is the main reason you are not currently working in nursing?’ and ‘What incentives could an employer offer you that would encourage you to return to work in nursing?’ (NHSRC, 2000, Appendix 1). These are recruitment questions, not retention questions, and the published results are a gross misinterpretation as to why NSW nurses resign.

The findings of this survey did reveal that: a) the most common incentives to return to work would be suitable working hours (67%), better pay (30%), support in education and retraining (26%), improved working conditions (18%), and management process change (17%); and b) the main reasons why nurses are not currently working in nursing were family responsibilities (28%), and to move to a role that was more suited to their lifestyle and responsibilities (10%) (NHSRC, 2000, p. 8).
Information from the 2000 report *NSW Nursing Workforce Research Project 2000* that revealed what would entice nurses back into the NSW workforce was published in 2001 but, one year later, the same office released NSW Health’s (2002) *Recruitment and Retention of Nurses – Progress Report*. This report was to provide an update on current recruitment and retention strategies but, when examined, there were no recruitment or retention strategies that reflected the findings from the results of the *NSW Nursing Workforce Research Project 2000*. The findings of the two reports found the following:

- The *NSW Nursing Workforce Research Project 2000* indicated that the most common incentives for NSW nurses to return to work would be suitable working hours, better pay, support in education and retraining, improved working conditions and management process change (NHSRC, 2000, p. 8).

- NSW Health’s (2002) *Recruitment and Retention of Nurses – Progress Report* initiatives list recruitment and retention strategies such as 10-hour night duty, clinical nurse specialist review, employer-sponsored child care, $5 million to redevelop mental health courses, overseas recruitment, nurse scholarships, accommodation initiatives, development of safety manuals and grievance procedures, study leave reporting requirements and nurse practitioner classification.

There is a lack of consistency between the two reports although they were initiated from the same office and are supposedly related to each other. It remains unclear what evidence supported the retention strategies listed in NSW Health’s (2002) *Recruitment and Retention of Nurses – Progress Report*. 
This serious error in data interpretation and reasons why nurses leave nursing from the *NSW Nursing Workforce Research Project 2000* continued to snowball as the inaccurately reported data on why nurses resign were then used to guide retention strategies for the NSW nursing workforce in the NSW Health Ministerial Standing Committee’s *NSW Nursing Workforce Action Plan* (2001).

In 2002, the findings from the *NSW Nursing Workforce Research Project 2000* were used correctly by the NSWNA as evidence to the 2002 Senate Inquiry into Nursing to demonstrate that the number one incentive for nurses to return to work was flexible working hours (Commonwealth of Australia, 2002, CA529). Senator Tchen, a member of the Senate Community Affairs References Committee that chaired the inquiry, failed to see the value in data from nurses who had left nursing. When referring to the nurses who participated in the *NSW Nursing Workforce Research Project 2000*, Senator Tchen commented that they were ‘probably not typical because they are nurses who are not at work at the moment’ (Commonwealth of Australia, 2002, CA529). If these nurses are ‘not typical because they are not at work in nursing’, then who is typical of knowing the reasons why NSW nurses may choose to return to the workforce? Clearly, Senator Tchen fails to see the importance of asking thousands of nurses who have left the hospital system why they left.

In 2002, a report was prepared for the NSWNA by the ACIRRT titled *Stop Telling Us To Cope*. This research built on from the information contained in the *NSW Nursing Workforce Research Project 2000*. Ten focus groups of nurses who were currently or had been employed in a NSW hospital were asked to explain
why they and/or their colleagues are leaving NSW public hospitals today. A total of 87 registered and enrolled public hospital nurses and ex-nurses participated in the focus groups; no rural nurses were included. Key findings indicated that changes in hospital management systems have had major implications for the nature of nursing work (ACIRRT, 2002). Noted problems for participants included a shift to cost control in the management of illness; an increase in the intensity of nursing activity with staff levels that do not reflect accurate workloads; an increase in nursing responsibility with reduced support from managers; and an increase in nurses working in areas in which they are not trained. These noted problems led to nurses not being able to provide quality care to patients (ACIRRT, 2002). Interestingly, this report identifies that many NSW nurses do wish to return to nursing in the hospital system, just not to the system that currently exists (ACIRRT, 2002).

The ACIRRT also examined the *NSW Nursing Workforce Research Project 2000* and asked for feedback from nurses who had participated in this study. The nurses stated that the problem with the survey tool was the closed-ended questions that did not allow nurses to give in-depth responses. The ACCIRT also found that there were fundamental flaws in the survey design that allowed for no interrogation of the health system, and the coding frame was limited (ACIRRT, 2002). It is important to remember that the information from the *NSW Nursing Workforce Research Project 2000* was then provided to the Health Minister as ‘an assurance by NSW Health to address a number of issues that surround the recruitment, retention and return of nurses to the health system’ (NSW Health, 2003, p. ii). This very important issue also outlines the limits with research survey
tools where nurses are asked to tick boxes for the reasons they have resigned. Research needs to be conducted that also allows the nurse to express their views honestly without fear of reprisal if the nurse wishes to return to the workforce.

In December 2006, the Auditor-General’s Office conducted a performance audit and, from this, published a report titled *Attracting, Retaining and Managing Nurses in Hospitals: NSW Health*. This report examined how nurses were managed in four public hospitals: two metropolitan hospitals and two rural hospitals. The audit objective was to examine how hospitals managed nurses: whether wards were staffed adequately, and whether hospitals were attracting and retaining the nurses they needed to continue operations. Surgical and medical wards were also examined. The report did not take information from employees who had resigned from NSW hospitals. The cost of the audit was $380,000 (NSW Audit Office, 2006).

The report indicates that NSW Health used a number of strategies to increase nurse numbers. First, nurses’ wages were improved. This is interesting given that the issue of increased wages had not been a significant factor as to why nurses resign (Hegney et al., 2001). Second, NSW Health recruited 2,500 nurses back into the public health sector (1,000 of these nurses were recruited from overseas and 1,500 ex-nurses were recruited). Despite these gains, the report also highlighted that there may still not be enough nurses, and included plans to work with the Commonwealth to increase the number of nurses entering the workforce (NSW Audit Office, 2006).
Key findings from the audit showed that there was no objective way to determine nurse numbers and no clear methodology to determine the number of nurses required based on patient load. It also highlighted that there is still room for improvement as far as managing nurses’ workloads. The audit found that nursing shortages arose when positions were vacant, when nurses were absent from the ward, when patients needed more care than usual, or when extra beds were opened. Hospitals dealt with these issues by asking the nurses already on duty to cover the shifts or by employing casual nurses (NSW Audit Office, 2006).

NSW Health claims to have reduced the number of nurse resignations and increased the number of nurses recruited (NSW Audit Office, 2006), although recent data show that nurse retention rates have decreased (Doiron et al., 2008). NSW Health was not able to quantify the gain, or assess whether the number of nurses was enough to meet demand. Alarmingly, NSW Health was not able to report on the cost of overtime, or of casual and agency nurses, nor the total number of working hours for these nurses, and also could not identify why these nurses were used. The four hospitals in the performance audit stated that their first response to a nursing shortage was to see if the existing staff on duty could manage without the nurses and cover the extra workload themselves (NSW Audit Office, 2006). One hospital ward reported having one-third of its ward nurses as first-year nurses with another third being agency nurses (NSW Audit Office, 2006). In addition, the audit revealed that most of the hospitals did not routinely conduct exit interviews to find out why nurses were resigning, and that ‘the department and hospitals report overall resignation rates but they do not analyse the resignation rates by considering factors such as length of service. Better
analysis would be useful in developing targeted retention strategies’ (NSW Audit Office, 2006, p. 25).

While it is encouraging that the Audit Office of NSW included two rural hospitals, the data from rural and metropolitan hospitals were aggregated. It remains unclear if issues of rurality were a factor in this research. While the report is very valuable, it does appear to focus more on recruitment than on retention although there was a recommendation to retain nurses but no strategies were provided (NSW Audit Office, 2006).

In 2008, an independent inquiry into the delivery of acute care services in public hospitals of NSW was commissioned under the *Special Commissions of Inquiry Act 1983* (NSW). This was prompted due to increasing public disquiet over the state of the NSW hospital system regarding incidents which cast doubt in the public mind on how safe hospitals were and whether the quality of care they provided was what patients expected (Garling, 2008). The inquiry was led by Peter Garling, Senior Counsel. Garling and his team visited 61 public hospitals across NSW; heard evidence from 628 people including patients, community members, doctors, nurses and allied health professionals; received over 1,200 written submissions from over 900 individuals and organisations; conferred with 27 peak bodies such as the specialist medical colleges, professional associations like the Australian Medical Association and the NSWNA; and received extensive briefings from NSW Health and representatives of the eight AHSs (Garling, 2008).
The findings from this report indicate that, while NSW has an excellent public health system, the system is overworked and filled with problems compounding the overuse. The problems include outdated information systems and clinicians prioritising their own needs over patients'. From his report, Garling recommended four pillars of reform that are required to address the current crisis in NSW public hospitals and has included 139 recommendations for reform. These four pillars will be the basis of reform and change to the system and include a clinical innovation and enhancement agency, a clinical excellence commission, an institute of clinical education and the establishment of a bureau of health information (Garling, 2008).

Garling (2008) also highlights specific rural issues and his recommendations include taking immediate action to increase the number of skilled health workers, developing packages and strategies that will attract and retain rural health care workers and addressing rural transport issues for rural care provisions. Specific recommendations for nurses include reviewing and revising the role of the Nursing Unit Manager (NUM), reviewing the current induction program of overseas nurses, creating a new classification for experienced nurses, increasing funding for nurse practitioners and revising the workplace general workload calculation tool. In response to the Garling Report (2008), NSW Health has accepted 134 of the 139 recommendations with the government allocating $485 million to implement these changes (NSW Health, 2009). It remains unclear whether these measures will have an impact on nurse retention.
Table 4 provides a synopsis of the literature discussed in this section that relates to the NSW nursing shortage.

When data from the NSW reports and inquiries listed in Table 4 are compared and contrasted to Hegney et al.’s (2001) and Duffield, Roche, et al.’s (2007) research, several deficiencies are noted. First, these investigations into NSW nurses failed to ask nurses why they had resigned. The one study that does include nurses who have resigned was the *NSW Nursing Workforce Research Project 2000* and this did not ask the sample group why they resigned. Instead, the study asked, ‘What is the main reason you are currently not working in nursing?’ and ‘What would entice you back to nursing?’ The data that identified the reasons why nurses were not currently working in nursing were then misreported as to the reasons nurses resign. This misinformation was then provided to the NSW Health Minister. In addition this 2000 investigation did reveal that of the five criteria that were the main incentives to return to nursing, 11 years later the only criterion that has been addressed is better pay.
### Table 4: Summary of NSW Investigations into the NSW Nursing Shortage

<table>
<thead>
<tr>
<th>Report/research title</th>
<th>Year</th>
<th>Author/s and or commissioning body</th>
<th>Aim</th>
<th>Key findings</th>
<th>Identified weakness or problems</th>
</tr>
</thead>
</table>
| NSW Nursing Workforce Research Project | 2000 | NSW Health commissioned the NHSRC to carry out the research | To identify the main reasons why NSW nurses who are not currently working in nursing may choose to return and the main incentives to return to nursing | The most common incentives to return to work would be:  
- Suitable working hours (67%)  
- Better pay (30%)  
- Support in education and retraining (26%)  
- Improved working conditions (18%)  
- Management process change (17%)  | Inaccurate and misreported data findings. The inaccurate findings were then used to guide retention strategies for the NSW nursing workforce in the NSW Health Ministerial Standing Committee’s NSW Nursing Workforce Action Plan |
| Recruitment and Retention of Nurses – Progress Report | 2002 | NSW Health | To provide an update on current recruitment and retention strategies for NSW nurses | Report lists the current recruitment and retention strategies of NSW Health to increase both recruitment and retention of NSW nurses employed by NSW Health | Retention strategies do not reflect the findings from the NSW Nursing Workforce Research Project 2000, even though from the same office of NSW Health |
| Stop Telling Us To Cope | 2002 | Commissioned by the NSWNA. Carried out by the ACIRRT | To provide ancillary information that could be of assistance to the 15% work value claim currently before the NSW Industrial Relations Commission  
- To generate new information on membership conditions that would assist the | Recent changes in hospital management systems have had major implications for the nature of nursing work. These include:  
- the shift to a ‘cost control’ approach to managing illness  
- a change in the objective nature of the work undertaken by nurses  
- changes in the objective conditions of work have major implications for the subjective experience of work. In particular, they are diminishing some of the intrinsic, less | Aim of the research is unclear and confusing. The report claims to provide an answer to why nurses are leaving, but the aim of the research is to investigate nurses’ wages and work conditions for the NSWNA  
Assumes that nurses resign due to wage issues |
<table>
<thead>
<tr>
<th>Report/research title</th>
<th>Year</th>
<th>Author/s and or commissioning body</th>
<th>Aim</th>
<th>Key findings</th>
<th>Identified weakness or problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attracting, Retaining and Managing Nurses in Hospitals: NSW Health</td>
<td>2006</td>
<td>NSW Auditor-General’s Office</td>
<td>• To examine how four NSW hospitals managed nurses: whether wards were staffed adequately and whether these hospitals were attracting and retaining the nurses they needed to continue operations</td>
<td>• There is no objective way to determine nurse numbers and no clear methodology to determine the number of nurses required based on patient load</td>
<td>Recommends that retention strategies be implemented but does not offer retention strategies</td>
</tr>
<tr>
<td>The Garling Report</td>
<td>2008</td>
<td>Commissioned under the Special Commissions of Inquiry Act 1983 (NSW). Inquiry led by Peter Garling, SC</td>
<td>• To conduct an independent inquiry into the delivery of acute care services in public hospitals of NSW</td>
<td>• 139 recommendations have been initiated from the Garling Report to address current problems in the delivery of acute care services in NSW public hospitals</td>
<td>Only explores acute care services in public hospitals</td>
</tr>
</tbody>
</table>
Second, NSW Health retention strategies do not reflect evidence-based needs of nurses. It is unclear what basis there is to the retention strategies. Third, the data contain little information on rural nurses. Finally, there is identified miscommunication within NSW Health. Research and investigations within the same office as to what nurses need are not reflected in the NSW Health recruitment and retention strategies. While the Garling Report of 2008 was salient in identifying NSW nursing problems within the public hospital system, it provides little insight into rural nursing in NSW from a non-acute and non-public hospital perspective. Considerable research has concentrated on health workforce recruitment strategies in Australia; much less attention has been focused on the effectiveness of retention strategies (Buykx et al., 2010).

This section of the literature review has provided a critique of current NSW Health investigations and reports into the current nursing shortage of NSW. It has identified that current NSW Health retention strategies have failed to address the loss of nurses from hospitals and do not appear to be evidence based. Retention strategies within these reports and papers appear to be bandaid measures with no evidence provided on which to base current retention strategies and there is no link between these retention strategies, current research and, in particular, data from nurses who have already resigned.

2.5 Literature Review Discussion

This literature review was conducted to explore and critique current literature pertaining to the nursing shortage. The review has highlighted strengths and limitations of reports and literature, outlined gaps in current knowledge and
identified emerging theoretical issues. The review was also driven by the need to understand the context of the current nursing shortage in rural NSW, and to gain a clearer picture of contributing factors.

While there is continuing and growing research on Australian rural nursing retention, there is an identified absence of literature relating to the retention of NSW rural nurses. How NSW may differ in terms of retention needs compared to international and national research remains unclear. Issues for NSW nurse retention may be impacted upon by the system within which NSW nurses work: large geographical rural areas, AHS structures, management systems and remoteness. Hegney et al.’s (2001) Queensland research that reveals the importance of job satisfaction in relation to nurse retention is a salient piece of research with regard to the Australian rural nursing shortage. Hegney et al.’s (2001) study provides evidence that rural lifestyle is important for nurses’ decisions to remain and be attracted to rural nursing, but raises the issue of what constitutes a rural lifestyle. In addition, the study introduces the importance of community satisfaction in the decision to stay in rural practice (Manahan & Lavoie, 2008).

This review also highlights that the problem of the nursing shortage is complex and multifaceted with nurses resigning for many reasons including job dissatisfaction, workplace violence, lack of nurse leadership, poor management styles and staff conflict. Several reasons have been put forward as contributors to the nursing shortage such as generational explanations and changes to nurse education. The literature also identifies that senior nurse managers have not made
the critical link between human resources, the characteristics of the work environment and the impact on patients, nurses and the system as a whole (Stone et al., 2003).

The literature review identified several gaps in the research pertaining to the NSW rural nursing shortage. First, there is limited research into nurse retention for rural NSW nurses. Second, there is a gap in research that asks nurses why they have resigned. Third, there is a gap in Australian research that explores the exit interview process for nurses who have resigned. Fourth, the review identifies that current NSW Health retention strategies are not evidence based and there is poor communication within NSW Health about the flow and dissemination of nurse retention information. Finally, current NSW research does not explore or examine the system within which NSW nurses work.

While this literature review identifies current knowledge and theories on nurse retention, it also highlights a deficit about placing the identified issues of nurse retention and job dissatisfaction into a theoretical framework that accounts for rural nurse resignations. In other words, taking the individual identified issues and collectively analysing data to establish a theory on why nurses resign. Current literature and theories do not examine the collective or bigger picture; rather, current research identifies individual indicators of retention and job dissatisfaction. While these identified issues provide a worthwhile description of contributors to nurse retention matters, it is important to develop a theory that accounts for much of the relevant behaviour of nurse resignations. Issues have been identified on the nursing shortage but these findings show deductive reasons
of why nurses resign. There is a need for inductive research that conceptually links these issues to form an inductive theory on nurse resignations.

In order to gain effective and rich data, there is a need for qualitative research that explores in depth the reasons registered nurses resign and also explains the phenomenon of why hospitals do not understand the reasons why nurses resign. So much has been written on the nursing shortage but still no explanation can be given as to why this shortage still exists.

To perform research that fills the identified gaps, this study will explore the reasons nurses resign from rural NSW hospitals. Data will be explicated from the interviews of those nurses who have worked in the rural hospital system and have resigned; a methodology of grounded theory will be used. This way of interpreting data and identifying themes to base theory on is relevant to the research aim as it allows for nurses’ thoughts, feelings and identified reasons for resignation to be the basis of understanding the very recruitment issues that must be addressed in order to partly resolve this nursing shortage.

2.6 Chapter Summary

This chapter has critiqued and analysed research and investigations into nurse retention. International and national research on nurse retention, nurse education and seminal Australian research and inquiries into the NSW nursing shortage have been reviewed and identified gaps in current research have been discussed.
The nursing shortage is endemic and the major contributor to nurse resignations is lack of job satisfaction. Current research indicates that the main contributors to job dissatisfaction include dissatisfaction with nurse management, workplace violence, lack of leadership, lack of resources, understaffing, not being able to provide satisfying patient care to patients and poor communication within the hospital sector. Many reports and investigations into the Australian nursing shortage have failed to provide strategies to increase nurse retention.

To summarise, the main points from this review are the following:

- There was a predicted shortfall of 40,000 nurses in Australia in 2010 (no data were available for predictions of the nursing shortfall beyond 2010).
- The current nursing shortage in hospitals is related to poorer health outcomes for patients.
- The shortage of nurses, both internationally and nationally, has severe financial consequences for both the health industry and communities.
- NSW Health retention strategies do not reflect current research on why nurses resign. Instead, they address tangible factors such as wages.
- There is poor communication within NSW Health about the flow and dissemination of nurse retention information.
- Current research, while identifying contributors to nurse resignations, has not generated a theory to explain collectively why nurses resign; data are mainly descriptive and deductive.
- There is minimal data on the resignation process of registered nurses.
- There is minimal data collected from the largest and most knowledgeable cohort, that is, the nurses who have resigned from the health system.
There is an identified need for qualitative research that explores in depth the reasons why registered nurses resign and explains why hospitals do not understand the reasons why nurses resign.

There is a need for inductive research that conceptually links the reasons nurses resign to an inductive theory on nurse resignations.

The next chapter will outline the methodology of grounded theory, discuss research paradigms, provide an overview of grounded theory, identify the components of grounded theory and provide evidence that a grounded theory approach will answer the research questions and address the objectives of this study.
CHAPTER THREE

Methodology

3.1 Introduction

This chapter discusses the ontological, epistemological and methodological position taken to answer the research aim and objectives outlined in Chapter One. Discussions will include an overview of grounded theory; a synopsis of research paradigms and a debate on their influence on grounded theory; the components of grounded theory; an outline of researcher reflexivity, and the relevance of grounded theory to this study. The research method will be discussed in the following chapter. The aim of this study is to explore the reasons why registered nurses resign from NSW rural hospitals.

3.2 Grounded Theory – An Overview

Grounded theory is a specific research method for the purpose of building or generating theory from data (Corbin & Strauss, 2008; Glaser, 1978; Glaser & Strauss, 1967). Grounded theory is not a methodology as such rather it is a set of methods that can be applied by using a variety of methodological frameworks. These methodological frameworks with their underlying philosophies influence how the researcher works with the participants. Methodology is a set of principles that inform and guide the research design of the study at hand whereas methods are practical procedures that are used to generate and analyse the data (Birks & Mills, 2011)
Grounded theory sets out to find what theory accounts for the current research situation and to discover the theory implicit within the data and to generate a theory that accounts for the pattern of behaviour which is relevant and problematic for the participants (Glaser, 1978, 1992).

When the components of grounded theory are followed, a researcher using this approach will formulate a theory, either substantive (setting specific) or formal (conceptualised to a broader population) about the problem being studied. Grounded theory contradicts the traditional positivist framework of research, where the researcher chooses a theoretical framework and applies this framework to the studied problem (Glaser, 1978, 1992; Glaser & Strauss, 1967).

Grounded theory was first described during the 1960s in the USA by two sociologists, Barney Glaser and Anselm Strauss, in response to the positivist reductionist approach to research methods of the time (Glaser & Strauss, 1967). In their research on dying patients together they developed the constant comparative method of data collection and analysis, known as grounded theory. Strauss, who was trained in symbolic interaction by Herbert Blumer, and Glaser, who was trained in quantitative sociology by Paul Lazarsfeld, both felt that a new methodology would assist in analysing qualitative data (Glaser, 1992). While both researchers had differing backgrounds, they also came from complementary backgrounds; Glaser was strongly influenced by methodology and its generation and Strauss had a long history in qualitative research and analysis. They shared similar ideas; the need to stick to the data, be in the field and to generate theory that reveals and respects the perspectives of the subjects in the substantive field.
under study (Glaser, 1992). This shared view encouraged the collaboration of the two sociologists (Glaser, 1992) and grounded theory was developed.

Glaser and Strauss’ grounded theory method was first described in their 1967 book *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Their emphasis was on generating theory from the data; the data being the words or observations of participants gathered from interviews and/or observations. Grounded theory, therefore, is a process of induction rather than deduction (Glaser, 1978, 1992; Glaser & Strauss, 1967; Mills, Bonner, & Francis, 2006; Minichiello, Sullivan, Greenwood, & Axford, 2004). During this inductive process, a theory is generated from the data and then verified either by revisiting the field or by reviewing the data within the transcripts (Glaser, 1978, 1992; Glaser & Strauss, 1967; Strauss & Corbin, 1990).

Glaser and Strauss in their original 1967 book describe two methods of coding data in grounded theory: substantive coding and theoretical coding. Substantive coding, the initial phase of analysis, consists of open and selective coding. In open coding, data are initially sorted into as many codes (loose categories) as possible in order to open up the data, then selective coding ensues. This is the detailed development of the codes into categories with selection of a main or core category occurring by integrating categories (Glaser & Strauss, 1967). Theoretical coding, also emergent, conceptualises how the substantive codes relate to each other as hypothesis to be integrated into the theory (Glaser & Strauss, 1967). The constant comparative method refers to the concurrent data collection and analysis using both substantive and theoretical coding methods. Therefore the aim of the
constant comparative method of joint coding and analysis is to generate theory more systematically than allowed by simply coding first and then analysing all data at once (Glaser & Strauss, 1967).

The constant comparative method involves comparing incidents with each category; integrating categories and their properties; delimiting the theory; and writing the theory. The comparative method allows for concepts to emerge which drive the subsequent data collection (Glaser & Strauss, 1967).

Since their original research and subsequent seminal book of 1967, Glaser and Strauss began to diverge on their application of grounded theory. After co-writing *The Discovery of Grounded Theory* (1967) with Strauss, Glaser then wrote the methodology book *Theoretical Sensitivity* in 1978 and has since written several books (e.g. *Basics of Grounded Theory Analysis* (1992) and *Doing Grounded Theory* (1998)). In addition, Glaser founded the Grounded Theory Institute in 1999 which is a non-profit, web-based organisation dedicated to his evolving methodology. The institute provides an online forum for the discussion of grounded theory, and publishes the journal *The Grounded Theory Review*. Glaser has always advocated that the fundamentals of grounded theory must be drawn from analytic methodology and procedures of inductive quantitative analysis discovered in the 1950s and 1960s (Glaser, 1978).

After Strauss’ work with Glaser in 1967, Strauss went on to write *Qualitative Analysis for Social Scientists* (1987) and then publish his version of grounded theory in *Basics of Qualitative Research: Grounded Theory Procedures and*
Technique (1990) and Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory (1998) with Juliet Corbin. These books describe a reformulated approach to grounded theory with changes to the original methodology. Strauss’ background as a relativist, pragmatist and symbolic interactionist drove him to develop the original grounded theory method with the conditional matrix as a way of situating action at the centre of analyses. Using a conditional matrix positions the researcher to reconstruct meaning on the research process (Mills, Chapman, Bonner, & Francis, 2007).

Much has been written on the split between the original creators of grounded theory and how their methods differ (see, e.g., Annells, 1996, 1997a, 1997b; Glaser, 1992; Heath & Cowley, 2004; Mills et al., 2006). This split has resulted in two versions of grounded theory: traditional (or Glaserian) grounded theory which views grounded theory methodology according to Glaser; and contemporary or evolved grounded theory, that advocated by Strauss, then by seminal contemporary grounded theorists such as Corbin, Charmaz and Clarke (Mills et al., 2006). Common to both traditional and contemporary grounded theory are the components of theoretical sensitivity, coding, treatment of the literature, and the identification of the core category (Mills et al., 2006).

While differences in the ontology, epistemology and methodology of research paradigms will be discussed in Section 3.3, the components of grounded theory will be detailed in Section 3.4. The following outlines how the main components of grounded theory differ between traditional grounded theory and contemporary grounded theory.
Theoretical sensitivity is the quality the researcher brings to the study not only to aid the generation of concepts from the data but also to assist in relating these concepts to theory development (Glaser, 1978, 1992). Both Glaser and Strauss agree on the relevance of theoretical sensitivity to grounded theory; however, they differ as to how this is achieved. Glaser (1978) believes that theoretical sensitivity occurs by the researcher entering the inquiry with as few preconceived thoughts as possible so that they remain sensitive to the data – a blank slate with minimal pre-existing biases. Theoretical sensitivity is attained through immersion in the data, line by line, comparison by comparison, memo by memo, and code by code (Glaser, 1992) with the only technique used being constant comparison. In contrast, contemporary grounded theory (Corbin & Strauss, 2008; Strauss & Corbin, 1990, 1998) asks researchers to use techniques such as questioning, and analysing words and phrases, and the flip-flop technique to enhance theoretical sensitivity and to stimulate ideas about what is in the data (Mills et al., 2006).

The literature also differs between traditional and contemporary grounded theory. Traditional grounded theory takes the view that there is no need to view literature prior to data collection and analysis as this may bias the researcher; literature is viewed after analysis (Glaser, 1992). Contemporary grounded theory views the literature quite differently. Literature is reviewed from the beginning of the research process (Strauss & Corbin, 1998) as an additional source of data (Mills et al., 2006).

Coding within traditional grounded theory is the basic analytic tool with the constant comparison method sitting alongside both substantive and theoretical
coding (Annells, 1996; Glaser, 1978; Mills et al., 2006) to generate theory more systematically than coding first and analysing all data at once (Glaser & Strauss, 1967). In contrast, contemporary grounded theory (as advocated by Strauss and Corbin) encompasses open, axial and selective coding (Strauss & Corbin, 1990). The emergence of the core category (main theme) in grounded theory integrates the theory’s various aspects (Mills et al., 2006). In traditional grounded theory the core category emerges from many categories and will ‘core out’ on its own (Glaser, 1978, p. 95).

The change in Strauss’ grounded theory method includes viewing the data systematically for causal conditions, phenomena/context, intervening conditions, action strategies and consequences (Glaser, 1992). Glaser strongly rebukes this change to the original grounded theory methodology and states that this is not true grounded theory in its intended form (Glaser, 1992). According to Glaser (1992), Strauss’ reformulated grounded theory method asks the researcher to use the constant comparative method and then to interrupt true emergence by asking preconceived substantive questions. Glaser describes this as ‘forcing’ the data rather than letting it ‘emerge’, and this is Glaser’s greatest concern with Strauss’ reformulated method of grounded theory. Glaser criticises the deductive overplay of Strauss’ as requiring the researcher to concentrate on what might be in the data instead of what exists in the data (Heath & Cowley, 2004).

Many grounded theorists caution that, with two versions of grounded theory underpinned by differing components and methodologies, grounded theory has become too flexible and that researchers using qualitative methods are calling
their studies grounded theory when they are in fact qualitative thematic analyses (Charmaz, 2006; Jones & Noble, 2007). This can be overcome by the following. First, researchers must clearly state which school of grounded theory they are using; for example, a traditional approach such as that advocated by Glaser’s work and Strauss’s earlier work or the more contemporary approach to grounded theory used by theorists such as Strauss, Corbin, Charmaz and Clarke. Second, the objective of a grounded theory study must be to produce an inductive theory about a substantive area (Glaser, 2007). And third, grounded theory research should always encompass the basic procedures of grounded theory as advocated by both Glaser and Strauss, that is, ‘encompassing the joint collection, coding and analysis of data, theoretical sampling, constant comparisons, category and property development, systematic coding, memoing, saturation, and sorting’ (Jones & Noble, 2007, p. 7).

An overview of grounded theory, the historical origins of the method and the divergence between Glaser’s and Strauss’ approaches have been discussed in this section. Understanding how research paradigms shape grounded theory is important from a philosophical standpoint and will now be examined in light of the current research paradigms.

3.3 Methodology

This section provides an overview of different research paradigms and their relevance and application to grounded theory. This critique will include an examination of the ontology, epistemology and methodology of research paradigms and will use the works of the originators of grounded theory, Glaser
and Strauss, as well as of contemporary grounded theorists such as Charmaz and Clarke.

**Research paradigms**

All research whether it be qualitative or quantitative is based on underlying assumptions or paradigms (Charmaz, 2006; Clarke, 2005; Guba & Lincoln, 1994, 2000, 2005). A research paradigm is ‘the basic belief system that guides the investigator, not only in choices of method but in ontological and epistemologically fundamental ways’ (Guba & Lincoln, 1994, p. 105). In order to ensure a strong research design, it is important for the researcher to choose a research paradigm that sits comfortably with the researcher’s beliefs about the nature of reality (Mills et al., 2006). There are five underlying paradigms for research that guide inquiry: positivism, post positivism, constructivism, critical theory and participatory (Guba & Lincoln, 2005). Guba and Lincoln (2000, 2005) comment that by asking three questions the researcher can better determine the research paradigm:

1. Ontological question: What is the nature of the knowable or, what is the nature of reality?
2. Epistemological question: What is the nature of the relationship between the researcher and the known?
3. Methodological question: How should the researcher go about finding out the knowledge?

Guba and Lincoln (2000, 2005) suggest that the answers to these three questions can be seen as the basic belief system that may be adopted by the researcher but
indicate that these belief systems are human constructions and therefore subject to all the errors that accompany human endeavours. Epistemology is defined as the nature of the relationship between the knower and what can be known. Epistemology is also constrained by the answer to the ontological question, meaning that a person’s view on the nature of reality will affect how that person comes to gain knowledge of their reality (Guba & Lincoln, 2000, 2005). Ontology raises fundamental questions about the nature of the human being in the world and the nature of reality, while methodology focuses on the best ways for obtaining knowledge about the world (Guba & Lincoln, 2005).

As mentioned earlier, research can be viewed from five paradigms: positivist, post positivist, constructivist, critical theory and participatory. Each of these paradigms will be discussed in detail in the following sections. When viewing these five paradigms of qualitative research, the methodological lens of each paradigm is quite different. The research paradigm chosen will dictate the research methods (Guba & Lincoln, 2005). The following table, Table 5, summarises the five research paradigms and the ontological, epistemological and methodological position of each.
Table 5: The Different Ontologies, Epistemologies and Methodologies in Relation to the Five Research Paradigms

<table>
<thead>
<tr>
<th></th>
<th>Positivism</th>
<th>Post positivism</th>
<th>Constructivism</th>
<th>Critical theory</th>
<th>Participatory</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ontology</strong></td>
<td>Real reality but apprehendable</td>
<td>Real reality but only imperfectly apprehendable</td>
<td>Relativism; co-constructed realities</td>
<td>Reality shaped by cultural, social, political and gender values</td>
<td>Participatory reality; subjective-objective reality co-created by mind and given cosmos</td>
</tr>
<tr>
<td><strong>Epistemology</strong></td>
<td>Dualist/realist; findings true</td>
<td>Modified objectivist; findings probably true</td>
<td>Transactional/subjectivist; co-created findings</td>
<td>Transactional /subjectivist; value mediated findings</td>
<td>Critical subjectivity in participatory transaction with cosmos. Co-created findings</td>
</tr>
<tr>
<td><strong>Methodology</strong></td>
<td>Experimental/ manipulative</td>
<td>Modified experimental. May include qualitative methods</td>
<td>Hermeneutical/dialectical</td>
<td>Dialogic/dialectical</td>
<td>Political participation in collaborative action inquiry</td>
</tr>
<tr>
<td></td>
<td>Quantitative methods</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Source:** Adapted from Guba & Lincoln, 2000; 2005
Ontological differences in the research paradigms

Ontologically, traditional grounded theory is situated in a post positivist paradigm, as data are viewed by the researcher as (most likely) real in and of itself. Traditional grounded theory removes the social context from which the data emerge – the influence of the researcher (modified objectivist) – and does not take into account, or in fact see as relevant, the relationship between the researcher and the participants. Data are seen as representing objective facts about a knowable world, finding those facts and then discovering theory from these facts (Charmaz, 2006). Guba and Lincoln (1994) outline that the ontological perspective of a post positivism paradigm is that of critical realism; reality is ‘assumed to exist but to be only imperfectly apprehendable because of basically flawed human intellectual mechanisms and the fundamentally intractable nature of phenomena’ (p. 110). In contrast to the post positivism paradigm, constructivism views reality as an assumed multiple, apprehendable and sometimes conflicting social reality (p. 111) while in critical theory, reality is shaped by values such as gender, politics, culture and society. Participatory reality is a subjective-objective reality co-created by mind and given cosmos (Guba & Lincoln, 2005).

Epistemological differences in the research paradigms

Epistemologically, a post positivist paradigm requires the researcher to be a detached observer, that is, a modified objectivist (Charmaz, 2006; Guba & Lincoln, 1994). While detachment is not truly possible as researchers are all social beings who bring to the research individual values and experiences (Charmaz, 2006; Glaser, 1978; Glaser & Strauss, 1967), it is possible to position oneself as a modified objectivist. This occurs with the researcher at all times taking a stance of
passivity with the participant in the interview and data collection process (Glaser, 1978). Section 3.6 details the application of the researcher’s position of a post positivist.

In contrast to the post positivism paradigm, the participatory and constructivism paradigms encourage the researcher and the participant to engage in a dialogue and co-create the findings (Guba & Lincoln, 2005). Grounded theory research from a constructivist paradigm places the priority on the situation or events of the research and constructivists view the analysis of data as a construction of their own making (Birks & Mills, 2011). Constructivist research focuses on how the participants give meanings to their actions and acknowledges that the resulting theory is an interpretation (Mills et al., 2006). The theory depends on the researcher’s view and does not stand outside of this (Charmaz, 2006). Glaser (2002) strongly refutes this approach to grounded theory stating that ‘constructivism is used to legitimate forcing’ (p. 4) and strongly suggests that grounded theory cannot take a constructivist approach as the basis of grounded theory is that categories are objective if the researcher uses the constant comparative method; emerging theory is therefore real, not constructed (Glaser, 2002). According to Glaser (2002), a constructivist approach to grounded theory is inappropriate as constructivism is a descriptive form of qualitative data analysis (QDA) and not grounded theory. While Glaser believes that there is nothing unfavourable about QDA, it lacks the abstraction and conceptualisation that is the key in grounded theory studies (Glaser, 2002). While QDA will give the participant a voice that constructivists’ value, this voice does not generate concepts from the data and does not establish a parsimonious theory from in-vivo
concepts that fit, work and are relevant (Glaser, 1978). Glaser’s view of Strauss’ constructivist approach is that it forces descriptions, irrespective of emergence, on the theory to locate its conditions, to contextualise it and to make it appear accurately pinned down, thereby losing its true abstraction and, hence, generalisability (Glaser, 1978).

Grounded theory was never intended to give a voice to participants; rather, grounded theory is generated abstractions from the participants ‘doings’ (Glaser, 2002, p. 5). The early work of Strauss and all of Glaser’s work within grounded theory stress that one of the main points of the emergence of categories is not to allow the data to be forced, the data speak for itself and is not a construction of the researcher but will stand alone (Glaser, 1978, 1992; Glaser & Strauss, 1967).

**Methodological differences in the research paradigms**

Methodology also differs according to research paradigms, particularly in coding and analysis of the data. Constructivists such as Strauss and Corbin (1998) and Charmaz (2006) identify that the researcher will be coloured by their own assumptions and experiences. Glaser (1992) refutes this and suggests that these assumptions and coloured views of the researcher are not in themselves bad or wrong, as they help the researcher to develop alertness and sensitivity, but, they are not the participants’ view and, whilst they may permeate coding, they will not dictate it due to the constant comparative method.

From a constructivist perspective, methodology takes a reflexive stance. Data and analysis are social constructions that reflect what their production entailed.
Analysis is contextually situated in time, place, culture and situation (Charmaz, 2006). In contrast, according to Glaser (2002), grounded theory is abstract of time, place and people. One of the most important aspects of grounded theory is conceptualisation (see Section 3.4) and concepts last forever, unlike descriptions that soon date. Concepts are timeless in their application and this is the crux of grounded theory (Glaser, 2002). Without abstraction from time, place and people there can be no multivariate, integrated theory based on conceptual hypothetical relationships (Glaser, 2002).

Clearly, there is confusion and divergence in the methodologies: Glaser’s approach as the modified objectivist which only allows emergent data to shape theorising (Glaser, 1978); Strauss and Corbin who take a more provocative and interventionist approach to influence the data (Jones & Noble, 2007); and Charmaz and Clarke who take the approach of constructing data from a relationship that is inherently shared between the researcher and the participant (Charmaz, 2006).

Heath and Cowley (2004) suggest that the difference between Glaser’s traditional view and Strauss’ contemporary view is methodological rather than ontological and epistemological, whereas Annells (1996) and Mills et al. (2006) suggest they differ in their epistemology and ontological perspective as well as their methodological approach. If Glaser and Strauss had discussed epistemological, ontological and methodological views then this may have accounted for their different views of grounded theory: Glaser’s approach to grounded theory is that of a post positivist with an ontological stance of critical realism, an epistemology
of a modified objectivist and a methodology of modified experimental (Annells, 1996). Strauss and Corbin’s philosophical perspective towards grounded theory is that of constructivism with an ontology of relativism, an epistemology of subjectivism, and a methodology of construction. This fits within a constructivist paradigm which views theory as being a construction of the researcher (Annells, 1996; Mills et al., 2006).

Traditional and contemporary grounded theorists may take different approaches to grounded theory; these different approaches allow the researcher to position themselves in the study and guide how grounded theory methods are applied. It is important to realise that the grounded theory methods themselves essentially remain the same (Birks & Mills, 2011). It is only by analysing and understanding how research paradigms influence research can the author fully defend her position for her chosen paradigm and methodology including her application of grounded theory to the research.

The previous paragraphs have outlined the differences between research paradigms and their influence grounded theory methods. According to Glaser, the heart of grounded theory is the constant comparative method of data analysis (Glaser, 1992, 2002; Glaser & Strauss, 1967) and it is this method that allows for the true emergence of theory from the data. Glaser does not advocate a constructivist paradigm in grounded theory and makes it very clear that the real meaning of a social process is grounded in the data (Glaser, 1992) and will ‘fit the reality under study’ (Glaser, 1992, p. 15). Approaches such as constructivism and
critical theory force the data and hence the emerging theory, which is not what grounded theory was created to do (Glaser, 1992).

This study is a grounded theory study of rural nurse resignations and is ontologically, epistemologically and methodologically placed and performed in a post positivist paradigm using a Glaserian approach to grounded theory. This was done after careful analysis of the research paradigms, their relation to grounded theory, the research problem, and analysis of the grounded theory seminal authors. Grounded theory fits within the frame of post positivism epistemologically, ontologically and methodologically (Annells, 1996, 1997a). The relevance of grounded theory to this study is detailed in Section 3.7.

This discussion has so far revealed the researcher’s stance on taking a post positivist traditional Glaserian grounded theory approach to the substantive area of rural nurse resignations. Details of the components of grounded theory will be outlined in the following section and, from this point of the thesis, only traditional Glaserian grounded theory methods and their application will be discussed.

3.4 The Components of Grounded Theory

This section will outline the various components of Glaserian grounded theory including purposive and theoretical sampling, comparative data collection and analysis, theoretical sensitivity, substantive and theoretical coding, memoing, conceptualising, the basic social process and theory generation. In addition, the role of the literature review in traditional grounded theory will be discussed. Researcher reflexivity and the relevance of grounded theory to this research will
be discussed in the forthcoming sections. The subsequent chapter will present the application of grounded theory to this study.

**Purposive and theoretical sampling**

In grounded theory, participants are recruited using both purposive sampling and theoretical sampling. Purposive sampling is a starting point for participant recruitment where a researcher initiates data collection with a participant who is related to the basic problem (Glaser, 1978). Purposive sampling continues until enough data see the emergence of theory. Following that, theoretical sampling is used to continue data collection from new or the same participants for generating theory (Glaser, 1978, 1992; Glaser & Strauss, 1967).

Theoretical sampling is the conscious, grounded deductive feature of data collection and analysis and constantly focuses and delimits the collection and analysis of data (Glaser, 1998) – feeding into data for further induction as the theory develops. Theoretical sampling occurs with the researcher constantly and concurrently collecting and analysing data, generating codes and then deciding where to collect data from next in order to develop the emerging theory. It is only as the emerging theory develops that participants can be recruited; this cannot be planned prior to the research (Glaser, 1992, 2007). Theoretical sampling allows the researcher to check the emerging conceptual framework, rather than verifying a preconceived hypothesis, and moves the theory along (Glaser, 1978, p. 45).
Comparative data collection and analysis

The constant comparative method of data collection is fundamental to grounded theory and involves coding and comparing data for categories and their properties. Categories are generated from the data and properties are generated concepts about the categories (Glaser, 1978, 1992, 2002; Glaser & Strauss, 1967). The basis of grounded theory is to discover theory during data collection and not prior to it; it is important for the data to be analysed prior to collecting the next piece of data (Corbin & Strauss, 2008; Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). The constant comparative method involves four stages: comparing incidents with each category; integrating categories and their properties; delimiting the theory; and writing the theory (Glaser & Strauss, 1967). The comparative method allows for concepts to emerge which drive the subsequent data collection. Identified categories are then compared to previous data and this constantly occurs until all data have been collected and saturation achieved. Saturation is when further data collection does not change the categories or its properties (Glaser, 1978).

In addition, the constant comparative method allows the researcher to explore relationships between the data. For instance, if data are collected through interview, the first interview will identify what is happening, and what is the situation. Subsequent interviews are conducted with an emerging theory in mind from the previous interview (Glaser, 1978, 1992). The defining rule of the constant comparative method is that whilst coding an incident for a category it is necessary to compare it with the previous incident in the same and different groups coded in the same category. This constant comparison of the incidents

**Theoretical sensitivity**

Theoretical sensitivity is the ability to generate concepts from the data and then relate these to theory development (Glaser, 1978, 1992). Within the development of theoretical sensitivity, researcher reflexivity is embedded (Glaser, 1978, 1992); this is discussed in Section 3.5. Sensitivity, or insight into the data, occurs from the researcher’s immersion in the data as well as what the researcher brings to the research. In Glaserian grounded theory, Glaser (1992) suggests that, in order to be objective and theoretically sensitive, two aspects will arise. First, as grounded theory deals with what is happening in the action system being studied, observations are not enough (in the case of this research it was not possible for observations to be included as the nurses had already resigned from the hospital). The researcher should also interview participants to ensure that assumptions as to the context of the actions are not made. Observations alone do not give meaning to the researcher. Second, if the data are forced, constantly comparing the data (the heart of grounded theory) to discover underlying meanings will soon iron out and reveal preconceived meanings by the researcher – preconceived assumptions and meanings will not pattern out (Glaser, 1978, 1992).

**Coding**

In Glaserian grounded theory, coding of data entails three types of coding: substantive coding, theoretical coding and the constant comparative method. Substantive coding consists of open and selective coding where the researcher
conceptualises the observed substance of the area of research (Glaser, 1978, 1998). Open coding is the initial sorting of data into descriptive codes. These codes are given preliminary names that may change as data analysis progresses. Open codes are compared with other open codes for similarities and differences and are often subsumed together to form categories. As data collection and analysis progress, more open codes emerge. The researcher will continue to compare open codes and again subsume like codes. Once a main theme (the core category) emerges, open coding ceases and selective coding ensues (Glaser, 1978, 1992). Selective coding delimits coding to only those variables that relate to the core category in order to develop theory (Glaser, 1992).

Theory then develops around the core category (Glaser, 1992). The core category accounts for variation in the behaviour of the participants. The core category has several functions: for generating a grounded theory, density, integration, saturation, completeness and delimiting the focus (Glaser, 1992, p. 75). The core category is the main theme or area which emerges; it is the main concern or problem for the participants (Glaser, 1978, 2007). Glaser (1978) suggests that the core category must be related to as many categories and their properties as possible and must account for a large section of the variation in the pattern of behaviour. It must be central, it must reoccur often in the data, it will take time to saturate due to its relationship to many categories and properties, it relates with meaning to other categories easily, has clear implications for formal theory, and it does not lead to dead ends in theory. It is variable in degree, dimension and type with conditions varying it effortlessly (Glaser, 1978, 2007).
Theoretical coding is where a researcher conceptualises how the substantive codes relate to each other to integrate the substantive codes into a theory (Glaser, 1978, 1998). Theoretical codes are not the theory but the abstractions that model the integration of the substantive codes (Glaser, 2005) and are not based on sorting data but sorting memos (Glaser, 2005). Substantive and theoretical codes are considered to be emergent. Substantive coding opens the data up and theoretical coding ‘weaves the fractured story back together’ (Glaser, 1978, p. 72). Theoretical codes without substantive codes are ‘empty abstractions’ (Glaser, 1978, p. 72).

**Memoing**

Memos are informal written notes on analysis (Charmaz, 2006; Glaser, 1992; Glaser & Strauss, 1967; Strauss & Corbin, 1998) and are written up as they occur to the researcher when constantly comparing data, analysing and coding (Glaser, 1978, 1992). Both Glaser and Strauss suggest that memoing is an integral component of data analysis in a grounded theory study (Glaser, 1992; Strauss & Corbin, 1998). Memos are a crucial step between data analysis and writing, and assist the researcher in capturing their thoughts and prompt them to ask questions about what is emerging. Memos also allow the researcher to make comparisons between codes, data, categories and concepts (Charmaz, 2006) and to think aloud on paper.

Through the use of memos the researcher is able to engage with their research to a greater degree than would otherwise be the case. A richer relationship is established with data that facilitates the researcher to achieve a deeper sensitivity
to the meanings contained therein. The most pragmatic use of memos is to record the decision-making trail that establishes and guides the research through its many phases from conceptualisation to completion (Birks, Chapman & Francis, 2008). Theoretical memos are ‘the core stage of grounded theory methodology’ (Glaser, 1998, p. 177) and are ‘the theorising write-up of ideas about substantive codes and their theoretically coded relationships as they emerge during coding, collecting and analysing data’ (Glaser, 1998, p. 177). Glaser distinctly instructs researchers that theoretical codes emerge from memos and not the data (Glaser, 2005). Once theoretical memos are written throughout the research, sorting then occurs. Sorting refers not to data sorting, but to conceptual sorting of the theoretical memos into an outline of the emergent theory, showing relationships between concepts (Glaser, 1978).

**Conceptualising**

Grounded theory is the generation of emergent conceptualisations into an integrated pattern or theory which contains a core category that has properties. Categories and their properties provide conceptual empowerment (Glaser, 1998). Glaser believes that grounded theory differs from QDA. QDA focuses on time, place and people whereas grounded theory is abstract of these, meaning that QDA will be confronted with the problems of context and construction. Grounded theory, however, will generate conceptual hypotheses that can be applied to any time, place and people with emergent fit (Glaser, 2002). Once concepts are discovered they leave the level of ‘people’ and, instead, become the focus of the research.
Grounded theory is based on a third-level conceptual analysis. The first level is the data; the second level is the conceptualisation of the data into categories and their properties. A category is a higher level concept than a property. There are conceptual levels of categories with the core category the highest, followed by categories, then by properties (Glaser, 1998). The third level of conceptualisation is the substantive theory. Grounded theory aims to find at least the third level of conceptual analysis: a substantive theory, where discovering the core category organises other categories to resolve the main concern (Glaser, 2002).

**The basic social process**

A basic social process describes an account of variation in the problematic behaviour of the participants (Glaser, 1978) which in this study is the reasons that lead to rural nurse resignation. A basic social process has a minimum of two clear emergent stages. These stages are the prime property of a basic social process (Glaser, 1978). These two emergent stages should differentiate and account for variations in the problematic pattern of behaviour. A basic social process processes a social or social psychological problem. It may or may not solve the problem, but it will process it (Glaser, 1978). This process occurs over time and involves change over time, and these changes have discernable breaking points (Glaser, 1978). Basic social processes involve stages and these function as an integrating scheme which ties together various sets of properties. Stages have a time dimension; they have a beginning and an end. The transition from one stage to the next is contingent upon one or more things happening (Glaser, 1978).
Generating theory

Developing theory is complex. Data analysis may be either descriptive, conceptual ordering or theorising (Glaser & Strauss, 1967). A grounded theory is not findings; rather, it is an integrated set of conceptual hypotheses and the systematic generation of theory from data following a systematic method (Glaser, 1998). This systematic method for generating grounded theory incorporates the organised collection and analysis of data, the constant comparison of that data, and the use of theoretical sensitivity and theoretical sampling to build theory (Glaser, 1992). In the constant comparative method of data analysis, different groups or subgroups of people are compared and built into theory. After examining the data, patterns in the data can lead to the development of concepts (Glaser, 1992, 2002; Glaser & Strauss, 1967). These concepts can then be built into increasingly broader, theoretical propositions which can then be evaluated and compared to other groups of data. Glaser (1992) suggests that the logic of grounded theory relates to two questions: first, what is the chief concern or problem of the people in the substantive area and what accounts for most of the variation in processing the problem?; and secondly, what category does this incident indicate?

According to Glaser and Strauss (1967, p. 23) ‘in discovering theory, one generates conceptual categories or their properties from evidence, and then the evidence from which the category emerged is used to illustrate the concept’. The researcher’s aim is not to provide a perfect description of an area, but to develop a theory that accounts for much of the relevant behaviour (Glaser, 2002; Glaser & Strauss, 1967). Exploring a new area of research with a preconceived theoretical
framework will merely blind the researcher to the richness of the new data (Glaser, 1992; Glaser & Strauss, 1967).

**The literature review in grounded theory**

According to Glaser (1978, 1992), there is no need for the researcher to perform a literature review prior to data collection as this may constrict or constrain the researcher to generating ‘known’ categories (Glaser, 1978, 1992). In comparison, contemporary grounded theorists such as Clarke (2005) feel that extensive knowledge of the substantive area should be seen as valuable rather than a hindrance. Strauss and Corbin (1998) suggest that all researchers bring with them an extensive background, a professional knowledge base of literature and professional experience and that this knowledge assists the researcher in developing sensitivity to the research. Contemporary grounded theorists outline that in today’s modern research world an extensive literature review is or often has been performed by the researcher for the purpose of research proposals and dissertations – quite true for this researcher and, in fact, the literature review performed prior to data collection can assist the researcher in gaining sensitivity (Clarke, 2005; Corbin & Strauss, 2008).

Glaser (1998) acknowledges that for a PhD and some funded dissertations, there is often no choice for students but to immerse themselves in the literature prior to the research proposal; it is a university requirement. Both traditional and contemporary seminal grounded theorists enforce the importance of theoretical sensitivity. Theoretical sensitivity is the ability to generate concepts from the data and then relate these to theory development (Glaser, 1978, 1992). Sensitivity also
occurs from the researcher’s immersion in the data as well as the experience the researcher brings to the research (Charmaz, 2006; Clarke, 2005; Corbin & Strauss, 2008; Glaser, 1978; Strauss & Corbin, 1998). A defence for not adhering to this particular aspect of traditional grounded theory will now be presented.

For this study, a traditional Glaserian approach to grounded theory was used with the exception of the literature review. While the traditional approach to research, whether quantitative or qualitative, is to read and critique the literature prior to data collection, traditional grounded theory refutes this. In a grounded theory study that adheres to the traditional Glaser methodology, the literature review is performed either concurrently with data collection or after theory emerges (Glaser, 1978, 1992). Glaser (1998) strongly advocates that the grounded theory researcher should not perform the literature review prior to data collection and analysis. This is to keep the researcher free and as open as possible to emerging concepts from the data.

For this study, the author remained in keeping with a Glaserian ontology, epistemology and (mostly) methodology. The only time the author swayed from a strict Glaserian methodology was with the literature review where a more contemporary approach was adopted. This was because the nursing shortage had been so extensively researched that the author wanted to explore the literature prior to data collection.

Taking the above argument into consideration, this study encompasses a rich and comprehensive literature review in the second chapter. The literature review was

3.5 Researcher Reflexivity

Dynamic and creative, reflexivity gives qualitative research its pulse (Kleinsasser, 2000). Researcher reflexivity involves reflecting upon the ways in which personal values, beliefs and experiences may shape or influence the research. It also involves thinking about how the research may affect and possibly change the researcher (Kleinsasser, 2000). Reflexivity is embedded within the development of theoretical sensitivity, an important component of grounded theory (Glaser, 1978, 1992).

In grounded theory, the researcher starts with an area of intense personal interest; it is this personal interest that is vital for the researcher to have the motivation for the study (Glaser, 1998). Glaser refers to reflexivity as sensitivity. Researchers do not enter an area of study empty or, give up their knowledge. As a registered nurse, the researcher had resigned from a rural hospital as a result of job dissatisfaction. For the purpose of a grounded theory study, experience of the research phenomenon is beneficial to the study as it allows the researcher to be theoretically sensitive, a requirement for grounded theory (Glaser, 1978).

Theoretical sensitivity and reflexivity encompass using personal attributes consciously to facilitate the analytical process. This includes the examination of personal beliefs and assumptions against data collected rather than exploring them
for the impact they may have had on the process of accessing a sample or data collection (Neill, 2006). Glaser (2001) clearly rejects reflexivity as a distraction from the data, seeing constant comparative analysis (refer to Section 3.4) as having the ability to expose researcher effects on the data.

Two aspects of the research design limited the potential bias of researcher reflexivity. First, as is advocated in traditional grounded theory, this research is from a post positivist paradigm where the researcher remains a detached observer. In light of this, the participants were not aware of the researcher’s background or personal experience of rural nurse resignations. This is in contrast to a constructivist approach where the researcher and the participant co-create the data. Second, in traditional grounded theory if data are forced by researcher bias, constantly comparing the data to discover underlying meanings will reveal preconceived meanings by the researcher and these will result in an ill-fitting theory (Glaser, 1992). As constant comparison generates categories, researcher bias is corrected by the same process. A category or concept based on impression or researcher experience can be biased. The researcher will soon realise that no matter how much they may distort the data through bias, as incidents are compared, the distortion will be revealed. The bias will be corrected by this process (Glaser, 1992).

3.6 Relevance of Grounded Theory to this Research

The purpose of this study was to explore why registered nurses resigned from rural hospitals. This study examined the apprehendable reality for rural nurses in order to generate a potentially useful substantive theory; a theory which could be
used to assist in developing retention strategies for the nursing workforce in NSW rural hospitals.

It is important to select an appropriate method and theoretical perspective to fit the research problem and this should be driven by the problem itself (nursing resignations), the aim of the research (to establish the reasons why nurses resign from rural hospitals) as well as the researcher’s paradigmatic beliefs (post positivism) (Newman, 2008). While grounded theory has been used often to study areas in which little previous research has been conducted, it is also used to gain a new viewpoint in familiar areas of research (Burns & Grove, 2003). Glaser (1992) suggests that grounded theory can open up areas that have been heavily studied (e.g. the nursing shortage).

Ontologically, Glaserian grounded theory will enable the emergence of a theory based on the assumption that the reality of rural hospitals was shared by all participants. This reality is a single apprehendable reality assumed to exist but to be only imperfectly apprehendable because of basically flawed human intellectual mechanisms and the fundamentally intractable nature of phenomena.

Epistemologically, the researcher maintained a detached role during the study rather than a co-creator, fitting with Glaserian grounded theory. Detachment was achieved by in-depth interviewing of participants but at all times the researcher remained passive. The relevance of this detached role was to ensure that the data were not constructed or co-created; rather, data were drawn from the participants’ experience. In Glaserian grounded theory, forced or constructed data will not iron
out when analysing, and concepts will fall over, resulting in a weak theory that does not fit the study at hand (Glaser, 1978, 1992). The reasons why nurses resign must emerge from the data.

Lastly, methodologically, Glaserian grounded theory was used following the processes outlined in this chapter in accordance with Glaser (with the exception of the literature review). These included purposive and theoretical sampling, substantive and theoretical coding, using the constant comparative method to compare incident to incident and a substantive grounded theory emerged using the constant comparative method, theoretical sampling and theoretical sensitivity.

3.7 Chapter Summary
This chapter has sought to clarify and discuss grounded theory methodology and research paradigms. It also detailed the inception of grounded theory by Glaser and Strauss, discussed the methodology of a grounded theory approach to this research and explained the processes involved in order to achieve a Glaserian grounded theory.

The chapter also summarised the ontological and epistemological views of research paradigms and how they relate to grounded theory, the relevance of grounded theory to this research and, the importance of the constant comparative method of data analysis. The chapter discussed both the seminal traditional grounded theorists such as Glaser and Strauss (early work) as well as contemporary grounded theorists including Charmaz and Clarke. This was done to provide a current overview of grounded theory and to provide an explanation to
the reader as to why the author chose a post positivist approach to grounded theory and why a Glaserian grounded theory methodology was chosen.

In the following chapter, the application of grounded theory methodology to this study will be described. The study design, methods and the steps taken to generate the substantive theory will be discussed.
4.1 Introduction

The aim of this study is to understand why nurses resign from NSW rural hospitals from the perspective of participants who have already resigned. Capturing data from these participants and understanding what the basic social problem is will guide the emergence of a grounded theory. The previous chapter detailed the methodology of grounded theory and explored associated research paradigms. Specifically, the chapter provided evidence as to why the researcher chose to situate the study within a post positivist paradigm which requires Glaserian grounded theory. What follows now is a discussion as to how Glaserian grounded theory was applied to the collection and analysis of data to generate a core category around which a substantive grounded theory of rural nurse resignations emerged.

Details of the participants and their recruitment, ethical considerations and data collection through interviews will be discussed as well as a detailed account of the data analysis. The analysis will reveal the development of categories, details of substantive and theoretical coding and theoretical saturation. Finally, the emergence of the core category, the basic social process and a substantive grounded theory will be discussed. Data management and issues of rigour and trustworthiness are also included.
As is consistent with grounded theory, data collection and data analysis occurred simultaneously. Nurses who had resigned from NSW rural hospitals formed the substantive group from which data were collected leading to the emergence of a theory of rural nurse resignations. Therefore, this study is limited to a substantive rather than formal theory. This section begins with details of this substantive group of rural nurses.

4.2 Sample and Recruitment

This section details how participants were recruited and also discusses how purposive and theoretical sampling were utilised in accordance with grounded theory methods. Participants were twelve registered nurses who had worked in a rural NSW hospital and who met the following inclusion criteria:

- they had resigned from a rural hospital or AHS after 1 January 2000; and
- the reasons for resignation were not associated with maternity leave, retirement or a family member’s geographical relocation.

Identification and recruitment of registered nurses were problematic for this study. As this is a substantive study of nurses who have resigned from rural hospitals, locating these participants was difficult. The NSW NMB was responsible for maintaining the register of nurses at the time of this study; this register could be used to generate a mail-out to groups of registered nurses. Using the NSW NMB to initially locate participants was not considered feasible for this study. This was because the NSW NMB does not keep records of where nurses resign from and, secondly, nurses may choose to let their annual registration lapse, so the NSW NMB would no longer have information about these nurses’ locations. It was also
identified that contacting rural hospitals requesting information about registered nurses who had recently resigned was a clear breach of the hospital’s confidentiality policy and would in fact breach current legislation that governs personal information.

The first participant was recruited using purposive sampling when the researcher was talking to a work colleague about the research. Purposive sampling is consistent with grounded theory (refer to Section 3.4). The work colleague stated that she fitted the criteria and was happy to be interviewed. The second participant was identified by one of the researcher’s supervisors and this person was contacted and agreed to be interviewed. Purposive sampling continued by an advertisement being placed on the Charles Sturt University (CSU) daily electronic newsletter CSU What’s New and News as this reaches across the Dubbo, Orange, Bathurst, Wagga Wagga and Albury regions covering a large area of rural western and southern NSW. This advertising resulted in a further four people contacting the researcher stating they would be happy to be involved in the research. All four fitted the inclusion criteria (see earlier) and were subsequently interviewed. The four participants along with the initial two participants resulted in six participants being interviewed.

Data collection up to this point had been elicited only from nurses who had resigned from general public rural hospitals. The researcher then employed theoretical sampling to see if interviewing nurses from non-public (i.e. private) or non-general hospitals would assist in saturating current categories, to identify the emergence of new categories, or would confirm the emerging theory. This method
ensured that maximum opportunities had been explored to compare events and incidences and to determine how categories vary in their properties. In order to ensure saturation of emerging categories, Glaser (1992, 2007) guides the researcher to ask what subgroups should be included in the study next and for what theoretical purpose; this is theoretical sampling. A registered nurse from a private rural hospital was recruited when another advertisement was placed on CSU What’s New and News and interviewed. A total of seven participants had now been interviewed.

An advertisement was then placed in the Bathurst daily newspaper The Advocate inviting registered nurses who had resigned from rural hospitals to contact the researcher. The Advocate was chosen because of its weekly magazine insert that appears across western rural NSW. Unfortunately, this recruitment strategy did not result in any new participants. A subsequent advertisement was then placed in a fortnightly newsletter that registered nurses access (name of publication withheld to de-identify data); this resulted in two participants, and a conversation at a research forum identified another participant. This gave a total of ten participants for the study. These interviews were coded and compared and, at this time of participant recruitment, the core category had emerged.

A further participant was found after discussing the research with a colleague who stated they knew of someone who fitted the inclusion criteria and also worked in a non-general public hospital. That person was contacted and agreed to be interviewed. Eleven participants had been interviewed and a twelfth participant was identified via the researcher’s supervisor to make a total of twelve registered
nurses that had been interviewed. Fortunately, at this point, data saturation had occurred with full saturation of the categories and properties and the emergence of the core category.

**Characteristics of participants**

All participants were registered nurses who had worked in and subsequently resigned from a NSW rural hospital (either public or private). Participants had received entry level nursing qualifications from either a hospital or university; nursing experience ranged from eight to thirty-two years, and there was one male participant. Participants formerly held positions from senior nurse management to clinical ward-level positions and included nurses from large rural hospitals to extremely remote rural clinics. The research also explored what area of employment nurses went into after resigning from their hospital position (i.e. nursing or non nursing). Table 6 details the demographic details of the twelve participants.
<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Gender</th>
<th>Initial Nursing Qualification</th>
<th>Type of Rural Hospital</th>
<th>Area Nurse Worked in When They Resigned</th>
<th>Where did Nurse Work After Resigned</th>
<th>Year Qualified as a Registered Nurse</th>
<th>Years in Nursing</th>
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</thead>
<tbody>
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<td>Anne</td>
<td>35–40</td>
<td>Female</td>
<td>Hospital</td>
<td>Large rural hospital</td>
<td>Cardiac</td>
<td>Non nursing</td>
<td>1987</td>
<td>18</td>
</tr>
<tr>
<td>Belinda</td>
<td>50 plus</td>
<td>Female</td>
<td>Hospital</td>
<td>Rural AHS</td>
<td>Senior Management</td>
<td>Non nursing</td>
<td>1969</td>
<td>28</td>
</tr>
<tr>
<td>Lee</td>
<td>41–50</td>
<td>Female</td>
<td>University</td>
<td>Large rural hospital</td>
<td>Accident and Emergency</td>
<td>Nursing community</td>
<td>1995</td>
<td>10</td>
</tr>
<tr>
<td>David</td>
<td>30–34</td>
<td>Male</td>
<td>University</td>
<td>Large rural hospital</td>
<td>Nurse Education</td>
<td>Nurse academic</td>
<td>1997</td>
<td>10</td>
</tr>
<tr>
<td>Jenny</td>
<td>41–50</td>
<td>Female</td>
<td>Hospital</td>
<td>Remote area clinic</td>
<td>Remote Area Nursing</td>
<td>Nurse academic</td>
<td>1981</td>
<td>25</td>
</tr>
<tr>
<td>Sally</td>
<td>41–50</td>
<td>Female</td>
<td>Hospital</td>
<td>Rural AHS</td>
<td>Senior Management</td>
<td>Non nursing</td>
<td>1977</td>
<td>32</td>
</tr>
<tr>
<td>Jade</td>
<td>20–30</td>
<td>Female</td>
<td>University</td>
<td>Private rural hospital</td>
<td>High Dependency</td>
<td>Nursing projects</td>
<td>1999</td>
<td>8</td>
</tr>
<tr>
<td>Judy</td>
<td>50 plus</td>
<td>Female</td>
<td>Hospital</td>
<td>MPS</td>
<td>General and Management</td>
<td>Nursing projects</td>
<td>1976</td>
<td>31</td>
</tr>
<tr>
<td>Wynette</td>
<td>50 plus</td>
<td>Female</td>
<td>Hospital</td>
<td>Rural hospital</td>
<td>Senior Management</td>
<td>Nurse academic</td>
<td>1974</td>
<td>31</td>
</tr>
<tr>
<td>Juanita</td>
<td>50 plus</td>
<td>Female</td>
<td>Hospital</td>
<td>Large rural hospital</td>
<td>Midwifery</td>
<td>Nursing projects</td>
<td>1975</td>
<td>28</td>
</tr>
<tr>
<td>Sylvia</td>
<td>41–50</td>
<td>Female</td>
<td>Hospital</td>
<td>Rural mental health hospital</td>
<td>Mental Health</td>
<td>Nursing community</td>
<td>1984</td>
<td>23</td>
</tr>
<tr>
<td>Stella</td>
<td>35–40</td>
<td>Female</td>
<td>University</td>
<td>Large rural hospital</td>
<td>Intensive Care</td>
<td>Nurse academic</td>
<td>1994</td>
<td>16</td>
</tr>
</tbody>
</table>
Theoretical sampling

Theoretical sampling is the process of deciding where (or who) to collect data from next in order to develop the emerging theory and allows the researcher to check the emerging conceptual framework and progress the theory (Glaser, 1978). For this study, some aspects of theoretical sampling occurred, not by intent, but serendipitously. As alluded to earlier in this chapter, participants for this study were difficult to locate. Due to this difficulty, the idea of choosing participants selectively for the purpose of developing the emerging theory was not possible. However, theoretical sampling did occur and an account of this will now be discussed.

The data collected and analysed from the first four participants in this study related to their work as registered nurses in large rural hospitals. Codes emerged easily. By sheer chance, the fifth participant had been employed as a remote area nurse. This created an opportunity for the researcher to explore if data from nurses in remote areas would further saturate current categories or identify new categories. Data collection continued and again by chance another variation occurred in the participant profile. Up to this stage of collection, all participants had worked in public hospitals but a participant was identified who had been employed in a non-public hospital (i.e. private). Again, the researcher maximised this opportunity to see if this would further saturate categories. Data collection continued and another participant was identified to employ theoretical sampling. This participant had worked in a non-general public hospital and again this opportunity was used to see if this would further saturate emerging categories.
Theoretical sampling ensured that maximum opportunities had been explored to compare events and incidences and to determine how categories varied in their dimensions and properties, how they assisted in saturating current categories, identified the emergence of new categories and assisted in confirming the emerging theory.

4.3 Ethical Considerations

Ethical considerations are an important and essential part of research. Ethics approval for this research was gained from Charles Sturt University Ethics in Human Research Committee in November 2004, approval number 2004/228. This section provides an overview of the ethical considerations of this study including harm avoidance; participant informed consent; privacy, anonymity and confidentiality; security and integrity of data; and a risk and benefit analysis.

Avoidance of harm to participants

It was identified that there was a small potential risk of participants being harmed psychologically by retelling their story, especially if their resignation from a hospital involved traumatic events for the participant. All participants were made aware of this in an information sheet (see Appendix A) and all participants were offered counselling should this occur. One participant became distressed during the interview process and was offered counselling. The participant declined. One month later, a follow-up email was sent to this participant thanking her for her time but, more importantly, this was used as an opportunity to offer counselling a second time. The participant stated that she was fine and counselling was again declined.
Informed consent

Informed consent was obtained from all participants. Participants were provided with a consent form (see Appendix B) and an information sheet explaining both the nature of the research as well as the aim of the research. Participants were informed of the risks associated with their participation, their right not to participate and their right to withdraw consent at any time. All participants were over the age of eighteen and had the capacity to give consent. No participants were from non-English speaking backgrounds or Indigenous backgrounds. Participants were informed of the time needed to be involved in the research prior to being interviewed.

Privacy, anonymity and confidentiality

All participants were informed of confidentiality and its limits. This was contained in the information sheet. Limits to confidentiality were identified as there being a small chance that people may be able to identify the participant due to certain information that they may give even though pseudonyms would be used. This may be an issue of anonymity and not confidentiality and could occur particularly in small rural towns or if a nurse held a position in a health area that was identifiable. The participants were made aware of this prior to data collection. Pseudonyms were used during the interview and subsequently appeared in the transcripts and the research findings. This was a strategy to maintain confidentiality.

All participants were informed in their consent form that the research findings may be published, but their real names would remain confidential. After transcription, participants were sent their transcript for clarification that their
words had been accurately captured and to see if the participant needed to change any ‘identifying’ information. One participant had mentioned the name of the hospital that she worked in and her position. As this would make her identifiable, the hospital name was removed from the transcript and replaced with the wording *a small rural hospital in the southern area of NSW*.

**Security and integrity of data**

All data were secured at all times. Dictaphone tapes were kept in a locked filing cabinet or a locked office while transcribing. Transcripts were also kept in a locked filing cabinet at the researcher’s home. All computer-entered data were placed on a password-protected computer. After the research was completed, dictaphone tapes, transcripts and coding entry books were stored in the researcher’s home in a locked filing cabinet, and will be destroyed by shredding in five years time.

**Risk and benefit analysis**

A risk and benefit analysis was performed by looking at both the benefit and risk to the participant, the community and also to the discipline of nursing. The benefit to the participant is the cathartic notion that their story is being told and heard and that someone does care why they resigned from a hospital nursing position. The participant may also feel that they are contributing to addressing the NSW rural nursing shortage. In hindsight, two participants informed me that the interview was therapeutic for them and they felt that they were contributing to a greater cause of identifying issues with the health system. One participant explored the idea of starting a support group for registered nurses who had resigned from NSW rural hospitals. This participant had felt angry when she resigned from the hospital.
and required counselling and felt there was a need for a support group for other nurses.

This study will have benefits for both the community and the discipline of nursing. By identifying the reasons why NSW rural registered nurses resign, relevant retention strategies could be implemented to address issues that lead to resignation, therefore creating better patient care, reducing stress on existing nursing staff, and creating job satisfaction and team cohesion with less health funding dollars spent on recruiting and retaining nurses.

4.4 Data Collection

This section of the chapter discusses how data were collected from the participants and details how interviews were conducted. For this study, data were collected from twelve participants; two participants were re-interviewed in order to elicit further data on key concepts and to explore if certain themes were in fact saturated. This is consistent with grounded theory. Each participant was interviewed alone and initially asked a series of identical questions to gain a demographic profile. Demographic data were collected from participants to elicit further information that may shape the emergent substantive theory of rural nurse resignations. These data included age group, gender, years of nursing experience, initial nursing qualification, hospital type and size, area of work that the nurse resigned from, and where the participant went to work after resignation (see Table 6).
Consistent with grounded theory, in-depth interviews were used. This allowed the researcher to clarify responses, probe responses in-depth, and was more effective at eliciting participants’ complex feelings. In-depth interviews also allow the researcher to discover the unexpected (Fontana & Frey, 2005). Furthermore, in-depth interviews take a semi-structured approach as they are specifically designed, through the recursive method of interviewing, to draw information from the participant that is relevant to the phenomena being studied. Recursive interviewing involves using what is being said by the participant to define the next question. The purpose of the recursive style of interview is to encourage participants to offer relevant data by participating in a conversation with the researcher. The goal of this interview technique is to draw out detailed and richly textured, person-centred data (Minichiello et al., 2004).

Interview techniques were used that assisted the participants to engage with the researcher and to disclose information. These included funnelling techniques where the researcher commenced the interview with open-ended broad questions such as ‘Tell me about what happened when you resigned’ and ‘Tell me your experience of working in a rural hospital’. The questions then narrowed down to the topic using questions such as ‘Tell me about the patient care you provided’. Probing techniques were used to gain further detail or to seek clarification.

As is consistent with a post positivist paradigm, the researcher remained a modified objectivist (detached observer) at all times. This was achieved by the researcher taking a stance of passivity with the participant in the interview. The researcher did not engage in a discussion of either personal or participant experiences and interviews were not co-constructed.
At the beginning of each interview and prior to taping, the researcher engaged in a short conversation with the participant to firstly break the ice and secondly to establish a pseudonym for the participant to use during the interview. This was so that participants would feel that they could not be identified and feel more confident in disclosing their story. The length of each interview varied and ranged from fifty minutes to two hours. The interview finished when no further data were forthcoming. Initially, each interview was taped on a dictaphone. However, on one occasion after interviewing one of the participants, some data were lost due to the malfunction of the dictaphone, so two dictaphones were then used to ensure greater integrity. Data from one dictaphone were transcribed and the second tape was securely stored as a back-up.

Interviews were conducted in a place chosen by the participant that allowed for privacy and lack of distractions. Participants were offered the choice of being interviewed in their place of work or the researcher’s office. For participants who lived a long distance from the researcher, it suited the participant to be interviewed in their place of work to avoid them having to travel.

Following each interview, the researcher also made memos that described the participant, location and date of interview, comments, thoughts and feelings of the researcher, thoughts on themes that had emerged, and contact details of the participant. These memos were then used when analysing the data to confirm or to assist emerging themes.

The first interview consisted of engaging in a dialogue with the participant; this interview was semi-structured with a few questions such as ‘Tell me about your
experience of working in a rural hospital’. After the first interview was transcribed and analysed, codes emerged quickly and this led to the researcher preparing a list of open-ended questions for the next participant which was then given to the participant approximately one week prior to interview. This was done to allow the participant time to think the questions over. Questions evolved after each transcript was analysed and, as the research progressed and more participants were interviewed, the questions increased. All questions were open ended and were not asked in a methodical order; rather, the researcher listened to the participants and then used the list of questions as a prompt for further story telling. As is consistent with grounded theory, data collection and analysis occurred concurrently and the next section will detail how the analysis evolved.

4.5 Data Analysis

Chapter Three presented a discussion on the constant comparative method of data analysis used in Glaserian grounded theory research. This section of Chapter Four details the application of these methods to this study including coding and data comparisons; it describes how codes were named and subsumed to form substantive codes (categories) and then illustrates how the main or core category emerged with the integration of the substantive codes as properties of the core category. Additionally, theoretical memos will be included to show the process of the emergence of theoretical codes that illustrate the relationships and integration of the core category and its properties into a dense and rich grounded theory.

Fourteen transcripts yielded 219 single-spaced pages in word documents that were then imported into NVivo and coded (see Section 4.7 Data Management). All data
were coded by the researcher with initial coding discussed with both supervisors. Each interview was transcribed and analysed prior to the next interview. Prior to transcribing each interview from the recording, the full interview was listened to by the researcher in order to commence the phase of immersion in the data. During this stage, memos were made to assist in the analysis process. Once the interview had been listened to, each recording was then transcribed verbatim.

Following this process, the transcript was then sent to each of the participants to check that the transcript was an accurate account verbatim. Member checking, a process whereby participants are invited to check if the analysed data reflects their situation (Glaser, 2002) was not employed. Glaser (2002) believes that member checking is not warranted in grounded theory as participants may not recognise the analysis due to the level of abstract conceptualisation of the data to generate theory. In order to further enhance category development, two participants were re-interviewed; this process will be discussed further in this chapter.

**Constant comparative data analysis**

All data were analysed using the constant comparative method of data analysis. The following diagram, Figure 2, demonstrates the concurrent process that was used throughout the research process. Participants were interviewed, transcripts were then analysed and interview questions formed for the next participant. As each transcript was analysed, codes and categories emerged and developed. Participants continued to be interviewed. Data from the participant interviews allowed the categories to develop and eventually the theory was saturated. This process continued until a substantive grounded theory emerged.
What follows now is an in-depth discussion as to how each component of the constant comparative method was employed to generate a theory of rural nurse resignations.

**Open coding**

The first stage in constantly comparing data is the process of open coding (Glaser, 1978, 1992, 2002, 2007; Glaser & Strauss, 1967). Participants’ transcripts were examined line by line and subsequently open codes were assigned. Open codes provide a descriptive account of what is occurring in the data for the participants. At this early stage of analysis, the researcher has no preconceived ideas and open coding allows the data to be opened (Glaser, 1978, 1992). The open codes that emerged from the data were given a name that described what was occurring in the data; the names of the codes at this stage were purely provisional and descriptive but provided a starting point for grouping and analysing data. The naming of open codes was facilitated by the theoretical sensitivity of the researcher’s experience in the field of nursing and experience of resigning from a
rural hospital. The following three excerpts from transcribed interviews provide an example of how open codes were given their descriptive name.

... the biggest thing for me I think was though that I felt like I couldn’t deliver like the level of nursing care that the patients deserved and that I wanted to give. (Jade)

Initial open code ‘Nurse not being able to give the care they wanted’

And then if an ambulance came through and you had no beds, then you get a bed from recovery, like any time, running around from x-ray with a bed, like just to put a patient on it. (Lee)

Initial open code ‘Inadequate resources’

I was told that I didn’t see anything, that if I wanted to stay in the profession and I wanted to work in a hospital I will keep my mouth shut, I was basically threatened. (Sylvia)

Initial open code ‘Bullying’

The open codes were grouped as ‘free nodes’ in NVivo. Free nodes are stand-alone nodes that have no clear connection or logic with other nodes and are used at the beginning of the coding process.

After analysing the first transcript, the next interview was then conducted; this is consistent with grounded theory where the researcher jointly codes and analyses data to generate theory (Glaser & Strauss, 1967). From the emerging open codes, interview questions were determined for subsequent participants. This process of open coding and developing participant interview questions evolved for five interviews. After the fifth interview, eighty-three open codes had emerged from the data and a descriptive account of nurse resignations was emerging. The eighty-three open codes were becoming cumbersome and overlapping of codes was occurring.
In order to reduce the open codes into more succinct and meaningful codes that would eventually lead to theory emergence, the descriptive open codes were typed into a word document and sorted manually by cutting and pasting until groups of like codes were clustered together. These clusters were the preliminary categories and were given a name, again purely descriptive. This process took many weeks to complete with the researcher constantly reorganising and comparing codes. Similar and dissimilar codes were compared and sorted. Sorting occurred using the constant comparative method of examining the free nodes and comparing them to other free nodes and the data that were contained in these nodes. Overlapping codes were compared and subsumed and this reduced the number of free nodes. The free nodes were compared and those with similar meanings were then grouped together to create preliminary categories or, in NVivo language, tree nodes. Tree nodes are organised in a hierarchical structure and group the free nodes into categories. Appendix C provides a table of the initial eighty-three open codes and preliminary categories.

Moving from open coding to preliminary categories to core category

As described above, comparisons were made incident to incident, concept (crude names given to like incidents [Glaser & Strauss, 1967]) to more incidents and then concept to concept following a Glaserian grounded theory method (Glaser, 1978, 1992, 2007; Glaser & Strauss, 1967). The eighty-three open codes were subsumed to form nine preliminary categories: human resources, culture, societal issues, organisational structure, rural issues, patient care, work conditions within the hospital, family and personal reasons and impact of the job on nurses’ health. These preliminary categories provided a description of what was occurring in the data. While this assisted the researcher by placing the analysis into meaningful
categories, the categories lacked linkage and were descriptions only. A further two interviews (now a total of seven) saw the preliminary nine categories compared and re-sorted to form twelve categories that gave a better fit to the data: restructuring and centralising of health services, outdated and inflexible patient care systems, cumbersome hierarchy, management culture, bullying – limiting nurses’ voices, expendable nurses, different priorities – being money focused, inadequate resources for patient care provision, insufficient and inexperienced staff, powerlessness – participating in and witnessing poor patient care, lack of connectedness and shared vision and impact on nurses’ health. The open codes assisted in the development and saturation of these twelve categories.

Another interview was conducted (a total of eight interviews) and analysed. While new open codes emerged, these did not change the twelve newly named categories. The twelve categories were again reviewed and compared to look for similar and dissimilar features. During this process the researcher realised that the categories could be grouped and subsumed to better reflect the data and the twelve categories were subsumed to form four newly named categories: organisational structure, organisational attitudes, compromising care and compromising self. The twelve previous category names remained the same and became the properties of the four newly named categories. Further analysis of these four category names revealed that an important theme had emerged: internal and external factors. The data reflected two streams: organisational structure and organisational attitudes captured the work environment’s structure and attitudes; compromising care and compromising self captured how nurses felt about the care they wanted to provide or were providing, and the impact this had on the participants’ wellbeing.
At this stage of analysis, a whiteboard was used to ‘think out aloud’ and categories and their properties were written on the whiteboard, moved and rearranged in order for the researcher to capture what was happening in the data. From this strategy, the idea that there were two streams of data that reflected internal and external factors developed further. One stream was the external environment in which the participants worked and the other was the participants’ internal perception of nursing. *Organisational structure* and *organisational attitudes* were conceptualised to make one category that better fitted the concept of the external work environment in which the participants’ work occurred. This was relabelled as *organisational values*. The categories of *compromising care and compromising self* were conceptualised into *personal values*. The two categories of *organisational values* and *personal values*, while better reflecting the data, were still not the core category.

While the two categories of *organisational values* and *personal values* grouped and pinpointed the triggers for nurse resignation, the researcher felt that there was still a missing underlying reason for the trigger to be activated; the conceptual link. While these two categories provided a conceptual analysis, the core category and theoretical meaning that would link the categories together (i.e. a substantive grounded theory) were still not evident.

Of the two categories, neither could be identified as a core category; it was still elusive. The ninth interview was conducted and analysed to establish if the categories could be further saturated; no new categories emerged from the analysis of the ninth interview. Once again, the researcher was able to identify the triggers but was still not capturing the underlying concept or what was activating
the trigger, so the researcher wrote a memo. This memo captured an important theme that the researcher had missed. This memo stated:

*Wynette appears to be talking about how she had lost control of her ability to nurse how she wanted to. When Wynette was managing under the Hospital Board, she had control of budgets, services and staff including nursing and auxiliary staff. Wynette and the Board shared a common vision of how health care services and nursing should be provided and this allowed Wynette to nurse/manage in a way that she felt was the best way for the health system and allowed the best provision of nursing, health and patient care. When this style of Hospital Board management was in place she could control the ‘system’ and felt happy that the big picture health service provision was very good and that she could control a ‘good’ health service. When restructures and centralisation occurred she noticed a shift in how she felt nursing should occur and what she could now do. The services that affected her patients and staff and the community health system were not as ‘good’ as they were before (e.g. linen service moved, it became difficult to appoint staff), staff appointed by others outside of her control did not have a sense of caring for patients which Wynette would have tried to capture if she was controlling the staff appointments, she couldn’t pay a nurse more money to retain her even though this was a ‘good’ nurse, she lost decision-making power that impacted on service provision. When the Board was disbanded Margaret also lost ‘good’ communication with the next tier above her. The change in AHS restructuring created a shift from how Wynette was nursing to how she could now nurse, yet Wynette’s vision of nursing had not changed. This prevented her from being a ‘good’ nurse and providing good nursing care from primary to tertiary care levels. She was in a situation where the new structures conflicted with how she wanted to nurse. (Memo, February 2008)*

A new category and concept had emerged from this memo that linked the two categories of *organisational values* and *personal values*: *conflict*. Initially, this category was labelled *conflicting vision*, but was later changed to *conflicting values* as this provided a conceptual account of what was occurring for all participants and gave a better fit.
Conflicting values emerged as the core category and the two preliminary categories of organisational values and personal values were subsumed as categories (characteristics) of the core category. The core category related to most other categories; this is consistent with grounded theory. Through these relations the core category accounted for most of the ongoing behaviour in the substantive area of rural nurse resignations; again, this is consistent with grounded theory (Glaser, 1998). With the emergence of the core category of conflicting values, the nine transcripts were then reread and comparisons made for fit of the core category. The fit was clearly evident.

Figure 3 demonstrates the process of using the constant comparative method of data collection for category and property development with the emergence of the core category.
Initial Open Coding

- Human resources
- Culture
- Societal issues
- Organisational structure
- Rural issues
- Patient care
- Work conditions
- Family & personal reasons
- Impact of the job on nurses' health

Preliminary Categories

- Restructuring & centralising of health services
- Outdated & inflexible patient care systems
- Cumbersome hierarchy
- Management culture
- Bullying – limiting nurses' voices
- Expendable nurses
- Different priorities – being money focused
- Inadequate resources for patient care provision
- Insufficient & inexperienced staff
- Powerlessness – participating in & witnessing poor patient care
- Lack of connectedness & shared vision
- Impact on nurses' health

Category names changed after further analysis

- Organisational structure
- Organisational attitudes
- Compromising care
- Compromising self

Categories subsumed into 4 categories. Other categories become properties

- Organisational values
- Personal values

Further subsuming

- Conflicting Values

Core

Figure 3: Emergence of the Core Category
Selective coding and saturation

At this stage of the analysis, nine participants had been interviewed and the core category had emerged (*conflicting values*). In grounded theory, once the core category emerges, open coding ceases and selective coding occurs. Selective coding delimits coding to only those variables that relate to the core category in order to develop theory (Glaser, 1992). A 10th and 11th interview were conducted to facilitate selective coding and to confirm that saturation had occurred. No new categories emerged from these two interviews; saturation of the core category and properties had occurred. Saturation in grounded theory refers to when further data collection does not change the categories or its properties (Glaser, 1978).

The core category

A core category is the central problem for participants in this study. The core must also occur frequently in the data and relate easily and meaningfully to the other categories (Glaser, 1978). A core must be central and related to as many other categories and their properties as possible and the core will account for a large proportion of the variation in a pattern of behaviour (nurse resignations). In this study, *conflicting values* provides the central problem of why nurses resigned. While the core category emerged in the ninth interview, the 10th and 11th interviews were conducted to ensure absolute confidence that the core was saturated. The 10th participant was also used to test the core category for relevance; the core category resonated with this participant.

The following table, Table 7, provides an overview of participant sampling, data analysis coding and where in the range of participants open coding ceased,
selective coding ensued, the core category emerged, saturation occurred and finally the theory was tested.

Table 7: Sampling Methods, Data Analysis, Coding and the Core Category

<table>
<thead>
<tr>
<th>Participant</th>
<th>Sampling Method</th>
<th>Data Analysis and Coding</th>
<th>Emergence from the Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant 1</td>
<td>Purposive</td>
<td>Open coding</td>
<td>Emergence of 83 open codes</td>
</tr>
<tr>
<td>Participant 2</td>
<td>Purposive</td>
<td>Open coding</td>
<td></td>
</tr>
<tr>
<td>Participant 3*</td>
<td>Purposive</td>
<td>Open coding</td>
<td></td>
</tr>
<tr>
<td>Participant 4</td>
<td>Purposive</td>
<td>Open coding</td>
<td></td>
</tr>
<tr>
<td>Participant 5</td>
<td>Theoretical</td>
<td>Open coding</td>
<td></td>
</tr>
<tr>
<td>Participant 6*</td>
<td>Purposive</td>
<td>Open coding and development of nine emerging categories. Open codes subsumed into categories to form properties</td>
<td>Open codes grouped</td>
</tr>
<tr>
<td>Participant 7</td>
<td>Theoretical</td>
<td>Open coding and re-sorting of categories to form 12 categories. Categories renamed</td>
<td>Further saturation of categories and emergence of new categories</td>
</tr>
<tr>
<td>Participant 8</td>
<td>Purposive</td>
<td>Open coding and category saturation continues</td>
<td>Further saturation of categories and emergence of new categories</td>
</tr>
<tr>
<td>Participant 9</td>
<td>Purposive</td>
<td>Open coding</td>
<td>Emergence of core category. Saturation of categories. Open coding ceases</td>
</tr>
<tr>
<td>Participant 10</td>
<td>Purposive</td>
<td>Selective coding</td>
<td>Saturation confirmed. Core category tested</td>
</tr>
<tr>
<td>Participant 11</td>
<td>Theoretical</td>
<td>Selective coding</td>
<td>Saturation confirmed</td>
</tr>
<tr>
<td>Participant 12</td>
<td>Theoretical</td>
<td>Selective coding</td>
<td>Theory tested</td>
</tr>
</tbody>
</table>

Note: *Participants 3 and 6 were re-interviewed.
4.6 The Process of Theory Building

In this study, the process of theory building was facilitated in three ways: by the use of theoretical coding families, by the sorting of theoretical memos, and by the emergence and integration of theoretical codes. What follows now is a discussion of how these three aspects of theory building were used to generate a substantive grounded theory.

**Theoretical coding families**

Theoretical codes conceptualise how substantive codes relate to each other and provide the model for theory generation (Glaser, 1978). Theoretical coding families provide a range of options for theoretical coding as well as a list of theoretical codes to assist the researcher in exploring relationships among the categories. Which coding family to use in grounded theory is a question of emergence during the sorting of memos. Theoretical codes must earn their relevance as do all variables in grounded theory (Glaser, 2004).

Glaser (1978) initially identified eighteen coding families but at a later date identified more (Glaser, 1998) and believes that there are still more to come (Glaser, 2004). Glaser’s coding families were reviewed by the researcher to look for ‘fit’. Coding families are not mutually exclusive (Glaser, 1978) and in some instances may overlap considerably; this occurred in this study. The researcher may start with one or two codes from a coding family and then move to other coding families as new ideas develop (Glaser, 1978); this ensures relevance and fit to the emerging theory. Three coding families had relevance to the emergent categories because of their ability to explain the theoretical relationships between
the properties (personal values and organisational values) and the core category (conflicting values). These three coding families are listed in Table 8 and the relevant descriptors are bolded.

<table>
<thead>
<tr>
<th>Table 8: Coding Families Utilised in this Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glaser’s Coding Family</td>
</tr>
<tr>
<td>THE SIX Cs</td>
</tr>
<tr>
<td>THE DEGREE FAMILY</td>
</tr>
<tr>
<td>THE CUTTING POINT FAMILY</td>
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Source: Glaser, 1978

Using the descriptors from these three coding families allowed the researcher to see the movement and process required for both a basic social process and substantive theory emergence. Categories were compared and conceptually analysed using the SIX Cs FAMILY, the DEGREE FAMILY and the CUTTING POINT FAMILY. The result was a dense, rich theory which integrated the categories and had fit, relevance and workability. Chapter Seven provides the basic social process and the substantive grounded theory of nurse resignations including an explanation of how the theoretical codes link the categories, properties and theory.

Theoretical memos

To assist with establishing the theoretical relationship between categories, several theoretical memos were utilised to explore the link between the core category and
properties. The following memo in particular assisted in the emergence of three theoretical codes:

The core category of conflicting values is nicely saturated with relevant properties but what links them? What links personal values and organisations’ values and conflicting values? Why are personal values and organisations’ values different? Why do they conflict? What are values?

The participants’ values are different from the organisations’ and it is this difference that has caused nurses to resign so where do the values come from and if these values are established, what changes? Nurse or organisation? What drives these values?

Nurses’ values are established when they enter nursing and they feel these values don’t change. The organisation establishes its values but they change then re-establish and depending on how they are re-established they may or may not fit with the nurses’ values. This creates a value alignment continuum. There appears to be a range of value alignment between the personal values and the organisations’ values that is dynamic and influenced by the organisation but how does this occur? When nurse and organisation values misalign participants resign. So nurse and organisation start with established values, then something drives a change in these values and values are re-established but the nurse is unable to realign their values with the re-established organisation values. Somewhere in the value alignment continuum there is a point that the nurse reaches in the misalignment of values that triggers a resignation. This point is probably different for each nurse. (Memo, January 2010)

Theoretical codes

Theoretical codes conceptualise how substantive codes relate to each other and provide the model for theory generation. It is the interaction between substantive and theoretical codes which characterises grounded theory and explains how two categories relate to theory (Glaser, 1998). In addition to helping with the analysis, theoretical codes also assist the analyst to maintain a conceptual level in writing about concepts and their interrelations (Glaser, 1978).
At this stage of the research and with the saturation of the core category the theory began to emerge. Glaser (2005) distinctly instructs grounded theorists that theoretical codes are found in memos and not in the data. While the core category and properties gave an account of nurse resignations, the researcher needed to identify what linked them theoretically in order to start writing a theory of rural nurse resignations.

Three theoretical codes emerged that linked the core category and its properties to form a theory. These were sharing values, conceding values and resigning. An overarching theoretical concept emerged as degree of value alignment. With the emergence of these three theoretical codes relating to values, the researcher wanted to further explore ‘values’. This exploration resulted in the recruitment and interview of a 12th participant as well as re-interviewing two participants to discuss both the issue of nurse values, including what values the participants held, and where these values came from. Ethics approval was re-sought (and granted) at this stage as the researcher had failed to include the details of re-interviewing participants in the initial ethics proposal.

The data also indicated that once a nurse resigned there was a phase after resignation and prior to the last day of employment where there was a potential opportunity to retain the nurse; the researcher wanted to explore this further. Again, probing and funnelling techniques were employed but set questions were also used, these included:

1. How long had you been considering resigning when you left the hospital?
2. Was there any way the hospital could have retained you? How?
3. Did you consider going to your employer to try and resolve the issues that made you resign? Why or why not?

4. Did you hope that your employer would talk you out of resigning? Why?

5. If your employer had come to you to try and resolve the issues that made you resign, would you have been receptive?

6. Tell me more about your thoughts and the process for you when you considered handing in your resignation? What was going through your mind?

7. Tell me about your values that guide your work?

8. Where did these values come from?

The data collected from these three interviews confirmed theoretical links and assisted in theory emergence and a three-stage basic social process. The emerging grounded theory was tested on the 12th participant for ‘fit’ and resonated with this participant (this is discussed further in Chapter Nine).

This section of the chapter has detailed how data were analysed using the constant comparative method of data analysis by utilising a Glaserian post positivist paradigm. The constant comparative method led to a core category, and theoretical memos revealed the theoretical links between categories that formed the basis of a substantive theory on rural nurse resignations. The next two sections of this chapter will detail how data were managed and the criteria used to evaluate this study.
4.7 **Data Management**

All data were collected from face-to-face interviews, taped on two dictaphones and then transcribed. Each transcription was analysed and coded before the next interview commenced. A software package (NVivo) was used to store, file and sort data. NVivo was employed basically because it was the favoured software of the university and available on all university computers. NVivo is computer assisted qualitative data analysis software (CAQDAS). Qualitative software makes research easier (Hesse-Biber, 2007) but not all researchers have welcomed software in QDA. Corbin and Strauss (2008) raise concerns that software may stifle creativity but they acknowledge that the time has come to recognise their use in qualitative research. They now advocate software use for storing, sorting and shuffling the data and outline that computers cannot do the thinking required for analysis or memo writing. Computer software also provides a concise audit trail with accessible records (Corbin & Strauss, 2008).

Within NVivo, data to be coded were highlighted (shaded, using the computer mouse) and then assigned a code by the researcher. Coding stripes were activated to show the researcher what had been coded and into which categories. This system was employed until the full transcript had been coded. Initially, coding occurred as free nodes (open codes). Data were then subsumed into tree nodes. Due to the volume of typed transcripts and the number of initial codes, it was not considered feasible to manage the data without the use of software.

NVivo was used for the purpose of storing transcripts and sorting data into categories and properties. All modelling and diagrams were performed manually.
by the researcher, first by hand and then in a word document. As categories emerged and data needed to be teased, a whiteboard was often used as a drawing board for grouping and collating ideas. This allowed the researcher to ‘think out aloud’ and scribble ideas as well as make connections between emerging categories and themes. This method proved very useful for gauging bigger pictures and organising categories. When the researcher was happy with new constructs, they were then manually transcribed from the whiteboard to paper.

4.8 Rigour, Trustworthiness and Evaluation Criteria

Scientific rigour is valued in all research as it is associated with greater worth. Rigour is a term that is associated with quantitative research, and qualitative research has been deemed to lack rigour (Burns & Grove, 2003). Rigour needs to be defined separately for qualitative research as the desired outcome is different (Burns & Grove, 2003) and is associated with openness, strict adherence to a philosophical perspective and thoroughness in data collection. Rigour can be evaluated by the logic of the emerging theory and the clarity with which it sheds light on the phenomenon being studied (Burns & Grove, 2003).

Guba and Lincoln (2000, 2005) argue that qualitative research cannot be judged on the positivist idea of validity, but rather should be judged on an alternative criterion of trustworthiness. This is made on the basis that the positivist worldview is incommensurable with the interpretive view. Different criteria of rigour and quality need to be developed in all qualitative research which reflects the different assumptions that interpretive researchers hold about the nature of
reality and appropriate methods of inquiry (Burns & Grove, 2003; Guba & Lincoln, 2000, 2005).

To evaluate qualitative data from a post positivist perspective (as opposed to a positivist view), Guba and Lincoln (2000, 2005) suggest using the criteria of trustworthiness, credibility, transferability and conformability. Charmaz (2005), a constructivist grounded theorist, is more specific and suggests criteria for evaluating grounded theory may include credibility, originality, resonance and usefulness. Glaser (2004) suggests that, as grounded theory emerges from the data, there is no need for techniques that establish accuracy and he argues against Guba and Lincoln’s ‘zeal’ (p. 16) for accuracy and credibility techniques. Glaser (2004) does not believe that grounded theory needs to be categorised into a restricting credibility framework and comments that grounded theory produces concepts with immense grab and fit. This is the nature of grounded theory. ‘Trust in the researcher is a research value that applies absolutely’ (Glaser, 2004, p. 16) and there is no reason to alter data to suit the theory, since the theory is generated inductively from the data and data are not forced to fit a theory. Grounded theory is accurate as far as it goes, and is then modified by constant comparison with further data. It is the basis of what grounded theory is that belies the need for rigour (Glaser, 2004).

Glaser states that the fundamental sources of trust in grounded theory are the four criteria for its evaluation (1998, p. 236); fit, relevance, workability and modifiability (1978, 1998). For the purpose of evaluating this study, these four criteria will be used and an explanation of these will now be provided.
Fit or validity, according to Glaser (1998), relates to the concepts that represent the data and how closely the concepts fit with the incidents they are representing. Fit is continually sharpened by constant comparison (Glaser, 1998). Data cannot be forced, and using the constant comparative method eliminates forcing. Fit is the first functional requirement of relating theory to data (Glaser, 1998) and, as grounded theory categories emerge from the data, the criterion of fit is met (Glaser, 1978).

What emerges with fit is relevance, the second of the four evaluative criteria. Fit makes the research important as it deals with the main concern of the participants. A relevant study addresses the concerns of participants, evokes grab and captures attention. It is automatic that the emergent concepts will relate to the issues of the participants in the substantive area under study. Relevance, like good concepts, evokes instant grab (Glaser, 1998).

The impact of fit and relevance leads to the third criterion of workability. Workability explores if the concepts and the way they relate in theory account for how the main concern of the participants is continually being resolved. The theory works when it explains how the problem is being solved with much variation. With concepts that fit and are relevant, the researcher then commences integrating a core and sub-core category. These categories account for most of the behaviour of the participants and explain how the main problem of the participants is continually being resolved. Concepts and theoretical coding are closely related to what is going on. This instils trust that can be understood and applied to a theory that works (Glaser, 1998).
Through the constant comparative method, the theory can be constantly modified (the fourth criterion) to fit and work with relevance. Theory does not force data; the theory is modified by it (Glaser, 1998). A modifiable theory can be altered when new relevant data are compared to existing data. Grounded theory is never right or wrong, it just has more or less fit, relevance, workability and modifiability (Glaser, 1998).

Glaser’s four criteria of fit, relevance, workability and modifiability will be used as criteria for evaluating this study. These criteria and their relevance to this study will be detailed in Chapter Nine.

4.9 Chapter Summary

This chapter has detailed the sample group of this study – their characteristics and recruitment. Participants consisted of twelve registered nurses who had worked in and resigned from rural hospitals which varied in size and were either public or private facilities. Participants had held nursing positions from senior nurse managers to ward-level nurses. A total of 14 interviews were conducted (two participants were interviewed twice).

Ethics approval was sought and all participants were provided with information sheets and consent forms. Data were collected from face-to-face, one-on-one, semi-structured, in-depth interviews and coded in an NVivo data software program. Each participant was provided with their transcript in order to verify the accuracy of the transcription of the interview. Analysis revealed the development of categories and the emergence of a substantive grounded theory that explained
the reasons why NSW registered nurses resigned from rural hospitals. The application of grounded theory to this study was also discussed as well as issues of rigour and trustworthiness.

The next three chapters will reveal the findings of the study. Chapter Five will provide the details of the first category of the core category and its sub-categories and properties while Chapter Six will provide details of the second category of the core category and its sub-categories and properties. Chapter Seven will detail the theoretical links between these properties and then reveal the basic social process and the substantive grounded theory of rural nurse resignations. All findings chapters will include interview excerpts.
5.1 Introduction

This was a study of rural nurses and the aim of the study was to discover why registered nurses resign from NSW rural hospitals. Using grounded theory methods, data were collected and analysed from nurses after their resignation. The major problem identified was conflicting values which emerged as the core category. As previously described in Chapter Three, a core category must be central and relate to as many other categories and their properties as possible and the core will account for a large proportion of the variation in a pattern of behaviour (nurse resignations). This chapter is the first of three chapters of findings and will reveal the first of the two categories of conflicting values: organisational values and its sub-categories and properties.

5.2 Conflicting Values

Conflicting values conceptualised disparity between the participants’ expectation and vision of how patient care and nursing should occur (personal values) and the reality of how patient care and nursing do occur (organisational values). Participants revealed that the hospitals’ organisational structures conflicted with how they could carry out high quality nursing and patient care that fitted with their own values. Conflicting values occurred for the participants when their attitudes to care provision did not align with the organisational attitude of the
hospital. These organisational structures and organisational attitudes resulted in participants compromising care and compromising self as participants were unable to perform nursing in a manner that aligned with their personal values.

The following figure, Figure 4, provides a representation of the core category of conflicting values, its two categories of organisational values and personal values and their sub-categories and properties. It should be noted here that the sub-categories of personal values which are ‘compromising care’ and ‘compromising self’, are not the nurses’ ‘actual values’. Rather, these were conceptualised into a category titled personal values. The core category of conflicting values depicts the conflict.
Figure 4: The Core Category of Conflicting Values, Categories, Sub-categories and Properties

- **Core category**
  - **Conflicting Values**
    - **Organisational Values**
      - Organisational Structure
      - Organisational Attitudes
    - **Personal Values**
      - Compromising Care
      - Compromising Self

- **Sub-categories**
  - Organisational Structure
    - Restructuring and centralising of health services
    - Outdated and inflexible patient care systems
    - Cumbersome hierarchy
  - Organisational Attitudes
    - Management Culture
    - Bullying-limiting nurses’ voices
    - Expendable nurses
  - Compromising Care
    - Different priorities-being money focused
    - Inadequate resources for patient care provision
    - Insufficient and inexperienced staff
  - Compromising Self
    - Powerlessness-participating in and witnessing poor patient care
    - Lack of connectedness and shared vision
    - Impact on nurses’ health
What follows now is a discussion of the findings of data elicited from the participants that form the first of the two categories of conflicting values.

5.3 Organisational Values

This section begins by revealing the first of the two categories of conflicting values: organisational values. Organisational values consists of two sub-categories: organisational structure and organisational attitudes. These two sub-categories collectively explain organisational values. In this study organisational values refers to the standards, rules and attitudes that the nurses perceived the organisation held and these values were pervasive and influenced the ways in which the organisation allowed patient care to be delivered. This study revealed that the structures within the organisation seemed to impact on the participants and prevented them from providing patient care which aligned with the participants’ own internal values. In addition, the attitudes within the organisation conflicted with the participants’ held beliefs of how an organisation should support and treat their staff and allow for the provision of patient care. Both disparity in hospital systems and a poor attitude by the hospital conceptualised organisational values.

Organisational structure

As a sub-category of organisational values, organisational structure links together codes which emerged from the data that explained the way in which rural hospitals arrange, organise and implement systems for the purpose of patient care, managing staff and communicating and allocating duties and responsibilities. These components of the organisational structure reflected the participants’
experiences and reality of the organisation in which they worked and then resigned from. The components within the organisational structure that contributed to a conflict of values included restructuring and centralising of health services, outdated and inflexible patient care systems and a cumbersome hierarchy. Figure 5 below provides a visual representation of the sub-category organisational structure and its properties.

Figure 5: The Sub-category Organisational Structure
Within *organisational structures*, restructuring and centralising of health services created a conflict in values for participants who worked in the public system. As mentioned earlier and to provide a contextual perspective of the environment in which the participants worked, during 2005 NSW Health restructured seventeen AHSs to form four rural and four metropolitan services. This was in an attempt to streamline administrative and corporate services as well as to eliminate bureaucratic duplication. This restructuring aimed to create a saving for the government of over $100 million which would then be redirected to front-line services (NSW Health, 2005a).

Concern was voiced by those participants who were employed in a rural public hospital during and following the restructuring. This concern was the impact that the AHS restructuring had on the provision of both patient care and nurse management systems, particularly in smaller rural hospitals. Participants identified many contributors to conflict within the newly created AHSs including the vast geographical size of newly defined AHSs; the dilution of senior nurse roles; lack of transparency as to how hospitals were reclassified in the restructuring; and a loss of control of services at the local level by health service managers. Participants did not see the forecasted increase in front-line services that the government proposed as a result of restructuring. One senior nurse manager explains her experience of restructures:

*This was the third restructure that I have been exposed to from a senior position and this one was the most unclear from the very beginning, the previous ones had always informed the senior managers of the process and what the likelihood of restructures was going to be so that you always knew right from the word go where you would probably end up sitting in that new organisation, but with this restructure there was nothing clear,*
there was nothing brought to really focus on this or look forward to. (Belinda)

Wynette, also in a senior nurse management role, explains the impact of restructures on her role and describes here how she lost control of health services because of the restructures:

_I was powerless, everything had been centralised ... Well it was all to do with centralisation and still controlling it from above, but not letting people actually manage it on site._ (Wynette)

Wynette also tells how she was personally impacted upon as a member of the local community due to AHS restructuring and, in addition, she notes the financial implications for small rural towns:

_... the loss to the town like the pay office and the pharmacy, well see that pharmacist that was providing that service, she moved to Canberra because there wasn’t a job for her, so it had big implications the changes that were happening with loss of people from the community and then loss of income in the community ... I don’t think the Area Health Service staff knew how difficult it was for local managers and the implications to the changes that occurred to individuals outside of work hours._ (Wynette)

Participants also noted that there was little transparency in the restructuring of the AHSs in the decision making as to which health service managers would be downgraded and which would remain the same. This led to confusion and uncertainty amongst the nursing staff, as Sally observed:

_Why would that health service manager be downgraded to X level when that health service manager in a neighbouring town was only going to be downgraded to Y level when the hospitals were a similar size, there was no transparency in the system at all there was no matrix done that had activity, patient numbers, staff numbers, doctors in town, isolation rating that gave you a bottom line comparative figure, there were no apples with apples. It was fairly subjective rather than being an objective process._ (Sally)
Prior to the restructuring of AHSs by NSW Health, individual rural hospitals were run by a Hospital Board at the local level. Hospital Board appointments consisted of local community members – those who lived and worked in that community and ‘the Board really had a sense of doing the very best they could for their community’ (Wynette).

According to the participants in this study, the move from rural Hospital Boards to AHSs removed a sense of community ownership and community control from the running of rural hospitals. It was also perceived that it was not in the best interests of the community to have local hospitals governed from afar. Following the abandonment of Hospital Boards to seventeen AHSs, then the amalgamation of these to eight AHSs, Wynette described a loss of community ownership and involvement of the hospital and expressed concerns about a distant management system running the hospital that did not know or understand the local community. There were fears that decisions made were not in the best interests of the community:

It was a great little community that had it all going for it and then it just sort of all dissipated and then of course the community health part of it was put under the management of another community health manager who managed the community health services within our network and she didn’t reside in *** (name of town removed to de-identify) and then those community health staff were expected to travel greater distances and provide more outreach services, a lot of them burnt out and our community team almost disappeared. (Wynette)

The community members that encompassed the Board of Directors also became powerless as Wynette describes:

... the Board of Directors was just devastated when they became an advisory board which meant they were powerless. (Wynette)
Following the 2005 restructures, participants who were previously senior nurse managers described the difficulty in managing nursing services effectively across a widely dispersed geographic area and, in addition, meeting the local hospital mission and philosophy of nursing. Belinda describes her concerns as a senior nurse manager in trying to deal with this:

*I couldn’t reconcile the fact that because my management style is very open, very visible, I felt sitting in a regional office to cover the region the size of the area health service as it was going to ... was not something I wanted to be part of.* (Belinda)

Another aspect of the restructure that the participants highlighted was that, prior to the restructuring to larger AHSs, nurses had an opportunity to develop a career in senior health management and this had now been reduced in rural areas. Participants perceived that NSW Health was reducing the number of on-site managers as well as reducing the identity of each rural facility so that there could be an amalgamation of facilities and a generic (or flattened) management structure spanning one, two or three rural facilities.

*... there was a considered effort to dilute the level of management and identity of each facility so that you could amalgamate facilities and put a generic management across the top of one or two or three facilities and there was an effort to dilute the role of the senior nurse who had taken on a general management role and stepped outside of the professional nursing role because they had day-to-day management for non-nursing staff.* (Sylvia)

Participants felt that, in the restructuring, there was a concerted effort to dilute the role of the senior nurse who had taken on a general management role and stepped outside of the clinical nursing role. Participants were unsure whether this was to disempower the nursing management systems or to return nurses to nursing as Sally discusses here:
From a nursing perspective restructures were unacceptable to the Senior Nurses who had fought and justified their role over a long period of time to get to where they were within the organisation and in many cases the respect the nurses had at that executive level was being eroded. (Sally)

The role of the NUM also changed during the restructuring of AHSs with NUMs required to take on additional functions previously undertaken by people elsewhere in the organisation. NUMs were not provided with required resources to allow them to take on those extra functions as well as manage the clinical aspect of nursing. Belinda describes this situation as:

... the fact that the Nursing Unit Managers had to take on roles of personnel management, occupational health and safety ... all of those extraneous issues which was perhaps previously undertaken by people higher up in the organisation as times gone by those functions have been relegated to a Nursing Unit Manager but they have not been given the resources to allow them to take on those roles as well as manage the clinical side. (Belinda)

While some services were devolved to the NUMs, many other services that were locally available in smaller rural towns were centralised to larger rural towns in the restructure. These included human resource services such as recruitment and payroll, some pharmacy services, linen and laundering services, ward supplies and stores, and the preparation and cooking of patients’ meals. Senior nurses at individual hospitals lost control of decision making to appoint, order and manage these resources; this was now being performed at a location a fair distance from that rural hospital – in some instances several hundred kilometres away. Wynette explains that prior to restructuring she could retain good staff but lost this control with the centralisation of services:
... because of the centralisation they would only let me pay her at that level, but previously I had the flexibility to offer people bonuses ... and we did that, to retain staff. (Wynette)

Additionally, Wynette explains that because of the centralisation of human resources she lost control of who was employed in the facility:

... the recruitment of staff was centralised and so we couldn’t recruit our own local staff and the radiologist gave me three months notice that he was going to take long service leave. So I contacted HR to get a locum radiographer ... they let me know that this person would be coming and it was someone that had not been a high performer and was almost, well it had been discussed to take her off the books anyway. So that was the person we ended up with and it was a disaster, it was an absolute disaster ... but when I heard that she was being rough with the patients, that was the end of the line and so I actually asked the Director of Corporate Services if he could arrange for someone because I was powerless, everything had been centralised. If I’d been managing the staff I would have told her to get out and not to come back and I would have made other arrangements, you know I would have recruited someone else. (Wynette)

Similarly, Sally described that while the restructures may have been prompted by altruistic ideas to improve services and reduce management costs, putting this into practice was not successful:

I think that the restructure was generated out of an altruistic notion to improve management and to reduce management dollars I don’t think putting that into practice was done terribly successfully and I think that some of the personalities in the positions who are managers and the practice did not support the philosophy. (Sally)

Sally also spoke about redundancies which were offered during the restructuring. Many experienced, front-line nurse clinicians took a redundancy as a way out of restructures that they did not believe in, resulting in a decrease of clinical nurses at a time when rural nurses were in short supply:
There was an imperative to reduce head counts and what was underneath that head wasn’t considered ... there were large numbers of clinical staff who put up their hand and were given redundancies when that wasn’t the philosophy behind cutting full time equivalents which is where I think the philosophy of the restructures was not put into practice. (Sally)

Compounding these issues, there were also significant problems surrounding the restructure of the hospital management structures at the local level which were directly affecting the nursing structures. Sally describes this as:

*Health service managers were being downgraded and the restructure that was published generated grievance between the NSW Nurses’ Association, the AHS and NSW Health. The restructure that was promulgated by executive members of the Area Health Service had no apparent pattern behind it; there was no clarity or transparency in the decision making. It was fairly subjective rather than being an objective process which created unrest and uncertainty for senior nursing staff. Redundancies were offered to senior level staff just to cut the numbers which left many rural hospitals with no managers. (Sally)*

The findings in this study so far suggest that the restructuring of rural AHSs impacted on participants and their ability to provide optimal nursing services within the hospital in which they worked. Participants who were in management roles felt that the restructure with the centralisation of services created a loss of control of nursing services for them as well as a dilution of senior nursing roles with less front-line positions. Prior to this centralisation, nurse managers had a sense of control of the provision of rural services to their community. When nurse managers worked within Hospital Board systems they felt they had control of hospital finances, services and staffing including nursing and other staff such as the pharmacy department, linen services and so on. This control of services enabled participants to provide appropriate, relevant and timely patient care to small rural communities. Due to restructuring, participants experienced a loss in
alignment of their values with the hospitals’ values in relation to the provision of care to their community.

Inflexible and outdated patient care systems were also a factor for the participants. Within organisational structures it was revealed by participants that patient care systems within the hospital were outdated and inflexible; this hampered patient care delivery. The systems identified by participants that impacted on patient care were models of care, patient classification systems, nurse/patient ratios, rostering systems and ward procedures. For instance, the patient classification system implemented in hospitals ought to provide a clinically meaningful way to predict appropriate staffing numbers for the current number of patients taking into account the resources required. Participants felt the classification system could not factor in the time and resources required for patient care – the system was too outdated and remote. Juanita summarised this well:

They’ve got all these wonderful systems in place ... you’d write up on this huge great big board about what staff you had yesterday and about whether [the patients] needed this care or that care and you couldn’t actually identify the fact you’ve spent three hours helping them breast feed, you’d get ‘1’ for that, because they were breast feeding for example. If they weren’t breast feeding you wouldn’t get a ‘1’ but you might have to spend three hours showing them how to use a bottle and I just thought this is just silly and I like to be a little bit more creative I think in my work. (Juanita)

Participants described models of care for providing patient care as inappropriate for the available resources within a hospital. The models of care need to be flexible enough to change if necessary to take into account the greatest advantage of the skills and resources available, even if this requires changing the model of care day to day. Sally believed that:
Participants felt that inflexible and outdated models of care were not always efficient or allowed participants to carry out a high standard of nursing care. Concern was also raised that senior staff did not have the skills, flexibility or knowledge to adjust care models or operating systems to reflect current staffing and patient loads. Jenny uses an analogy to surmise this:

\[ \ldots \text{a wonderful analogy of Pooh Bear and Christopher Robin dragging Pooh down the stairs and Pooh saying ‘there has to be a better way than this it hurts my head so much’ … that is what nurses do and we do, we say we are too busy, we can’t possibly do it any other way. We are actually doing something the hardest way but we won’t get out of the square to change it because we haven’t got time.} \] (Jenny)

In addition, hospitals employ a system of nurse/patient ratios for patients in critical areas that need high acuity care. This is to ensure that there is adequate nursing staff on a given shift to provide care for patients, particularly those patients who are unconscious. Lee states that this did not occur:

\[ \ldots \text{but the hierarchy don’t look at that sort of patient/nurse ratio type stuff, they’re supposed to but it doesn’t happen.} \] (Lee)

Nursing staff rostering systems were also described by participants as ‘inflexible and antiquated’, as Juniata describes here:
... you were given THE [participant’s emphasis] roster ... and there was no way you could change it, because everyone was you know pedantic about keeping with these shifts and a lot of people requested things like, weekends off for weddings away and stuff and they weren’t given the shifts. (Juanita)

Participants were unable to request days off for special events or explore a self-rostering system that had some flexibility to it. In desperation, nurses learnt not to request a day off for a special event but instead took sick leave. This inflexibility to change the rostering system was described by Juniata as ‘because that’s not the way they do it ... they weren’t really open to any suggestions’. As working parents, participants also found the inflexible rostering system very difficult. Often, the only way to ensure time off for special events with children was to book holiday leave, but this also failed as one participant had her holiday leave cancelled at the last moment and she was also then placed on six weeks of night duty. Lee describes the frustration of this:

I thought as a working mother, full-time working mother that I should have been given some consideration in what, if they were going to cancel my holidays they should have at least asked what shifts would suit me or what I’d be prepared to work but they just said no, you know, you’ve got six weeks holiday and you’ll be doing six weeks night duty instead. (Lee)

Some participants who had previous experience in other hospitals brought ideas with them for streamlining current practices on the wards. Juniata tells of her frustration of trying to suggest a simpler way to perform a nursing task on the ward but was met with resistance. She eventually stopped making suggestions:

... oh no we can’t do that, we’ve always done it this way here and well I said that’s three jobs, three IV trolleys, and they weren’t being effective so that, nothing happened, so then I came up with a few other ideas, that I think I suggested in a gentle enough manner, but no, no, we don’t do it like that here. (Juanita)
The inflexible and outdated operating systems within rural hospitals hindered participants’ efforts to provide patient care that aligned with their personal values. These systems were also contributors of frustration and angst to participants.

A cumbersome hierarchy also emerged in the data as an issue for participants in both the public and private sector. For participants in the private sector, this was due to an invisible and distant management structure that appeared to be impossible to access. For participants in the public sector, they felt they could not wade through the many layers of management following the restructure. The hierarchy was perceived by participants as too cumbersome, too many layers, too distant and top heavy, with those in the upper layers of the hierarchy seeming to lack knowledge in local patient care needs. The new hierarchy therefore created a gap between management and clinical nurses.

Participants expressed difficulty trying to communicate with a hierarchy that did not appear to have a line of communication for clinical nurses to access. This was evident at both the local (ward) level and the broader level (hospital and AHS). From a local perspective, participants became frustrated when they could not be involved in issues and decisions relating to the local ward that they worked on. For participants who were clinical nurses, their line of reporting was the ward NUM but often the NUM would not take issues further. Lee found this frustrating as she explains:

... you’d have your meeting, the Nursing Unit Manager would hear your gripes and argue with you but then nothing would change, you know, the things that you’d want to put in place or what would just be, stay the same, you might discuss it and talk about it, no, nothing ever happened. (Lee)
Lee also explains how a new manager arrived and changed the work environment with no consultation with local ward staff:

The new Nursing Unit Manager came in like a whirlwind and wanted to change routines and the way we did things and the way we didn’t do things and with no consultation with senior staff and a lot of senior staff started to resign and it came down to being her against us and no one got along and it was just a horrible environment to work in. (Lee)

At the broader level (hospital and AHS level), senior managers often made decisions that impacted on patient care at the local level, but clinical nurses had minimal input into these decisions. Participants experienced frustration as they could not communicate or reach those above that made these decisions. This had a flow-on effect to participants providing direct patient care who were not involved in decision making but were affected by the decisions made. These decisions were often seen by participants as inappropriate and not based on the needs of patients. The hierarchy often failed to consult with those performing direct patient care, and opinions were not sought for solutions, problem-solving, planning, shift hours or systems that would impact on nurses’ work; there was no consultation. Conflict between nurse and organisation arose in providing patient care, as Jade explains here:

... those nurses could say that they were never even asked, how the wards should be set up or how the rooms should be set up, you know what would be easier for them and things like that, like you think that they would be the first people you would ask, I mean even if you were building a bank, a new office system or something, you would think you would still ask the people that worked there what’s going to work well for them what’s going to make their life easier, you know all those sorts of things and they were never consulted at all, it’s the same as the things we talked about in terms of our shifts. We weren’t really consulted, it was just like well twelve hours are coming in and that’s what you’re
doing, you can raise your concerns but it’s not really going to change. (Jade)

Anne describes how the management systems impacted on morale:

... people are very unhappy and morale is really bad and it’s got a lot to do with that management structure, or lack of. (Anne)

Participants reflected that low morale was often as a result of senior management not trusting nurses, and participants felt they had no input or contact with management. Management was also viewed as unsupportive and not respected by their staff:

And you don’t have the support either, like many times you’d ring up and say we’re drowning down here, you know there’s patients coming out of the woodwork and we haven’t, one, haven’t got the staff, two, we haven’t got enough beds and they just say deal with it. (Lee)

In summary organisational structure detailed how conflicting values occurred for participants in relation to the way in which rural hospital systems are organised. Organisational structure consisted of the restructuring and centralising of health services, inflexible and outdated patient care systems and a cumbersome hierarchy. Organisational structure assisted in partially explaining the way in which the work environment of rural hospitals impacted on the disparity in values of nursing care provision between participants and the hospital. What follows now are details of how the second sub-category of organisational values also created conflict for participants.
**Organisational attitudes**

Organisational attitudes, the second sub-category of organisational values, conceptually linked together the data which related to the attitudes, beliefs and behaviours of the people in the hospital as perceived by participants. Organisational attitudes consisted of a negative management culture, bullying, and nurses being viewed by the organisation as expendable. Figure 6 below provides a visual representation of the sub-category organisational attitudes and its properties.
In this study, a negative management culture describes the attitudes and actions of managers which impacted on participants providing nursing care. All participants spoke negatively about management culture regardless of the position they held immediately prior to resignation. Participants identified issues such as management not trusting nurses to nurse, a sense of ‘them and us’, perceived incompetence of managers by participants, lack of direction from management, poor communication from management, and a general lack of understanding from management of what it is that nurses actually do and need in order to provide nursing care.

Anne became frustrated that she was working hard to the point of accumulating extra work hours which alerted managers to check on her:

_I worked hard ... it meant that I didn’t have morning tea and I didn’t have lunch and it meant that I worked longer hours than I was meant to, but even that caused problems because at one stage they got jack of me putting down extra hours and they decided that they would check up on me._ (Anne)

Participants expressed concern that senior managers did not have a clear understanding of what it was they did or what was actually happening in the wards. Jade expresses her concerns here:

... _the Director of Nursing, like I thought you know this person seems to be a fairly well travelled and experienced sort of man to even say that if you did work in neonatal intensive care nursing you would be fine in intensive care nursing, I felt like he didn’t have a grip on reality really._ (Jade)

One participant noted that there was an increase in morale throughout the entire hospital when the Assistant Director of Nursing went on long-term sick leave:
One of the main factors that made that hospital actually improve overall in morale in the last years was when the Assistant Director of Nursing went on long-term sick leave. (David)

Concern was also raised that managers were incompetent and made decisions that were not in the best interest of the provision of safe patient care:

There were lots of talks with the HR department, they thought that the manager was totally incompetent and the decisions that were being made weren’t implemented properly, they weren’t safe decisions ... everybody felt that they were being managed by somebody who had no idea what she was doing. Everybody felt that the facility was going further and further down in standards, you get some nurses who’ll just turn a blind eye and say oh it’s convenient I don’t have to travel, so life’s easy, but I think the words of the nurse manager that I took over from said every time you walk in the door you think Coroner’s Court, and I think that was so true. (Judy)

Lack of consultation in decision making combined with an attitude of being ‘told we had to do that’ became difficult for participants, as Jade describes:

... while I was there we changed from doing 8 hour to 12 hour shifts ... that was again not a choice that we got. We were told we had to do that and I found that really difficult, that’s something I hadn’t done before. (Jade)

Concern was also raised by many participants about managers who had worked for a long time within the rural organisation and had become ‘stagnant and just waiting for retirement’ and failed to update their skills. For instance, Sally commented that:

I think we have particularly in rural areas because the opportunity to lose are not as obvious as they are in metropolitan areas we get stagnant and we get particularly at that middle management level we get a stagnant, not a scum on top of a pond, but certainly a stagnant layer of nursing management who are unimaginative, they have not progressed professionally they have not taken responsibility for their own professional progression
and I think that they are inflexible and not able to change umm I think flexibility describes it the best way ... so there is no stimulus, there is no professional development, there are no new ideas. We are stagnant. (Sally)

Participants also expressed concerns about the culture of an unfair employment system where staff with minimal experience or qualifications in specialised nursing areas gained positions over those with experience and qualifications. One participant who applied for a Clinical Nurse Consultant (CNC) position was shocked to find that the job was given to a ‘displaced employee’ with no experience or qualifications in the CNC specialised area. NSW Health policy was normally that to be eligible for a CNC position an applicant must have at least five years’ experience and a qualification in the area of specialty. According to Sylvia:

... people get promoted because they got the biggest voice, or they’re someone’s best mate, or they go running together, or they’re having sex together or they’re you know it’s not because they’re the best person for the job and very often it’s because it’s got, I mean it should be about qualifications and it should be about ability ... I said that was a job for the boys and you know it, I know it, I said well you know, I can appeal but I can’t win, cause of the way it’s set up. (Sylvia)

Participants also felt that management was too far removed from what was happening at ward level and, for Stella, she was asked by management to:

... go and be my spy and come back to us and tell us what’s going on on the floor. Why is there such a gap? Why did the management not know what’s going on on the floor? Why have they kept themselves up in the ivory tower? (Stella)

... they weren’t concerned about changing, they were concerned about finding out, they wanted me to be a squealer or a spy for

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2 Displaced employee refers to staff of the NSW Health Service who are advised in writing that their positions have been deleted and that they are excess to the workforce needs of the Division of the NSW Health Service in which they are employed. Once a staff member who was displaced is appointed to a permanent position, that staff member is no longer considered displaced (NSW Health, 2007c).
them, almost like pointing fingers, what names, who did this, when did they say that. It’s not about individuals … it’s a cultural thing. (Stella)

In addition to a perceived negative culture within management, bullying also was described by participants as a problem and tended to result in the silencing of nurses’ voices. Silencing occurred in two ways: first, by participants being threatened that their jobs or hospitals would be lost or downgraded if they complained to management about either poor standards of patient care or hospital buildings in need of repair; and second, by creating an unsafe environment for nurses to speak openly about their concerns at meetings about the provision of health care within their hospital. These two tactics by managers ensured silence.

In one incident, a participant (who was previously a remote area nurse) was campaigning for a new health facility in that remote location as the current facility was ‘falling down the hill’. In this facility that serviced a remote community of two hundred people, three staff slept in the one room that doubled as a clinic in the daytime. The participant was threatened by management that if she continued to push for a new hospital clinic then they would just ‘close the current hospital’.

Another participant reported a nurse for physically harming a mental health patient and was threatened by her nurse manager that she would lose her job:

I was actually told to shut up or I’d lose my job … I was told that I didn’t see anything, that if I wanted to stay in the profession and I wanted to work in a hospital I will keep my mouth shut, I was basically threatened … I was intimidated enough to not go any further, I felt really sick about it. (Sylvia)
Other participants spoke of staff being humiliated at meetings if they spoke up, and they soon learnt to agree with management:

I witnessed a couple of times people stood up and actually had a voice and they were annihilated, humiliated ... So it came to the crunch if you didn’t want to be, and this was, I’m talking, I’m not sort of talking in a small little group, there might have been seventy or eighty people in this room and to be humiliated in front of peers and the executive staff, some of the executive staff were humiliated as well. (Wynette)

Most participants cited incidents of bullying with one participant experiencing such a harsh time with bullying that she required counselling after she resigned. Judy revealed that:

I’ve had such a bad experience and been told that the bully boys at the top run the show, that this is standard procedure ... these people are very, very controlling ... I was in a pretty poor state when I left the place and went to the psychologist, afterward and he said this was a common story in this area. It is well known that [name removed for privacy] area health service is full of it. (Judy)

Within organisational attitudes, data also emerged from the participants that related to an attitude within the organisation that nurses were expendable and easily replaced, even though the organisation was short staffed and it was perceived that positions were often unable to be filled. Lee describes here this attitude from her manager:

... I’m not going to back down I’ll resign if that’s what you’re going to do and she said well do you think you’re irreplaceable and I said well in one breath you’re telling me that my holidays have been cancelled because there isn’t any senior nurses and in the next breath you’re telling me I’m replaceable, well replace me and that was it. (Lee)
Participants felt that they were expendable when, after they resigned, no effort or process was evident to either retain them or to conduct a process to establish the reasons why they were resigning. Participants believed that if the reasons why nurses were resigning were identified, then these issues could be addressed. Two issues emerged from this study. First, a ‘window period’ was identified where nurse may have been retained. Second, there was a flow-on effect from rural nurse resignations; due to lack of rural employment opportunities, nurses were leaving the profession of nursing.

The identified ‘window period’ described a time frame after the participant had tendered a letter of resignation and prior to their last day of employment. The ‘window period’ was perceived by participants as an opportunity for the organisation to address the reasons for their resignation and hopefully retain them as an employee. Participants also described the ‘window period’ as a time for organisations to prevent further nurse resignations by addressing issues causing the participant to resign. For instance, when Sally resigned she claimed that ‘they had the opportunity to keep me right up until the afternoon I left’.

Participants expressed concern that the hospital did not seem to care that nurses were resigning, and Judy describes this attitude somewhat like the Emperor and his new clothes:

... we are all walking around like the Emperor, we all know it’s happening but nobody is saying a word about it. (Judy)

Neither the participants nor the organisation engaged with each other to try and resolve the problems. Participants felt that it was up to the hospital to resolve the
problem and that the handing in of their resignation was a demonstration of their feelings. Lee explains here that, even though she was distressed enough to resign, there was an opportunity for negotiation, but this did not occur:

*I think if she [the NUM] had of spoken to the Director of Nursing at the time and they had of contacted me either Thursday or Friday and maybe been a bit flexible with the holidays or working hours or whatever in that six weeks, I might have changed my mind, but there was no contact.* (Lee)

Participants felt that if they had had some avenue of addressing the problems that led to their resignation, and management was more approachable about addressing the problems that were causing them to resign, then they may have considered staying. Jade explains how she could have been retained and why she did not approach the hospital to retain her:

*The hospital could have retained me by creating change that improved patient care.*

**Interviewer: Why didn’t you approach them?**

*I had resigned, doesn’t that say it all?* (Jade)

In addition to participants feeling that the attitude of managers was that nurses were expendable, participants also revealed a flow-on effect from their resignations. This was because for most of the participants there was a lack of options to continue to work as a rural nurse due to a lack of nursing opportunities in rural areas. This was because most rural towns only have one hospital:

*There is such a limited opportunity to move, there are no options you either work at X hospital or Y hospital. The only other option to that is to leave which often means you are leaving nursing.* (Sally)
Of the twelve participants in this study, after resigning from their rural hospital, not one remained in a nursing position in a rural hospital. Five participants obtained work in a rural community health setting, three left the profession of nursing and four became rural nurse academics. All participants stated that they would not return to work in the current hospital system, but many commented that they missed being a hospital clinical nurse very much. For instance, Wynette stated that:

*I miss the clinical scene. I miss the decision making I really miss the interaction with the nurses, the other nurse managers and I miss the interaction with the doctors and I certainly miss the interaction with the patients.* (Wynette)

Participants felt quite strongly that they did not want to return to the current rural hospital system but that they would love to go back to nursing:

*I would love to go back into a good hospital system ... If that manager wasn’t there and if there was a supportive manager there, I would love to go back and do that because I think it could be done and it could absolutely be the bees knees, and it’s devastating to watch, the system’s been pulled apart for people running these nasty games, it’s got nothing to do with what the town requires.* (Judy)

Once participants had resigned, they experienced a mixture of feelings. Initially, participants felt relief when they resigned and felt as if a weight had been lifted off their shoulders; they had resolved their feelings of conflict. Mixed with this relief was also a sense of sadness and self-blame that the participant had failed. Judy and Stella both explain their feelings as:

*I felt relieved and flat after resigning. I felt flat because I thought I had lost my touch, that I had done something wrong.* (Judy)

and
Chapter 5: Conflicting Values – Organisational Values

Deflated, really deflated. (Stella)

Others described a sense of defeat when they made the decision to resign and this was expressed by Jade as a feeling of losing:

They won; I can’t do this anymore. (Jade)

Organisational attitudes is conceptually linked to conflicting values as the attitudes of hospital managers conflicted and differed from the participants’ attitudes, and it is this difference that resulted in a conflict of values. Conflict arose for participants when the attitudes of staff in the hospital conflicted with the participants’ beliefs as to how nursing and caring should occur; these attitudes did not support the participants to carry out patient care. This occurred as a result of a perceived negative management culture that was not conducive to the provision of high quality patient care, did not allow participants to raise their concerns professionally, silenced nurses by bullying, and viewed nurses as expendable and replaceable.

5.4 Chapter Summary

This chapter has discussed the core category of conflicting values and detailed the first of its two categories, organisational values. Conflicting values conceptualised disparity between the participants’ expectation and vision of how patient care and nursing should occur and the reality of how patient care and nursing do occur. Organisational values was conceptualised as the perceived values of the rural hospital by participants and consists of two sub-categories: organisational structure and organisational attitudes.
In the next chapter, the second of the two categories of conflicting values (personal values) assists in explaining the final aspect of how conflicting values occurred for the participants and details how participants felt they compromised patient care as well as their own values and integrity. It is only in the totality of the two categories and their sub-categories and properties that the full findings reveal the reasons for rural nurse resignations.
CHAPTER SIX

The Core Category of Conflicting Values (The Second Category – Personal Values)

6.1 Introduction

This study has identified that conflicting values was the major problem for the participants in this study. While the previous chapter revealed how organisational values impacted on rural nurses, this chapter will detail the second category of conflicting values: personal values. What follows now is a discussion of the findings of data elicited from the participants.

6.2 Personal Values

Personal values, the second category of conflicting values, conceptually linked together codes associated with the way in which participants believed they were compromising both patient care and their own values and integrity. Participants believed that by working in a rural hospital they would be providing quality nursing care to patients who were admitted to that hospital; but participants found this did not occur. Compromising patient care in turn led to feelings of dissatisfaction and an erosion of professional integrity as a nurse. Conflicting values arose for participants when they were unable to provide patient care in a manner that fitted with their personal values. The two sub-categories of personal values that emerged from the data were compromising care and compromising self and these will now be discussed.
Compromising care

This study revealed that participants experienced nursing in a manner contrary to their personal and professional values. In a work environment whose core business is that of patient care, not being able to provide the patient care that participants believed was appropriate and feeling that they could not act to change how patient care occurred resulted in conflict. Participants felt that they were unable to provide appropriate patient care as a result of three factors: the participants had a different priority to the hospital; there were inadequate resources for patient care provision; and there was insufficient and inexperienced staff. Figure 7 below provides a visual representation of the sub-category compromising care.

Compromising care occurred for participants when patient care was compromised due to different priorities between what participants revealed as priorities in the delivery of quality nursing care and the priorities hospitals valued. Participants expressed concerns that the major priority of the rural hospital in which they worked appeared to be that of running a business rather than a facility to provide patient care. This resulted in the organisation being more concerned about saving money and this focus compromised how participants could provide a high standard of patient care. Sally captured this well when she said:

*I think that whilst we are stewards of public money and whilst I acknowledge that we need to be good stewards with public money I also think we have lost focus on patients.* (Sally)
For some participants, the focus on money meant tight budget allocations for hospital wards which impacted severely on patient care provision. Participants were concerned that the focus on saving money was often at the cost of basic health care supplies required to deliver appropriate patient care. The focus on saving money saw nurses, for example, providing wound dressings to patients not based on clinical nursing assessments, but on the financial cost of the dressing.
Participants perceived that patient care was compromised as there was no ready access to basic items such as food, linen and basic dressings:

\[\text{... the push was on to save as much money as you possibly could.} \]
\[(Wynette)\]

Participants found themselves in situations where, because of limited ward budgets, they were often unable to provide an adequate meal to a patient, or if patients asked for more food this could not be provided. Nursing staff resorted to purchasing basic supplies out of their own pocket such as bread and Vegemite to feed their patients:

\[\text{We were out of food again last night because there wasn’t enough food, try to order at least two meals extra so we can split it up, you know and it’s like no that’s all they get, budget, budget, budget.} \]
\[(Sylvia)\]

Linen was also limited as a result of ward budgetary restrictions with patients only being allowed one towel and if that towel became wet nurses were informed by their manager that patients could not have another. Participants described embarrassment trying to explain this to patients. Added to this frustration, Sylvia described how her manager was then verbally rewarded by senior hospital staff for coming in under budget, even though this meant patients had suffered reduced food and linen:

\[\text{They were being rewarded, all the NUMs, by how they undercut the budget and this NUM [name removed] was the only one that ever got an applaud or an award, or congratulations ... he would congratulate her but not anyone else because she comes under budget, all the other wards never ran out of food ... The individual thing in terms of the NUMs for linen and for the food, because we always ran out of linen, we were always ringing up trying to get towels and stuff ... Little things like that were really frustrating that you were always running out of, that you never} \]
had any of and you were fighting a constant losing battle.
(Sylvia)

In contrast, participants also saw budgets wasted on frivolous and unwarranted activities such as corporate lunches, and on poor planning of larger expenditures such as equipment and refurbishments that did not meet patients’ needs. Sylvia describes her experience of wasting money:

... setting up the unit with very limited budget from the government and having to brownnose those politicians and having to have tea and coffee and dinner with them in Sydney on my budget to brownnose them to give me more money, it just got the better of me. (Sylvia)

The perception that organisations were money focused above and beyond the provision of patient care created conflict for the participants who were unable to provide the care they wanted to. Another aspect that contributed to compromised care was a lack of resources required by the participants to carry out nursing.

Inadequate resources grouped together the examples revealed during participant interviews as to what contributed to their resignation. Participants believed that a lack of resources hindered them in delivering the quality nursing care which they believed patients deserved. Inadequate resources refers to a lack of items for patient care provision and included ward supplies (e.g. patient food, patient beds, batteries etc.), realistic and adequate budgets, money and time for the provision of professional support for nurse education including that of new graduates. Participants found that, due to the lack of these resources, patient care was compromised and Jade captures this in the following quote:
I pride myself in what I do and I just felt like I couldn’t do it properly because I didn’t have the time and didn’t have the resources. (Jade)

Anne explains how the hospital failed to keep the batteries that she required for cardiac equipment and she would buy the batteries for her department herself:

... at one stage I was actually going to the shops and buying batteries for all of the equipment because [the hospital] couldn’t supply me with the right batteries through Stores ... I would have to pay for all of these batteries and then claim it back, but they weren’t paying me for petrol to get there and back and the use of my car. (Anne)

Participants assumed that all patients would be provided with a bed but this did not always occur. When beds for patients could not be found, participants described running to other wards to find a spare bed. If a bed could not be found then participants used a portable trolley as a bed for patients. Patients would then have to be placed in the corridor and nursing care delivered in the corridor. Lee describes the frustration of this situation as:

... you get extra beds from anywhere you can, like trolley beds, put them up in the middle of the hall ... if an ambulance came through and you had no beds, then you get a bed from recovery, like any time, running around from x-ray with a bed, like just to put a patient on it. (Lee)

Participants felt that they often did not have the time and resources required to carry out nursing care in a manner that fitted with their own beliefs and, most importantly, that they were unable to give the type of nursing care that they wanted to provide. For instance, Lee and Jade revealed that:

... you didn’t have the time to give the patient care to your patient that you are expected to look after. (Lee)
and

*I think that was the biggest thing that got to me that I thought that I was a fairly good nurse and I could deliver a good level of care but I didn’t always feel like I could do that when I was there.*

(Jade)

For the participants in this study, there was often a sense of having to ‘sneak’, ‘pinch’ and ‘steal’ within the hospital to provide resources required for patient care delivery. Participants described sneaking, pinching and stealing items such as linen, beds, staff and food. In order to make wards run efficiently, participants needed to ‘pinch from here and pinch from there’. Sylvia describes how the staff would steal towels from other wards:

*... we were always ringing up trying to get towels and stuff and steal them from other wards.*

(Sylvia)

In addition to inadequate ward supplies, participants believed that patient care was also compromised as the organisation did not have the money to enable nurses to update their nursing knowledge. Participants expressed the need to ensure that their nursing knowledge was current and this could be achieved by further education. Participants found that the hospital would not support them to attend continuing professional development and refused to provide funding to cover costs (e.g. paid time off work, travel costs). Participants felt that without further education they could not provide the best quality care. Some participants managed to further their nurse education but did it in their own time and paid the fees themselves. Anne explains how frustrating this was for her work:

*Training, there was none. When I did ask for training I was told it would be at my own cost.*

(Anne)
Participants also cited cases where new nursing graduates were employed in rural hospitals under a program that offered support, mentoring and ongoing education to the new graduate. These programs provided funding which allowed for new graduates to have a reduced patient load as well as structured education programs to support the transition from student to registered nurse. Participants raised concerns that, while these programs existed in theory, in reality, new graduates were not resourced adequately and were given full patient loads immediately, and minimal support:

*When you do your new grad you still don’t get the one on one or anybody walking around helping you, you’re still put into a ward and expected to have a patient load, so having a post grad and just getting a job in a hospital is really no different ... I don’t think those post grad years are worth the paper they’re written on because they are training at the deep end, they are put in on the ward and made to do everything and have a patient load and it’s just a title really, it is just a guaranteed 12 months employment.*

(Lee)

The provision of continuing professional development and education for nurses was also impacted upon by a lack of funding within the organisation. David describes that:

*The manager was too budget focused he was not supportive of education he would say one thing like he was supportive of education but we don’t have enough money for it.* (David)

One participant applied for work in a rural hospital under the *Nurse Re-Connect Scheme*. This scheme was a NSW government initiative to address the nursing shortage by providing a program where registered nurses who had been out of the nursing workforce for several years could be assisted and supported to re-enter the workforce. The scheme lacked adequate resources to support these nurses. Rather
than being supported, the participant (who had been out of the workforce for some time) was placed in a specialised nursing position as a sole clinician where she had no experience; no training was provided and she was left on her own:

I had no idea how to check a pacemaker, the company that provided the equipment were willing to teach me, but that was in Sydney and they would provide the course for free, but they [the hospital] wouldn’t give me a car to go there, or time to do it. (Anne)

In summary, inadequate resources impacted on participants’ ability to provide nursing care. This contributed to the conflict the participants felt between being able to provide the standard of nursing care they wished to deliver and what actually occurred within their work environment. Jade expresses her concerns about her nursing:

... the biggest thing was that I felt like I couldn’t do what I wanted to do like I couldn’t be the nurse that I wanted to be. I know that sounds a bit corny but that’s what I felt. (Jade)

Participants also described that care was compromised because of staffing problems, in particular, insufficient staffing levels and inexperienced staff. Insufficient staffing relates to having insufficient numbers of nursing staff on the ward to provide patient care which the participants found compromised patient care. Lee explains how insufficient staffing numbers impacted on her:

There wasn’t enough staff and depending on, I suppose you know if you had five patients through you could give them the right amount of care but you know you couldn’t because of the staff numbers on the floor you couldn’t look after them the way you would if you had the time to do it ... you know now some people would be sent to the wards still in bloody sheets and stuff like that because you didn’t have time to change them. (Lee)
Participants expressed concern that they were inadvertently providing compromised patient care when there were insufficient nurses on a given shift. Jade discusses that not only was her ward short staffed, but the entire hospital too:

_We didn’t have enough staff … I think the rest of the hospital obviously had the same issues as us in terms of nursing shortage._ (Jade)

Judy had concerns over compromised care as a result of insufficient staff numbers and also expressed concern that as an experienced nurse if something went wrong she would be accountable to the Coroner:

_When I first came to the area … you were put on a thirty-four bed ward … all you’re doing is giving IV antibiotics. You don’t know the patients … I need more staff, you’re viewed as the newcomer what would you know and yes if an incident occurred and I was at the Coroner’s Court I would be asked, you’re a nurse with thirty years experience why did you allow this to happen._ (Judy)

... are the management going to adequately resource the staffing levels to ensure patient care actually happens? (Judy)

Participants described patient care being compromised when working in critical care areas when there were insufficient nursing staff numbers. In critical care areas, patients are often unconscious, intubated, ventilated and seriously ill. Hospitals employ a system of staff to patient ratios to ensure critically ill patients receive appropriate care. Jade explains that this often failed, jeopardising safe patient care:

_And then there was times, especially in Intensive Care, when one person had to go and have their dinner and you would be the only person there … the nursing supervisor was meant to come to you when that happens and that’s often, they rang and said I can’t come so you’ll just be by yourself, so then there was like four or five monitored patients … so there’s too many times you were left by yourself._ (Jade)
While participants revealed that insufficient staffing levels impacted on their provision of patient care, they also identified that the placement of inexperienced staff on wards undermined the provision of nursing care. Inexperienced staffing relates to placing nursing staff in areas where they have minimal experience in a particular area or specialty of nursing, or the ratio of senior to junior nursing staff was deemed inappropriate. This had a twofold effect. First, participants who were very experienced felt that they had to supervise these nurses as well as perform their own nursing care resulting in increased pressure, stress and workload. Rural hospitals in which these participants worked were often unable to fill shifts which resulted in the placement of inexperienced nurses to high acuity areas such as emergency departments. Inexperienced nurses were then given a full patient load and, once again, Lee surmises the impact of this on junior nursing staff:

_You could be working with a nurse who is like twelve months out, who has never worked in an emergency department and so you were virtually responsible for everything that happened in that ward and you had to check everything ... it’s just too stressful and for the junior nurses as well ... you have certain beds allocated to certain patients and you can’t put a junior nurse on someone who is having cardiac arrhythmias or something like that so then you’d have to always look after the sickest patients plus look after them as well, so it was just stressful for everyone, them as well. They would feel it._ (Lee)

Second, participants spoke about their own inexperience when sent to another ward; this made them feel helpless and a burden to other nursing staff. Participants described working in a rural hospital ward in which they had experience and a level of expertise but then being sent from one ward to another to cover meal breaks and staff shortages for shifts that could not be filled. This resulted in nurses moving from the ‘experienced nurse’ to the ‘inexperienced
nurse’ and back to ‘experienced nurse’. The deployment between different wards caused participants to become frustrated:

... they give you patients in rooms one to five and you think now where’s rooms one to five, I wonder what you do in surgical and then the next time, you’d only be there for half an hour, you’d read the reports you can’t work out what was wrong with the people, because you weren’t familiar with it, and then they’d say oh we’ve got someone in labour you’ll have to go back to the labour ward. (Juanita)

Participants believed that working on different wards constantly created conflict in how they could provide a high standard of nursing care as they constantly changed from being an experienced nurse to being an inexperienced nurse. Lee, an experienced emergency care nurse, describes how long it took her to do a simple medication round when she worked on a different ward:

I had to do occasional shifts up in the other wards from the emergency department ... and it was like hours to do a pill round because you didn’t know half the pills and stuff like that but the hierarchy don’t look at that sort of patient/nurse ratio type stuff, they’re supposed to but it doesn’t happen. (Lee)

For one participant who was a midwife, she described beginning her eight-hour shift on the maternity ward and was then subsequently sent to the medical ward, the surgical ward, paediatric ward, intensive care unit, emergency department and then to the operating suite to count the drugs, then back to maternity to deliver a baby, all in one shift. According to Lee:

They [management] didn’t care who was rostered on as long as they filled the shift, you know, it didn’t matter if they were junior nurses or whether they ever worked in the emergency department before, they just needed numbers. (Lee)
Some participants worked in smaller rural hospitals where there were no doctors, and the allocation of shifts to inexperienced nurses created great concern to participants as nursing staff relied on each other to provide all aspects of care including whatever emergency came through the door. In one small rural hospital, AINs were being placed in the emergency department where no doctor was present. There would be one registered nurse for the entire hospital, and Judy found this terrifying:

*The quality of nurses that were left is appalling, there’s a mix of AINs that are now working in Acute and in A & E which I find really, because the ambulance system is such that because it’s a public hospital that centre puts a callout ... you can get really really ill patients, flat patients being treated by people that have no idea with what they’re doing.* (Judy)

According to participants, hospitals often failed to address the issues of insufficient staffing levels and inexperienced staff on wards. Conflict arose for participants when either or both of these two aspects of staffing arose. Participants believed that both staffing issues resulted in the unsafe provision of patient care and Judy surmises this well:

*... the standards of care were appalling, the staff mix, the staff ratio, were really lame, there was no support, very little support, it was a really horrible experience.* (Judy)

The issues of insufficient staffing levels and inexperienced staff caused stress and conflict for the participants as to how they could provide a high standard of patient care within a rural hospital. While the participants valued providing adequate care it became evident that the organisation could not provide the staff required to fulfil this value.
**Compromising self**

In addition to the compromise of patient care, participants also detailed how they themselves became compromised. The factors that participants revealed which contributed to compromising themselves were a sense of powerlessness due to participating in and witnessing poor patient care, a lack of connectedness and shared vision with the organisation, and their own health being affected by their unhappiness at work. Each of these will be described below. Figure 8 below provides a visual representation of the sub-category *compromising self*.

![Figure 8: The Sub-category Compromising Self](image-url)
Participants described feelings of powerlessness and helplessness related to two aspects of patient care provision: first, when they witnessed a poor standard of patient care; and second, when they unwillingly participated in the provision of poor patient care. Participants unwillingly participated in poor patient care when they did not have adequate resources such as food, linen, beds, time or appropriate staffing levels, and when they made clinical judgments based on budgetary needs not nursing assessments. Providing poor patient care was because of circumstances that participants could not control, and it was this that jeopardised participants’ sense of integrity and moral responsibility.

Participants described situations that had the potential to cause harm to patients. Participants who were nurse managers, commented that patient care was compromised as a result of the centralising of health services, reduced resources and diminished control of nursing decisions. Wynette describes how an allied health worker who had been employed by a centralised human resources section was providing a very poor standard of patient care. Wynette personally witnessed this staff member treating patients poorly, but she was powerless to change the situation. Prior to the centralisation of health services, Wynette would have been able to deal directly with the situation and recruit someone else.

Participants spoke of the difficulty and frustration of not being able to approach patient care from a holistic perspective. For instance, when Sylvia resigned from a rural hospital and then worked in a community setting, she found that she was able to provide holistic patient care. She explained how the hospital approached patient care:
I didn’t like the way that people were categorised into an illness and basically not treated with an holistic approach and I found working in the community allowed me to expand my skills and my knowledge but also what I had to offer to people in terms of approaching them in an holistic way and giving them care and, like I can’t be everything to everybody but I was able to look at every aspect of their life rather than just stick them in a dressing or give them out a pill or injecting them because they were psychotic, you know that’s as far as it went in the psych hospital ... I saw very minimal approaches to the holistic or whole person it was very much crisis intervention and band aiding and trying to shut people up. (Sylvia)

While participants did manage to provide nursing care, it was often not in a manner they were happy with:

I think it was [being] very very efficient [how nursing care was provided] and I think that was different, I didn’t want efficiency when I had my babies, I wanted someone to love me, and to say so yes it is awful to be sore. (Juanita)

Powerlessness also emerged in this study for the participants when they were unable to voice their reasons for job dissatisfaction to the organisation at the time of resignation; exit interviews were not offered to most participants. Exit interviews were perceived by participants as an important way to communicate feelings of unhappiness as well as assist the hospital in identifying problems that may lead to nurse resignations. Participants felt that they were being silenced by not having an avenue, such as an exit interview, to discuss problems; after their resignation nearly all participants were not offered an exit interview. The study revealed that if participants had been offered exit interviews they would have stated the real reasons for their resignation.

Judy believes she was not offered an exit interview because the manager who needed to organise the exit interview did not want the reasons why she was
resigning to be revealed. This was because the problems were the person who would be conducting the interview:

... because I don’t think she wanted the reasons to come out.
(Judy)

In addition to powerlessness, a lack of connectedness and a lack of a shared vision were identified as contributors to compromising self. In this study, participants revealed the importance of feeling connected to where they were working and their rural community. Connection related to sharing ideas, sharing values, feeling a sense of belonging, working collaboratively and sharing a common vision. Participants found that there was minimal alignment of vision between themselves and the work environment. Participants’ spoke of feeling disengaged and expressed a lack of connectedness with the health system. Sally stated that:

I think that I had a feeling that our corporate goals were no longer the goals that I could support morally and ethically.
(Sally)

Anne described a sense of loneliness in her work. Anne worked in a large rural hospital but felt quite disconnected to the hospital as she was physically and emotionally isolated in her position and describes:

I worked through morning tea, I never had lunch, I never had anyone come and see if I was OK, never had anyone come and say, you know, we need you too, how is everything going or what sort of support do you need. (Anne)

Participants experienced a sense of frustration when the work environment failed to share a common goal of providing patient care. Lee felt that nobody in the
hospital cared what was happening to patients or nurses in the hospital, particularly staff in management roles:

... they just don’t care ... and they just got to the stage well who cares ... I think too if you don’t get support from your fellow nurses, if you can’t go to work every day and be happy where you’re working and you just become disheartened don’t you. (Lee)

This sense of no one caring contributed to issues of low morale and a sense of helplessness for the participants. Difficulty arose for participants who were trying to provide nursing care but were faced with attitudes of complacency.

Data also revealed that participants experienced a strong sense of community, belonging and identity from their work as rural hospitals are often the heart and soul of rural communities. This was very important to rural nurses but they lost this sense of belonging. For instance, Wynette states that:

I really loved being health service manager and actually having a vital role in the community to look after the needs of a whole rural community. (Wynette)

I was really well placed to be in a great little community that had it all going for it and then it just sort of all dissipated. (Wynette)

In addition to feelings of powerlessness because of poor patient care provision, a lack of opportunity to discuss issues at exit interviews and a lack of connectedness with the health system, participants stated that the impact of working in the hospital system was affecting their own health and happiness. Participants believed that working in an environment where values conflicted contributed to personal health issues which affected them, such as high blood pressure, headaches, emotional stress, episodes of crying, palpitations, chest pains and
abdominal problems related to their work. Wynette describes the impact of several stressful hospital management meetings:

*I was due to go back the next day for another meeting and I was sort of awake all night with chest pains and I thought I’m going off to hospital and I had really high blood pressure and I was in hospital a couple of nights and but that was just because of that, I know it, because I never have high blood pressure but I was in such a rage ... All the stress it’s not worth it you know, I’m not going to be dead over this job.* (Wynette)

Juanita explains the physical symptoms she felt each night when she went to work:

*When I went to work every evening on night duty I felt sick in the stomach and I felt palpitations.* (Juanita)

One participant describes how working in a rural hospital impacted on her mental health which then impacted on her personal life and she subsequently required counselling to address the problems:

*I was just devastated, absolutely devastated, I’ve been, my confidence was shattered, my confidence in myself was shattered, it’s affected my, I’ve got a, he’s now fifteen year old son, he’s coming home to a mother that’s crying all day, his father’s stressed because of the financial implications, we’ve moved back here and we’ve just both been working and having a reasonable comfortable life, it puts enormous strain on that and it’s still, it’s still being felt.* (Judy)

For participants, being a rural nurse had moved from a sense of satisfaction and enjoyment to one that now compromised both the delivery of quality nursing to patients as well as feeling that they had compromised themselves. Participants became despondent and ‘*frustrated and angry with the system*’. The unwilling provision of a poor standard of patient care, combined with a loss of
connectedness and shared visions of providing care impacted on the participants’ own health.

6.3 Chapter Summary

The two sub-categories of personal values – compromising care and compromising self and their properties have assisted in explaining the second category of conflicting values and detailed how participants felt they were compromising their personal values.

Participants found themselves in situations where they were unable to provide patient care that aligned with their values; this occurred as a result of a perceived different priority between participant and organisation, inadequate provision of resources for patient care provision and insufficient and inexperienced staff. When participants compromised patient care, this then had a flow-on effect: participants experienced a sense of compromising themselves. Compromising self occurred when participants became powerless to control how patient care could be provided and participants found they had lost a sense of connectedness with the organisation. From this, participants experienced an impact on their own health which included both physical and emotional symptoms. For the participants in this study, when their personal values were compromised, the only way to deal with this was to resign; resignation was the way to deal with conflicting values.

Conflicting values consists of two categories: organisational values and personal values. A conflict in values occurred for the participants due to organisational structures that imposed boundaries of control that hindered patient care provision.
and by *organisational attitudes* that were not congruent with the participants’ beliefs as to how nursing should occur. These two factors impacted on the participants’ own belief system and undermined the participants’ moral integrity adding to job dissatisfaction.

While the category of *organisational values* conceptualised the work environment and its impact on how participants could carry out nursing, the category of *personal values* conceptualised the distress felt by participants because they could not provide the standard of patient care they wanted to. Together, unsupportive organisational structures and attitudes accounted for participants’ subsequent resignation.

This chapter has provided details of the substantive codes that collectively form the second category of the core category of *conflicting values*. The next chapter will provide an explanation of the theoretical codes that link the substantive codes from Chapters Five and Six into an emergent grounded theory and reveal a basic social process of *conflicting values* and the substantive grounded theory of rural nurse resignations.
CHAPTER SEVEN

A Grounded Theory of Rural Nurse Resignations

7.1 Introduction

This chapter is the third of the findings chapters and presents the basic social process of conflicting values and the substantive grounded theory of NSW rural nurse resignations. The theory inductively emerged from the data and conceptualised why nurses resigned from NSW rural hospitals. Using Glaserian grounded theory, this study revealed that the major concern for the participants was that they were unable to perform nursing care in a manner that aligned with their personal values. This concern was conceptualised as the core category of conflicting values. The previous two chapters detailed conflicting values and its categories.

This chapter consists of three sections: the aspects of theory building utilised in this study; the three-stage basic social process of conflicting values; and the grounded theory titled Degree of Value Alignment – Why NSW Rural Nurses Resign. Using the aspects of theory building in accordance with a Glaserian grounded theory facilitated linking the substantive codes into a basic social process that explained the process of conflicting values. Through the relationships of categories and properties the theory became ‘dense and saturated’ (Glaser, 1978). These relationships increased leading to theoretical completeness and the emergence of a substantive grounded theory on rural nurse resignations.
7.2 Theory Building

In this study, the process of theory building was facilitated in three ways: by the use of theoretical coding families; by the sorting of theoretical memos; and by the emergence and integration of theoretical codes (see Section 4.6). While substantive codes conceptualise the empirical material of the research, theoretical codes conceptualise how the substantive codes relate to each other as hypothesis to be integrated into theory (Glaser, 1978). In addition to helping with the analysis, theoretical codes also assist the analyst to maintain a conceptual level in writing about concepts and their interrelations (Glaser, 1978). This section of the chapter will detail theoretical coding families, theoretical memoing and theoretical codes.

Theoretical coding families

The use of theoretical coding families was the first aspect of theory building used in this study and detailed in Chapter Four (Section 4.6 and Table 8). Three theoretical coding families provided an explanation of the theoretical relationships between the core category (conflicting values) and the categories (organisational values and personal values). Using the SIX Cs, the DEGREE FAMILY and the CUTTING POINT FAMILY allowed for the exploration of cause, consequence, range, intensity, continuum, cutting point, critical juncture, deviation, turning points, scales, tolerance levels, dichotomy and points of no return which then assisted with the emergence of a basic social process (conflicting values) and the grounded theory of rural nurse resignations (degree of value alignment). The use of several coding families explained the theoretical concepts in relation to nurse resignations and ensured relevance and fit to the emerging theory (Glaser, 1978).
What follows now is an explanation of how these coding families explain the theoretical relationships between the core category (*conflicting values*) and the categories (*personal values* and *organisational values*).

**Conflicting values**

The *six cs* explored the relationship in the data of *cause* and *consequence*. Nurses commenced employment in the hospital and initially their values were congruent with the organisation (i.e. hospital). At some point for the nurse an event occurred (*cause*) and as a *consequence* of this event the nurse perceived that the organisation’s values had changed. These *causes* form the sub-category and properties of *organisational values* and resulted in a *deviation* in value alignment between nurse and hospital. *Cause* and *consequence* demonstrated the relationship between the two categories of *conflicting values* (*organisational values* and *personal values*). As a *consequence*, nurses were unable to provide nursing care in a manner that fitted with their personal values. As a result, they believed that patient care was compromised (*compromising care*). Another *consequence* of compromised care was that nurses felt their personal and professional integrity was also compromised (*compromising self*). The *consequences* are an important aspect of the grounded theory as they assist in demonstrating the relationship of conflict between the nurse and the organisation.

The *degree family* theoretical codes of *deviation* and *continuum* demonstrate the movement from shared values between nurse and organisation to that of *conflicting values*. The degree of *deviation* between the values occurs along a *continuum* of value alignment. The *continuum* is crucial in explaining the
substantive grounded theory (degree of value alignment) as it explores the movement within the range of conflicting values; that is, the ‘degree of value alignment’ between the nurse and the organisation. The DEGREE FAMILY also explains the deviation between the two categories of organisational values and personal values. For nurses to provide a high standard of patient care, they believed that their values needed to align with the hospitals’ values. When these values were not sufficiently aligned, conflict ensued for these nurses, and this conflict becomes the implicit reason why rural nurses resign.

The CUTTING POINT FAMILY enabled the recognition of a cutting point or breaking point within the continuum of value alignment. The breaking point was where nurse resignation occurred. For the nurses in this study, the breaking point was what triggered their resignation but was not the reason for their resignation. The breaking point reflects reaching a threshold within the continuum of value alignment and triggered the nurse to resign; this is an important facet of grounded theory as current studies in nurse resignation often explore the trigger, and not the underlying cause of resignation.

Organisational values

The DEGREE FAMILY and CUTTING POINT FAMILY highlighted critical junctures within the data that had been coded within organisational values. The critical junctures in this study are labelled as catalysts (these catalysts are the properties of conflicting values [refer to Figure 4]). For the nurses in this study who worked in the public sector, a key catalyst was the restructuring of AHSs and the centralising of services. This is illustrated in the following interview excerpt:
I first of all made a decision that I didn’t want to be part of the restructure, that was the hardest decision, but once I had made that decision I just moved on. (Belinda)

And Sally describes here:

... I had a feeling that our corporate goals were no longer the goals that I could support morally and ethically. (Sally)

Other catalysts included outdated and inflexible patient care systems as well as cumbersome hierarchies. Nurses felt that both of these influenced a change in the values of the organisation and caused a deviation between their personal values and the organisations’ values.

**Personal values**

The degree family and the cutting point family also assisted in revealing the critical junctures, points of no return, turning and breaking points for participants working in rural hospitals. The nurses in this study reached critical junctures and breaking points within their work as nurses when their professional integrity (compromising self) and patient care (compromising care) were compromised. At this point, nurses were unable to realign their values to the organisations’ changed values. For example, Jade reached her breaking point when she was unable to provide the type of patient care that she wanted to give:

‘They won; I can’t do this anymore’ (Jade).

Wynette reached a turning point when she could no longer manage her rural hospital how she wanted to:
I think I was just backed into a corner and there was not much more I could do about it. (Wynette)

Lee reached her **point of no return** when her holiday leave that she had booked months in advance was cancelled at short notice due to short staffing:

... the Nursing Unit Manager in the middle of the nurses’ station, in front of doctors, nurses, everybody else that was there just said to me, your holidays have been cancelled and I said excuse me, you know why I’ve taken these holidays, I’m not going to back down, I’ll resign. (Lee)

The **point of no return** and the **breaking point** were important in building a substantive grounded theory on rural nurse resignations. It was at this point that nurses felt they could no longer cope; it was also at this point that the nurses could no longer accept the lack of alignment between their values and the organisations’. Subsequently, nurses resigned.

In summary, using the theoretical coding families allowed the researcher to see movement and relationships between the core category and the categories during the later stages of data analysis. Collectively, the three coding families were used to ask questions of the data and they provided explanatory value as to the theoretical relationships between properties and concepts. The emergent data had **range** (movement from shared values to conflicting values), **intensity** (distance between personal and organisational values), **scales** (balancing personal values with organisational values), a **continuum** (degree of aligning personal and organisational values), a **cutting point** (a final incident that tipped the scales) and a **point of no return** (nurse resignation). The next stage of theory building
involved the sorting of the theoretical memos that had emerged throughout the study.

**Theoretical memos**

The second aspect of theory building utilised in this study was the sorting of theoretical memos. The use of theoretical memoing in a grounded theory study has been explained in Chapter Four (see Section 4.6). This section describes the process of sorting the theoretical memos generated during data collection and analysis and explains how these memos assisted in the emergence of a substantive grounded theory of rural nurse resignations. Early in the data collection, the researcher commenced memoing and the memos were then grouped into ‘subject headings’. During the final stages of analysis, the memos were then arranged into a series of events, process and movement that assisted with generating theory. Using these memos together with the theoretical coding families detailed above, the researcher was able to move the theory forward (Glaser, 1978). Memos were grouped as ‘reasons for resigning’, ‘poor patient care’, ‘Wynette’s interview – the issue of conflict and control’, ‘what drives values’ ‘coding families’ ‘themes emerging’ and ‘changing values’.

**Theoretical coding**

The third aspect of theory building was facilitated with theoretical coding. Theoretical codes conceptualise how substantive codes relate to each other and provide the model for theory generation (Glaser, 1978). While the core category of *conflicting values* and its categories gave a thematic account of nurse resignations, the theoretical link to the grounded theory was generated from
theoretical codes; these link the substantive codes into a basic social process and theory that account for rural nurse resignations. By using the three theoretical coding families and sorting the theoretical memos, three theoretical codes – *sharing values, conceding values* and *resigning* – emerged to form a three-stage basic social process of *conflicting values*. What follows now is an explanation of the basic social process. First, an overview of this basic social process will be provided followed by a detailed account of each of the three stages.

### 7.3 The Basic Social Process of Conflicting Values

*Conflicting values*, the core category of this grounded theory, captures the entirety of a three-stage process that explains rural nurse resignations. The three stages are *sharing values, conceding values* and *resigning*. The transition from one stage of the basic social process to another was contingent on at least one catalyst occurring; these catalysts are found in the properties of *conflicting values*. It was these catalysts which caused the nurses to move into each subsequent stage. While all participants went through these stages, not all participants went through these stages in the same manner; this is typical of a basic social process (Glaser, 1978). The basic social process explains initially a time of sharing values between nurses and organisations (Stage 1) and collectively providing a high standard of care to patients. A catalyst then changed the organisations’ values and nurses found it difficult to provide the same level of care they had previously provided; this is depicted as Stage 2. After a period of time, certain catalysts moved the nurses into Stage 3, a time of ‘giving up’ and finally resigning from employment. In summary, as a consequence of changes in the *organisational structure* and *organisational attitude*, patient care became compromised (*compromising care*).
As a result, nurses themselves became compromised (comprising self) and as a consequence resigned. The following figure, Figure 9, depicts the three stages of conflicting values and the catalysts (the properties of conflicting values) that moved the nurses into each stage.

![Diagram showing the three stages of conflicting values and their catalysts](image)

**Stage 1: Sharing values**
- Restructuring & centralising of health services
- Outdated & inflexible patient care systems
- Cumbersome hierarchy
- Management culture
- Bullying – limiting nurses’ voices
- Expendable nurses

**Stage 2: Conceding Values**
- Powerlessness – participating in & witnessing poor patient care
- Lack of connectedness & shared vision

**Stage 3: Resigning**
- Impact on nurses’ health

*Figure 9: The Three Stages of the Basic Social Process of Conflicting Values*

What follows now is a detailed account of each of the three stages of the basic social process of conflicting values including a discussion on the catalysts that moved the nurses throughout the stages.
**Stage 1: Sharing values**

Sharing values, Stage 1 of *conflicting values*, theoretically explains that for the nurses in this study their personal values were (once) shared with the organisation in which they worked. Providing a high level of patient care was a value that all nurses in this study had in common and underpinned how they nursed. Having particular values underpins all human behaviour (Sullivan, Sullivan, & Buffton, 2002) and, in this study, this was reflected by the principles by which both individuals (nurses) and organisations (hospitals) co-existed. Values are subjective and vary between people, groups and cultures. The sharing of values was attributed to the fact that these nurses believed that they had the necessary support and resources required to provide a high standard of care; these resources included adequate staffing levels, good communication with nursing hierarchies and budget allocations that were conducive to a high level of care provision (adequate food, linen, dressings etc.). Evidence of this sharing of values emerged when nurses spoke of the ‘enjoyment of going to work’ and ‘satisfaction with work’, being in ‘a supportive environment’ and having ‘a team to back you’.

When nurses were asked where their values came from, they identified three areas: personal values derived from family and life experience; their nurse education; and their work colleagues. There was an assumption by the nurses in this study that the organisation in which they worked would have similar values and provide necessary resources for nurses to carry out patient care that concurred with their own personal values.
For the nurses in this study, their values that emerged from the data were both implicit and explicit. These personal values of what it is to be a ‘good nurse’ included providing a high standard of patient care, caring for the sick, being a person of high morals, being seen as a professional, treating all with respect, making people comfortable and always doing the right thing. Nurses alluded to their enjoyment of working with like-minded nurses and, while they were busy and ‘running around like chooks with heads cut off, they would still laugh and have fun’; their work was ‘immensely satisfying’.

In this stage of sharing values, nurses experienced sufficient levels of job satisfaction and this was alluded to during their interviews when they spoke about their experiences in the hospital system prior to the events that led to their resignation. Nurses expressed great pride in their work, a sense of satisfaction in being a nurse and an enjoyment of mutual satisfaction with colleagues. Nurses’ ‘workloads were high but they were energised and excited by their work and had a good network and rapport’ with other staff. Nurses also felt that the organisation ‘was a nice place to work’ and they felt ‘appreciated and respected’. These descriptions of a time of enjoyment in nursing with immense satisfaction were reflected by every nurse interviewed in this study.

The stage of sharing values between a nurse and an organisation may continue indefinitely. As long as the nurse shares common values with the organisation and is provided with the resources to carry out work that aligns with these values then job satisfaction levels will remain high. However, there were catalysts that moved nurses from Stage 1 to Stage 2 of the basic social process and these were found in
the properties of organisational values. These catalysts facilitated the nurse to move to the next stage; from a stage of sharing values to a stage of conceding values.

Moving from Stage 1 to Stage 2 – The catalysts

While nurses enjoyed a time of sufficient job satisfaction in the sharing values stage, there were specific events that nurses perceived changed the values of the organisation. These events saw nurses move from Stage 1 to Stage 2. For the nurses in this study, the catalysts that moved them from Stage 1 to Stage 2 are depicted as the properties of organisational values. These catalysts are restructuring and centralising of health services; outdated and inflexible patient care systems; cumbersome hierarchies; management culture; bullying and an attitude that nurses are expendable. Each of the catalysts has been discussed in detail in Chapter Five.

For the participants in this study employed in the public sector, the strongest catalyst was the perceived changes in the organisational values following the 2005 restructuring of AHSs. This restructure brought with it changes to both health care delivery and nurse management structures which then impacted on the structure in which participants worked. The restructure saw changes to administrative structures and hierarchy, the centralising of services and constrained budgets because of larger rural geographical areas. For nurses, particularly those in management, many implicitly shared values and goals changed and nurses began to lose control of nursing decisions.
Stage 2: Conceding values

The word ‘concede’ means to ‘give over, surrender or yield something that one possesses’ (Pearsall, 1998, p. 379). In this stage of the basic social process, nurses begin to concede their values; in other words, nurses begin to surrender their values and perform nursing in accordance with the organisations’ new values and not their own personal values. As nurses concede their values, they begin to become frustrated and increasingly dissatisfied with their work as the alignment between their values and the organisations’ begins to diverge. Nurses become dissatisfied in their effort to maintain a high standard of patient care that fits with their personal values. This stage is where values begin to conflict.

As a consequence of the catalysts that moved the nurses from Stage 1 into Stage 2, patient care now becomes compromised and Stage 2 of this basic social process encompasses all the properties of compromising care: different priorities between nurses and hospitals, the inadequate provision of resources for patient care and insufficient and inexperienced staff. It is in this stage that nurses become aware that their priorities are different to the organisations’. In the sharing values stage, the nurse and hospital shared a priority of providing a high standard of patient care, but in Stage 2 nurses became aware that there had been a change in the organisations’ priority; nurses perceived that the organisations’ priority was money driven and organisations seemed to focus on cost savings to the detriment of patient care. In addition, nurses found that resources for providing care were limited or difficult to access due to changes in the financial governance and restructure of the organisation, contributing even further to a decrease in patient care standards. Frustration levels became higher for nurses and job satisfaction
decreased as patient care was compromised. In this stage, nurses felt they were losing control of nursing decisions that allowed them to provide a high standard of care. Value alignment between nurse and hospital diverged even further in this stage.

This stage is an important part for nurse retention strategies as it is in this stage that the issues that caused decreased job satisfaction have the ability to be changed or modified; this would give nurses back control of both nursing decisions and their ability to provide a high standard of patient care. Therefore, realigning values between nurse and organisation in this stage would allow the nurse to move back to Stage 1 (*sharing values*) where there is greater congruency between nurses’ personal values and the values of the organisation in which they work. However, realignment of values was difficult to achieve as it would necessitate a large change in the nurses’ values or the organisations’ values or both. Nurses progress through this stage and, for some, they may remain disatisfied in their work but still be able to compromise their values within a range that is somewhat agreeable to the nurse; for others, the range between personal and organisational values becomes too great. Unable to realign their values to those of the organisations, a catalyst occurs that triggers the movement of the nurse into the third and final stage of the basic social process.

*Moving from Stage 2 to Stage 3 – the catalysts*

The catalysts that moved nurses from Stage 2 to Stage 3 are the properties of *compromising self; powerlessness – participating in and witnessing poor patient care; a lack of connectedness and shared vision and an impact on the nurses’*
personal health. As a consequence of patient care becoming compromised (compromising care), nurses now became compromised (compromising self). These catalysts became interwoven in the nurses’ work and nurses found themselves in situations where they were no longer able to carry out their work in a way congruent with their values. This is a time of deep distress for the nurses as patient care has been compromised as well as the nurses’ personal and professional integrity.

As nurses move from Stage 2 to Stage 3 they experienced moral distress. Moral distress in nursing has been defined as uncomfortable feelings that occur when nurses are conscious of morally appropriate action a situation requires, but cannot carry out that action because of organisational barriers such as lack of time, lack of management support, conflicting cultural values and institutional policy (Jameton, 1984).

As nurses believed that their ability to provide patient care became too compromised, they wrestled with their own personal values and felt that they were becoming increasingly powerless. Goals were no longer shared and the organisations’ (new) values could no longer be supported ‘morally or ethically’ by nurses.

**Stage 3: Resigning**

The final stage of the basic social process is resigning. During this stage the nurse resigns, both in the verb meaning to ‘give up’ and the noun meaning to ‘cease employment’. As the nurse had conceded too much of their personal values, this
led to an overwhelming sense of compromised integrity. Realigning personal values with the organisations’ new values was not possible for the nurses in this study as values were too conflicted. Nurses entered a phase of ‘giving up’ as they were unable to resolve the problem (conflicting values). Nurses felt powerless and despondent and believed that the organisation had ‘won, [they] can’t do this any more’. This was when nurses began to feel powerless, lacked a sense of connection with the organisation and also experienced physical and emotional symptoms such as high blood pressure, crying bouts, helplessness, abdominal pain, guilt, frustration and anger.

Within this stage, nurses resign themselves to hopelessness and powerlessness and are unable to reconcile the conflict between their personal values and the values of the organisation. This sense of resigning is conditional on the degree of divergence between the nurses’ and work environments’ priorities. In this stage, job satisfaction is very low.

This stage is where the nurse has reached a ‘values threshold’ where they are no longer able to concede their values and the degree of value (mis)alignment is too great. When nurses are in the stage of resigning and have ‘given up’, an event either small or large triggers the nurse to resign from employment. For the nurses in this study, these triggers included cancelling holiday leave with short notice, not getting a promised position in the hospital, feeling trapped by hospital administrators, losing control of staffing, an inability to provide a level of patient care the nurse wanted to, the AHS being too big to manage, and not being appreciated by senior staff members.
In this stage of the basic social process, a ‘window period’ was identified. This ‘window period’ was the time after the nurse resigned and prior to their last day of employment and was perceived by participants as an opportunity for the organisation to address the reasons for nurse resignation and hopefully retain the nurse. Nurses expressed concern that the hospital did not use this ‘window period’ to attempt to identify and correct the issues that had caused a conflict in values. Identifying and correcting the problems may only be accommodated if the organisation and nurse were able to realign values to a point of congruency whereby shared values could be re-established. Many participants did not pursue further employment in the nursing profession as living in a rural area meant that there were no other employment options. The more remote the area the nurse lived in, the greater the likelihood that there was only one facility to gain employment in; therefore, nurses had no option but to leave the nursing profession.

**Basic social process summary**

This basic social process of *conflicting values* is a three-staged process that explains the process that leads to rural nurse resignations. Stage 1 is a *sharing of values* between the nurse and the organisation and is a time of job satisfaction for nurses. The link between shared values and job satisfaction is extremely relevant to rural nurse retention. The properties of *organisational values* then become catalysts that move the nurse into Stage 2, a time of *conceding values* where patient care becomes compromised (*compromising care*) and values diverge further between the nurse and the organisation. It is possible for a nurse to move back to Stage 1 if the catalysts that moved the nurse from Stage 1 to Stage 2 can
be reversed or reduced. If not, values continue to conflict; patient care becomes increasingly compromised; and this leads nurses to compromise their own values and professional integrity (*compromising self*). These catalysts then move the nurse into Stage 3 of *resigning* – a time where the nurse ‘gives up’.

It is within Stage 3 that the nurse will reach their ‘values threshold’ where the divergence of values between nurse and organisation is too great; the nurse then resigns from employment. Once the nurse resigns, there is a ‘window period’ between resignation and the last day of employment where the nurse and organisation have the opportunity to resolve the issues that caused values to conflict and possibly move the nurse back to Stage 1 or Stage 2. What follows next is the grounded theory of rural nurse resignations.

### 7.4 Degree of Value Alignment – Why NSW Rural Nurses Resign

The aim of this research was to discover why NSW registered nurses resigned from rural hospitals. This study has generated a substantive grounded theory titled *Degree of Value Alignment – Why NSW Rural Nurses Resign* referred to in the following text as *degree of value alignment*.

NSW registered nurses resigned from rural hospitals due to the degree to which they could or could not align their personal values with the organisations’ values. One of the main values that nurses have is to provide a high standard of patient care and at some point there was a sharing of value alignment between the nurse and the hospital. If certain catalysts occurred that altered the values of the organisation, the *degree of value alignment* between the nurse and the hospital
needed to undergo realignment. As value alignment decreased, it is evident that job satisfaction also decreased.

The *degree of value alignment* occurs along a continuum and as a nurse moves along the continuum certain catalysts may cause the nurse to move in either direction. The more values are shared the greater the *degree of value alignment* and this seems to occur in tandem with increased job satisfaction. If values grow further apart, moving nurses further along the continuum in the opposite direction, a ‘point of no return’ is reached. This point of no return is the threshold where a nurse can no longer work in the hospital as their values are compromised to such an extent that they would be conceding their personal values too much.

During the entire process, the nurse needs to realign their values with the changed hospital values in order to create balance; the hospital does not seek to realign its values with the nurse. The realignment of the nurse’s values is a basic social process used to balance conflicting values. When a nurse is no longer able to balance the *degree of value alignment*, the value threshold is reached and resignation occurs.

Major catalysts that caused a decrease in the *degree of value alignment* between nurse and hospital were: changes to rural health care systems (restructuring and centralising of rural health services), lack of adequate resources for patient care provision, outdated and inflexible systems, cumbersome hierarchies, insufficient and inexperienced staff, and bullying nurses by silencing them to conform to these systems. The focus on saving money, cost cutting and using a business model to
run hospitals resulted in *organisational values* of rural hospitals shifting. These catalysts resulted in nurses compromising patient care which then led to nurses compromising self.

The *degree of value alignment* may be likened to a set of ‘value alignment scales’. When the *degree of value alignment* between nurse and hospital moves, the scales also move and may become unbalanced. Realigning nurse and hospital values will balance the scales (and increase job satisfaction) but for the nurses in this study they could not find the balance (realigning their values with the hospitals) and the point of no return (nurses’ value alignment threshold) on the scales was reached and the scales tipped, resulting in nurse resignations.

What this grounded theory suggests is that a nurse will commence working in a rural hospital and there is a period where the nurse shares (to a degree) values with the organisation. This sharing of values brings a level of job satisfaction for the nurse as they are able to provide a high standard of patient care. There is at this point implied collaboration, co-existence and co-agreement between nurse and hospital as to how patient care should be delivered and performed. As certain events (known as catalysts) impact on the perceived values of the hospital, the *degree of value alignment* between nurse and hospital will move closer into alignment, further apart or remain static. These catalysts are any event that may cause a perceived change to hospital values (from the perspective of the nurse) and may also cause a change to the work environment. Within the value alignment scales, a ‘value threshold’ exists where, for nurses, there is a point where
conflicting values can no longer be tolerated; job dissatisfaction escalates and nurse resignations ensue. At this point nurses have ‘had enough, no more’.

Catalysts occur that change the organisations’ values. One of the major catalysts identified for nurses who worked in NSW rural public hospitals was the restructuring and centralising of services. Restructuring occurred in an effort by the state government to save money and be cost effective; therefore restructuring became one of the catalysts that decreased the degree of value alignment. Prior to the restructuring and centralising of services, nurses were able to perform nursing care in a way that was more closely aligned with their values, and which these nurses believed enabled them to provide a high standard of patient care. With the implementation of restructuring that increased the geographical size of AHSs, combined with the centralising of hospital services such as payroll, linen, recruitment and food, nurses noticed a move in the rural hospital values from being patient focused to being cost efficient. For the nurses in this study, there was a shift in value alignment which caused them to lose a degree of control of how they could perform nursing care; they saw that nursing care was being driven and directed by financial constraints rather than by what patients actually required.

Another catalyst was outdated and inflexible systems within rural hospitals that determined patient/staff ratios and models of nursing care. These systems caused movement within the value alignment scales resulting in a decrease in value alignment. This was because these systems aligned with the rural hospitals’ values of being cost effective but conflicted with the clinical nurses’ ability to carry out
patient care according to their values. These *outdated and inflexible systems* often resulted in inadequate staff/patient ratios with nurses having too many patients to be able to provide nursing care in a manner that aligned with nurses’ values. Adding to this was the interpretation that organisations were often using ‘*models of nursing care that were too inflexible to reflect current resources*’.

In addition, *organisational attitudes* contributed to a decrease in the *degree of value alignment*. This occurred when nurses perceived that the management culture did not align with their personal values. Nurses in this study viewed management as ‘*an invisible body that was too far removed*’ from them and ‘*did not understand what it was that nurses did and require in order to perform nursing*’. For nurses, this contributed to a decrease in the *degree of value alignment* as they were nursing with a ‘*lack of direction*, *poor communication*’ and ‘*a general lack of interest from management*’. There was a sense of ‘*we have always done it like this so we will continue*’, even to the detriment of patient care.

As the *degree of value alignment* decreased for the nurses in this study, they experienced an increase in *conflicting values* as they perceived patient care to be compromised. *Compromising care* occurred when nurses perceived the hospital to have a different priority to them; nurses prioritised patient care while the hospital prioritised cost savings. As a result of these cost savings, the organisation was unable to provide adequate resources for nurses to provide appropriate patient care. This led to nurses either providing patient care that they did not believe was to a standard they wanted to provide or the nurses witnessed other nurses providing compromised patient care.
Nurses described issues and incidents within rural hospitals that conflicted with their own values and created a sense of helplessness. Participants described nursing positions given to applicants who lacked qualifications and experience and did not have the capacity to provide an appropriate standard of care but, as these applicants were ‘either a friend of the manager’ or a ‘displaced employee’, they were subsequently employed. When nurses witnessed the provision of poor patient care within rural hospitals that opposed their values, they attempted to raise these issues with their managers but were bullied by management to be silent. If they complained formally, nurses were viewed as ‘trouble makers’. This negative culture within management opposed nurses’ values and contributed to a decrease in the degree of value alignment.

Nurses felt that rural hospitals held a value of ‘just filling shifts with anyone’ regardless of suitability to the hospital area, experience or qualifications. Nurses were moved from ward to ward frequently, sometimes mid shift or were placed in a ward that was short staffed often resulting in inexperienced nurses working in specialised fields of nursing. This fitted with the organisations’ value of ‘just filling shifts with anyone’ but conflicted with nurses’ values of providing a high standard of patient care.

As the degree of value alignment decreased, nurses became disconnected from the hospital and found that the hospitals’ vision and goals ‘were no longer goals that they could support morally or ethically’ and that the hospital had ‘lost focus on patients’. Nurses felt that their professional integrity was compromised. They experienced moral distress when appropriate care could not be provided as well as
a sense of powerlessness when there was no avenue to remedy the situation. Eventually, the compromise of patient care and self impacted on the nurses’ own personal health and nurses experienced symptoms of poor physical and mental health.

Unable to realign values or increase the *degree of value alignment* to a sustainable level, *conflicting values* led nurses to reach their values threshold. For nurses, there was a point for each of them where reaching this threshold tipped the *degree of value alignment* to a point where they could no longer work in a rural hospital. Reaching the values threshold was a process that occurred over a period of time and was cumulative; but one final issue ‘tipped the scales’.

The following figure, Figure 10, schematically depicts the grounded theory of *degree of value alignment*, the basic social process (*conflicting value*) and the three stages (*sharing values, conceding values* and *resigning*). The catalysts tip the continuum (scales) changing the *degree of value alignment* between nurse and hospital.
Chapter 7: A Grounded Theory of Rural Nurse Resignations

Figure 10: Value Alignment Scales

- **Catalysts to move to Stage 2**
  - Restructuring & centralising of health services
  - Outdated & inflexible patient care systems
  - Cumbersome hierarchy
  - Management culture
  - Bullying
  - Expendable nurses

- **Catalysts to move to Stage 3**
  - Different priorities
  - Inadequate resources
  - Insufficient & inexperienced staff
  - Powerlessness
  - Lack of connectedness & shared vision
  - Impact on nurses’ health

- **Value Alignment Scales**
  - Sharing values
  - Conceding values
  - Resigning
In summary, nurses and hospitals may have a sharing of values; at this stage nurses’ job satisfaction is high. Due to catalysts occurring, hospital values are perceived by nurses to change and the nurses in this study found that their values conflicted with the changed values of the hospital. Unable to realign their values to the hospitals’, the degree of value alignment decreased to a point where nurses reached their value threshold; when this point was reached, nurses resigned from the rural hospital.

### 7.5 Chapter Summary

The purpose of the chapter was threefold. First, it provided an explanation of the aspects of theory building utilised in this study. These included using theoretical coding families, theoretical memos and theoretical codes. Second, it detailed the basic social process of conflicting values, a three-stage process. Last, it provided the grounded theory of *Degree of Value Alignment – Why NSW Rural Nurses Resign* that explains why nurses resign from rural hospitals. Nurse resignations from NSW rural hospitals are based on the degree to which nurses can or cannot align their values with the hospitals’ values. The following chapter is a discussion of the findings.
8.1 Introduction

This chapter is the discussion component of the thesis and will provide a discussion of the findings in regard to NSW rural nurse resignations. In keeping with grounded theory these findings are congruent with relevant literature. This study sought to explore the reasons why registered nurses resigned from NSW rural hospitals; the previous three chapters outlined the findings of the research. The major finding of this study revealed that nurses resigned from rural hospitals due to the inability of rural nurses to realign their values with the hospitals’ values when changes occurred; value realignment between nurse and hospital is crucial for NSW rural nurse retention. The substantive grounded theory of degree of value alignment emerged around the core category of conflicting values which was also the basic social process, a three-stage process that nurses moved through prior to resignation. What follows now is a discussion of the findings, namely, the basic social process and the substantive grounded theory. This will be followed by a discussion on job satisfaction and retention of nurses in the Australian rural workforce.

8.2 Conflicting Values

The degree of value alignment between nurse and hospital occurs as a three-stage basic social process titled ‘conflicting values’, and the three stages were sharing values, conceding values and finally resigning. These stages elucidated what
occurred for the participants in this study and assisted in further understanding the process of rural nurse resignation. *Conflicting values* is a dynamic process and nurses have the potential to move through the three stages to either increase or decrease the *degree of value alignment*; this is imperative in understanding nurse resignation. The identification of the catalysts in this basic social process that moved nurses throughout the stages is vital for implementing appropriate nurse retention strategies. What follows now is a discussion of *conflicting values* that explores the three stages of the basic social process in relation to current literature and examines the new findings that emerged.

*Sharing values*

The first stage of the basic social process (*sharing values*) or ‘value congruence’ is well established in the literature. Locke’s (1976) theory of value congruence explains that employees are more satisfied with their employer and managers when they share common values. Locke (1976) refers to this as an ‘entirety relationship’ as it involves a response to the other person as an end in itself. Locke’s (1976) theory of value congruence extends to nursing and this study confirms both national and international findings that value congruence is a factor which leads to increased job satisfaction and retention of nurses (see, e.g., Duffield, Roche, et al., 2007; Gullatte & Jirasakhiren, 2005; Horton, Tschudin, & Forget, 2007; Leiter, Jackson, & Shaughnessy, 2009; Tourangeau & Cranley, 2006).

This study extends what is known about value congruence theory by identifying two further stages that follow *sharing values*. These stages broadened Locke’s
(1976) value congruence theory by identifying the process that occurs when nurses move from a state of value congruence to job resignation. Importantly, the study identified what catalysts caused nurses to move throughout the three stages. Nurses moved from Stage 1 to Stage 2 as a result of the catalysts of restructuring and centralising of health services; outdated and inflexible patient care systems; cumbersome hierarchies; negative management culture; bullying; and an attitude that nurses are expendable.

Nurses moved from sharing values to conceding values as a result of AHS restructures that directly affected senior nurse managers and indirectly clinical nurses. Senior nurse managers experienced a loss of resources, decision making and control of managing rural hospitals due to the restructures. This then had a flow-on effect to clinical nurses who experienced a loss of resources and diminished lines of communication with senior staff. Senior nurse manager roles were also diluted in the restructures and managers felt AHSs were too large to manage. Interestingly, and following several very severe patient incidences in NSW public hospitals, the NSW Government convened a major review of the health system led by Senior Counsel, Peter Garling. In Garling’s (2008) report, he comments that the greatest criticism of current AHSs in NSW is that they are too big, with decision makers too remote from the people affected by decisions. The findings of this study also revealed similar findings. This is particularly relevant to the rural AHS of GWAHS which represents over 55 per cent of the land mass of NSW with a much dispersed population resulting in large distances between decision makers and workers (NSW Health, 2010a). The 2005 NSW AHS restructures impacted greatly on moving nurses from a time of sharing values to a
time of *conceding values*. Similarly, a study of remote area nurses across Australia found that the major contributor to job dissatisfaction and reduced levels of nurse retention was the physical distance of health managers from the actual work location (Weymouth et al., 2007).

In response to the *Garling Report* (2008), NSW Health published an action plan titled *Caring Together: The Health Action Plan for NSW* (2009). This is the first stage of the NSW Government’s response to the findings and recommendations of the *Garling Report* and provides a strong mandate for change. Garling (2008) highlights that the NSW Health system is under pressure which has resulted in clinical care suffering as well as the compassion shown for patients, families, colleagues and support staff. The NSW Health plan of action includes measures that will be put in place immediately to help improve not just clinical care, but the environment in which that care is delivered, and the compassion and sensitivity with which it is delivered (NSW Health, 2009). NSW Health states that in their action plans everything must be about the patient with the patient being the centre of the health care system (NSW Health, 2009). This NSW Health plan of action will be delivered via six major strategies: creating better experiences for patients; safety; education for future generations; new ways of caring; strengthening local decision making; and monitoring progress (NSW Health, 2009). This approach by NSW Health may assist in promoting a sharing of values between nurse and hospital and therefore may assist in nurse retention; even the title of the action plan (*Caring Together*) instils a sense of sharing values.
To date, this study appears to be the first to report a link between NSW rural nurse resignations and the effect of health restructuring on rural nurses. Regardless of the large size of the nursing workforce, nurses have relatively limited input into the way restructuring has occurred, but are often the most affected. Each time structure is changed, the consequences and costs to nursing and patient services are often unacknowledged or not considered. While restructuring often focuses on increased efficiency, factors affecting the quality of patient care and the work life of nurses are often neglected (Duffield, Kearin, Johnston, & Leonard, 2007). Evaluation of restructuring will always be challenging in hospitals due to the inability to measure outcomes in a suitable time frame. The findings of this study add weight to the claim that restructuring and the centralisation of services impact on nurse retention. The health care environment is highly dependent on nurses’ knowledge and expertise; restructuring, while sometimes necessary, must be adequately considered in terms of the potentially negative impact on nursing and patient outcomes (Duffield, Kearin, et al., 2007).

Following Garling’s (2008) report and the federal government’s proposal to reform the Australian health system, the NSW Premier announced that the current eight NSW AHSs would be restructured to form eighteen LHNs (NSW Health, 2010a). This doubles the number of NSW rural AHSs. The establishment of LHNs aims to decentralise public hospital management and increase local accountability; provide a transparent and nationally consistent approach to public hospital funding; give LHNs the flexibility to shape local service delivery according to local needs; and provide an effective means of engaging with the
local community and local clinicians to incorporate their views into the day-to-day operation of hospitals (Council of Australian Governments, 2010).

These new LHNs only commenced operation on 1 January 2011. At this stage, it is unclear how these restructures will impact on the degree of value alignment between rural nurses and hospitals. This study has indicated that smaller regional AHSs combined with the decentralisation of public hospital management and an increase in local accountability may be a positive move towards increased rural nurse retention and improved patient care services. It must be remembered that research indicates that any restructuring of hospital organisations always brings with it emotional exhaustion, cynicism and perceived threats to job security for nurses (Burke & Greenglass, 2001), and leads to distrust and low morale for nurses (Duffield, Kearin, et al., 2007). These negative aspects of restructuring can be reduced by several strategies: the development of an organisational vision for the future; staff involvement and participation in the restructuring planning, implementation and management; fairness of sacrifice in the process; visible and approachable leadership; open and active communication; and strong efforts to rebuild and repair staff morale during the downsizing and restructuring process (Burke & Greenglass, 2001). Implementing these strategies would appear to enhance the transition of another restructure as these strategies may increase the degree of value alignment between nurse and hospital.

What is also currently known is that the cultural relationship between NSW rural health care workers and their hospital has been shown to be something to which ‘city-based bureaucrats and politicians are blind’ (McAlpin, 2008, p. 5). Without
an awareness of this important part of rural life and connectivity, bureaucrats ‘inadvertently de-value and demolish long-standing loyalties’ (p. 5). This results in bureaucrats and politicians eliminating themselves from an essential part of communication that ironically would have allowed them to have the level of examination they require in order to manage an organisation as complex as a health service (McAlpin, 2008, p. 5).

In addition to AHS restructures, outdated and inflexible patient care systems were identified as another catalyst that had the potential to move nurses from sharing values to conceeding values. This study revealed that clinicians were more up-to-date with models of patient care than management were and that outdated models of care impacted on a nurse’s ability to provide a high standard of patient care. This raises the question of why nurse managers are not up-to-date with current research and practice systems to support nursing. Models of care should not be prescriptive but rather have the capacity to accommodate ward circumstances including patients’ needs, skill mix and staffing levels and also be based on clinical decisions. The ability to change the model of care is a necessary function of hospital wards and may need to change daily or even per shift to accommodate patients' needs, skill mix and individual ward environments (Duffield, Roche, Diers, Catling-Paull, & Blay, 2010). Essential requirements for all rural and remote models of care are the availability of sufficient staff, funding mechanisms that support and not constrain, input from the community, strong supportive management and adequate infrastructure (ANF, 2008b).
Garling also indentified inflexible patient care systems as a contributor to poor health service delivery in NSW. Many of Garling’s recommendations formalise what the nurses in this study identified as occurring in their hospital in relation to outdated and inflexible models of care and patient care systems. Garling (2008) recommends the implementation of up-to-date information systems by 2013. These include the identification, development and publication of patient care measurements regarding access to treatment, clinical performance, safety and quality, cost, patient experience, staff experience and sustainability. There will also be proposed changes to the current models of care, the redesigning of rostering systems, and improvement in collaborative partnerships between clinicians and administrators to ensure the quality of patient care and patient safety (Garling, 2008).

The concept of a negative culture within management (termed ‘organisational culture’ or ‘corporate culture’ in the literature) emerged in this study as another catalyst for moving nurses from sharing values to conceding values. There is a strong link between hospital organisational culture and nurse retention (Shermont & Krepcio, 2006). Organisational culture emerges from the sharing that occurs between colleagues in an organisation, including shared beliefs, attitudes, values and norms of behaviour. Thus, organisational culture is reflected by a common way of making sense of the organisation that allows people to see situations and events in similar and distinctive ways (Davies, Nutley, & Mannion, 2000). Garling (2008) identified issues associated with management culture within NSW Health and recommended that a change of the present culture between clinicians and managers is required to improve health services within NSW.
Legge (1994) notes that, in using the term ‘corporate culture’, many writers envisage a culture created by senior management for the lower orders to accept. The notion of shared values or value congruence is posited as central to the pursuit of corporate excellence, signifying the alignment of employees in the achievement of organisational goals. Therefore, the guiding aim of corporate culturism (Willmott, 1993) is to win the hearts and minds of employees to the organisations’ purposes by managing what the employees think and feel, and not just how they behave.

Bullying was also identified in this study as a catalyst for the movement of nurses from Stage 1 to Stage 2. The literature on bullying within the health care sector and the profession of nursing is discussed in Chapter Two of this thesis and there is extensive literature that relates bullying to nurse resignation; this is not a new finding. However, what this study does identify is that bullying is a catalyst that has the potential to move the nurse to the next stage of conflicting values.

The findings of this study contribute to what is also already known about the relationship between bullying and decreased job satisfaction for nurses within the NSW rural sector (Hegney et al., 2005; Roche et al., 2010). Verbal bullying from senior managers was used to ensure that nurses remained silent about unfavourable incidents that occurred within the hospital such as poor treatment of patients, complaints about physically small remote area health clinics and also about challenging management decisions. The nurses in this study learnt to be silent for fear of retribution or of being embarrassed in front of colleagues by voicing their opinions. Feedback from nurses to Garling also indicated that nurses
feared retribution if they spoke out or made suggestions for improvement (Garling, 2008) thus confirming the participants’ views in this study.

**Conceding values**

Stage 2 of the basic social process, *conceding values*, was a stage where the nurses perceived that the way they were able to provide patient care was starting to be compromised. In this stage, the nurses experienced a sense of different priorities between themselves and the hospital. They felt that the hospital was being too money focused and that there were inadequate resources as well as insufficient and inexperienced staff for patient care provision that fitted with the nurses’ values. *Conceding values* resonates with Jameton’s (1984) descriptions of moral uncertainty, moral dilemmas and moral distress. Moral uncertainty is a time when nurses are unsure what moral values apply or what the moral problem is; nurses feel dissatisfied with the patients’ treatment. Moral dilemma describes where two or more moral principles apply but they support mutually inconsistent courses of action. Moral distress describes when nurses know the right thing to do but institutional constraints make it impossible to pursue the right action (Jameton, 1984). Moral distress occurred for the participants in this study when there were inadequate resources such as food, linen, dressings, beds and adequate staffing levels to provide a standard of care that aligned with the nurses’ values. Moral distress presented itself in the stage of *conceding values*; a time when uncomfortable feelings occurred when nurses were conscious of morally appropriate action a situation required, but could not carry out that action because of organisational barriers such as lack of time, lack of management support,

Previous research has found that the major sources of nurse moral distress are the treatment of patients as objects when meeting institutional requirements (Hardingham, 2004; Jameton, 1984), health policy constraints (Corley, 2002), insufficient staff (Corley, 2002; Erlen, 2004; Zuzelo, 2007) and the effects of cost containment (Corley, 2002; Corley et al., 2005). Increased moral distress leads to conflict arising within the organisation when costs are controlled and nurses cannot provide adequate patient care as a result of inadequate resources (Corley et al., 2005; American Association of Critical-Care Nurses [AACN], 2005). The findings of this study support existing literature on moral distress. As the goals of nursing are linked to the protection and care of patients (Corley, 2002), when nurses cannot fulfil this role because of reasons such as insufficient and inexperienced staff and a lack of resources, the professional goals of nurses are blocked and they suffer moral distress (Corley, 2002).

This study explicitly found that nurses moved from Stage 2 (conceding values) into Stage 3 (resigning) due to several catalysts. These catalysts were feelings of powerlessness by participating in and witnessing poor patient care, a lack of connectedness and shared vision with the hospital, and an impact on the nurses’ own health – all of which are symptoms of moral distress. The physical and emotional symptoms experienced by the nurses in this study are similar to Jameton’s (1984, 1993) descriptions of moral distress; and participants in this study experienced anxiety, high blood pressure, weepiness, palpitations and sleep
disturbances. These symptoms arose for the participants as a result of a conflict of values. Jameton (1993) confirms that people feel frustration, anger and anxiety when faced with institutional obstacles and interpersonal conflict about values.

In order for nurses to make their work meaningful and to avoid burnout, they need to express their values and understand their expectations of patient care (Glasberg, Eriksson, & Norberg, 2007; Jameton, 1984). Values play a key role in predicting levels of burnout (Maslach & Leiter, 2008); values conflict is attributed to burnout in nursing (Horton et al., 2007). The nurses in this study expressed their values by attempting to provide a high standard of care; moral distress occurred for these nurses as they were unable to provide this care due to inadequate resources provided by the organisation. In this stage of the basic social process, there was a chance for appropriate interventions to reduce moral distress that may move the nurses back to sharing values; this is an important finding of this study. If interventions are not implemented then nurses will progress to Stage 3, the stage of resigning.

**Resigning**

Stage 3, resigning, occurred because nurses in this study felt a sense of ‘giving up’ and ‘hopelessness’. The literature describes this as moral residue, ‘that which each of us carries with us from those times in our lives when in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised’ (Webster & Baylis, 2000, p. 218). Moral residue can be deeply felt and is often very painful and lasting (Jameton, 1984, 1993; Webster & Baylis, 2000). Moral residue occurred for the nurses when the moral distress experienced
in Stage 2 was not resolved. The nurses in this study seriously compromised themselves or let themselves be compromised resulting in the violation of genuinely held beliefs, values and principles. When they spoke about their experience of resigning from a rural hospital most of them did so with some anger, tears and distress. Of importance, moral residue has also been reported in the USA and Canada as a contributor to decreased levels of job satisfaction and lower retention rates of nurses (Erlen, 2004; Elpern, Covert, & Kleinpell, 2005; Hardingham, 2004; Pendry, 2007). Australian research has also found that a positive relationship exists between increased moral distress and burnout for nurses (Schluter, Winch, Holzhauser, & Henderson, 2008) and this contributes to an increase in nurse turnover.

When integrity is threatened and moral distress and moral residue occur there is often abandonment of the profession. The solution to retaining nurses requires changes in the health care environment and organisational culture with an emphasis on building a moral community as an environment in which to practise ethically (Hardingham, 2004). A moral community is one in which there is coherence between what a health care organisation publicly professes to be and what employees, patients and others both witness and participate in to achieve an environment that will support moral integrity and decision making (Webster & Baylis, 2000).

While Jameton (1984, 1993), Webster and Baylis (2000) and Hardingham (2004) established that moral dilemmas, moral distress and moral residue are related to nurse resignation, this study extends this knowledge by identifying the stages
within *conflicting values* in which these occur. Stage 2 found that nurses experienced moral uncertainty, moral dilemmas and moral distress whereas moral residue occurred in Stage 3. *Conflicting values* captured the culmination of moral uncertainly, moral dilemmas, moral distress and moral residue. By identifying the catalysts and understanding the stages of this basic social process, this study identified that moral dilemmas, moral uncertainty and moral distress decreased the degree of value alignment and resulted in nurse resignation.

The findings also revealed a ‘window period’ in Stage 3 of the basic social process, which has not been previously reported in the nursing literature. The window period was identified as a period of time after the participant resigned and prior to the last day of employment. Neither the participants nor the work environment engaged with each other to try and resolve the problems. Participants felt disappointed that there was no avenue for negotiation. Participants acknowledged that if they had had some avenue to address the problems that led to their resignation and nurse managers were more approachable about addressing these problems that were causing them to resign, then they would have considered staying. While the literature discusses the importance of exit surveys and exit interviews (Brookes, 2007; Franckeiss, 2010), and what leads to nurse job dissatisfaction (see, e.g., Best & Thurston, 2004; Duffield, Roche, et al., 2007; Hegney et al., 2002a, 2002b; Hegney et al., 2005; Lei et al., 2010; Tran et al., 2010), the period between formally submitting a resignation notice to an employer and the last day of employment has not been previously discussed. This study was the first to specifically find that a window period exists and could be used as an opportunity to halt the resignation process. By acknowledging this window period
after nurses resign, NSW rural hospitals could implement strategies for nurses and hospitals to negotiate employment concerns and address the issues that had led to nurse resignation prior to the nurse exiting the hospital.

This study was also the first to explicitly find that there is a lack of options for nurses to continue to work once they have resigned in NSW rural locations. Most rural towns have only one hospital and therefore there is a lack of employment options available for nurses. In this study no participants at the time of interview were currently working in a hospital setting. This finding seems to indicate that rural nurses are likely to leave the profession of nursing, and this may be exacerbating the rural nursing workforce shortage. In addition, this finding has several implications for the nursing profession and the health care system as nurse turnover impacts on patient care and safety, nurse satisfaction and economic costs. The economic cost to the health care system to recruit into a vacant nursing position adds financial strain to an already strained system. The estimated cost of turnover per Australian nurse is $21,514 (O’Brien-Pallas et al., 2006). The indirect costs of nurse turnover are thought to be relevant due to the combined effects of an initial decrease in the productivity of the new employee and a decrease in staff morale and group productivity caused by turnover (O’Brien-Pallas et al., 2006). In addition, nurse turnover impacts on patient care as well as nurse job satisfaction due to fewer nurses performing more jobs in more intense, complex environments (O’Brien-Pallas et al., 2006).

It is interesting to note that Hegney and McCarthy (2000) believe there are rural nurses who must remain in employment no matter how dissatisfied they are,
simply because there are no other opportunities available to them. This in turn would have a twofold impact; nurses may experience moral distress due to a sense of powerlessness, compromised integrity and lack of control. Additionally, there may be an impact on patient care and staff morale; nurses who remain in the workforce but are unhappy provide poor patient care, create job dissatisfaction for nurses who want to provide good patient care and negatively impact the work environment and the quality of patient care (McNeese-Smith, 1999).

This study also found that the nurses in this study were not offered exit interviews when they resigned from a NSW rural hospital. It is widely acknowledged that exit interviews and surveys focus on identifying the reasons why employees resign, what may encourage them to stay, and what would entice them back to the organisation (Brookes, 2007; Franckeiss, 2010). However, previous research also indicates that data collected from exit surveys or exit interviews can be skewed due to several factors. Employees often do not want to leave on a bad note and their reasons for resigning may not be entirely truthful; the organisation may seek to prove that they have done nothing wrong; or exit surveys are performed when the departing employee still has emotional engagement, and often with a negative slant (Franckeiss, 2010). A better strategy is to approach the lost employee about three weeks after their final day through an external party who is able to collect information on why the employee resigned. The use of a neutral third party is invaluable in ensuring that genuine, as opposed to perceived, areas for action are uncovered, as confidentiality is assured (Franckeiss, 2010). Some companies also employ this strategy to build support to bring employees back into the organisation (Franckeiss, 2010).
In summary, the findings of conflicting values indicated that rural nurse retention is enhanced if nurses are in a stage of sharing values. To fully comprehend nurse resignations, attention must be given to the three phases of conflicting values. With the current nursing shortage in rural areas of Australia (ANF, 2008a; Hegney et al., 2002a; Kenny, 2009; Kenny & Duckett, 2003; Mills et al., 2007a; Pearson, 2008), retention strategies could be developed and implemented to either keep nurses in a stage of sharing values (Stage 1) or support nurses to move back from Stages 2 or 3 to sharing values. The next section of this chapter will explore the substantive grounded theory of degree of value alignment and its contribution to nursing knowledge.

8.3 Degree of Value Alignment

This study identified a theory that rural nurse resignations were attributed to the degree of value alignment between nurse and hospital. The degree of value alignment occurred along a continuum and the more sharing of values between the nurse and organisation, the greater the degree of value alignment. If values became further apart, nurses moved further along the continuum in the opposite direction until they reached their ‘values threshold’ where a nurse could no longer work in the hospital. This was because their values were compromised to such an extent that they would be conceding their personal values too much. Nurses moved along the continuum throughout their employment in the hospital and if the hospitals’ values changed then the nurses needed to realign their values to create balance; that is a sharing of values. It is important to note that this theory does not require the organisation (hospital) to realign its values with those of an individual nurse. When a nurse was no longer able to balance the degree of value
alignment, the value threshold was reached and resignation occurred. Degree of value alignment has relevance to rural nurse retention as it is within this counterbalance movement that there is the potential to move the alignment between nurse and hospital closer prior to the nurses’ ‘values threshold’ being reached that results in rural nurse resignation.

Milton Rokeach, an eminent social psychologist, explored the concept of human values. According to Rokeach (1973, pp. 4–5), there are three types of beliefs: existential beliefs which are capable of being true or false; evaluative beliefs where the object of the belief is judged as good or bad; and prescriptive beliefs where the end of an action is judged to be desirable or undesirable. Values can be defined as ‘an enduring belief that a special mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct or end-state of existence’ (Rokeach, 1973, p. 5). For the nurses in this study, their personal values influenced their nursing actions; if nurses are influenced by a strong value system, they will tend not to conform to conditions they oppose (Horton et al., 2007).

Rokeach (1973) argues that values last over time and that a learned value becomes integrated into an organised system of values. Within this system, values are ordered in priority with respect to others so that change is a reordering of priorities in a relatively stable value system. Rokeach suggests that values are cognitive/affective representations of a person’s beliefs plus instilled societal and institutional ideals. In light of this, Rokeach developed the Rokeach Value Survey (RVS), a classification system of human values that is used as an instrument for
measuring personal and social values. The RVS has been used by psychologists and sociologists to understand what values are and what people value. The RVS measures ‘terminal values’ which are desirable end-states of existence: what a person would like to achieve in a lifetime, and ‘instrumental values’. These are preferable modes of behaviour that assist in achieving terminal values (Rokeach, 1973). The RVS asks people to rank the importance of 18 terminal and 18 instrumental values therefore providing a hierarchical model of values that occurs when there is a joining of internal and external ideals (Rokeach, 1973). This study resonates with Rokeach’s (1973) work: as nurses move further along the value alignment continuum to a point of resignation, a conflict in values occurs between organisational values and nurses’ values; therefore, harmonious balance does not always occur.

Organisational values was an important component of the degree of value alignment grounded theory and these values comprised organisational structures and attitudes. Organisational values forms the core of management practice (Padaki, 2000) and individuals seek meaningful, rather than simply well-paid, work. The traditional satisfiers of wages and benefits are no longer the principal satisfiers of today’s nurses. In the context of the nursing shortage, the aspects of nursing that are the most rewarding are those that are most often sacrificed in the interest of getting the job done (Morgan & Lynn, 2009; Sullivan et al., 2002). This was reflected in the findings of this study. Most participants were satisfied with their salary and this was not a factor in their resignation. Rather, the inability to perform a high standard of patient care was the problem.
Clarifying individual and organisational values assists in creating a harmonious work environment for all with individuals finding meaning in their work, and organisations developing a committed workforce that is able to function well through periods of change. Values help the organisation to engage the hearts and minds of employees in pursuit of organisational goals and it is important that organisational values are congruent with individuals’ personal views (Murphy & Mackenzie Davey, 2002; Sullivan et al., 2002). Organisations with explicit values attract people who hold those values, allowing the organisation to recruit and retain staff who will feel fully committed. Being part of an organisation that has clear values with which individuals can identify is a rewarding experience and can result in feelings of gratification with the relationship (Sullivan et al., 2002).

Nursing managers need to ensure that their work creates a culture that balances humanistic values, organisational goals and patient advocacy. The first step in achieving this goal may be the acknowledgment that organisational culture is the core of an organisation because it explains how people relate to one another in a work environment. Of importance to the findings of this study, Garling (2008) described a negative and stifling management culture within NSW Health and recommended the immediate implementation of a workplace culture improvement program based on the ‘Just Culture’ program. This program clearly identifies acceptable behaviours in the workplace that are linked to NSW Health’s corporate values (Garling, 2008). These corporate values are defined by NSW Health (2005d, p. 69) as ‘integrity, openness and honesty’ and are promoted and demonstrated through leadership and behaviour (NSW Health, 2005d, p. 1). Sadly, the participants in this study reported a management culture that did not
reflect NSW Health’s values of integrity, openness or honesty – in fact, quite the opposite. To ensure that the program is implemented, Garling (2008) recommends annual audits to monitor the performance and compliance of the ‘Just Culture’ program with the agreed targets, and also to measure the program’s success. This demonstrates a link between values and culture.

Previous research has found that personal values are an integral part of nursing. According to Horton et al. (2007), values are determinants of social behaviour and it is imperative to understand the connection between personal values and nurses’ job descriptions. Research regarding value systems has shown that personal value systems influence professional lifestyle. Nurses’ personal value systems influence the actions they take and this has great control over the way in which nurses think and carry out patient care (Naden & Eriksson, 2004). Nursing students emerge from their undergraduate education program with three, well-defined nurse values which are reflected in their nurse education curricula and the nursing mandate: the delivery of patient-centred holistic care, the delivery of high quality care, and care influenced by a theoretical knowledge base and research evidence (Maben, Latter, & Clark, 2007). This correlates with the participants in this study; the provision of a high standard of patient care was paramount. Participants in this study identified that their values were influenced by their families, their nurse education and other nurses. If nurses are able to enact their moral values, they experience job satisfaction and resignation rates decrease (Lemonidou, Pathanassoglou, Giannakopoulou, Patiraki, & Papadatou, 2004). If managers focused more on supporting nurses to attain their personal values, retention figures could rise (Horton et al., 2007).
Personal and organisational values determine goals and actions and dictate what time and money are spent on (Sullivan et al., 2002). This study revealed similar findings, as the nurses’ values did not align with the organisations’ values regarding how money should be allocated, utilised and prioritised for patient care provision. Horton et al. (2007) suggested that the need for understanding nurses’ values is important as these underpin the way in which nurses interact with each other and with patients, and how satisfied they are with their job. Understanding the values in today’s nursing practice will help nurses to work together with a common comprehension of their aims and will allow a greater appreciation of the practice of nursing, highlighting the equal importance of both fundamental basic nursing care and the advanced clinical role. If nurses hold shared values, they themselves form a powerful group that can start to influence the thinking and attitudes of policy makers and governments towards the nursing profession.

A common theme in the data was that compromising self as well as compromising patient care contributed to nurse resignations. Nurses in this study reported that when the organisational culture led them to compromise self, they felt that they also comprised patient care. Compromising patient care was a result of a lack of resources such as food, linen, beds, time and staff, and making clinical judgments based on budgetary constraints not nursing assessments. Being forced to behave in a manner that conflicts with personal values results in the individual feeling compromised (Sullivan et al., 2002). This study is consistent with Sullivan’s work. Participants felt compromised when they could not provide a standard of patient care that fitted with their personal values of nursing and this was revealed in the categories of compromising self and compromising care. This compromise
resulted in participants compromising their professional integrity and their personal beliefs. The result was high levels of job dissatisfaction and eventually resignation.

**Degree of value alignment summary**

The grounded theory, *degree of value alignment*, which emerged from the data expanded the current body of knowledge related to nurse resignation in seven ways. First, this study identified a basic social process of *conflicting values* that was a dynamic process with three distinct stages that nurses moved through prior to resignation. It may be implicit to suggest that if the nurses in this study moved throughout these three stages prior to resignation then there is the potential for nurses to move back to a time of *sharing values* and increase nurse retention. Second, in order to fully understand rural nurse resignation, this theory identified that nurses moved along a values continuum in which their values could either align closer to or further away from the hospitals’ values. Third, this study found that nurses have a values threshold, and when the threshold is reached resignation occurs. The grounded theory assumes that the values threshold will be different for each nurse and this is an area where further research is indicated to better understand this concept. Fourth, the study identified a ‘window period’ in the third stage (*resigning*) of the basic social process where nurses were open to negotiate their employment with the hospital and hopefully resolve issues that led to a conflict of values. Fifth, exit interviews were not routinely offered to registered nurses who resigned from NSW rural hospitals. Sixth, in NSW rural areas many nurses leave the profession of nursing after they resign as a result of a lack of rural nursing employment options. Finally, this theory identified the
catalysts that contributed to a *decrease in value alignment*. This was a significant feature of the theory as this is where evidence-based retention strategies could be developed.

### 8.4 Job Satisfaction

The findings of this study have relevance for nurses’ job satisfaction as a *decrease in value alignment* appears to be linked to decreased job satisfaction. Nurses’ job satisfaction has been measured both qualitatively and quantitatively. McNeese-Smith (1999) was one of the first to explore nurses’ job satisfaction qualitatively and her findings indicate that nurses’ job satisfaction is linked to patient care provision, the work environment, balanced workloads, relationships with co-workers, personal factors, wages, conditions and the career stage of the nurse. Further empirical literature expands on these themes and includes contributors to job dissatisfaction. These are abuse from patients, poor patient outcomes, lack of patient response to care, not being able to provide adequate patient care, insufficient staffing and lack of time, negative relationships with co-workers, negative attitudes by co-workers, co-workers not following policy, rude doctors who blame nurses for errors and a perceived lack of ethics. Organisational factors that contribute to job dissatisfaction include threats to personal safety, poor leadership, not being heard by management, low morale and having no say in organisational matters (Best & Thurston, 2004; Hegney et al., 2002a, 2002b; Hegney et al., 2005; Lei et al., 2010), reduced autonomy and control over practice (Duffield, Roche, et al., 2007) and uncertainty and inconsistency within the nurses’ role (Tran et al., 2010).
Current job satisfaction instruments that measure job satisfaction quantitatively for nurses are the revised Nurses Work Index (NWI-R), the revised Conditions of Work Effectiveness Questionnaire (CWEQ-II), the Job Activities Scale (JAS) and the Organisational Relationships Scale (ORS). Currently, qualitative and quantitative common measures of job satisfaction instruments for nurses do not explicitly measure or examine personal values, the sharing of values or the *degree of value alignment* between nurse and hospital. Therefore, the theory of *degree of value alignment* assists with increasing the current understanding of nurses’ job satisfaction by adding a new quantifiable measurement to nurses’ job satisfaction. This may have the potential to be used to measure a nurse’s level of job satisfaction. Each stage of the basic social process (*sharing values, conceding values* or *resigning*) could also serve as an indicator of intention to leave a job.

8.5 **Retention of Nurses in the Australian Workforce**

Historically, NSW Health directives to address nurse retention in NSW included the implementation of ten-hour night duty shifts, a clinical nurse specialist review, employer-sponsored child care, $5 million to redevelop mental health courses, overseas recruitment, nurse scholarships, accommodation initiatives, development of safety manuals and grievance procedures, study leave reporting requirements and nurse practitioner classification (NSW Health, 2002). Currently, the federal government’s proposal to reform the Australian health system will see the introduction of the Rural Nursing Locum Scheme at a cost of $28.8 million. This scheme aims to improve the retention and distribution of nurses across Australia and improve health care access in rural and remote communities. The scheme’s $28.8 million will be used for nurses to attend continuing professional
development, support 1,224 university places for undergraduate registered nurse students, and increase scholarships for undergraduate and postgraduate nursing students (DoHA, 2010).

The findings of this study indicate that these current retention strategies as outlined by both NSW Health and the federal government may be ineffective in addressing the issues for registered nurses to remain in a stage of sharing values. This is because the government’s retention strategies do not contribute to a sharing of values. While these NSW Health and federal government strategies may enhance recruitment, recruitment does not lead to retention. The problem with current nurse retention strategies is that few strategies have been rigorously evaluated and there is currently little evidence to demonstrate the effectiveness of any specific strategy (Bukyx et al., 2010).

The findings of this study signify that, in order to retain the current nursing workforce in Australia, work environments must provide supportive structures and infrastructures that allow nurses to carry out the provision of a high standard of patient care and concurrently empower nurses in their role. Work environments must support and encourage professional integrity by eliminating inflexible and outdated patient care systems and refine cumbersome hierarchies and allow nurses the flexibility to draw upon nursing knowledge to provide patient care, use expert judgment to solve patient care issues and communicate with management structures above them. A flattened level of nursing management combined with participatory management would assist in distributing power and allow nurses greater control in providing the standard of care they wish to provide and in turn
allow nurses to be involved in the decision-making process for resource allocations for care provision such as medical supplies, food and linen and equipment. Obtaining adequate supplies for nurses so that they are able to do their jobs competently is an essential element for retention (Morgan & Lynn, 2009; Upenieks, 2005).

The issue of retention is multifaceted and care must be taken not to assume that one retention strategy can be effective given the many factors that contribute to nurses’ job dissatisfaction. Recent Australian research has identified a retention framework that identifies six layers that may be effective in retaining nurses. These layers are maintaining adequate and stable staffing; providing appropriate and adequate infrastructure; maintaining realistic and competitive remuneration; fostering an effective and sustainable workplace organisation; shaping the professional environment that recognises and rewards individuals making a significant contribution to patient care; and ensuring social, family and community support (Bukyx et al., 2010). Bukyx et al.’s (2010) framework correlates with some of the findings of this study; in particular, the need to address insufficient staffing levels, providing infrastructure and a sustainable workplace organisation, rewarding nurses for high standards of patient care delivery and ensuring social support. This framework is the first to acknowledge that retention strategies must be evidence based and is worthy of consideration.

8.6 Chapter Summary

This study has generated important findings that are relevant for Australian rural nurses. First, a substantive grounded theory that accounts for rural nurse
resignations emerged from the data. The theory involved a core category, *conflicting values*, which was also a process that nurses moved through prior to resignation. Importantly, this study has added to the body of nursing knowledge by identifying the following. Nurses resign from rural hospitals based on the degree to which they can or cannot align their values. *Conflicting values* (value incongruence) occurs in a three-stage process with the capacity for movement forward to resignation or backward to a time of *sharing values* and there are known catalysts that move nurses throughout these three stages. Nurses move along a values continuum in which their values can either align closer to or further away from the hospitals’ values. Nurses have a values threshold and when the threshold is reached resignation occurs. There is an identified window period after resignation where nurse and hospital have the potential to negotiate and retain staff/employment. There is a lack of rural nurse exit interviews, therefore retention strategies are not evidence based. In rural NSW, many nurses leave the profession of nursing due to lack of employment opportunities in nursing. These findings are also unique in that they are in the context of an Australian rural setting and the data generated came from registered nurses who had resigned. While existing literature has identified and highlighted the contributors for nurse job dissatisfaction, this research has advanced these findings by identifying what creates job dissatisfaction for rural nurses.

The next chapter will conclude the thesis, and explicate the implications of these findings for rural nurses, hospital managers, nurse education and research. Recommendations will be made and the strengths and limitations of the study will be discussed.
CHAPTER NINE
Implications, Recommendations and Conclusion

9.1 Introduction
This study explored the reasons why registered nurses resign from rural hospitals and developed a substantive grounded theory of degree of value alignment. The study added to both national and international literature on nurse retention. Understanding the degree of value alignment between nurse and hospital is crucial for rural nurse retention. In addition, considering the three-stage basic social process of conflicting values that nurses moved through prior to resignation, and understanding the catalysts that caused this movement are imperative for the implementation of appropriate retention strategies. This chapter is the last of the thesis and is comprised of four main sections: the implications of this study, recommendations, strengths and limitations and the conclusion. Implications and recommendations are made to improve retention rates and job satisfaction of nurses currently employed in rural hospitals. The strengths and limitations of the study are outlined and the thesis will then finish with a short conclusion.

9.2 Implications
The process of generating a substantive grounded theory of rural nurse resignations has led to useful insights and knowledge relevant to the nursing profession. From this study, several findings arose that are significant and the following discussion will identify these implications for rural nurses, hospital managers, nurse education and research.
**Implications for rural nurses**

The findings of this study indicated that rural nurses resigned when the *degree of value alignment* between nurse and hospital became too great and rural nurses were unable to provide a standard of nursing care aligned with their personal values. Rural nurses need to understand the importance of the *degree of value alignment* between themselves and the hospital in which they work. As rural nurses are often limited in their choice of hospital employment, it is imperative that the three stages of *conflicting values* be better understood so that nurses can establish which phase they are in and understand why they are in that phase and gain a clearer understanding of what is required for them to move back to a time of *sharing values*. While nurses may not always be able to control some of the catalysts that moved them through the stages, they do have the power to recognise that there is a *decrease in value alignment* and hopefully engage in meaningful conversation with hospital managers.

It is pertinent that rural nurses (in fact, all nurses) reflect and consider what values they hold, to what point they are willing to concede their values and how they can assist hospitals in helping nurses to sustain these values. Active self-reflection by rural nurses of their values and how they align with the organisations’ values may assist rural nurses to identify where their job dissatisfaction stems from.

Rural nurses also need to consider that resignation from a rural hospital may mean leaving the profession of nursing due to limited employment choices. In the window period that this study identified, nurses must engage with their organisation to see if some compromise can be reached in a professional and
meaningful way; this is best done with an understanding of the three phases of conflicting values and the relevant catalysts. If resignation does ensue rural nurses need to ensure that they ask for an exit survey or exit interview if the organisation fails to initiate this process. Exit interviews need to be undertaken at a time when the nurse is not angry or emotive so that useful data can be collected.

**Implications for hospital managers**

The findings of this study have major implications for NSW rural hospital managers. Data from this study have revealed that nurses resigned due to frustration in not being able to carry out nursing in accordance with their personal beliefs of how nursing should occur. In order to address issues of nurse retention, this study may assist hospital managers in identifying ways in which organisational and nurses’ values may be better aligned and appropriate retention strategies implemented. Hospital managers need to have clear ways to articulate and imbue the organisations’ values and be explicit in how these values accommodate nurses’ values. Hospital managers such as NUMS, who provide leadership at the ward level, need to ensure that the organisations’ values (both explicit and implicit) are incorporated in the culture of the ward. The strongest recruitment strategy that a hospital can employ is public perception and evidence of strong nurse retention within that hospital.

The following points relate to how the degree of value alignment between nurse and hospital can be increased to allow nurses to provide a high standard of patient care within a complex and complicated health care system. The critical underpinning strategy to enhance nurse retention lies in the sharing of values...
between nurse and hospital. Recommendations are detailed in Section 9.3 but additionally hospital managers need to be aware of the following points:

1. Nurses wish to provide patient care based on nursing assessments and not budgetary restrictions. Nurses become frustrated when they do not have access to adequate resources for patient care such as food, adequate linen, dressings, beds, staffing etc. Nurses need to feel they have control over these matters so that they can provide appropriate patient care in accordance with responsible stewardship of financial resources.

2. Nurses express concern about lack of consultation between themselves and managers who make decisions that impact on nurses’ work conditions particularly in relation to inflexible and outdated patient care systems.

3. Moral distress in employees needs to be recognised and acknowledged (moral distress arises when there is an inconsistency between one’s beliefs and one’s actions). For nurses, this occurs when they are unable to provide a standard of patient care that they believe is right, due to institutional constraints such as a lack of resources and a negative management culture. Moral distress leads to compromised professional and personal integrity.

Hospital managers may wish to:

a. acknowledge that moral distress occurs in their institution and that its occurrence can lead to nurse resignations;

b. introduce information into their hospital procedures about moral distress;

c. implement relevant training for hospital staff about moral distress; and

d. provide support and strategies for nurses experiencing moral distress.
4. The notion of moving towards a framework of a moral community could be explored. A moral community is a community in which there is coherence between what a health care organisation publicly professes to be and what employees, patients and others both witness and participate in (refer to Chapter Eight).

5. Nurses seek intrinsic rewards in their work such as being thanked by managers, having a sense of pride in their work, and being able to provide a standard of nursing care that they are happy with. Nurses seek this rather than extrinsic rewards of money. Hospital managers could consider a simple system where nurses are recognised for theses intrinsic factors.

6. Rewarding senior staff, both nursing and non nursing, for cost cutting and ‘coming in under’ budget should be discouraged. Rather, rewards should be based on patient and staff satisfaction feedback.

7. It is recognised that some hospital decisions need to be brought back to the local level and include community input. This may well be addressed under the newly implemented NSW AHSs and LHNs (refer to Section 8.2). Acknowledging community feedback and local decision making is vital for nurse retention.

8. When nurses resign they often want to discuss their reasons for resignation but are not always given the opportunity by hospital managers to do so. Valuable information could be gained that the hospital can use to its advantage in retaining nurses.
**Implications for nurse education**

The implications for the education of nurses would be to include subject topics relating to value alignment in undergraduate nursing curricula. This could occur as a two-staged process. First, consideration could be given to incorporate topics into either an ‘ethics’ subject or a ‘nursing foundations’ subject. Second, to consolidate this information, reference could be made again in a third-year, advanced subject such as a nursing synthesis, nurse leadership or transition to practice subject.

Stage 1 topics could include:

- What are values?
- Identifying ones’ own values.
- Identifying barriers to fulfilling values in the hospital setting.
- Reflective professional practice.
- Understanding the mission statement and values of hospitals.
- How patient care can be impacted by values (both nurse and hospital).
- What is moral distress and moral residue (signs and symptoms)? How do these impact on nursing and the self?
- Understanding the relevance of value alignment between nurse and hospital and the implications this has on job satisfaction and patient care delivery.

Stage 2 topics could include:

- Communication skills for addressing identified problems within the hospital setting with managers.
- Professional and moral integrity – the role of self-reflection.
Chapter 9: Implications, Recommendations and Conclusion

The Self – addressing issues related to patient care provision such as:

- when patient care becomes compromised;
- addressing patient needs in an under-resourced environment;
- how to recognise moral distress and moral residue – course of action to address the issue.

Additionally, postgraduate education for nurse/health managers should encompass topics relating to nurse managers and their role in value alignment. Subject topics could include:

- What are values?
- Identifying ones’ own values.
- Identifying barriers to fulfilling values in the hospital setting.
- Reflective professional practice.
- Understanding the mission statement and values of hospitals.
- The nurse manager’s role in articulating and enacting organisational values.
- Promoting management behaviours that encourage value alignment.
- Moral distress and moral residue (signs and symptoms).
- The role of the nurse manager in addressing moral distress and moral residue.
- Understanding the relevance of value alignment between nurse and hospital and the implications this has on staff job satisfaction and patient care delivery.
**Implications for research**

Glaser (1978, 1998) observes that a grounded theory study concludes with a discussion of implications for future research. This occurs in three ways: future research, comebacks and elevation to formal theory.

**Future Research**

This study has identified three future research areas that would enhance knowledge on nurse retention. First, while this grounded theory study revealed the reason that registered nurses resigned from rural hospitals, participants were nurses who had already resigned. Future research that explores why nurses who are dissatisfied with their work choose to stay employed in the hospital is warranted; this would elucidate a greater understanding of nurse retention. It is assumed that some nurses currently employed in rural hospitals are in the third stage of the basic social process (resigning) but do not actually submit their resignation. This may be due to the fact that there are limited employment opportunities in small rural areas. Knowing the reason why these nurses stay and how they deal with this sense of ‘giving up’ would enhance the understanding of nurses in the rural workforce.

Second, this study identified that nurses reach a ‘values threshold’ that can lead to resignation. Further research that explores this threshold including how nurses reach it, what it actually is and how nurses come to the decision to resign would further assist in understanding the complex issue of nurse retention. Third, it is assumed that some nurses in the workforce have a strong value alignment with the
organisation. Further research could explore who these nurses are and what factors contribute to this value alignment.

*Comebacks*

Comebacks, according to Glaser (1998), are those categories that emerged from the data in the study that have less relevance to the theory but provide more areas for research. Comebacks prompt researchers to come back to these areas to study them in more detail. This study generated a substantive grounded theory of rural nurse resignations and also raised three areas of ‘comebacks’. First, an open code of ‘not offered exit interview’ emerged in the data. While this did not lead to nurse resignations, it is an area that would be worthy of coming back to and exploring how many nurses are actually offered an exit interview at their time of resignation. Potential research may include a study of rural nurse resignations that: encompasses a research design to collect data on how many nurses are offered exit interviews when they resign from NSW hospitals; explores the process of exit interviews for nurses in rural hospitals; and examines how data collected from exit interviews are analysed and disseminated back to the hospital to improve nurse retention.

Second, one participant spoke of their disappointment with the NSWNA (nurses’ union) for not tackling core nursing issues especially in light of the current nursing shortage. The participant perceived that the NSWNA only discussed politics from a Labor Party perspective as well as the issues of nurses’ wages. The participant stated:
I think that they’re in bed with the government and they’re not interested in maintaining standards and I again think that that’s really sad that if we had a decent strong union or association that was actually there to ensure that standards were met, in case management wouldn’t have been able to get away with this. (Judy)

While this statement in the data was given an open code, it did not provide information that led to nurses resigning. It would be feasible to suggest that this perception by a participant may be an area of interest, particularly as this study revealed that nurses do not seek extrinsic rewards such as wages, but rather intrinsic rewards. Research could be directed at exploring the role of the NSWNA in relation to what nurses see as relevant nursing issues.

The third comeback this study identified was a lack of research into support/support groups for nurses who did resign from rural hospitals. This was also given an open code but did not lead to the reasons why nurses resign. The participant who identified the need for support groups left her position quite distressed and felt very isolated in her rural community after her resignation and wondered if other nurses may be in a similar situation:

I felt well how many other people are like me, sitting at home isolated. There’s no support for them, where do you go, how do you start a support group … we need support groups, we need to be contacting people somehow, we need to be letting them know, because I think that these people are out there in isolation. (Judy)

Research questions could be aimed at identifying the lived experience of rural nurses after resigning from hospital employment (this would be suited to a phenomenology study), and the assessment of support structures for rural nurses after resignation.
Elevation to Formal Theory

The grounded theory that emerged from this data is a substantive theory: it is relevant to rural registered nurses in NSW. Elevating the substantive grounded theory from this study to the values of all workers within an organisation could be achieved by performing comparative analysis amongst different types of substantive cases which fall within the formal area (Glaser & Strauss, 1967). This would be achieved by comparing data of substantive groups from a wide variety of public and private organisations to see if the degree of value alignment theory fits.

9.3 Recommendations

This study proposes nine recommendations for hospital managers and nurse educators to address nurse job satisfaction and rural nurse retention. Most of the recommendations address the catalysts that move nurses from the stage of sharing values to conceding values and from conceding values to the stage of resigning. Recommendations are aimed at improving the sharing of values between nurse and hospital.

The first eight recommendations are directed at increasing the degree of value alignment between nurse and hospital. It is acknowledged that it is beyond the scope of this thesis to ‘fix’ the current NSW health system; however, unless change occurs, nurse retention will continue to be a problem. It is recognised that some levels of hospital management – decision making and resource allocation – need to be brought back to the local level and include community input. This may be timely due to the current transition period in NSW of moving from AHSs to
LHNs. The last recommendation (9) is directed at nurse educators to assist in incorporating subject topics into both undergraduate and postgraduate nursing curricula that relate to values and their impact on both patient care provision and moral and professional integrity within nursing.

**Recommendation One**

*Return control of resources and decision making back to the local level of rural hospitals*

One of the identified catalysts that caused nurses to move from a stage of *sharing values* to handing in their resignation was a lack of resources and decision making at the local level as detailed in Chapters Five and Six. Recommendation One is that individual NSW rural hospitals are given more control of what occurs within their facility in relation to resources and the financial management of these resources. This would include the decentralisation of services and the transfer of these services back to the local facility. This comprises the appointment of staff for employment in the local facility, the supply of patient food, linen and items required to carry out patient care such as dressings. This would assist in addressing the issues of the *centralising of health services* and *inadequate resources for patient care provision* that emerged from this study. Local control is important and would allow senior nurse managers to have control of nursing resources at the local level which in turn will enhance the capacity of the hospital to support nurses in patient care provision. This could be considered under the implementation of the new LHNs in NSW.
Nurses in this study identified that they were often unable to provide a high standard of patient care due to budget restrictions but then saw managers being rewarded for coming in under budget. Nurses seek intrinsic rewards in nursing therefore Recommendation Two is that NSW hospitals are discouraged from rewarding senior staff for cost cutting and coming in ‘under budget’. Rewards for staff should be based on patient and staff satisfaction feedback and may include recognising staff at staff meetings who have received positive feedback from patients or a staff member, or establishing an ‘employee of the month’ commendation as well as ensuring that any positive feedback that managers receive is fed back to the relevant staff member. This would assist in addressing the issue of different priorities – being money focused that emerged in this study.

**Recommendation Three**

*Mandate nurse/patient ratios within NSW hospitals*

This study identified that insufficient nursing staff levels and inappropriate skill mixes (i.e. nurse not experienced in the clinical area or being a junior nurse) hindered nurses in providing a high standard of patient care. Recommendation Three is that the NSW Government introduces mandated nurse/patient ratios that accommodate staff skill mix and acuity in NSW hospitals. Mandated nurse/patient
ratios currently occur in Victoria. This means that each area of a hospital (e.g. medical/surgical, intensive care, paediatrics etc.) would have allocated ratios of nurses to patients that consider the acuity of the patient and the specialty of the nurses working on the ward. Currently, the NSWNA is proposing mandatory nurse/patient ratios in NSW public hospitals. This recommendation supports the proposal by the NSWNA and seeks to address the finding in this study of insufficient and inexperienced staffing levels within NSW rural hospitals.

**Recommendation Four**

*Hospital managers acknowledge that moral distress occurs in nursing and implement appropriate strategies to manage and decrease moral distress*

Moral distress was a major contributor to nurse resignations. Recommendation Four is for hospital managers to recognise the impact of moral distress in relation to nurse retention and consider adopting similar strategies to those in place in Canada and the USA. For example, the AACN (2008, p. 2) in their *Position Statement* recommends that hospitals:

- implement interdisciplinary strategies to recognise and name the experience of moral distress;
- establish mechanisms to monitor the clinical and organisational climate to identify recurring situations that result in moral distress;
- develop a systematic process for reviewing and analysing the system issues enabling situations that cause moral distress to occur and for taking corrective action;
• create support systems that include:
  - employee assistance programs
  - protocols for end-of-life care
  - ethics committees
  - critical stress debriefings
  - grief counselling;

• create interdisciplinary forums to discuss patient goals of care and divergent opinions in an open, respectful environment;

• develop policies that support unobstructed access to resources such as the ethics committees;

• ensure nurses’ representation on institutional ethics committees with full participation in all decision making; and

• provide education and tools to manage and decrease moral distress in the work environment.

This recommendation would assist in addressing the issues of powerlessness – participating in and witnessing poor patient care and impact on nurses’ own health.

**Recommendation Five**

5a) Implement a policy and procedure for nurse exit surveys/interviews

5b) Ensure that data collected from exit surveys/interviews are analysed to determine local retention strategies

5c) Acknowledge the ‘window period’ between resignation and the last day of employment and attempt to retain staff
This study identified that nurses were not being offered exit interviews and there is evidence in the literature that retention strategies are not evidence based (see Chapters Two and Eight). Recommendation Five entails three aspects relating to nurse resignations. First, policy must be implemented and enacted so that exit surveys or exit interviews are offered to all nurses when they resign. Consideration should be given to use a third party (i.e. external organisation) to perform this. Using a third party is vital to ensure accurate data collection for appropriate nurse retention strategies and to ensure that nurses have a voice that portrays their reasons for resigning. Second, data from these exit surveys/interviews must be analysed to determine appropriate and relevant local nurse retention strategies. Third, hospital managers need to acknowledge the ‘window period’ this study identified that occurs after the nurse resigns and implement a ‘user friendly’ approach to engage in discussion with the nurse prior to their last day of employment to hopefully retain the nurse. It may be appropriate for the NSW Health Chief Nurse to write these recommendations. This would assist in addressing the issue of nurses feeling expendable as well as result in valuable data being collected that should drive retention strategies.

**Recommendation Six**

*Implement nurse retention strategies that reflect current research as to why rural nurses resign*

Recommendation Six is that NSW hospitals consider implementing retention strategies that are evidence based. Evidence may come from current research and
Chapter 9: Implications, Recommendations and Conclusion

the analysed data from Recommendation 5b. Additionally, strategies that address the catalysts that move nurses through the three-stage process of conflicting values that this study revealed should be considered. The relevance of the degree of value alignment in nurse resignations and understanding that nurses reach a ‘values threshold’ are also important factors to be considered in implementing retention strategies.

Recommendation Seven

Employ a Nurse Retention Officer within each AHS or LHN

Recommendation Seven is that NSW Health initiates a position of a Nurse Retention Officer in each AHS or LHN. This position would be responsible for:

1. providing strategic advice and leadership on nurse retention;
2. analysing the data collected at exit surveys/interviews;
3. developing strategies from current research and analysis of the data from the exit surveys/interviews to increase nurse retention rates;
4. collecting statistics on nurse turnover that accurately reflect retention rates; and
5. being research active on issues of nurse retention.

Recommendation Eight

Hospital managers ensure that their actions reflect the organisations’ values and mission statements and ensure that current practice within the hospitals addresses and supports these mission statements and values
Recommendation Eight is that hospital managers ensure that the organisations’ values and mission statements are liveable and workable documents and that current practice within the hospital reflects these values and statements. At the time of employment, nurses should be given a copy of these values and mission statements and consider if their values match those of the organisation. This may assist in decreasing the lack of connectedness and shared vision that emerged from this study.

Recommendation Nine is that the providers of undergraduate nurse education incorporate into curricula the subject topics detailed in Section 9.2. This will hopefully place the issue of degree of value alignment within the context of nurse education and raise awareness of this important issue.

**Summary and comparisons of recommendations**

The recommendations from this study have some congruency with the recommendations from the Garling Report (2008) and NSW Health’s response to the Garling Report titled *Caring Together: The Health Action Plan for NSW* (2009). Table 9 summarises and compares these recommendations.
## Table 9: Comparison of Recommendations from this Study to the *Garling Report* and NSW Health’s *Caring Together*  

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<tr>
<td>1. Return control of resources and decision making back to the local level of rural hospitals</td>
<td>Not mentioned</td>
<td>One of the six strategies that NSW Health will use to implement Garling’s recommendations is to strengthen local decision making</td>
<td>Eighteen new LHNs are being implemented throughout NSW in 2011. At this point it is not clear how this will impact on returning decisions and control to the local level</td>
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<td>2. Implement a reward system for the recognition of a high standard of nursing care</td>
<td>Not mentioned</td>
<td>N/A</td>
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<td>3. Mandate nurse/patient ratios within NSW hospitals</td>
<td>A redesign of the General Workload Calculation Tool to take into account nurses’ designation (clinical nurse specialist, registered nurse, enrolled nurse, trainee enrolled nurse, assistant-in-nursing) and years of nursing experience, together with the capacities created by a team-based nursing model of care</td>
<td>NSW Health will work with the NSWNA regarding the redesign of the General Workload Calculation Tool to incorporate all clinical care provided by nurses such as CNCs, clinical care coordinators and others</td>
<td>This recommendation may assist in addressing the issues of insufficient and inexperienced staffing levels identified in this study but stronger action such as mandating nurse/patient ratios needs to be implemented. The NSWNA is currently campaigning for mandating nurse/patient ratios</td>
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<td>4. Hospital managers acknowledge that moral distress occurs in nursing and implement appropriate strategies to manage and decrease moral distress</td>
<td>Not mentioned</td>
<td>N/A</td>
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### Chapter 9: Implications, Recommendations and Conclusion

**Recommendations from this Study**

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<td>5. a) Implement a policy and procedure for nurse exit surveys/interviews</td>
<td>Not mentioned</td>
<td>N/A</td>
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<td>b) Ensure that data collected from exit surveys/interviews are analysed to determine local retention strategies</td>
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<td>c) Acknowledge the ‘window period’ between resignation and the last day of employment and attempt to retain staff</td>
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<td>6. Implement nurse retention strategies that reflect current research as to why nurses resign</td>
<td>Reviewing the existence of and developing, as required, employment packages with features which would attract and retain skilled staff to work in rural communities. This may include developing formalised partnership structures between metropolitan hospitals and rural hospitals which facilitate the transition of clinicians between the hospitals</td>
<td>The government has been successful in attracting new staff to Bourke, Walgett, Brewarrina and Wilcannia as part of a previous pilot in remote areas. NSW Health has also been working with a cross government taskforce to review recruitment strategies including incentives; accommodation; smarter service delivery models; career opportunities for young people in regions where they live; and strategies for Indigenous communities. NSW Health will consider the introduction of any new initiatives resulting from taskforce deliberations. Country careers officers will now be permanently allocated in each rural AHS to support recruitment of doctors, nurses and other clinical staff</td>
<td>This implementation from NSW Health only addresses recruitment issues and not retention issues</td>
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### Recommendations from this Study

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<td>7. Employ a Nurse Retention Officer within each AHS or LHN</td>
<td>Not mentioned</td>
<td>Country careers officers will now be permanently allocated in each rural AHS to support recruitment of doctors, nurses and other clinical staff</td>
<td>This implementation from NSW Health only addresses recruitment issues and not retention issues</td>
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<tr>
<td>8. Hospital managers ensure that their actions reflect the organisations’ values and mission statements and ensure that current practice within the hospitals addresses and supports these mission statements and values</td>
<td>This is somewhat implied in some recommendations</td>
<td>Some measures will be taken to focus on the patients’ experience, as well as what the patients, their families and health professionals’ value about effective and relevant patient care. Building on this, the Chief Nursing and Midwifery Officer will supervise a program designed to achieve greater efficiency and design of nursing work practices, giving consideration to shared care and teamwork principles. To ensure successful implementation, NSW Health will achieve this in every ward</td>
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<td>9. Providers of undergraduate nurse education ensure that their curricula have sufficient focus on nurses’ personal values and organisational values by implementing the subject topics of ‘values’ into curricula</td>
<td>N/A</td>
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9.4 Strengths and Limitations of the Study

**Strengths**

All research has both strengths and limitations. The strengths of this study are twofold. First, the emergent theory is relevant to NSW rural nurses and explains why rural nurses resign. This is because data collection came from nurses who had already resigned from NSW rural hospitals, and the use of a grounded theory methodology enabled nurses’ experiences and reasons for their resignation to be revealed. While there is a plethora of research on nurse retention, there is little research on rural nurse resignations. This study specifically examined the reality for rural nurses in order to generate a potentially useful substantive theory – a theory which could be used to assist in developing retention strategies for the nursing workforce in NSW rural hospitals.

Second, this theory has resonance for nurses who have resigned from NSW rural hospitals. The categories, sub-categories and properties of conflicting values captured the entirety of the data collected and saturation readily occurred. The core category also portrayed the fullness of the problem for the participants who had resigned from NSW rural hospitals. The core category of conflicting values was tested on one participant who felt that this captured what led to her job dissatisfaction. The emerging grounded theory was then presented to another participant. This grounded theory resonated with the participant as it offered an insight into their resignation. The participant enthusiastically affirmed that the theory resonated with their experiences.
Evaluating grounded theory

Chapter Four outlined a detailed discussion of evaluating grounded theory research. Glaser (1998, p. 236) has addressed the issue of evaluating research by suggesting that the fundamental sources of trust in a grounded theory study are the four criteria for evaluation: fit, relevance, workability and modifiability. As noted in Chapter Four, Glaser’s (1998) four sources of trust have been used to evaluate this study.

Fit

Fit can be verified in grounded theory studies by reviewing the process of theory generation. Fit implies that a credible theory must fit the data it represents; data should not be forced (Glaser, 1978). The use of the components of grounded theory allowed the theory on rural nurse resignations to emerge from the data. Evidence of the researcher using the components of grounded theory to generate a substantive theory has been demonstrated by the use of open codes that led to the emergence of categories and properties; this data were collected directly from interviews with nurses who had resigned from NSW rural hospitals. The use of direct quotes from the participants in the findings chapters also provided evidence of fit.

Relevance

Relevance can be defined as the degree to which a study’s findings contribute to the understanding of the phenomenon under study in the substantive area (Glaser, 1992), and a substantive grounded theory will account for their behaviour. In this case, the behaviour was rural nurse resignations. The theory and the basic social
process together explain that a lack of value alignment causes rural nurses to experience job dissatisfaction and therefore resign. The basic social process of conflicting values is highly relevant to rural nurses and rural hospitals as it explains the process that leads to nurse resignations. By identifying these stages, this study has relevance for nurse retention that has not been evident in previous research. As mentioned previously, when the substantive grounded theory emerged, one participant was shown the grounded theory and this participant related to the theory and stated that that accounted for their resignation from a rural hospital.

Workability

The workability of a grounded theory explores how the main concern of the participants was resolved while accounting for all variations. In addition, it must explain what happened, envisage what will happen, and interpret what is happening in the substantive area (Glaser, 1992). This theory was able to explain what was happening for the participants in this study, and nurses resolved their conflicting values, the core category, by resigning. This applied to nurses from large rural hospitals, remote area clinics, experienced and less experienced nurses, senior nurse managers and clinicians.

Modifiability

Modifiability relates to the flexibility of a grounded theory and its ability to accommodate new data. A modifiable theory can be altered when new data are compared to existing data (Glaser, 1992). Additional future data may result in the modification of the current substantive theory and the basic social process. This
modifiability as new data emerge means that the theory will continue to fit, work and be relevant as time passes and conditions change.

**Limitations**

The theory of rural nurse resignations generated by this study cannot claim to capture the full complexity of rural nurse resignations. There are two limitations of this study. First, the emergent theory is based on twelve participants and fourteen interviews. Other participants may have identified additional issues and categories not captured by the current theoretical framework. It is acknowledged that, while this study encompassed participants from a broad geographical spread of rural and remote NSW and included nurses from the role of clinical nurse to senior management, the study was based on a small sample.

Second, and in keeping with qualitative research, the findings from this study cannot be generalised to all rural nurses. While the participants interviewed resigned from their rural nursing positions due to a conflict in values, this does not mean that all nurses who experience a values conflict resign. However, this study deliberately sought to understand, from the perspective of those who had recently resigned, why rural nurses resigned.

**9.5 Conclusion**

Chapter One stated the aim of this study which was to explore the reasons why registered nurses resign from NSW rural hospitals and discover the emergent substantive grounded theory that explained nurse resignations from NSW rural hospitals. Five research objectives emerged:
1. identify why registered nurses resign from rural NSW hospitals;

2. identify and describe particular issues of rurality in the current light of the nursing shortage;

3. discover the basic social process of nurse resignations;

4. develop a substantive grounded theory that accounts for rural nurse resignations; and

5. provide a knowledge base on which to structure recommendations and appropriate retention strategies for rural nurses.

Each of these objectives has been achieved and in summary this study has:

1. identified that registered nurses resign from NSW rural hospitals due to a conflict between their personal values as to how nursing should occur and the hospitals’ values as to how nursing does occur;

2. identified and described the particular issues of rurality for the nurses in this study. These include the fact that the large size of rural geographical AHSs compounds the issue of nurse retention and, when nurses resign from rural hospitals, they often leave the profession of nursing due to a lack of rural nursing employment options. This results in the profession of nursing losing experienced nurses and their knowledge;

3. identified the basic social process of rural nurse resignations. This was conceptualised as a dynamic three-stage process that emerged around the core category of conflicting values. The three stages encompass a stage of sharing values, a stage of conceding values and a stage of resigning. Nurses move throughout these stages when identified catalysts occur;
4. identified a substantive grounded theory titled *degree of value alignment* that emerged and accounted for rural nurse resignations; and

5. provided a base on which to structure nine recommendations and appropriate retention strategies for rural nurses.

Chapter Two examined and critiqued literature on the current nursing shortage from an international and Australian perspective. This included an analysis of the literature pertaining to job dissatisfaction, recruitment and retention and a critique of NSW Health reports on the current nursing shortage.

Chapter Three examined grounded theory methodology and its usefulness for this study. This included an historical overview of grounded theory, a discussion of the differences between traditional Glaserian grounded theory, Strauss grounded theory and contemporary grounded theories such as that advocated by Charmaz and Clarke. Research paradigms were also discussed including a summary of ontological, epistemological and methodological positions and their relevance to grounded theory. The chapter concluded with a defence of why the researcher used a Glaserian post positivist grounded theory method.

Chapter Four detailed the method and data analysis for this study. Details of the sample group, their recruitment, ethical considerations and data collection were discussed. An account of data analysis was detailed including how categories were developed and conceptualised from open codes to the core category of *conflicting values*. The process of theory building was also outlined including the use of theoretical coding families, the sorting of theoretical memos and the
emergence and integration of theoretical codes to generate a substantive grounded theory. Data management and issues of rigour and trustworthiness were also described.

Chapters Five, Six and Seven revealed the findings of this study. Chapters Five and Six discussed the core category of *conflicting values*; Chapter Five discussed the first category of *organisational values* while Chapter Six discussed the second category, *personal values*. Both of these chapters included quotes from the participants that validated the findings. Chapter Seven, the third chapter of findings, discussed the aspects of theory building utilised in this study, detailed a three-stage basic social process of *conflicting values* and presented the grounded theory titled *Degree of Value Alignment – Why NSW Rural Nurses Resign*.

Chapter Eight provided a discussion on the findings of the research in light of current literature, and summarised the study. This included the basic social process, the substantive grounded theory of rural nurse resignations as well as a discussion on job satisfaction and retention of nurses in the rural workforce. The chapter highlighted the major points and findings of this study.

Chapter Nine concluded the thesis by discussing the implications of the study for rural nurses, hospital managers, nurse education and research. Strengths and limitations were detailed including evaluating a grounded theory study using Glaser’s criteria of fit, relevance, workability and modifiability. The chapter included nine recommendations to improve nurse job satisfaction and increase rural nurse retention rates; these were mainly aimed at hospital managers.
In conclusion, the nursing workforce in rural and remote areas needs to be supported and expanded if the health of people in rural and remote areas is to be maintained and improved. The size and diversity of the nursing workforce, and investment in ways to attract and retain nurses in rural and remote areas, require better central planning and coordination at a national level (ANF, 2008b). This study has identified that a decrease in value alignment between nurse and hospital leads to nurse resignation. Catalysts identified in decreasing value alignment are the restructuring and centralising of health services for nurses in the public health system, outdated and inflexible patient care systems, cumbersome hierarchies, negative management cultures, bullying, nurses feeling expendable, different priorities between nurse and hospital with nurses viewing hospitals as being money focused, inadequate resources for patient care provision, insufficient and inexperienced staff, nurses feeling powerless as they participate in or witness poor patient care, and a lack of connectedness and shared vision between nurse and hospital. The findings of this study correlate with other research on value congruence as well as the impact of moral distress and moral residue on nurses’ job satisfaction. It has also identified new findings including the acknowledgment of a window period after resignation when nurse and hospital have the potential to negotiate employment; that rural nurses are often not offered an exit interview when they resign; and that nurses leave the profession of nursing due to lack of employment opportunities in nursing.

The main innovation of this research though is that it has linked the findings of conflict between nurses’ and hospitals’ values as the core indicator of reduced job satisfaction in rural nursing in NSW and identified a three-stage process of
conflicting values including the catalysts that cause nurses to progress throughout the three stages. By understanding this process, relevant retention strategies that have the capacity to either keep nurses in Stage 1 where values are shared or move nurses back into Stage 1 when values are either conceded or nurses have ‘given up’ will assist in rural nurse retention.

In addition, this research highlighted the relevance of the degree of value alignment to nurse job satisfaction and, when this degree of value alignment diverges too far, nurses reach their values threshold and resignation follows. Effective retention strategies must address the contributors that cause a decrease in value alignment and work towards encouraging nurses’ and hospitals’ values to coalesce. Finally, this theory identified the catalysts that contributed to a decrease in value alignment. This is a significant feature of the theory as this is where evidence-based retention strategies will emerge.

Retention strategies must acknowledge that efforts to recruit more people into the profession without addressing the pressing issue of retaining qualified nurses will not have a sustainable impact on the growing nurse shortage (Duffield, Roche, et al., 2007). Implementing retention strategies must aim to increase the degree of value alignment between nurse and hospital. This includes reducing the impact of current NSW AHS structures and the decentralisation of services, implementing flexible and evidence-based patient care systems that enhance patient care, streamlining nursing hierarchies, addressing the issues of poor management culture and bullying, ensuring that nurses do not feel that they are expendable, provide strategies that make nurses feel empowered about the type of patient care
they provide and promote a sense of connectedness and a shared vision between nurse and hospital.

*Conflicting values* described the three-stage process that rural registered nurses encountered when hospitals’ values changed and nurses were unable to realign their values with the hospitals’ new values. As the *degree of value alignment* between nurse and hospital decreased, nurses’ job satisfaction also decreased. At this stage, nurses found that the standard of patient care provision had decreased, the work environment was not conducive to patient care and nurses themselves became emotionally and physically unwell. Nurses were more likely to remain nursing if they and their employer shared similar values. These values related to the expectations of what nursing is and how nursing should be performed to achieve good patient outcomes. When values were not shared, conflict was created for nurses as to how they could carry out nursing in a manner that fitted with their personal values and integrity. Over time, conflict built up to the point where nurses resigned and this was often triggered by a small incident that was resolvable.

The nursing shortage in rural Australia is expensive to both hospitals and communities and also impacts on the delivery of a high standard of patient care. As more rural nurses leave the workforce, there is increased pressure on nurses who remain in nursing; this is not sustainable. Retention strategies to keep the rural nursing workforce must ensure that the *degree of value alignment* between nurse and hospital remains closely aligned. The issue of nurse retention will always be complex and multifaceted and nurses will continue to move to other
jobs for various reasons – natural attrition of the nursing workforce is normal. What remains clear, however, is that nurse turnover in many cases is avoidable and for the current rural nursing workforce to be viable and strong, evidence-based retention strategies must be implemented that allow nurses to carry out a high standard of care that aligns with their personal values and concurrently promotes a supportive work environment that is conducive to nursing.
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Appendix A: Information Statement

RESEARCH TITLE: “SILENT VOICES – WHY NSW RURAL REGISTERED NURSES RESIGN AND WHO LISTENS”.

Hello, my name is Susan Bragg and I am a registered nurse currently undertaking my PhD in Nursing at Charles Sturt University. As part of my research I will be interviewing registered nurses who have resigned from a NSW rural hospital after 1st January, 2000 and have not resigned for retirement, maternity leave or because a family member was geographically relocated. I will also be interviewing staff who were employed by a NSW rural hospital and have resigned after 1st January 2000 or are currently employed by a NSW rural hospital and are involved or have been involved in the exit interview process for registered nurses e.g. human resources staff or hospital management involved in either the collection of exit interview data or in the processing of this data.

Registered nurses will be recruited using a snowballing technique. The snowballing technique involves finding one registered nurse who fits the research criteria and then asking that registered nurse for referrals of prospective participants. To prevent possible bias in the snowballing technique there will be no more than two referrals from each registered nurse/ hospital staff member and no more than 5 registered nurses or 5 hospital staff from each hospital.

I seek your permission to interview you for this purpose and part of this permission involves this Information Statement so that you have a clear understanding of what is involved before you consent to it.

The research
The aim of this interview will be to collect information from registered nurses who have resigned from NSW rural hospitals after 1st January 2000 and from hospital staff involved in the exit interview process for registered nurses. The purpose of the research is to identify the reasons registered nurses resign from NSW rural hospitals.

How you participate
I will need to make contact with you three times:

1. Initial Meeting (10 minutes) – By phone or in person. The initial meeting should involve ten minutes where I can explain the research. This meeting may take place in person or via the telephone, depending on where you live. At our initial meeting I will also be giving you a Consent Form to sign or I will post it if this initial meeting was by phone. Consent will only be obtained after you have had the opportunity to read this Information Statement and ask me any questions relating to either the research or your participation in the research. Once the Consent Form has been signed and
Appendix A: Information Statement

296

returned to me by post in a stamped envelope that I will provide, I will
phone you to arrange an appointment for the Interview Meeting and also
answer any questions you may have.

2. Interview meeting (up to one and a half hours) – In person. An appointment
will be made for you to be interviewed by me. This interview may take up
to one and a half hours. This appointment will be arranged at a quiet place
free of distractions that suits you. You may choose your home or an
independent place such as an office at the University. While I am
interviewing you, a Dictaphone will be recording our conversation so that
I can then type our conversation into a transcript.

3. Participant reading the transcript (up to half an hour) – After I have typed up
our conversation I will post you a copy of the written transcript. I will
phone you about a week later to check that you are happy with the
accuracy of the transcript.

Additional information you need to be aware of:
This information and a discussion of what arises from our conversation will be
typed and the information will be used to identify the reasons why registered
nurses resign from NSW rural hospitals. This information will be seen by both me
and my supervisors who will be overseeing the research. One person will be
employed to type the transcripts, but your real name will not be known as we will
be using a code name for you in the interview. The information you give me will
be a part of my PhD thesis, and may also be published. You have the right at any
stage to withdraw your participation and you will not be subjected to any penalty
or discriminatory treatment. For your confidentiality, your name and identity will
not be recorded on our tape or typed in the research OR at any stage disclosed to
any person. If you give me any information that may suggest who you are, then all
efforts will be made to remove or change this information as long as it does not
affect the research. There may be a small chance that information you give me
may identify you, especially if you have worked in a very small rural town.
Sometimes when speaking about sensitive issues, emotional problems may arise.
If this does happen, you will be offered the opportunity to have counselling with a
qualified counsellor approved by CSU.

Contact Details
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Co-Supervisor
Dr John Grootjans
Assoc. Head of School

Principal Supervisor
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I ask for your agreement to participate in this interview by reading and signing the attached Consent Form. A copy of both the Information Statement and the Consent Form will be given to you. Please do not hesitate to contact me if you would like more information or to discuss any of the above matters.

NOTE: Charles Sturt University’s Ethics in Human Research Committee has approved this project. If you have any complaints or reservations about the ethical conduct of this project, you may contact the Committee through the Executive Officer:

The Executive Officer
Ethics in Human Research Committee
Academic Secretariat
Charles Sturt University
Private Mail Bag 29
Bathurst NSW 2795
Tel: (02) 6338 4628

Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome.
Appendix B: Consent Form

RESEARCH TITLE: “SILENT VOICES – WHY NSW RURAL REGISTERED NURSES RESIGN AND WHO LISTENS”

I,………………………………………………………………….. consent to my participation in the research project titled “Silent Voices – Why NSW rural registered nurses resign and who listens”.

- I understand that I am free to withdraw my participation in the research at any time, and that if I do I will not be subjected to any penalty or discriminatory treatment;
- The purpose of the interview has been explained to me including any potential emotional risks associated with the interview. I have read and understood the Information Statement given to me;
- I permit the investigator to tape record and publish information from my interview as part of this research;
- I understand that any information or personal details gathered in the course of this interview about me are confidential and that my name will not be used or published without my written permission. I also understand the limits of confidentiality in this research and understand that even though my name will not be used, there is a small chance that I may be identified due to information I give in the interview;
- I understand that the Charles Sturt University Ethics in Human Research Committee has approved this study;
- I understand that if I have any complaints or concerns about this research I can contact:

  The Executive Officer
  Ethics in Human Research Committee
  Academic Secretariat
  Charles Sturt University
  Private Mail Bag 29
  Bathurst NSW 2795
  Phone: (02) 6338 4628

Signed………………………………………………………………………

Dated………………………………………………………………………………

<table>
<thead>
<tr>
<th>Principal Investigator</th>
<th>Principal Supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Susan Bragg RN</td>
<td>Dr Jan Allan</td>
</tr>
<tr>
<td>246 Rivulet Road</td>
<td>Adjunct Assoc. Professor in Nursing.</td>
</tr>
<tr>
<td>PEEL NSW 2795</td>
<td>School of Nursing and Health Science</td>
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<tr>
<td>Phone: 02 6338 4310</td>
<td>Charles Sturt University</td>
</tr>
<tr>
<td>Email: <a href="mailto:sbragg@csu.edu.au">sbragg@csu.edu.au</a></td>
<td>Phone: 0409 455 630</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:jallan@csu.edu.au">jallan@csu.edu.au</a></td>
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# Appendix C: Initial Open Codes and Preliminary Categories

<table>
<thead>
<tr>
<th>Open Codes</th>
<th>Preliminary Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Area health restructure and centralisation</td>
<td>1. Organisational structure of hospital or Area Health Service (AHS)</td>
</tr>
<tr>
<td>2. Dilution of senior nursing roles</td>
<td></td>
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<tr>
<td>3. Hospital becoming a Multi Purpose Service (MPS)</td>
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<td>4. Reconnect scheme</td>
<td></td>
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<tr>
<td>5. New graduates</td>
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<tr>
<td>6. Management Structure:</td>
<td></td>
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<td>7. Nurse management structure</td>
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<td>8. Management perceived to be too top heavy</td>
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<tr>
<td>9. Didn’t get promised position/career block</td>
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<tr>
<td>10. Poor utilisation of staff</td>
<td>2. Human Resource issues</td>
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<tr>
<td>11. Staffing level inappropriate</td>
<td></td>
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<tr>
<td>12. Understaffing</td>
<td></td>
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<tr>
<td>13. Understaffing leading to more understaffing – vicious cycle</td>
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<tr>
<td>14. Bored in current position</td>
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<tr>
<td>15. Career path/block</td>
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<tr>
<td>16. Nurses holiday leave cancelled – no warning</td>
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<tr>
<td>17. Shift work and hours of work are inflexible</td>
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<tr>
<td>18. Out dated health system</td>
<td>3. Culture of the hospital or AHS</td>
</tr>
<tr>
<td>19. Female nurses being submissive</td>
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<tr>
<td>Open Codes</td>
<td>Preliminary Category</td>
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<tr>
<td>---------------------------------------------------------------------------</td>
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<tr>
<td>20. Feeling appreciated, supported or wanted</td>
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<tr>
<td>21. No feeling of connectedness with the health system</td>
<td></td>
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<td>22. No longer shared the vision of the hospital</td>
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<tr>
<td>23. Feeling isolated</td>
<td></td>
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<tr>
<td>24. Low morale of nursing staff</td>
<td></td>
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<tr>
<td>25. Health system lost focus on patients</td>
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<tr>
<td>26. Inflexibility of the health system</td>
<td></td>
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<tr>
<td>27. Power</td>
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<td>28. Staff conflict</td>
<td></td>
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<td>29. Politics</td>
<td></td>
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<td>30. New graduates</td>
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<td>31. Lack of professional development</td>
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<td>32. Postgraduate year</td>
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<td>33. Bullying</td>
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<td>34. Nurses being threatened not to speak out</td>
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<tr>
<td>35. Lack of consultation</td>
<td></td>
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<tr>
<td>36. Nurses not being heard</td>
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<tr>
<td>37. Lack of connectedness</td>
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<tr>
<td>38. Stagnant staff</td>
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<tr>
<td>39. Nurses choosing not to update their skills</td>
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<td>40. Nurse had to pay for own training</td>
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<tr>
<td>41. Lack of clinical support</td>
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<tr>
<td>42. Management culture</td>
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<td>43. Negative feedback from management</td>
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<tr>
<td>44. Personality clash with manager</td>
<td></td>
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<td>45. Management viewing the hospital as a business</td>
<td></td>
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<tr>
<td>46. Management not trusting nurses to nurse</td>
<td></td>
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<tr>
<td>47. Management – them and us</td>
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</table>
### Open Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>48.</td>
<td>Management – favouritism to certain staff</td>
</tr>
<tr>
<td>49.</td>
<td>Low morale for nurses due to management</td>
</tr>
<tr>
<td>50.</td>
<td>Lack of understanding by management as to what nurses actually do</td>
</tr>
<tr>
<td>51.</td>
<td>Lack of direction from management</td>
</tr>
<tr>
<td>52.</td>
<td>Lack of communication from management</td>
</tr>
<tr>
<td>53.</td>
<td>Incompetent manager/management as perceived by nurse</td>
</tr>
<tr>
<td>54.</td>
<td>Image of nursing</td>
</tr>
<tr>
<td>55.</td>
<td>Ageing work population/generational issues</td>
</tr>
<tr>
<td>56.</td>
<td>Change in the nature of nursing</td>
</tr>
<tr>
<td>57.</td>
<td>Suitability to nursing</td>
</tr>
<tr>
<td>58.</td>
<td>Nursing less attractive as a career</td>
</tr>
<tr>
<td>59.</td>
<td>Nursing as a career – career path and suitability</td>
</tr>
<tr>
<td>60.</td>
<td>Unsafe work conditions or practice</td>
</tr>
<tr>
<td>61.</td>
<td>Working in an area that nurse has no experience in</td>
</tr>
<tr>
<td>62.</td>
<td>Nurse feeling personally responsible for provision of hospital sundries to patient</td>
</tr>
<tr>
<td>63.</td>
<td>Poor standard of nursing care within the hospital</td>
</tr>
<tr>
<td>64.</td>
<td>Nurse not being able to give the care they wanted</td>
</tr>
<tr>
<td>65.</td>
<td>Job satisfaction</td>
</tr>
<tr>
<td>66.</td>
<td>Accommodation for nursing staff in rural areas</td>
</tr>
<tr>
<td>67.</td>
<td>Broken equipment</td>
</tr>
<tr>
<td>68.</td>
<td>Physical environment of hospital</td>
</tr>
<tr>
<td>69.</td>
<td>Inadequate resources</td>
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### Preliminary Category

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<th>Category</th>
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<tbody>
<tr>
<td>4. Societal issues</td>
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<tr>
<th>Category</th>
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<tr>
<td>5. Patient care</td>
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<tr>
<th>Category</th>
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<tbody>
<tr>
<td>6. Work conditions within the hospital</td>
</tr>
<tr>
<td>Open Codes</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>70. No computer access at work</td>
</tr>
<tr>
<td>71. Uniform</td>
</tr>
<tr>
<td>72. Care models</td>
</tr>
<tr>
<td>73. Lack of climate surveys</td>
</tr>
<tr>
<td>74. Wages were not an issue</td>
</tr>
<tr>
<td>75. Educating nurses’ children in remote areas</td>
</tr>
<tr>
<td>76. Lack of employment choice after resigning</td>
</tr>
<tr>
<td>77. Loss of nursing knowledge to the nursing profession as nurses leave</td>
</tr>
<tr>
<td>employment choice in rural areas</td>
</tr>
<tr>
<td>78. Participants taking up non nursing positions after resignation</td>
</tr>
<tr>
<td>79. Marriage break up</td>
</tr>
<tr>
<td>80. Nurses’ Union not supportive of core nursing issues – only seen as a</td>
</tr>
<tr>
<td>political party to push their own political agenda</td>
</tr>
<tr>
<td>81. Feeling sick at work/stress about going to work</td>
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<tr>
<td>82. Identification of a window period after the nurse resigned and prior</td>
</tr>
<tr>
<td>to her leaving her employment. An opportunity was present to rectify</td>
</tr>
<tr>
<td>issues and discuss.</td>
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<td>83. Not offered exit interviews</td>
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