ABSTRACT

It is widely accepted that there is a global shortage of nurses, and there are many studies in the health workforce literature about the negative aspects of nurse work environments, nursing workloads, decreased job satisfaction of nurses and the impact these have on patient health outcomes. In the past five years there has also been international and New Zealand-specific research into the effects of health restructuring on nursing leadership, retention of nurses, and on patient care. Much of this research has shown that countries with very different health care systems have similar problems, not only with retention of qualified nursing staff due to high levels of job dissatisfaction, but also with work design and the provision of good quality patient care in hospitals. This dissertation explores the many detrimental effects on nurses and nursing leadership, of extensive, and continuing, public health restructuring in New Zealand. The context of this dissertation is New Zealand public hospitals, with references pertaining to medical and surgical areas of nursing practice. Health reforms have negatively impacted on patient care delivery systems, patient health outcomes, and retention of educated nurses in the workforce. In order to resolve these issues, coordinated efforts are required in New Zealand District Health Boards to develop and sustain effective nursing leaders, who will promote and assist in the development of strong, healthy organisational cultures to retain and support professional nurses and the ways in which they wish to practise.

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On the writing side, this dissertation has been a long time coming, largely due to my road traffic accident in December 2006. As a result I have had to come to terms with many parts of my life, not least the delayed effects of concussion. This condition affected many ostensibly small things, but which when viewed collectively, added up to a significant impact on my cognitive functioning, and general ability to cope in life. Marty, and my friends Karen, Shirley, Croisella, and Heinz, have been mainstays without whom I would have been a mess.

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CHAPTER ONE

A GLOBAL NURSING SHORTAGE

Introduction

The current global nursing shortage has strong links with retention of nurses, and this impacts healthcare delivery in every corner of the world (Rosenkoetter, 2005). Effective nursing leadership has been shown to increase retention of nursing staff in some healthcare organisations. In recent years I have become increasingly passionate about the concept of retaining good staff in the health workforce, and so I have chosen to study nursing leadership for retention of nursing staff as the topic for this dissertation.

The Issues

The International Council of Nurses (ICN) has recognized the nursing shortage phenomenon as a critical workplace imbalance of supply and demand. Growing and ageing populations in this millennium are driving the demand for healthcare and for more nurses, but many countries are faced with serious nursing staff shortages (Buchan & Calman, 2004). Patterns of international recruitment of nurses have come under increasing criticism (Rosenkoetter, 2005), and recently New Zealand has been singled out as having the highest reliance on overseas nurses to bolster our health workforce (Aiken, Buchan, Sochalski, Nichols & Powell, 2004). However, according to statistics from the New Zealand Department of Labour (DOL) there are thousands of registered nurses and midwives educated in this country who currently choose not to practise (DOL, 2005).

Various internal job-related factors may cause dissatisfaction for nursing staff, which will be explored in the following chapters. In addition, external factors such as organisational restructuring, family commitments, other work demands, or relative ease

in finding alternative employment can contribute to poor retention rates of full and part-time nurse employees (Chan, McBey, Basset, O'Donnell & Winter, 2004). A high turnover of nursing staff in healthcare organisations causes negative consequences such as the cost of recruiting and training new nurses, losing nurses with experience and knowledge, an overall increase in nursing workloads, and a reduced capacity of the organisation to provide safe and effective care (Chan et al., 2004; Fabre, 2005).

As a career, nursing demands considerable physical, mental and emotional energy. It may also require substantial financial and quality of life sacrifices from individual nurses, whether Registered or Enrolled in the New Zealand system[1], in order to gain higher educational qualifications. During my years of comprehensive nurse education, and subsequent practice as a Registered Nurse (RN) - largely in acute medical/surgical hospital settings - I have encountered many nursing leaders. Some have motivated and inspired me to learn more, and to try to become a better nurse. But other nurse leaders, and the public health system in which we work, have caused me considerable frustration.

Although I am in the position of being a relatively senior Registered Nurse in a public hospital - which carries with it certain leadership responsibilities such as good role modelling, coordinating ward nursing care and bed management, preceptorship (guidance and teaching) of new staff – these responsibilities do not necessarily extend to being allowed to have control over many other issues related to patient care, ward resources and ward management.

1 A registered nurse is a nurse whose name is recorded on one of the Registers of Nurses; an enrolled nurse is a nurse whose name is recorded on the Roll of Nurses, both defined under the Nurses Act 1977. The scope of practice for enrolled nurses is restricted by legislation so that they must practise under the supervision of a registered nurse or medical practitioner (New Zealand Health Information Service (NZHIS), 2004).

Dissertation Position

This dissertation argues that Registered Nurses (RNs) and Enrolled Nurses (ENs) are valuable assets to hospital organisations in New Zealand, and that effective nurse leadership is crucial to safeguard, and enhance their working conditions and job satisfaction. These factors are paramount, in my opinion, if educated nurses are to be retained in the workforce. My objectives in writing this dissertation are:-

- To explore the impact of organisational change and health restructuring on DHB hospital nurses in the years from 1980 until the present time (2008).
- To analyse changes in the quality of patient care during, and subsequent to, health restructuring.
- To explore how nursing leadership has changed in New Zealand, and how effective leadership can help remedy nursing workforce problems.
- To explore strategies from overseas healthcare organisations which have been successful in developing healthy work environments that support recruitment and retention of nurses.
- To make a contribution to the knowledge base for nursing and for health care management, in order to improve the retention of educated nurses in the New Zealand health workforce.

Search Strategy

I have examined a range of national and international nursing literature written by public health researchers, sociologists, and nurse researchers, many with extensive experience of nursing management, from varied hospital and health management backgrounds. My search online has utilised the terms “nursing workforce”, “retention of nurses”, “nursing leadership”, “organisational culture” and “Magnet hospitals” in Google, and on internet databases including CINAHL, Pubmed, Medline, Proquest and Ebsco Host. I have hand-searched selected nursing journals including the Journal of

Nursing Administration, and the Journal of Advanced Nursing Practice, limiting my search to studies published from 1990 to the present time, unless there was a specific reason to find earlier studies, such as frequent citation. I have also hand searched three libraries for recent articles or books written about nursing administration and leadership, and New Zealand's healthcare system.

Dissertation Structure

This dissertation is divided into six chapters, with Chapter Two comprising a synopsis of changes to the New Zealand health system since 1938. This chapter is intended to assist readers to understand how successive governments have built on, or changed, health care policies in this country, particularly over the last 25 years.

Chapter Three provides a focus on positive and negative impacts of health reforms (restructuring and cost-cutting), both internationally and locally. A closer examination of the New Zealand reforms, particularly those of the 1990s era, shows their far reaching, and often detrimental effects on nursing leadership, nurse retention and patient care delivery within New Zealand public hospitals.

Chapter Four highlights the global aspect of nursing shortages. It introduces strategies for managing nurse retention which are part of the international nursing community's efforts to provide safe and effective health care, whilst also trying to monitor nursing turnover and migration around the world.

Chapter Five defines concepts of leadership, and examines ideas for building more effective leadership within nursing. Magnet Hospitals are explained, with recommendations drawn from their example for developing and maintaining healthy workplaces and positive organisational climates.

Chapter Six concludes the discussion about effective nursing leadership, its positive influence on healthy workplaces, and the reasons why effective nurse leaders will enhance retention of RNs and ENs in New Zealand hospitals.

CHAPTER TWO

THE CHANGING NEW ZEALAND HEALTH SYSTEM

Introduction

There has been considerable organisational change and restructuring of the New Zealand health system, particularly over the last 25 years. Health sector reforms have had a major impact on the organisation and morale of the New Zealand health workforce. This chapter will outline significant health sector changes, in order to provide a time frame for discussion about the impacts of restructuring on nursing work, nursing leadership, and patient health outcomes within the public hospital setting.

The Social Security Act of 1938 was developed and implemented by the first Labour government (Social Security, 1966), and was intended to create "a co-ordinated, state-funded and unified health service" which was accessible to all New Zealanders, regardless of socio-economic circumstance (Gauld, 2001, p.18). Various hospital services and benefits were introduced, including fully-funded mental health care, and free treatment in public hospitals (Medical Services, 1966). Nursing work in hospitals in the 1940s has been described as "typically that of rostered, state supported, state controlled employment, under medical oversight in an increasing complex secondary care environment" (Gage & Hornblow, 2007, p.331). A "dual" system of healthcare gradually developed whereby the public and private sectors operated alongside one another (Gauld, 2001, p.18).

By the 1970s, public health services were organised centrally by the Department of Health, and delivered regionally (Barnett & Barnett, 2005). Private hospitals housed around 20% of beds (Gauld, 2001). In 1974 the Labour government produced a White Paper on Health (Easton, 2002) describing the need for more health services integration,

a greater focus on preventive medicine, and better access to health care for all individuals. It proposed a new Department of Health (DOH) to supervise the work of 14 "regional health authorities" (Gauld, 2001, p.32), which would combine the regional public health, and local hospital board services into one organisation. But various influential groups including the medical profession disagreed (Gauld, 2001), and the Labour Party lost the election in 1975.

The National Government (1975 – 1984) and Area Health Boards

The succeeding National government decided to set up 14 "area health boards" (AHBs) (Gauld, 2001, p.35) to amalgamate existing hospital boards with district health offices. This scheme was piloted successfully, and legislation was passed in 1983 to proceed with the AHB concept (Gauld, 2001). A population-based (capitation) funding formula for Hospital Boards was also introduced (Poutasi, 2000).

The Fourth Labour Government (1984-1990)

The fourth Labour government, elected in 1984, continued to review the health system (Barnett & Barnett, 2005; Gauld, 2001). Under the population-based funding formula some regions had historically become 'overfunded' (Gauld, 2001, p.36), and were now subjected to funding constraints as the government attempted the re-allocation of resources. The new Finance Minister, Roger Douglas, favoured current management theories which recommended the creation of markets to stimulate competition and productivity. The State-Owned Enterprises Act was passed in 1986, and public restructuring of government organisations commenced (Gauld, 2001).

General management theories were then applied to the health sector, producing much uncertainty (Blank, 1994), and alienating health officials (Gauld, 2001). Legislation which proved critical for nursing included the State Sector Act (1988), and the

Employment Contracts Act (1991), both of which will be re-visited in Chapter Three. The State Sector Act (1988) effectively removed the traditional health management structure in each hospital board (of a triumvirate comprising senior doctor, nurse, and administrator), and replaced it with a Chief Executive Officer (State Services Commission, 2002). In 1989 the Labour government established 14 AHBs with national health goals and targets (Barnett & Barnett, 2005), and a focus on preventive population health strategies (Gauld, 2001).

The National Government (1990- 1996) and the Health Reforms

In 1990 the newly elected National government reviewed health services again (Barnett & Barnett, 2005). The Green and White Paper, published in 1991, planned a managed, competitive market in which purchasers were separated from providers of health services. Four Regional Health Authorities (RHAs) were established as purchasers of health and disability services, and instead of AHBs, 23 provider units called Crown Health Enterprises (CHEs) were formed. Directors for both RHAs and CHEs were government-appointed, predominantly from the business sector (Barnett & Barnett, 2005). There was "an explicit attempt" to exclude health professionals from decision-making for the sector. The new Chief Executives (as per the State Sector Act, mentioned above) had responsibility for their organisations, and hospital staff had "to take up employment with CHEs or resign" (Gauld, 2001, p.90).

Health professionals and health managers were thus significantly devalued by the government and its political agenda, regardless of their collective knowledge and experience.

Traditionally, access to health services is controlled by medical personnel, who make professional judgements over which patients should be treated, and when (Blank, 1994).

However, in 1991 the government established a National Advisory Committee on Core Health Services (NACCHS), to identify a set of services which should be affordable, accessible for patients, and available within reasonable periods of time. But the task proved to be exceedingly complex, and the NACCHS failed to produce definitive answers for the government's intended rationing of health services (Gauld, 2001).

In 1993 the DOH was replaced with a Ministry of Health (MOH) (Bloom, 2000). In order to meet their deadline of July 1993 for implementation of the reforms, National spent huge sums of money on private consultancy fees, administration and monitoring of contracts, and recruitment of new employees for RHAs, the new MOH, and top government departments (Gauld, 2001). Remuneration for board members and CHE management were "on a par with private sector executive salaries" (Gauld, 2001, p.92). Health service (hospital and pharmaceutical) user charges were introduced, but these proved to be an administrative and public relations disaster, so were removed a year later (Gauld, 2001).

Few Positive Results from Health Reforms

The financial costs to New Zealand of implementing the 1990s health reforms were considerable, and have been estimated to be between $80 and $800 million (Gauld, 2001). Positive outcomes included new ways of gathering information concerning public services costs (Gauld, 2003). Also savings for RHAs were achieved through the formation of Pharmac, a subsidiary company established to purchase pharmaceutical products (Gauld, 2001). But CHEs continued to experience service delivery problems within their contracted funding levels, and waiting lists for non-urgent treatments grew. CHEs tried to reduce costs by closing or downsizing services, including rural hospitals, but generally with limited consultation (Barnett & Barnett, 2005).

By 1996, only 3 of the 23 new CHE chief executives appointed in 1993 remained, indicating a lack of commitment to the complex healthcare environment. Various unions including nurses, medical specialists, and general staff, objected to the managerial style and objectives of the reforms, and staff turnover rates among hospital management were high. Meanwhile CHEs continued to reduce hospital staffing numbers (Gauld, 2001).

The National-New Zealand First Coalition Government, 1996-1999

By 1996, public concern about the health system contributed to the election of a more moderate coalition government (Barnett & Barnett, 2005). The National-New Zealand First government established the Health Funding Authority (HFA) as purchaser in place of the RHAs (Barnett & Barnett, 2005; Gauld, 2001). CHEs were re-named Health and Hospital Services (HHSs) in 1998, and Boards of Directors were allowed some community representation (Barnett & Barnett, 2005). Many hospitals remained unable to supply elective surgical procedures due to funding and staff shortages, and unpredictable demand for acute services (Gauld, 2001).

In 1998 a Ministerial Taskforce on nursing was formed in response to nurses' concerns about stress and heavy workloads impacting on delivery of effective patient care (Ministry of Health, 1998). In the same year, Robyn Stent, the Health and Disability Commissioner at that time, investigated Christchurch Hospital after receiving reports of unsafe practices leading to several patient deaths. Her investigation found that an environment of mistrust existed between clinical staff and management following hospital restructuring. In addition, senior clinicians had not been included in essential decision-making for the hospital, there was low morale in the health workforce, and the quality of hospital services and patient care had declined (Stent, 1998).

The Labour-Alliance Coalition, and this Decade

In 1999 the Labour-Alliance coalition government came to power. The HFA and the HHSs were abolished, and 21 District Health Boards (DHBs) were established in January 2001. DHBs were to perform some purchasing functions, with their funding calculated using a weighted population-based formula (Gauld, 2001).

In this decade the Public Health and Disability Act (2000) has facilitated a return to direct community representation, and most hospital board members are elected by the public. DHBs own and manage public hospitals, fund the non-provider arm of health care, and are accountable for their budgets and performance. Some funds have continued to be "ring-fenced", including public health and mental health (Barnett & Barnett, 2005, p.191). This concept ensures that neither funding nor provision resources are used elsewhere within the sector (Ministry of Health, 2003). A range of strategies are intended to provide national consistency in access, quality and type of care, including the New Zealand Health Strategy (2000), the Primary Health Care Strategy (2001), the New Zealand Disability Strategy (2001), and He Korowai Oranga (the Maori Health Strategy, 2002) (cited in Barnett & Barnett, 2005). In order to meet their population targets, DHBs now attempt to collaborate, to share resources and reduce costs (Olliver, 2002; Rousseau, 2008).

Summary

The New Zealand health reforms were largely driven by successive governments' demands for efficiency, flexibility, cost-effectiveness and improved access to healthcare (Gauld, 2001). However, sociologists like Gauld, Barnett and others have provided evidence which shows that huge sums of taxpayer money have been spent on structuring and then restructuring the public health system, and on expensive consultancy fees to private businesses or to individuals who had no affiliation (or

presumably, loyalty) to the health system. In contrast, multidisciplinary health professionals and health managers with considerable knowledge and experience in the health sector were ignored and pushed aside, in favour of general managers. Thus their views were devalued by those in government.

The negative repercussions of health restructuring raise serious questions about the political power of democratically elected governments in relation to maintenance of our national health workforce and appropriate health services for all New Zealanders.

The following chapter discusses the effects of hospital restructuring in New Zealand on nurses and nursing leadership, hospital staffing levels, and patient health outcomes.

CHAPTER THREE

HOSPITAL RESTRUCTURING AND NURSING

New Zealand has had four different health system structures in the last 25 years: Area Health Boards (AHBs), Crown Health Enterprises, Health and Hospital Services (HHSs), and District Health Boards (DHBs). This chapter will examine the effects of health sector restructuring on nurses, their leadership, nursing care and decision making, and on patient health outcomes.

Effects of Restructuring on Hospital Nursing and Patient Care

Nurses are the largest occupational group employed in hospitals around the world, which inevitably results in them being a target for cost savings in health systems. A recent study into the New Zealand health reforms by American nurse researchers McCloskey and Diers (2005) has highlighted the effect of various parliamentary Acts, which together with health restructuring, impacted significantly on the structure of nursing in New Zealand. The State Sector Act (1988) resulted in the removal of the nursing department within the Ministry of Health, leaving only one nurse to represent the profession at ministerial level. Then the Employment Contracts Act of 1991 (repealed in 2000), weakened the collective bargaining power of all national labour unions, including the nurses' union (McCloskey & Diers, 2005).

To reiterate, the State Sector Act (1988) abolished traditional structures, with the triumvirate model of hospital management (comprising the medical superintendent, the principal nurse, and the senior administrative officer) being removed (Gower, Finlayson & Turnbull, 2003). Nursing management positions began to be disestablished in the late 1980s.

Specific Changes to Nursing Leadership

Specific changes to the nursing hierarchy between the years 1988 to 1999 were captured by nurse researchers Finlayson and Gower in July 2002 (Gower et al., 2003). During this time, senior nurses were made redundant, or transferred into general management positions. Sixteen hospital organisations took part in Finlayson and Gower's study, and almost all had disestablished the position of Principal Nurse. It was replaced with the position of Nurse Advisor, which was considered by senior nurses to be an "ineffective" or "token" position which had professional accountability for nursing staff, but no authority over the management of nursing services or resources (Gower et al., 2003, p. 130).

Nursing Supervisors had previously been accountable to the Principal Nurse, and provided clinical advice and nursing leadership within public hospitals on a 24 hour basis. These Nursing Supervisor positions were removed, although most hospitals retained a limited number of supervisors for the *after hours* management of patient services (Gower et al., 2003). The remaining leadership position, Charge Nurse, had been responsible for the quality of nursing services at ward level. During 1993 and 1994 most Charge Nurses were also given responsibility for the financial and personnel management for their areas, and were expected to place more importance on general management tasks than on clinical leadership duties. This was to prove unacceptable for many nurses.

Health restructuring led to difficulties because many general managers had limited understanding of health services, and so did not comprehend the complexities of nursing care and ward management. This caused high levels of stress on both sides (Gower et al., 2003), and "ongoing conflict between clinical and management cultures" (Gage & Hornblow, 2007, p.332).

The continual organisational changes resulted in an overall lack of nursing leadership, which contributed to increased stress and job dissatisfaction of ward-level nursing staff. More nurses left the profession, from "across the spectrum of seniority and experience" (Gower et al., 2003, p.135). Hospitals made more use of casual nursing staff, thereby compounding problems of achieving desirable skill mixes within nursing teams. Nursing groups and the medical profession had increasing concerns about the quality of patient care in public hospitals (Gower & Finlayson, 2002).

Effects on the Nursing Work Environment, on Patient Health Outcomes

During the 1990s, hospital management also made major changes to the provision of hospital services. Various initiatives to reduce patients' average length of stay (ALOS) were the expansion of day-stay surgery (Gower et al, 2003); implementation of Diagnostic Related Groups (DRGs) (McCloskey & Diers, 2005); and the development by some CHEs of Integrated Care Pathways (ICPs) (Hewson, J., personal communication, Nursing Services Consultant ODHB, March 7, 2006).

To achieve reductions in ALOS, clinicians were required to discharge patients earlier; therefore nurse work-loads increased because it caused a higher turnover of patients (Gower et al., 2003), which explains some of the conflict between management and clinical staff discussed above. A higher turnover means for *nurses* that a larger proportion of patients are more acutely ill while they are in hospital, which effectively increases the nursing time required, and the intensity of nursing care for each patient.

Public hospitals began to re-establish the position of Principal Nurse by the mid 1990s, but cost savings were still directed at nursing services (McCloskey & Diers, 2005). Non-nursing managers had control over nursing budgets, so there were delays in filling nursing vacancies as a way to reduce costs. Senior nurses who left were replaced by

less experienced nurses or new graduates (Bamford, as cited in McCloskey & Diers, 2005). Clinical areas lacked basic supplies and equipment, the general environment was "in a state of disrepair"; and the nurse burnout rate was very high (Bamford, 2005, p.7).

McCloskey and Diers (2005) found links between declining numbers of nurses during the 1990s, and increases in nurse-sensitive adverse patient outcomes[2]. Their examination of New Zealand Health Information Service (NZHIS) data found that when numbers of fulltime RNs and ENs dropped by 36 %, so did nurse hours worked per 1000 medical/surgical patient discharges. EN numbers alone decreased by nearly 80% per 1000 patient discharges, partly because the Nursing Council of New Zealand (NCNZ) was phasing out the EN role in hospitals (McCloskey & Diers, 2005). However the slight comparative increase in RN numbers, and skill mix (in this case RNs numbering more than ENs) did not compensate for the increased nursing workload caused by shortened patient lengths of stay (McCloskey & Diers, 2005).

The managerial focus on cost effectiveness and process efficiency resulted in a 20% reduction in overall ALOS, but adverse clinical outcomes for patients increased substantially. Statistically significant relationships were found between lesser numbers of nurses (and therefore less nursing hours worked), the increase in skill mix, and adverse patient outcomes. These included central nervous system (CNS) complications, decubitus ulcers, and sepsis, in both medical and surgical areas. Further adverse outcomes for surgical patients included pulmonary failure (up 296%), wound infection rates (up 134%), deep vein thrombosis/pulmonary embolus (DVT/PE), sepsis, and urinary tract infections (UTI) (McCloskey & Diers, 2005).

2 'Nurse-sensitive outcomes' is a term that is applied to patient health outcomes which are considered to be reliant on the presence of appropriate nursing care (Needleman et al., 2001).

Whereas one might have expected that adverse outcomes for patients would decrease as nursing skill mix increased, McCloskey and Diers found that “in nurse work environments characterized by heavy workloads, overextended or absent nursing leadership, and poor morale, quality of patient care may not necessarily benefit from a richer skill mix” (2005, p.1145). This indicates that even well-educated, experienced RNs cannot prevent some patients’ conditions from deteriorating if their workloads and their working conditions are not conducive to the delivery of good nursing care.

The loss of a “nursing voice” and a “hospital-wide nursing perspective” in senior management have been significant contributing factors in the erosion of nursing leadership and nurse staffing levels in New Zealand (Gower et al., 2003, p.135). The next section describes some other issues which have been problematic for the future of nursing.

Six Major Issues for Nursing Identified By Research Participants

Nursing leaders in Gower et al.’s research identified six major issues of concern for the nursing profession, many of which are still relevant today:

- the lack of nursing involvement in changes to nursing positions
- the reduction in nursing-specific career opportunities
- the lack of senior role models and support for charge nurses, staff nurses, and students
- the lack of strategic planning, recruitment and retention for the nursing workforce
- the increased use of casual and agency nurses was identified as detrimental to nursing skill mix, and costly for nursing budgets
- the lack of opportunity for professional development, and further nursing education. Even when educational sessions were provided, nurses had

difficulties attending because first they needed to be relieved of their clinical responsibilities (Gower et al., 2003).

In order to decrease costs within the hospital sector, nursing leadership positions, nurse staffing levels, role responsibilities and lines of responsibility were altered. Thus nursing structures were weakened, and control over nursing practice and nursing careers vastly altered. Many changes were to the detriment of nurses, and ultimately, patients in New Zealand public hospitals.

Restructuring Requires Much Planning

The implementation of Diagnostic Related Groups (DRG) after restructuring did reduce ALOS, because that is what this budgeting system is designed to do. But shorter ALOS means that patients are more acutely ill and require higher levels of care while they are in hospital, thereby increasing nursing workloads (Finlayson & Gower, 2002; Kimball, 2004; McCloskey & Diers, 2005). New technologies to save work and time for nurses have been absent during re-engineering of health systems (Kimball, 2004). The nursing time available for direct patient care is further restricted if there are extra documentation requirements for compliance with new regulations (Kimball & O'Neil, 2002). Also, if new "bedside" technologies (for example, handheld computers) are to improve care and efficiency, they must first be developed and tested with front-line staff (Mason, 2008, p.11).

Inadequate nurse staffing adds to the risk of errors in patient care, and miscommunications between staff (Cho, 2001). When wards are understaffed nurses are forced to prioritize their patient care duties, which may lead to less frequent monitoring of patients, adding to the potential for adverse outcomes (Aiken et al., 2001; Cho, Ketefian, Barkausas & Smith, 2003). Therefore health restructuring, without

adequate planning and implementation of strategies to support and protect the nursing workforce, has compounding negative effects on patient care and health outcomes.

Effects of Restructuring on Nurses' Decision Making

The competitive environment of the 1990s caused difficulties in establishing who was responsible and accountable for decisions affecting patient care, according to a doctoral thesis written by RN Barbara Williams (2000). New Zealand nurses working in the 1980s had felt confined by hospital bureaucracies, but roles such as nurse clinician and nurse consultant had begun to emerge, due to increasing recognition for nurses' clinical expertise. Williams found that a lack of stable, experienced and adequately prepared nursing staff impedes effective, independent decision-making, and the ability of individual nurses to question work processes. Therefore many nurses working in the 1990s lacked confidence to act independently, especially if their actions might have financial implications for the hospital (Williams, 2000).

Williams' findings correlate with those of Aiken et al.(2001), who found that when "front-line nurse leadership roles" are reduced by restructuring, key pathways of communication between nurses at the bedside and hospital administrators are removed (Aiken et al., 2001, p.51). Therefore understanding between the two groups is diminished, and nurse confidence in their own practice decisions is undermined.

Subordination and Devaluing of Hospital Nurses

An American sociologist, Daniel Chambliss, writes that hospital nurses typically expect to be caring, professional, but also relatively subordinate members of the organisation (Chambliss, 1996). Caring involves working face-to-face with patients for extended periods of time, so that nurses have specialized knowledge about their patients, and treat them as human beings, rather than a disease or ailment to be cured. Their

professionalism emphasizes that caring be performed with special competence, even under trying and time-constrained conditions, but nurses are simultaneously subordinate to administrators and doctors in hospital organisations (Chambliss, 1996). In comparison, Dana Weinberg, another American sociologist, describes how restructuring (hospital cost-cutting and downsizing) has devalued the caring aspects of the nursing role, strained nurses' ability to act as professionals, and emphasized their subordination to institutions (Weinberg, 2003). Both authors describe the unique and invisible nature of caring which professional nurses have and use in everyday practice, but which is seldom acknowledged by health policy makers today.

Following on from the reports of the Health and Disability Commissioner and the Ministerial Taskforce on Nursing (1998), the Health Workforce Advisory Committee (HWAC) in 2001 acknowledged New Zealand Nursing Organisation's (NZNO) estimate of approximately 2000 nursing vacancies nationwide. The HWAC (2001) reported that factors contributing to nursing shortages included workload, lack of career pathways, international competition for nurses, fewer numbers entering nursing training, and that nurses felt they were not valued by their employers.

Summary

The loss of nursing leadership at all levels within hospital organisations has impacted on nursing care delivery, nursing support and education, and recruitment and retention of nurses in the New Zealand national nursing workforce. Both nurses and patients have suffered from reductions in the hospital nursing workforce, increased nursing workloads, and the enforced loss of nursing structure. Nurses' dissatisfaction has meant that a nursing career has become less attractive, both for those remaining in the profession, and for those looking in from the outside. Without good role models and effective nursing leadership, nurses lose confidence in their ability to make decisions

concerning patient care, thereby contributing to a loss of self-esteem. This, combined with a loss of credibility as a skilled professional in one's own right, enhances the felt subordination of the hospital nurse to others (such as doctors and administrators) who are perceived as more powerful within the organisation.

Chapter Four explores the impacts of health restructuring internationally, many of which are reflected in current New Zealand research. Successful initiatives to deal with nursing shortages are also discussed.

CHAPTER FOUR

GLOBAL NURSING WORKFORCE ISSUES

Introduction

There is a global shortage of qualified health personnel, of which a critical component is the nursing workforce. Nurses are recognised as the "frontline" staff in most health systems, and their contribution is essential to delivering safe and effective care (Buchan & Calman, 2004, p.4). A universal definition of nursing shortage is difficult to make because of marked variations in the availability of nursing skills in different countries. Nursing shortage is usually defined in relation to a country's historical staffing levels, demand for health services, and resources; it can also be an imbalance between requirements for nursing skills (usually defined as number of nurses) and the availability of nurses willing to work for specific wages or work related benefits (Buchan & Calman, 2004).

Nurses are ageing, compounded by fewer young people entering the profession, and the health needs of the ageing baby boomer population in many developed countries (Mion, Hazel, Cap, Fusilero, Podmore & Sweda, 2006). If nurse shortages and understaffing are not attended to on a local, regional and national level, then it is likely that a range of negative nurse and patient outcomes will follow (Buchan & Calman, 2004). These include increased cross-infection rates, increased incidence of adverse events after surgery (McCloskey & Diers, 2005), increased accident rates, patient injuries and patient mortality rates, increased needlestick injuries to staff, and increased incidence of violence against staff (Baumann et al., 2001).

International Background

Nursing shortages are expected to worsen because nurses' average age is in the low to mid 40s, especially in many developed countries, (ICN, 2003, as cited in Buchan & Calman, 2004). In contrast to other professionals, nurses begin to retire earlier, at age 55, primarily due to the physical nature of their work (Minnick, 2000). Internal migration of nurses within the profession or to other industries may cause nurse shortages because nurses take their skills and expertise with them. Employers from developed countries are increasingly recruiting outside their own countries, because of growing nurse shortages in their own labour markets (Buchan & Calman, 2004). This situation has raised concerns about the ethical standards of countries which target foreign trained nurses from poorer, developing countries, because the latter are the least able to afford to lose health workers (Buchan & Calman, 2004).

Funding shortfalls can create shortages which are not necessarily related to nurse availability. Where financial resources for employing nurses are limited, a planning "disconnect" may occur; hence more nurses are educated than there are funds to employ (Buchan & Calman, 2004, p.20). The opposite situation can also occur if nursing education faculty members are short-staffed, so applicants for nursing education are turned away (Shawn Kennedy, 2007).

Large International Study Examines Nursing Work Design

Research has revealed fundamental problems in the design of nursing work throughout hospitals in Europe and North America (Aiken et al., 2001). A study of more than 43,000 nurses practising in 700 hospitals in five countries showed that job dissatisfaction among hospital nurses was present in significant numbers (32-41%) of nurses in England, Scotland, Canada and the U.S. A standardized tool, the Maslach Burnout Inventory (MBI), was used to determine levels of emotional exhaustion and the

extent to which nurses felt overwhelmed by their work. Significant percentages (29-43%) of nurses in all countries except Germany had high burnout scores relative to the MBI norms for medical workers (Aiken et al., 2001). North American nurses reported regular patient and family complaints, and verbal abuse directed towards nurses. Nurses' frustration was thought to contribute to their high rates of burnout and job dissatisfaction. These factors were especially important due to the nursing workforce crisis, and for their potential impact on the quality of nursing care (Aiken et al., 2001).

Most hospital nurses in all five countries believed that they had good working relationships with doctors who provided high-quality care, and that they worked with clinically competent nurse colleagues. However, only 30-40% of nurses thought there were enough registered nurses available to provide high quality nursing care, and to get the work done. A slightly greater proportion of RNs believed there were enough nursing support services provided, but less than 50% of nurses from each country perceived that hospital management acknowledged nurses' contributions to patient care, made decisions in collaboration with nurses, and responded to their concerns (Aiken et al., 2001). Therefore many nurses would have limited trust in, and respect for hospital managers.

Low percentages of nurses in Canada and the U.S. were under age thirty, which meant that extended careers in nursing were less likely (Aiken et al., 2001). This correlated with other U.S. research published in 1999, which found that fewer young people were choosing careers in nursing (Buerhaus & Staiger, as cited in Aiken et al., 2001). Although this latter situation may be changing slightly in New Zealand (Cassie, 2008), the global outlook for nursing workforce planning is sobering if ageing nurses are not being replaced by younger nurses.

Survey of New Zealand Hospital Nurses

Nurse researchers Gower and Finlayson conducted a New Zealand survey in 2001, adapted from Aiken et al.'s (2001) international study. In keeping with international findings, the survey of New Zealand hospital nurses indicated that most nurses believed they worked with competent doctors and nurse colleagues, and provided a high level of nursing care. However, 25% of nurse respondents reported that the quality of care in their hospitals had deteriorated in the previous year. New Zealand nurses also felt they were not well supported, nor were they well recognised by hospital management. In spite of nursing shortages, there were less ancillary (support) staff, and nurses were increasingly responsible for non-nursing tasks such as housework and administrative duties (Gower & Finlayson, 2002).

The New Zealand survey found correlations between nurses' perceptions of autonomy, control over the patient environment, deterioration in the quality of care, and a lack of organisational support. Nurses' job satisfaction was most strongly correlated to their perception of a deteriorating quality of care. Approximately 30% of nurses were dissatisfied with their current job, and a similar number intended to leave their jobs within 12 months (Gower & Finlayson, 2002). This is of significance to health workforce planners in New Zealand, since job satisfaction is now widely considered to be a reliable predictor of nurses' intent to leave.

The New Zealand Nursing Workforce

A survey in 2000 of New Zealand RNs who paid to maintain their annual practising certificates (APC) but were not working in clinical practice, found that more than 75% of nurse respondents would consider returning to work *if conditions were favourable.* These conditions were more flexible hours of work, the availability of a return to work programme, better pay, and provision of childcare services (New Zealand Health

Information Services (NZHIS), as cited by Department of Labour (DOL), 2005). In 2003, the MOH reported that there were 4,452 RNs and midwives who had current APCs, but were not actively employed in nursing or midwifery (MOH, as cited by DOL, 2005). In 2004 the NZNO conservatively estimated that New Zealand had a shortage of 2,000 nurses, based upon a 5% nurse vacancy rate in DHBs (NZNO, as cited by DOL, 2005). However, the DOL (2005) reported that there was not a shortfall of trained nurses, but rather a lack of *available* nurses (see p. 22, paragraph 1).

In 2002 through to 2004, NCNZ registrations of overseas trained nurses exceeded those of New Zealand trained nurses (DOL, 2005). An international study by Aiken, Buchan, Sochalski, Nichols and Powell (2004) also found that 23% of registered nurses working in New Zealand were overseas trained, compared to only 8% in the UK and Ireland. These figures highlight New Zealand's dependence on overseas trained nurses, which, according to Aiken et al., (2004) is due to failed policies and underinvestment in nursing. New Zealand–trained nurses also regularly migrate overseas, attracted by higher wages and better conditions (Aiken et al., 2004; "Nursing levels near critical," 2007).

In 2006 the NZNO stated that initiatives like the Flexible Working Hours Bill were vital to attracting nurses back into the health workforce, since 30% of nurses who paid for APCs were not actively employed in nursing. NZNO further explained that female nurses faced issues of juggling shift work and family responsibilities, and some Maori health workers had particular needs in relation to meeting family obligations. A significant part of their work was in supporting members "…who were assured by their employers before taking parental leave that they would have flexibility on return to work, only to come back and find no acknowledgement of the arrangement" (NZNO, 2006c). Examples like this illustrate why nurses may lose trust in their employers.

New Zealand's nursing workforce problems correlate with the ICN report on the global nursing workforce, which stated that "challenges…are interlinked with …gender bias and discrimination in society and in employment" because in most countries, 90% percent or more of nurses are female (Buchan & Calman, 2004, p.7). This is consistent with New Zealand statistics, where females comprise 91% of the nursing workforce (Health Workforce Information Programme (HWIP), 2006).

Reliable Information Is Necessary for Workforce Planning

Adequacy of nurse staffing is of the greatest consequence in healthcare (Mason, 2008). Recent studies of nursing turnover in New Zealand DHBs have highlighted the lack of reliable information to assist with recruitment and retention of nurses, despite the negative impacts of institutional nurse shortages being well known. These include hospital bed closures, restricted elective surgery, reduced inpatient admissions and emergency department service restrictions (North et al., 2005). Other negative issues include employee cynicism (Andersson, 1996), a climate of distrust in management, loss of employee commitment to the organisation (Baumann et al., 2001), higher levels of absenteeism, and loss of talent in the workforce resulting in reduced collective corporate knowledge (Duffield, Kearin, Johnston & Leonard, 2007).

Current efforts to provide more information for health policy and planning include The Nurses & Midwives' E-Cohort Study, which involves several countries, and has invited New Zealand registered nurses and midwives to participate in an on-line questionnaire about nurses' health, wellbeing, and workforce participation (Nurses workforce study launched, 2006).

DHBNZ announced in 2006 that "workforce data collected across the 21 DHBs differs to varying degrees rendering it non-comparable." Therefore the Health Workforce

Information Programme (HWIP) was implemented so that DHB data collection for workforce planning could be standardized (DHBNZ, 2006; HWIP, 2006). So far, HWIP data shows that New Zealand's 45,000 registered nurses have an average age of 45 years, and comprise approximately 60% of the health workforce (HWIP, 2006). But the results of a recent study of NZ hospital nurses are of real concern for workforce stability. Almost 34% of nurses studied intended to leave their present jobs within 12 months, rising to 56.6% for nurses aged 30 and under, thus making NZ nurses' intention to leave the highest rate of six countries (Finlayson, Aiken & Nakarada-Kordic, 2007).

Addressing Nurse Shortages

The ICN warn that international recruitment of nurses may not be cost effective (Buchan & Calman, 2004). In addition, "short-term strategies such as signing bonuses and use of temporary personnel" do not address the real problems behind nursing shortages (Aiken et al., 2001, p.51).

Solutions to the nursing shortage must focus on factors which motivate nurses (Buchan & Calman, 2004). Recent New Zealand initiatives to address nursing shortages include recruitment of school leavers to nursing (Bland, 2005), Careers Open Days, and polytechnic promotions in some DHBs (North et al., 2005). The NZ University Students Association has suggested funded tuition, and universal allowances to alleviate debt for nursing students (NZUSA, 2003).

In 2007 the Nursing Entry to Practice Programme (NETP) was introduced nationwide. This is a 10-12 month structured support programme for nurse graduates which introduces a consistent set of learning outcomes across DHBs, and provides clinical preceptorship for new graduates (MOH, 2005b). It is aligned with the Nursing Council of New Zealand's (NCNZ) Professional Development and Recognition Programme

(PDRP) framework. These two programmes have been recommended for use by DHBs and other nurse employers (National PDRP Working Party, 2004) in order to enhance nurse retention.

The NZNO receives regular weekly calls from nurses enquiring about returning to work. Registered nurses wishing to return to practice after more than 5 years absence are currently required to complete a Return to Nursing programme. However, nurse participants are not eligible for student loans, and the programme's cost creates significant financial barriers for many applicants (NZNO, 2007). Therefore it seems the government could do more to ensure that New Zealand has sufficient numbers of educated nurses in the workforce.

Better Remuneration and Recognition for Nurses

Recruitment and retention of nurses in New Zealand may be improved by recent pay settlements between the DHBs and the NZNO (Department of Labour, 2005; NZNO, 2006a). The NZNO have also continued to work on their "safe staffing" goals of achieving better nurse to patient ratios (Safe staffing document in pipeline, 2006; NZNO, 2006b). The introduction of nurse-patient ratios in Victoria, Australia was very successful, and resulted in thousands of nurses returning to work in public hospitals within 2 years (Cassie, 2005). Given the right controls and feedback, a similar system could significantly improve nurses' workloads in New Zealand hospitals. However, despite warnings against short-term strategies (Aitken et al., 2001), as mentioned above, this is precisely what is currently being attempted in Australia, where the new Rudd government plans to attract nurses back to the profession using cash bonuses (Australia to pay returning nurses, 2008).

In order to retain qualified nurses in a competitive labour market, hospitals must develop personnel policies and benefits comparable with other workplaces, which promote organisational loyalty and retention. These could include opportunities for flexible work schedules, career advancement, and lifelong learning (Aiken et al., 2001). For younger nurses, incentives could include educational scholarships, and childcare facilities (O'Brien-Pallas, Duffield & Alksnis, 2004). Flexibility in work schedules is particularly relevant for nurses who have young families, so that they can achieve a better work-life balance (NZNO, 2006d).

An increasing proportion of RNs in Canada are retiring early, many by 56 years of age (O'Brien-Pallas et al., 2003). International research shows that the value of older nurses in the workforce is not always recognised (Watson, Manthorpe & Andrews, 2003). Personal safety and parking issues may be important to many nurses, and retention of older, experienced nurses may be enhanced with policies of job sharing, case load reduction, educator roles, and doing administrative or planning tasks. Older nurses may also appreciate an extra week of leave, or time off to care for family members (O'Brien-Pallas et al., 2004).

Some nurse leaders in New Zealand have taken further steps to retain nurses, including negotiating for fair salaries for nurse practitioners, and for extra full time equivalent staff (FTEs) to replace nurses who are participating in nursing education (O'Connor, 2005). Due to inadequate staffing, attendance at education sessions remains a problem for nurses in 2008. In addition, hospital organisations could enhance organisational commitment by making it a priority to look after the health of their nursing staff through occupational safety and health programmes.

Positive initiatives from nurse leaders can help nurses to *feel* valued, and also *be valued,* in order to retain their commitment to an organisation. In my experience, front-line nurses in public hospitals often feel powerless to alter their working conditions, and their workload. Therefore, systems for assessing patient acuity and/or dependency must be developed in conjunction with experienced nursing staff. If the work environment becomes intolerable, and their personal and family lives are affected too adversely by their hours of work, nurses will seek alternative employment, or older nurses may choose to retire early from the profession. For retention purposes, I believe that it is an economic disaster for hospital and nurse managers to place more importance on ward/unit budgets than on the retention of intelligent, well-educated, caring, skilled, hard-working and experienced nurses within the organisation.

Magnet Principles Provide Further Answers

The Ministry of Health has been enthusiastic about promoting Magnet principles in public health organisations in New Zealand, because of the remarkable success of "magnet hospitals" in the U.S. (MOH, 2005a). In the early 1980s, an American taskforce investigating nursing workforce shortages observed that some hospitals were able to retain, and attract new staff, even when there was a national shortage of nurses. The American Academy of Nursing (AAN) commissioned the "original" magnet study, led by American nursing researcher, Margaret McClure, to seek out common organisational characteristics of these hospitals (Armstrong, 2005, p.15). Magnet hospitals had features which promoted and sustained professional nursing practice, including flat organisational structures, influential nurse executives, decision-making at unit level, and investment in nursing education (Aiken, Havens & Sloane, 2000). Magnet hospitals also had higher nurse-to-patient ratios than other hospitals, but the cost of employing more nursing staff was easily offset by significantly shorter patient lengths of stay, and less patient ICU days (Aiken et al., 2000).

Summary

Since the first magnet study, there have been many examples in nursing literature of the comprehensive benefits of enacting the ‘magnet’ principles. Institutions that adopt magnet principles have better patient outcomes, higher patient satisfaction, reduced organisational costs, a lower staff turnover, and increased institution stability (Aiken et al., 2000; Aiken, 2002; Brady-Schwartz, 2005; Upenieks, 2003). Positive outcomes specific to nursing include retention of highly qualified staff, higher rates of job satisfaction, higher nurse ratings of quality of care, lower rates of needlestick injuries, and significantly lower rates of staff burnout (Aiken, 2002).

Chapter Five explores concepts and styles of leadership, and will explain how hospital organisations can develop effective nurse leaders and retain nursing staff in competitive healthcare markets.

CHAPTER FIVE

CONCEPTS OF LEADERSHIP

This chapter defines concepts of leadership, with limited reference to relevant theories from the last century. Researchers have found that "a combination of leadership styles and characteristics" assist with developing and maintaining healthy organisational work environments (Pearson, Laschinger, Porritt, Jordan, Tucker & Long, 2004, p.146). In this chapter, effective leadership is linked with organisational culture, and to nursing work environments. Magnet hospitals are further explored, in relation to their successful patient health outcomes and retention of high quality nursing staff.

Leadership Concepts and Theories

Various theories about leadership have included the Great Man Theory (a leader is born with the necessary personal characteristics to be great), and Trait Theory, which attributes successful leaders with superior abilities or traits of personality and character (Pieper Simons, 1993). Effective leadership is associated with personality traits such as self-confidence, creativity, adaptability and personal integrity; also intelligence traits including fluency of speech, knowledge of a specific subject and decisiveness, all of which are important to provide inspiration to others (Farley, 1993).

Leadership differs from management, in that people are motivated to achieve high goals, rather than simply being given instructions about what to do. Power alone does not make a leader; an individual's position may give him/her the authority to accomplish tasks within an organisation, but it does not necessarily make people wish to follow that person (Clark, 2000).

Transactional leaders have been described as those leaders who are concerned with day to day operations, with a focus on tasks and the use of tradeoffs to meet goals.
In contrast, transformational leaders have long term vision, are committed, and can empower and inspire other people to make their vision a reality (Burns, as cited in Marquis & Huston, 1996). However, transformational leaders may fail without also having the more traditional management skills attributed to transactional leadership. The organisation and work environment are critical to the development of leadership skills (Marquis & Huston, 1996).

Different Styles of Leadership

Leadership styles may exert considerable influence on the climate of work groups and their outcomes. Different styles of leadership were identified by behavioural scientists in the 1950s and 1960s. Authoritarian leaders were described as task-oriented, using their power to influence followers, while democratic leaders were more group-oriented individuals who gave their followers considerable freedom in their work (Marquis & Huston, 1996). Theorists Hersey and Blanchard believed that leadership styles existed on a continuum between authoritarian and democratic styles. However, when there were no policies or procedures established, and no one attempted to influence anyone else, then a "laissez-faire atmosphere" existed, which actually represented an *absence* of leadership (Hersey & Blanchard, 1969, p.63). The laissez-faire style of leadership could cause group apathy and disinterest unless all group members were "highly motivated and self-directed", but might be appropriate when problems were less well defined, and "brainstorming" for solutions could be useful (Marquis & Huston, 1996, p.15).

Characteristics of Effective Leaders

Warren Bennis was another theorist who spent over three decades studying leaders, and offered the following ingredients for successful leadership:

- a clear vision of what needs to be accomplished
- passion or an intense level of personal commitment
- integrity or character (Bennis, as cited in Manion, 2005, p.4).

Effective leaders have an understanding of gender differences and group dynamics, and they develop higher levels of trust and meaningful relationships with individuals, and with groups (Haynor, 2005). Communication is a key element of leadership, which involves verbal, non-verbal and written means of creating understanding, commitment and shared ownership of the leader's vision. A leader's ability to communicate may impact upon a group's cohesiveness, and the way the group meets organisational goals (Aroian, 2005).

In addition to communication, critical thinking skills are also essential to effective leadership, in order to process complex problems in a systematic and timely manner. Critical thinking incorporates "knowledge, reasoning and rational appraisal skills, analytic problem-solving behaviours, and reflective thinking" (Lemire, 2005, p.53).

Contemporary healthcare organisations demand transformational leaders who provide mentorship, and create collective and ongoing learning. Mentoring relationships are beneficial because leaders can carefully nurture and coach others to help them to develop in professional and personal spheres. Mentoring can be individual or collective, and can attract and retain talent within an organisation; it enables preparation for leadership roles, and strengthens the profession and the organisation (Lemire, 2005).

Extensive research reveals that the best leaders often demonstrate a delicate balance of self-confidence and humility (Manion, 2005). These leaders balance their own ideas by understanding that other people may have better ideas and insight on any given issue

(Kraemer, as cited in Manion, 2005). A study of excellent nurse executives, by nurse-researcher Dunham-Taylor, found that nurse leaders who were rated most highly by their staff were people who were "highly motivated, optimistic and energetic", but they freely admitted and owned their mistakes. They viewed their staff members as "pivotal" to the organisation's success, their own roles being to support and facilitate others (Dunham-Taylor, 1995, p. 25). Excellent nurse executives made coaching of others (teaching, facilitating and mentoring) a feature of their work, as Lemire (2005) also found. They had a sense of humour which helped them to keep perspective and balance. They tried to put the most important issues first, thereby practising effective decision making. These nurse leaders valued fairness, excellence, credibility, and respect for the individual, and they identified integrity and morality as necessary characteristics for leadership (Dunham-Taylor, 1995).

Creating Psychological Safety

Research into organisational behaviour by Amy Edmondson, a researcher at Harvard Business School, has shown that effective leadership at the work group level is very important, because team leaders have a commitment to improvement, and the power to create an atmosphere of trust. Edmondson's research found that teams of nurses who had the highest reported error rates were more comfortable with one another, and with their managers. Their team leaders (managers) valued a collaborative, problem-solving work style, and showed respect for their team members, thereby enhancing psychological safety. Conversely, teams with low error-reporting rates worked under authoritarian managers, and frequently blamed others for their problems (Pearce, 2002).

Beliefs about failure, mistakes, and learning can vary widely between teams within the same organisation. Effective leaders, however, acknowledge their own mistakes, and they play a major role in encouraging open communication across groups and ranks,

thereby enabling difficult issues to surface. Leaders who coach and provide clear direction to their subordinates in these ways create the most learning-focused, psychologically safe teams (Pearce, 2002).

Problem-Solving Behaviour of Nurses

Research into healthcare organisations has shown that dominant patterns of problem-solving behaviour among hospital nurses are a source of resistance to organisational change (Tucker, Edmondson & Spear, 2001). Nurses who encounter problems in their work commonly use only first order problem solving (PS), which is solving only the *immediate* problem, rather than second order PS (which deals with the root problem as well as the immediate problem). Tucker et al.'s research identified three critical aspects of the work environment which prevented nurses from using second order PS:

- nurses had heroic attitudes about their ability to care for and protect their patients
- they lacked time in their work cycles, and easy and convenient communication channels with people who could help
- nurses had lower status relative to doctors and administrators, and so were often reluctant to intrude upon a physician's time (Tucker et al., 2001).

Nurses rarely engaged in root cause removal of a problem, and then usually only to communicate that they had experienced a problem. This dramatically reduced the organisation's potential for learning and improvement, because only a small percentage of problems were revealed (Tucker et al., 2001). In contrast, defining the problem and altering its underlying cause could prevent recurrence, and so improve organisational performance (Fabre, 2005; Tucker et al., 2001).

Hospital work environments can therefore be improved by attention to second order problem solving, to hospital culture and micro-cultures within the organisation, and to leadership behaviour (Edmondson, 2004). Hospital organisations can make a commitment to the promotion of organisational learning, and the development of psychologically safe team environments.

Emotional Competencies for Effective Leadership

It has been recognised that nurses work in many healthcare services, but they are rarely hired as managers on the basis of emotional competencies necessary for superior leadership (Mathena, 2002; Snow, 2001). Emotional Intelligence is a recent behavioural model which was developed by psychologists in the 1970s and 1980s, but became prominent with Daniel Goleman's 1995 book called 'Emotional Intelligence.' This characteristic determines how much of our potential we use for work performance, and has become increasingly relevant to organisational development and human resource planning (http://www.businessballs.com/eq.htm). Goleman developed an emotional competence framework based on emotional intelligence (EQ = emotional quotient), as opposed to IQ or conventional intelligence (IQ= intelligence quotient). EQ consists of

- Personal competence: self-awareness, self-regulation, self-motivation.
- Social competence: social awareness, empathy, social skills (http://www.danielgoleman.info/blog/).

Snow, a nurse researcher, supports the idea that emotional intelligence (EQ) is necessary for superior leadership (2001). She describes EQ as interpersonal skills, innovation, networking and partnership. For outstanding performance, Snow states that nurse leaders need to have some competencies in all areas of EQ. These competencies are:

- self awareness (self-confidence, accurate self-assessment)
- social awareness (empathy, understanding others' perspectives, organisational awareness)
- self management (self control, adaptability, trustworthiness)
- social skills (visionary leadership, teamwork, conflict management, and development of others) (Snow, 2001).

Thus for effective leadership it appears that one must possess and/or develop essential personal and social competencies, including having self-confidence, knowing the organisation, understanding the perspective of others, and having the skills and insight to manage oneself and others in the workplace.

Features of Nursing Leadership in Magnet Hospitals

Data from the original magnet hospital study in 1983 indicates that Directors of Nursing (DONs) are "absolutely critical to the development of a positive nursing situation" (McClure, Poulin, Sovie & Wandelt, as cited in McClure & Hinshaw, 2002, p.11). High-quality nursing leadership attracts and retains more high-quality nursing leadership, so creating a positive and supportive environment. DONs in magnet hospitals have been found to be well educated, and active professionally outside of their own institutions. The organisational structure of magnet hospitals usually places DONs at executive level, reporting directly to the Chief Executive Officer (CEO), and their titles reflect this relationship (McClure et al., as cited in McClure & Hinshaw, 2002).

Common themes which illustrate decentralisation within magnet organisations are that nurses feel a sense of control over their immediate work environment because they have opportunities to formulate the budget, and to experiment with innovative staffing patterns. For example, new and flexible arrangements for work schedules can be

created and implemented by head nurses and staff, without needing to process them through various layers of hierarchy for approval. Shift rotation is usually minimised, and great efforts are made to reduce the number of weekends worked (McClure et al., in McClure & Hinshaw, 2002).

Nurse staffing levels in magnet hospitals are important, in particular the quality and quantity of staff. Clinical nurse specialists are employed, who add a dimension of nursing expertise not otherwise available to patients and their families. Salaries and benefits for nurses are competitive amongst magnet hospitals, or ahead of other hospitals in their communities. Opportunities for nurse promotion include the traditional managerial positions, and have been extended to clinical ladders that reward increased competence and expertise with title as well as salary changes. Committees retain significant nursing involvement, and focus on such areas as recruitment, nursing research, patient teaching, clinical ladders and in-service education (McClure et al., in McClure & Hinshaw, 2002).

Staff nurses in magnet hospitals regard professional practice as autonomy, primary nursing, professional recognition, respect, mentoring, and the ability to practise nursing as it should be practised. Attention to the organisational culture includes the transmission of these cultural values by staff to newcomers. Nurses have also gradually accepted the need for "cost awareness or fiscal responsibility" in practice (Kramer & Schmalenberg in McClure & Hinshaw, 2002, p.52); this is possibly because they are involved in their own unit budgets, and therefore gain better understanding of funding issues.

Many published studies build evidence as to the value of magnet hospitals, and they are considered the "gold standard" for creating optimal work environments for nursing and

patient outcomes (Goode, Krugman, Smith, Diaz, Edmonds & Mulder, 2005, p. 203). Achieving magnet status requires submission of a portfolio to demonstrate how the organisation meets standards set by the American Nurses Credentialing Center (ANCC). But before this, institutional leaders may need to spend years creating a culture that enables nurses to practise in an environment which promotes and supports individual growth, while facilitating delivery of high-quality care. Organisations which are committed to attaining magnet status must therefore start early to develop an education plan for nursing and non-nursing groups, so that the whole organisation can become knowledgeable about the magnet process (Goode et al., 2005).

In 2007 New Zealand gained its first accredited magnet institution. The Hutt Valley District Health Board (HVDHB) is the first New Zealand DHB to seek accreditation as a magnet hospital (NZNO, 2006/2007), and in June 2007 was successful, after more than four years of hard work (Magnet Project Document Writing Team, 2007).

Summary

Theories of leadership provide a basis for understanding why some individuals are exceptional leaders, and others only mediocre. Business research in diverse organisations shows that psychological safety exists at the level of work teams, and that leadership characteristics, skill development, and emotional competencies are important for the creation and maintenance of psychologically safe, positive hospital work cultures.

Chapter Six will provide a definition of healthy work environments, and a summary of effective nursing leadership and its positive impact on nurse retention.

CHAPTER SIX

EFFECTIVE NURSING LEADERSHIP POSITIVELY INFLUENCES ORGANISATIONAL CULTURE

Effective nursing leadership is known to increase job satisfaction and promote retention of hospital nurses (Hayes et al., 2006), and if organisations are to learn better ways of working together, then effective leadership is required at all levels (Carroll & Edmondson, 2006). However, corporate mission statements proclaiming commitment to openness and to learning do not guarantee that this will happen in an organisation (Edmondson, cited by Pearce, 2002). This chapter will summarise ways to develop effective nursing leadership and promote positive organisational cultures to retain qualified nurses.

Nursing Shortage Imposes a Vicious Cycle of Costs

The costs to an organisation which does not retain its nursing staff are significant. Nurse turnover includes many hidden costs in the form of advertising, interviewing, training, and providing orientation and ongoing support for new staff. Organisations may experience higher costs to staff their facility during transition periods, and because new staff are initially less productive (Fabre, 2005).

In the U.S., the Nursing Executive Center stated in 2000 that a typical accounting cost for a medical/surgical or specialty nurse represented only 24% of the real cost, because productivity costs were hidden (Nursing Executive Center, as cited in Fabre, 2005).
In New Zealand, the annual cost of nursing turnover was estimated by the Ministry of Health in 2002 to be NZ$40,000 for each registered nurse (MOH, 2002/03). However "international benchmarking" of overall nursing turnover costs was calculated at "about… $48,000 (NZ) per nurse" (MOH, 2002). In 2004, recruitment of nurses alone

was costing District Health Boards (DHBs) $100 million per year (NZNO, 2004). In 2007, Associate Professor Nicola North and her research associates reported a high turnover of public hospital nurses around the country, with nearly 40% of staff nurses leaving their jobs each year. Just as concerning was their finding that 73% of those nurses were being replaced by new graduate nurses, or by overseas-trained nurses, with these groups being the most expensive for healthcare organisations in terms of on-the-job training ("High turnover a problem for nursing workforce," 2007).

It is clear that strategies must be designed to address this problem. Fabre (2005) suggests that some organisations spend large amounts of money to recruit and train new nurses, but invest little to keep them. Therefore, in order to reduce nurse turnover, managers and nurse leaders should be coached in ways to improve nurse retention, including providing flexibility with scheduling of nursing staff, forming solid relationships with nurses by showing them respect, building trust, using effective communication, providing delegation and enabling nurses to make on-the-spot decisions about practice. If coaching of managers/nurse leaders results in reduced nurse turnover, then the organisation saves in recruitment, orientation and overtime costs (Fabre, 2005).

To protect recruitment into nursing and the future of nurses, their image must also be protected within the media (Auckland University of Technology (AUT), 2006; Gordon 2005), and even in primetime medical TV dramas. Research shows that entertainment television of this kind has a marked effect on the public's perception of health care (AUT, 2006), thereby damaging the image of nursing.

Healthy Working Environments

Other strategies to reduce nurse turnover include the New Zealand Guidelines for Healthy Working Environments, released in 2006 by the Health Workforce Advisory Committee (HWAC) of the MOH. These Guidelines were intended to encourage the health and disability sector to develop positive workplace environments to recruit and retain staff. The six core principles are organisational culture, leadership and decision-making, change management, information and knowledge-sharing, career development and employee recognition (HWAC, 2006).

However, this is a recurring theme: the provision by HWAC of general principles such as these does little to ensure that healthy working environments are pursued by healthcare organisations in New Zealand.

Nurse researchers in Canada recently carried out a systematic review to examine evidence about nursing leadership which was effective in fostering healthy work environments (Pearson et al., 2004, p.145). Healthy work environments *amongst nurses* were found to be characterised by the promotion of physical and mental health; job and role satisfaction; positive inter-staff relationships between nurses, physicians, teams and management; opportunities for professional development; participation in decision-making; autonomy and control over nursing practice and the work role; evidence of strong clinical leadership; and demonstrated competency and positive perceptions of the work environment, including work-life balance. Further evidence for nursing was as follows:

- the existence of desirable retention and recruitment rates
- low absenteeism, illness and injury rates
- low involuntary overtime rates
- low unresolved grievance rates

- low levels of nurse job strain and burnout (Pearson et al., 2004).

Healthy work environments in hospitals had positive effects on patient care, characterised by reductions in patient length of stay, acceptable costs per case, and the delivery of observable high quality patient care (Pearson et al., 2004). Studies show that magnet hospitals and other high-performing organisations focus on more than just reducing injury risks, absenteeism, or turnover. Instead, they have a truly holistic approach to healthy workplaces, and work-life balance is recognised as an increasingly important measure of “employee well-being” (Lowe, 2006, p.42).

Developing Effective Leadership

Choices and responsibilities for effective leadership lie with administrators within the organisation, and not just with individuals indicating an interest in leadership. Fabre (2005) suggests that a complete job description should be discussed with candidates before selection, in order to clarify expectations, and to reduce nurse leader burnout and turnover. Mentorship and orientation programs can also assist clinical nurses in their transition to managerial positions (Laborde & Lee, 2000); performance standards should be well-defined, and ongoing feedback provided (Thompson, as cited in Laborde & Lee, 2000).

Management of Change

The building of trust in the workforce, and the empowerment of employees are very important elements of good work climates, particularly in restructured organisations (Laschinger, Finegan, Shamian, & Casier, 2000). Corporate upheaval of healthcare environments in hospital settings results in ambiguity, and weakening levels of trust. The latter are observable psychological dynamics which create increasing costs for

organisations in terms of lost talent, productivity, and adverse effects on patient care (Pritchett, in Mathena, 2002).

Change processes may be negative for many senior personnel involved in day-to day planning and implementation (Gauld, 2003). But where there is robust feedback and staff members are given adequate support, organisations are better able to respond to emerging challenges. Reliable information channels should be implemented, to ensure that information flows are two-way (Gauld, 2003). Nurses can collaborate and strengthen the whole organisation if they understand the rationale behind organisational plans (Fabre, 2005). Change is an inevitable process, and a critical component of quality and safety improvement in the health sector; however comprehensive and effective communication is vital, to support the health workforce, listen to their concerns, and gain their understanding and collaboration.

Creating a Positive Culture to Empower and Retain Nurses

The reputation of an organisation within a community will influence where nurses wish to work. Nurses' collective knowledge should be valued as intellectual capital for the organisation, and as such, one of its most important assets. Employers can promote respect for nurses, and zero tolerance for active and passive forms of disrespect (Fabre, 2005). The professional care given by nurses should also be described clearly to the public, to explain why their knowledge and skill protect patients from danger and risk (Gordon, 2005).

Conclusion

Nursing shortages are not just an organisational challenge. The global nursing shortage is real, and serious efforts are required on the part of government and DHBs to ensure

that RNs and ENs are retained in New Zealand hospitals to develop long-term, satisfying careers.

Various economic policies from government have placed severe constraints on health spending, and have led to more attention being focused on the effectiveness of treatments and services, and ways of rationing health care. Continued restructuring of the health sector over the last 25 years has been largely detrimental to public health in New Zealand, and to relationships between government health officials and health professionals in the workforce. There is considerable documentation of health professionals' concerns about health sector reforms, especially in the late 1980s and early 1990s. Valuable lessons should have been learnt by policy makers, politicians and health administrators to prevent this type of restructuring, without adequate evidence and consultation, ever happening again in New Zealand.

As a consequence of these reforms, the national nursing workforce has been significantly diminished. Current policies of importing overseas-trained nurses are unsustainable due to the increasing worldwide shortage. More efforts must be made to improve working conditions within New Zealand DHBs, to support educated nurses back into the health workforce, and to encourage NZ nurses working abroad that satisfactory workplaces and employment are available on their return.

Retention strategies that ensure nurses have a sense of satisfaction and achievement in their job are critical to promoting long term commitment to their employers, and to the nursing profession. To maintain and improve workforce levels, more flexibility is required with nurses' hours of work, and nursing workloads must be measured and recorded as accurately as possible. Nurses need adequate protection from undue stress in order to give good quality patient care. This means nurse leaders treating nurses with

respect, and facilitating psychologically safe nursing work environments with enough nursing staff, nursing time and resources to get the job done. Autonomous decision-making in practice must be supported, as well as continuing education courses and promotional career ladders for nurses. Attending to the root cause of problems may cause many other organisational issues to surface, which can then be resolved for the benefit of the entire institution.

Effective nursing leadership has a very big part to play in establishing and supporting a hospital culture which assists in nurse retention. Effective nurse leaders are visible, and have good listening and communication skills, mentoring, and emotional competencies, in addition to the technical skills and clinical understanding necessary for the positions they hold. They develop close working relationships and high levels of trust with others, so they can impart their energy and vision for the future. Nurse leaders must also be honest and ethical, and have the courage to stand up for nursing to hospital management, and to the New Zealand government.

The Magnet Recognition program offers plausible solutions to the escalating problem of nursing shortages in New Zealand. International nursing workforce experts have repeatedly explained that magnet hospitals provide greater autonomy and give nurses greater control over their work, thereby improving nursing morale and patient care. Magnet values will assist in the development of effective, well educated, ethically minded, high quality nursing leaders. Positive and dynamic organisational cultures must be created to retain professional nurses who can gain personal growth and job satisfaction from working in New Zealand hospitals.

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