Nurses worth listening to

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EXECUTIVE SUMMARY

In 2001 the University of Southern Queensland (USQ) in conjunction with the Queensland Nurses’ Union (QNU) undertook a study of enrolled and registered nurse and assistant-in-nursing members. In Queensland, registered nurses (RNs) and enrolled nurses (ENs) are qualified to practice nursing and are licensed by the Queensland Nursing Council (QNC), an independent body responsible for the setting and maintaining of nursing standards in the State. Although not licensed by the QNC Assistants in Nursing (AINs) work within a nursing model of care. These workers may also have other titles such as Personal Care Assistants or Carers. Regardless of their title, they work under the direct or indirect supervision of a RN.

The study was confined to nurses employed in the public sector (acute hospitals, community health), the private sector (acute hospitals and domiciliary nursing) and the aged care sector (government and non-government). In 2004 a similar study was conducted.

The major findings of the 2004 study were that nurses believed:

- nursing is emotionally challenging and physically demanding
- their workload is heavy and that their skills and experience as a professional nurse are poorly rewarded (remunerated or recognised)
- work stress is high and morale is perceived to be poor and, similar to 2001, deteriorating
- there are insufficient staff in their workplace and that the skill mix is inadequate
- the majority of nurses are unable to complete their work to their level of professional satisfaction in the time available.

While there were some changes between 2001 and 2004 (some could be seen as improvements, others deteriorations), the overwhelming impression one has, especially from the qualitative data, is of a workforce frustrated and unable to provide safe and quality care to their patients/clients within the time allocated.

Some aspects of this study (for example, the increase in reports of workplace violence) require further investigation. For example, it is unclear as to whether workplace violence has increased or whether, due to an increased awareness of what constitutes workplace violence, nurses now recognise workplace violent behaviour.

The aim of both studies was to identify the factors impacting upon nursing work and to use the results to inform strategic planning of the QNU. The research questions of the 2004 study were:

- from the perspective of members of the Queensland Nurses’ Union, what were the factors impacting upon nursing work in Queensland?
- how satisfied were members of the Queensland Nurses’ Union with nursing work in Queensland?
- have perceptions of and satisfaction with nursing work changed during the period 2001 to 2004?
This report outlines the findings of the 2004 study. Comparisons are provided between the 2001 and 2004 studies if the same question was asked. The results are reported for each of the three sectors.

Of the 3000 participants (1000 from each sector) invited to participate in the 2004 survey, 1349 responded, representing an overall response rate of 45%. Response rates varied between the sectors (aged care 52%, public sector 45% and private sector 48%). In 2001, a total of 1484 nurses responded to the 2800 mailed surveys (51% return rate). Similarly there were some differences in the return rates across the sectors (47% aged care, 53% public and private sectors).

Data were gathered using a mail-out questionnaire containing 77 questions divided into eight sections – Your Current Nursing Employment, Your Working Hours, Your Working Conditions, Your Responsibilities Outside Work, Your Professional Development, Your Experience in Nursing, About You, and You and the QNU. The questionnaire and survey procedure were pilot tested before adoption. One reminder was sent to non-respondents four weeks after the initial mail out. In 2004, all quantitative data were scanned into the software program Verity TeleForm Version 9. Qualitative data were typed verbatim into a word processing document.

Quantitative data were analysed within and across the three sectors using descriptive and inferential statistical tools as appropriate to the scale of measurement involved. Also, where appropriate, 2001 and 2004 results were compared within each sector. In order to contain the false positive error rate, only inferences supported at the one percent level of significance are reported except where more than one sector exhibits a similar trend or where there is prior expectation of an effect. In these cases a five percent level of significance has been invoked. It should be noted that because the number of nurses in each of the sectors in the QNU database are not proportional to the number of respondents in each sector, measure averaged over the three sectors must be weighted to be valid. The appropriate weights for the 2004 data are 17.8%, 65.8% and 16.4% respectively for the aged care, public and private sectors.

There were three questions that collected qualitative data. The verbatim data were analysed question by question for each of the sectors. A content analysis of the data was then carried out to identify emergent themes and sub-themes within each sector for each of the three questions.

The study was approved by the University of Southern Queensland’s Human Research and Ethics Committee.

As each sector analysis was different, an overview of the major findings for each sector are discussed below.

**Aged Care Sector**

Reflecting the nature of work in aged care, these nurses were more likely to report that nursing work is emotionally challenging and physically demanding and that the workload is heavy. They also believed that an insufficient skill mix is impacting upon their workload. They were the most likely to believe they cannot complete their work
to their satisfaction within the paid time available, however this has improved since 2001. They also believe that ‘very seldom’ are there sufficient staff employed to meet patient/resident needs. Similarly, these perceptions have improved since 2001. Additionally, nurses in this sector were more likely to believe that too many unregulated care providers (has improved since 2001), lack of funding, employer policy on skill mix and too few experienced staff impact upon skill mix in their facility. They were the most likely of nurses in the three sectors to be replaced when on leave. They were more likely to report the workplace is safe and well-equipped. Nurses in this sector were more likely to indicate that a workload committee/process was in place than they were in 2001. However, nurses in this sector were more likely to believe that the committee or process was effective than nurses in other sectors.

Similar to the other sectors, nurses in this sector have reported an increase in workplace violence since 2001. In the aged care sector, the most common sources of this violence are clients/patients, medical practitioners, nursing management, other nurses, and visitors/relatives. The last three of these sources have all increased since 2001. They believe that workplace violence impacts upon workplace safety. The older the nurse in this sector, the more likely they are to report experiencing workplace violence. AINs and ENs were more likely to report workplace violence than RNs. Nurses who report low morale are more likely to have reported workplace violence, with those nurses reporting ‘extremely’ poor morale more likely to have been subjected to workplace violence than other nurses. Male nurses were more likely to report experiencing workplace violence than female nurses.

Permanent full-time nurses in this sector were more likely to work unpaid overtime or Time Off in Lieu (TOIL). However, they were also more likely than nurses in the other sectors to be able to take accrued TOIL. They are more likely to work on fixed non-rotating rosters and least likely to work on a request-based rostering system. They were least likely to be satisfied with rostering practices. Older nurses in this sector were more likely to be satisfied with the rostering system. Reflecting the fact that RNs have more input into the roster in their work unit, RNs, rather than ENs or AINs were the most satisfied with rostering practices.

The fact that the nurses in this sector are older (and the average age of nurses in this sector has increased since 2001) and they were less likely to have dependent children (decreased since 2001). In those nurses who indicated they had dependent children, these children were likely to be older than dependent children in the other sectors. In all sectors, childcare was seen to be inadequate, however, in the aged care sector nurses were more likely in 2004 than they were in 2001, to see the reason for this inadequacy as the inflexibility of childcare services. Nurses in this sector have reported a slight improvement in their perception of the adequacy of childcare since 2001.

They were most likely to indicate that family responsibilities influenced the hours they were available for work. However they were most likely to say that support for family responsibilities was adequate. Nurses in this sector were more likely to have a dependent spouse, dependent elderly relative or dependent disabled or ill family members.
Nurses in this sector were more likely to have had a longer break from nursing and, as a consequence, were more likely to have undertaken a re-entry program. Compared to nurses in the other sectors, they are more likely to have taken a break from nursing because of family responsibilities and are less likely to have taken this break as paternity/maternity leave. They are also more likely to have taken a break from nursing: due to ill-health, because they have lacked motivation or encouragement to continue their nursing career; or to go to a better paid position. While similar to the percentages of nurses in other sectors, the numbers leaving left to pursue further education, have increased since 2001.

These nurses have the most (over 35 years) or least (less than 10 years) experience in nursing. Reflecting the older workforce in this sector, these nurses are more likely to indicate they will leave nursing earlier than nurses in the other sectors.

With regard to education and training, the nurses in this sector are more likely to participate in workplace training by watching a training video but less likely to receive funding from their employer to attend a conference or seminar. While they often attend a talk or lecture within the facility, the number doing so has decreased since 2001. They are the least likely to have education and training activities funded by their employer. In contrast to the other sectors, nurses in this sector identified that the most common support given for education and training was in the form of meals. Possibly reflecting their older dependent children, they are less likely to identify family commitments as a barrier to education and training.

Aged care sector nurses are more likely to believe there is adequate support for new graduates and orientation for new staff. In particular, older nurses in this sector are more likely to believe this than younger nurses. They are also most likely to believe that nursing is a high status career and one that is valued by both the health system and the community. However, like nurses in the other sectors, half of the aged care sector nurses perceived morale to be low and over half considered morale to be deteriorating. Reflecting their low morale, they have the highest levels of reported workplace stress, believe their colleagues are unsupportive and are most dissatisfied with remuneration.

The nurses in the aged care sector, while working the shortest minimum and maximum shifts (these lengths have reduced since 2001), are more likely to be employed on a permanent part-time basis than a permanent full-time basis. They are the least likely of all nurses to work double shifts, though working double shifts has increased since 2001. Permanent part-time nurses in this sector work more paid overtime, and are most likely to indicate they wish to be permanently contracted to work more shifts. They are least likely to work continuous shifts or Monday to Friday shifts only. They are more likely to be employed on evening only shifts.

**Public Sector**

With regard to skill mix, nurses in the public sector are more likely to believe that too many inexperienced staff (this has decreased since 2001), too many casual staff and too few relief/agency staff (increased since 2001) and lack of funding (decreased since 2001) are all affecting skill mix. The perception of too few
experienced staff has increased since 2001. Despite these views on what affects skill mix the public sector nurses in 2004 reported skill mix as adequate and more respondents were likely to say, in 2004, there were sufficient staff to meet patient needs. Nurses in this sector are more likely to state that nurses are replaced when taking leave since 2001, however, this sector was the least flexible with regard to annual leave been taken at a time suitable to the nurse. In this sector, however, it is more likely that a workplace committee/process for workload is in place. Although there has been an increase in workplace committees/process since 2001 nurses in this sector were the most likely to believe that the committee was ‘never, very seldom or seldom’ effective.

Similar to other sectors, there has been an increase in reports of workplace violence since 2001. Clients/patients are the most common source of workplace violence in this sector (this has increased since 2001). Other sources of workplace violence in this sector are: visitors/relatives (highest of the three sectors and an increase since 2001); nursing management (increase since 2001); medical practitioners (no change since 2001); and other nurses (increased since 2001). Nurses in this sector associate the level of safety in the workplace with workplace violence. Male nurses are more likely than female nurses to report experiencing workplace violence. Those nurses who reported low morale were more likely to experience workplace violence. Nurses in this sector are most likely not to know if there is a workplace violence policy in place to manage workplace violence from other staff. In this sector, there has been an increase in the percentage of nurses who are aware of a workplace policy for clients/patients/visitors/relatives since 2001.

Morale in this sector is also not high. More nurses in this sector believe that autonomy is discouraged. They are also more likely to state that their workplace is unsafe. They are least likely to believe that their work is physically demanding.

The mean age of nurses in this sector, in line with other sectors, has increased since 2001. There are more male nurses employed in this sector. Nurses in this sector are also more likely to hold endorsements such as midwifery (though this has decreased substantially since 2001), mental health, immunisation, sexual health and rural and isolated practice than nurses in the other sectors.

Nurses in the public sector are more likely to be continuous shift workers and be employed on a permanent full-time basis than nurses in the other sectors. There are also a higher proportion of nurses employed on a temporary part-time basis in this sector than other sectors. Nurses in this sector work the longest minimum shifts, and are the least likely to take accrued TOIL. There has been an increase in nurses in this sector reporting they work double shifts since 2001. Nurses in this sector are the most dissatisfied with their working hours.

RNs in this sector are more satisfied with, and have more input into rostering practices than ENs. Younger nurses in this sector are more likely to have input into their roster than older nurses.

This cohort is more likely to state they have accessed family leave. This may be a result of the age of nurses in this sector, or it may be that the entitlement to family leave is promoted/advertised more widely. Nurses employed on a casual or part-
time basis are more likely to report that the support they have available to care for family members is inadequate. They have the youngest dependent children. Similar to the aged care and private sectors, nurses with dependent children saw childcare support as inadequate. However, there has been some slight improvement in this perception since 2001. In this sector nurses were more likely in 2004 than in 2001 to identify this inadequacy with the non-availability of vacation care and the childcare centre being in an inconvenient location.

Public sector nurses report more access to education and training (this has increased since 2001) and are more likely to report that employers have fully or partially contributed to their education and training. Nurses in this sector are more likely to be funded for registration fees, accommodation and travel than nurses in the other sectors. Since the 2001 study, there has been an overall decrease in the percentage of nurses watching a training video, a satellite broadcast, attending talks or lectures within the health facility and attending a conference or seminar. However, in 2004, public sector nurses are more likely to attend a workshop, watch a satellite broadcast and enrol in a course/program than nurses in other sectors. Fewer nurses in 2004 than in 2001 are stating that study commitments are impacting upon working hours.

**Private sector**

With regard to workload and skill mix, the nurses in this sector report too many agency staff, lack of funding, too few relief/agency staff (this has increased since 2001) as impacting upon skill mix. Nurses in this sector are more likely to say that employer policy on skill mix is affecting skill mix in 2004 than they were in 2001. With the exception of leave for education and training which has decreased, nurses in this sector are more likely to be replaced when on leave in 2004. These nurses are less likely to have a workload committee/process in place than nurses in the other sectors. There has been an increase in the percentage of nurses reporting the availability of a workload committee/process, however, nurses in this sector are less likely in 2004 than they were in 2001 to believe that this committee is effective.

Similar to the other sectors, the nurses also report an increase in workplace violence since 2001. The source of the increased reports is from patients/clients, visitors/relatives and nursing management. In contrast to the other sectors, nurses in the private sector are more likely to report workplace violence from medical practitioners (although this has not increased since 2001). Both RNs and ENs in this sector report an increase in workplace violence from 2001. Nurses who are employed on a permanent part-time basis are more likely to report workplace violence from medical practitioners (although this has not increased since 2001). Both RNs and ENs in this sector report an increase in workplace violence from 2001. Similar to nurses in the other sectors, there is an association between perceptions of the level of safety of the workplace and workplace violence. The lower the morale of these nurses, the more likely they were to report incidences of workplace violence. Nurses in this sector are more likely to not know if there is a workplace violence policy in place for dealing with violence from other staff.

The mean age of nurse in this sector has increased since 2001. Nurses in this sector are also more likely to hold a midwifery (this has substantially decreased since 2001) and mental health endorsement than nurses in the aged care sector.
The percentage of nurses employed in this sector who have a disability has increased since 2001.

Nurses in this sector are more likely to work Monday to Friday shifts only. They work the longest maximum shifts, and length of both maximum and minimum shifts has increased since 2001. The nurses in this sector are more likely to cite family responsibilities as affecting the hours they are available for work. Those who are employed on a part-time or casual basis are more likely to report that the support they have available to care for family members is inadequate. Childcare was seen to be inadequate and for nurses in this sector the cost of childcare has become a greater issue than it was in 2001. Similarly, the absence of emergency childcare has also increased as an issue since 2001.

With regard to education and training these nurses are more likely to attend a conference or seminar. They report access to more paid leave than nurses in the other sectors. They are more likely to state they cannot afford the fee for education and training than nurses in the other sectors.

This cohort of nurses has the poorest perception of support for new graduates.

Conclusion

The results of this study suggest that recruitment and retention issues will continue to face nursing in Queensland for some considerable time in the future. The data suggests that patient workloads remain problematic. International studies provide clear evidence that the patient to nurse ratio is not only related to patient outcomes but also to the length of stay (shorter when lower) and job satisfaction.

It is apparent that there are many variables in this study which will have an adverse affect on nurses’ job satisfaction. In particular many of the nurses in this study do not believe that they have the ability to delivery quality individualised care.

The increasing levels of workplace violence would be the most significant change in the data from 2001 and 2004. Workplace violence also affects recruitment and retention within the nursing workforce.

Many factors have been found in other studies to influence a nurse’s decision to leave are also identified in this study. These are:

- family responsibilities – including pregnancy and lack of childcare
- remuneration
- workloads and staffing
- stress/frustration
- travel
- career opportunities
- lack of recognition of nursing work
- lack of authority to make decisions
- working conditions.
As has been stated before, recruitment strategies will fail if the workforce issues that
make nurses leave are not addressed. This study suggests that urgent attention is
needed to areas such as workload and workplace violence.

There are also sector differences in the data that require some attention. In
particular, there was a large level of concern raised by the aged care nurses about
unregulated care providers being allowed to administer medications.

A major concern surrounding the results of this study is that poor staffing numbers
and skill mix do impact on patient safety, length of stay and patient outcomes.
Unless these factors are addressed, not only will the nursing workforce continue to
leave nursing, but it is possible that there will be increasing litigation against
employers of nurses who continue to ignore the international evidence on registered
nurse to patient ratios.
1.0 INTRODUCTION AND LITERATURE REVIEW

1.1 Background to the study

In 2001 the University of Southern Queensland (USQ) in conjunction with the Queensland Nurses’ Union (QNU) undertook a study of enrolled and registered nurse and assistant-in-nursing members. The study sampling was confined to nurses employed in acute hospitals, community health/domiciliary and aged care. For the purpose of the study, nurses were seen to be employed in three sectors – public (acute and community health), private (acute and domiciliary health) and aged care (public and private providers). The aim of the 2001 study was to identify the factors impacting upon nursing work and to use the results study to inform strategic planning of the QNU.

In 2004 a similar study was conducted with the same aim and with participants selected from the same sectors. The majority of questions asked in 2001 were retained for the 2004 study; however, some questions were modified and some new questions were added. The results are reported separately for the three sectors and, where appropriate, a comparison of the results of the 2004 and 2001 surveys is provided.

The 2001 and the 2004 studies received ethical approval from the Human Research and Ethics Committee of the University of Southern Queensland.

Of the 3000 participants (1000 from each sector) invited to participate in the 2004 survey, 1349 responded; representing an overall response rate of 45%. The estimated response rates and number of respondents from each sector (after adjusting for discrepancies in sector membership between the QNU database and survey responses, and after allowing for respondents who were no longer working in Queensland) were:

- 52% (n=428) aged care sector
- 45% (n=439) public sector
- 48% (n=475) private sector.

1.2 Literature review

1.2.1 Introduction

The Australian Bureau of Statistics (ABS) estimates that the Australian population will increase from 20 million in 2004 to between 24 and 28 million in 2050. While the population is increasing, so is the average age. For example, the median age of the Australian population has increased by 5.0 years during the past decade (from 30.5 years at 30 June 1984 to 36.4 years at 30 June 2004). The ABS projects that by 2050 the median age of the Australian population will increase by eight to eleven years.¹

A low birth rate contributes to the rise in median age, but the largest part of the increase is due to life expectancy. Whereas males and females born at the
beginning of the 20th century could expect to live for 55 and 59 years respectively, with the noted exception of Indigenous Australians, those born in 2005 can expect to live for 76 and 82 years respectively. 2

The increasing life expectancy and the decreasing birth rate ensure a larger number of older Australians. For example, for the year ending June 2004, the number of people aged 65 years and over in Australia increased by 58,500 (2.3%) and reached just over 2.6 million. This age group now comprises 13% of the total Australian population, an increase of 10.1% from 20 years ago. The older population is expected to continue to grow to around 6.5 million, or around one-quarter of the total population by 2050. 1

These increases will result in a greater demand for the employment of health care professionals. It is unclear how the demand for health care professionals will be met, particularly in light of the current shortage.

1.2.2 The impact of registered nurse shortages on patient care

Shortages of health professionals, particularly nurses, can result in poor patient outcomes. Recent research has linked the staffing levels of registered nurses with the number of urinary tract infections, pneumonia, upper gastrointestinal bleeding and shock in medical patients, and lower rates of ‘failure to rescue’ and urinary tract infections in major surgery patients. 3,4,5

Staff-to-patient ratios are used to demonstrate how understaffing and workload have an adverse affect on patient welfare. 6 One recent study exemplifies the effect of staff-to-patient ratios. The authors used cross-sectional analyses of linked data from more than ten thousand registered nurses (RNs), nearly a quarter of a million surgery patients and administrative data from 168 non-federal adult general hospitals in Pennsylvania, United States of America (USA). After adjusting for patient and hospital characteristics, they calculated that for each additional patient per nurse over a 4:1 ratio there was a seven percent increase in the likelihood of death in surgical patients. Furthermore, those patients in hospitals with the highest patient-to-nurse ratio (eight patients per nurse) had a 31% greater risk of dying than those in hospitals with four patients per nurse. 7

Other similar studies concur with these data. One such study reported on the New York State Public Employees Federation web site, which involved 2,190 hospitals, found that nurse staffing was a predictor of risk-adjusted mortality rates. The model showed that 10.7% of the variance in mortality is explained by nurse-staffing ratios. 8

The Department for Professional Employees, AFL-CIO 9, presented a fact sheet of the costs and benefits of improving staff-to-patient ratios. They note that 69% of hospital executives reported that the shortage of nurses had resulted in higher costs

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9 Department for Professional Employees is one of seven constitutional "trades" departments that are part of the American Federation of Labour – Congress of Industrial Organizations (AFL-CIO). The DPE currently represents 25 unions comprising of more than four million white collar workers. See http://www.dpeaflcio.org for more details.
to deliver care. Much of this was attributed to length of stay in hospital. For example, a Harvard School of Public Health study reported a 3-6% shorter length of stay for patients in hospitals with a high percentage of RNs. The Institute for Health and Socio-Economic Policy projects annual savings of about $2 billion a year for California hospitals just from the shorter patient stays that result from better RN staffing.¹⁰

Data such as this prompted the Australian government to commission The Australian Resource Centre for Hospital Innovations (ARCHI) to undertake a comprehensive review of literature on safe staffing and patient safety. Using a combination of health and non-health related literature, they presented papers that identified a range of quantifiable patient outcomes in relation to inadequate nurse-patient ratios. The reports’ authors recognised: a need to increase understanding of effective strategies that reduce fatigue and fatigue-related errors; the contributing factors that lead to poor communication in the workplace; physical and mental health of staff and their ability to provide safe patient care; and systems that prevent rule-based and skill-based errors in health care delivery.

The non-health literature reviewed by the study offers some insight for the development of these strategies, and has been incorporated into the recommendations for further research.¹⁰ Similarly, state governments are conducting their own research into the impact of nurse shortages on patient care. For example, in 2003 the New South Wales (NSW) government engaged a research team from the University of Technology in Sydney to undertake a three-year study into the responsibilities and workload of nurses, and how nursing shortages impact on health outcomes.¹¹

### 1.2.3 Shortage of nurses

The international shortage of health personnel is reflected in Australian data. Recent Australian information shows that of the 14 non-information and communications technology professions on the Australian Government’s Department of Employment and Workplace Relations national skills shortage list, 12 are health professions. Current nursing shortages on the register are general nursing, midwifery, mental health and enrolled nurses.¹²

Recently the International Council of Nurses (ICN) commissioned a report to assess the global situation of the nursing workforce. The overall conclusion was that there is a global shortage of nurses. Although variation exists among countries, it is the developing or low income countries that are most severely affected.¹³

The Organisation for Economic Co-operation and Development (OECD) has recognised that many of its high income member countries are affected, noting that ‘nursing shortages are an important [international] policy concern, in part because numerous studies have found an association between higher nursing staffing ratios and reduced patient mortality, lower rates of medical complications and other desired outcomes’.¹⁴
The USA estimates its nursing recruitment need as being in excess of one million registered nurses between 2004 and 2012\textsuperscript{15}, and the Canadian situation has been quantified as a shortfall of around 78,000 nurses by 2011.\textsuperscript{16} In the United Kingdom (UK) in 2002 the Royal College of Nursing (RCN) estimated that the number of vacancies for nurses was around 22,000 full-time equivalents.\textsuperscript{17} The college calculated that if retirement levels and other losses remained the same, the National Health System (NHS) would need to recruit 110,000 nurses by 2004.\textsuperscript{18}

At first glance the situation in Australia does not seem as bad. The 2002 Nursing Labour Force Survey notes an overall increase of 7,786 employed nurses from 1995 to 2002 with a total nursing population of 275,321.\textsuperscript{19} However, the rise in absolute numbers was accompanied by an increase in the proportion of nurses working part-time (48.8% in 1995 to 53.8% in 1999), and a decrease in average hours worked per week from 32.4 hours to 30.5 hours. These figures, when combined and adjusted for population increase, yield a net result of a fall in the national supply of nurses from 1,127 full-time equivalent nurses per 100,000 population in 1995 to 1,024 in 2001.\textsuperscript{19,20} The National Review of Nurse Education and Training projected a shortfall of 40,000 nurses by 2010 and the Australian Council of Deans also predict similar trends.\textsuperscript{21,22}

This shortfall is influenced in no small part by an ageing workforce and resultant retirements. At the national 1986 census, 23.3% of nurses were under 25 years of age. By 1999, however, this proportion had fallen to 4.3%.\textsuperscript{19} Corresponding yearly figures for those aged 45 and over had increased from 17.5% to 41.7%.\textsuperscript{19} From 1995 to 2001 the proportion of nurses aged less than 35 dropped over 8% and in those six years from 1995 to 2001 the average age of nurses increased from 39.3 to 42.2.\textsuperscript{19} The large increase in the 45–54 age group and a decrease in the under 34 age group suggests that the ageing of this workforce will continue for some years.\textsuperscript{19}

In addition to absolute numbers, workforce distribution is a key concern. Lists based on labour market intelligence undertaken by the Department of Employment and Workplace Relations show Queensland, South Australia and Western Australia had shortages against all categories of nurse specialisations in 2004, which was not the case in 2001.\textsuperscript{22} These shortages are unequally distributed, with greater shortages in Australia’s rural and remote and other disadvantaged areas.\textsuperscript{22} A similar situation is also found in the rural and remote areas of Canada and the USA and in lower socio-economic areas in cities such as London and Dublin.\textsuperscript{13}

Workforce shortages inevitably lead to understaffing within health facilities. However, shortages are more complex than the number of employees available for work. At the simplest level, shortage is an imbalance between need for services and the availability to meet that need. Shortages, therefore, can also be caused by economic influences such as a lack of funds to employ available nurses. In addition, choice influences workforce shortages, whereby nurses who choose not to work remove themselves from the pool.
1.2.4 Factors affecting supply

One way of overcoming the shortage of nurses available to work is to increase supply. This can be achieved by recruiting people into the profession, improving retention and encouraging nurses to return to the workforce.

1.2.4.1 Recruitment

Recruitment of nurses in some countries is being addressed successfully through active marketing of opportunities within the profession and improved conditions of service. For example, the UK Government has set a target to recruit more than 50,000 new nurses by 2008 to address the shortfall through the use of financial incentives, expanding roles and responsibilities and improved working conditions. In Canada a decade of fall in available registered nurses has been reversed by radical changes in policies including recruitment strategies.

There is an increasing pattern for developed countries to reduce their shortfall with recruitment from elsewhere. In the UK, overseas nurses account for 40 per cent of all new registrations and this is expected to continue to rise. Similarly, in the Australian state of Victoria, the five main source countries since the mid 1990s have been the UK, Ireland, New Zealand, the Philippines and Canada. In 2001, overseas registrants accounted for 28% of initial registrants in this state. These international recruitment policies have huge implications in the home countries, especially in developing countries where shortages are at a critical level.

A report based on research funded by the World Health Organisation (WHO), ICN and RCN provides a critical overview of the international recruitment situation. The research involved Australia, Ireland, Norway, UK and USA as destination countries and the Caribbean, Ghana, South Africa and the Philippines as source countries. Unlike many countries such as UK and USA which recruit nurses from lower income countries (e.g. Philippines and Indian sub-continent), Australia to date has recruited mainly from developed countries such as the UK and Ireland. However, this is likely to change, with the 2001 Senate Inquiry into Nursing making the recommendation that the Australian Government should ‘streamline visa arrangements and simplify the process of recognising overseas qualifications for nurses wishing to migrate to Australia on a permanent or temporary basis’. Recruitment alone is insufficient, as once nurses are recruited into the workforce, they must be retained. Bonner noted that ‘... the reality is we don’t have a problem with recruiting. Last year the demand for nursing places [in the higher education sector] exceeded supply by almost 100%... [What we] do have is a problem retaining graduates and experienced nurses long term’.

Similarly, Cowin and Jacobsson noted that Australian workforce planning has focused on nursing recruitment over and above that of retention. The authors stated that there is little point in pouring resources into recruitment if retention is poor. They noted that ‘there is no point in utilising resources to attract school leavers to the

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nursing profession when the health care workplace conditions are found to be so detrimental to the recruit that they are unable to be retained after graduation".30

1.2.4.2 Retention and turnover

Studies on retention and turnover suffer from ambiguity in definition. Retention is used to describe remaining within an organisation or a sector (e.g. private or public) or the profession. Retention and turnover are often used synonymously to refer to the departure and replacement of employees from their place of work. All too often the literature does not clearly delineate the differences between turnover and retention, and retention is frequently used as an all encompassing term for any departure regardless of final destination. For the purposes of this review we have made the separation between retention (remaining in the nursing workforce) and turnover (leaving a particular organisation or sector) when able to obtain this information from the literature cited.

Compounding the problem of lack of understanding whether the literature is referring to turnover or retention in the Australian environment, details are only available from the public sector. Thus, details of the 50% of the nursing workforce employed within the private sector are generally unavailable.

a) Turnover

Research on turnover demonstrates that deciding to stay or leave is a complex process not easily captured in a brief exit interview or letter of resignation.31 Measurement of likely turnover is a useful tool. Mitchell et al. adopted the construct job embeddedness from business management literature to compare retention health care workers and to predict employee retention in a health care setting.32 In this study, the authors found that the ‘embeddedness’ model was far more effective in predicting turnover than a combination of other more traditionally used measures of job satisfaction, organisation commitment and perceived alternatives.32 Moreover the study also reported that the factors for retention were similar for nurses as for other healthcare workers.32

b) Cost of Turnover

Staff losses are expensive. One report from the USA states that some organisations have a turnover of up to 40%.33 The author calculates the financial implications of loss of one individual registered nurse and replacement by another from the cost of the exit interview to the training of a new staff member as US$33,000 per individual.33

An international examination of the cost of turnover has been undertaken by researchers in Canada, where more than 30% of working nurses will leave the workforce by 2006 if they retire at 55. Using data from Australia, New Zealand, Canada and the USA, results from the pilot study showed turnover to be greatest in the USA, followed by Australia. Mean cost of turnover for the four countries was
calculated to be over US$21,000 per nurse. The cost for Australia: approximately US$16,000.\textsuperscript{34}

In contrast, other turnover calculations estimate costs to incumbent's salary. The cost to replace a Level 1 RN employed in the public sector at commencement would range from $20,000 to $92,115, excluding penalty rates, overtime and leave loading.\textsuperscript{35}

O'Brien-Pallas demonstrates that the direct costs of recruitment, temporary replacement and hiring can be exceeded by the indirect costs of termination and separation, orientation and training, and productivity of the new employee.\textsuperscript{34} The author considers that lost productivity is the major cost driver. She notes that it has been estimated that the cost of nurse turnover is four-to-five times higher than typically accounted for by hospitals, primarily due to lost productivity in the process of 'on boarding' a new employee.\textsuperscript{34}

c) Turnover Rates

In the USA, the Advisory Board Company estimated nurse turnover to be more than double the rates for professionals of comparable education and gender. Further, they noted that turnover rates were increasing – from 12% in 1996 to 15% in 1999.\textsuperscript{34} In contrast, it appears that turnover rates in Ireland are decreasing. For example, in 2002 there was a turnover rate of 10.7%.\textsuperscript{36} This contrasted with a turnover rate in 1999 of 17%. It is likely that factors such as improved pay and conditions of employment, more support for training and personal development opportunities, and the introduction of more flexible working opportunities, have had a positive influence.\textsuperscript{37}

In England and Scotland nurses who resigned in a 12 month period in 2002 demonstrated a higher turnover rate in both health visitors (16.1%) and district nurses (14.5%) than that for all registered nurses (13.1%).\textsuperscript{38} The Office of Workforce Economics also compared the data to the previous year for a sub-set of the National Health Trusts (representing about 25% of English Trusts). Data from this report revealed that some Trusts had a turnover rate for both district nurses and health visitors of 26%.\textsuperscript{38}

Struber cites figures for Australia of turnover rates in the public sector of 42% within two years and annual rural exit rates of almost 29% compared to metropolitan rates of 19%.\textsuperscript{39} Similarly, the Queensland Health Ministerial Taskforce on Nursing Recruitment and Retention (1999) reported that of the 21 Health Service Districts that had turnover higher than the state average of 20.2%, 18 were rural.\textsuperscript{40} Seven Health Service Districts experienced a nursing turnover rate of 28% or higher.\textsuperscript{40} The taskforce recommended that research be undertaken to establish the reasons for high turnover in rural districts. They also noted that low recruitment of nurses to rural areas was attributed to inadequate reimbursement of relocation expenses.

These turnover rates, however, were reported to have decreased to 15.5% in the period 1999 to 2000. The improvement was attributed to recommendations made by the Queensland Health Ministerial Taskforce on Nursing Recruitment and Retention
(1999) that included establishment of a nursing career advisory service, education programs, transition support, and new rostering practices.\textsuperscript{40}

Caution should be used, however, when examining turnover rate differences. Hegney argues that rates are lower in some rural areas than in remote or urban areas.\textsuperscript{41} The differences in rates she attributes to employment characteristics of rural nurses, where the partner’s occupation may be the reason for the nurse’s geographical location choice. She noted that the rate was highly variable from area to area, with the highest turnover of nurses in rural non-base hospitals.\textsuperscript{41}

Benchmarking research by Best Practice Australia (BPA) has looked into retention and turnover of nurses in Australia.\textsuperscript{42} The results reported to date are from the analysis of responses from more than 17,000 nurses employed in a combination of 110 public and private sector health care organisations throughout Australia and New Zealand.\textsuperscript{42} Their results suggest that 48% of nurses are at risk of leaving nursing and 41% of leaving their organisation. The combined at risk figure is 56%. Figures varied by state/territory (37% of nurses in Victoria were at risk of leaving the profession as compared to 53% in New South Wales, Australian Capital Territory and Queensland), location (10% more metropolitan employees were at risk of leaving the profession than those in the regional areas) and speciality (combined risk for orthopaedic nurses 71%, as compared to 50% in community health).\textsuperscript{42}

Although statistical analyses are not presented, there are some very clear trends from the data set. For example, the percentage of at-risk nurses in both categories falls with age 25 to >50. The highest at risk category is nurses aged 26 to 30. BPA places a conservative estimate of a cost of $20,000 to replace each nurse.\textsuperscript{42} Thirty one percent of nurses indicated that location of the organisation was the reason for their attraction to work there. This was followed by type of position (22%), development and experience (15%) and reputation (10%). Remuneration was only selected by seven percent.\textsuperscript{42}

Nurses were then asked to select from the reasons that they would consider leaving their organisation. Top reasons nurse gave were workload and staffing (33%), management (23%), shiftwork/hours (21%) and career/growth opportunities (16%).\textsuperscript{42} ‘The people I work with’ was given by 51% of nurses as the reason for staying in their organisation, followed by convenience (28%) and work enjoyment (24%).\textsuperscript{42}

d) Retention within nursing

Turnover or retention within an organisation is of great significance to the nursing profession; however, even more critical is retention within the profession, for which figures are difficult to obtain. For example, the Office of Manpower Economics (OME) reports that approximately nine percent of nurses left the NHS in the period March 2002 to March 2003.\textsuperscript{38} However, how many of these nurses entered non-NHS programs is not clear in the report. OME estimated that almost half of all nurses who left the NHS did remain in nursing, typically in non-NHS nursing posts or general practice nursing.\textsuperscript{18}
At the Australian population census in 1996, 19.8% of persons aged 15-64 years with their highest qualification in nursing were not in the labour force. A study undertaken in New South Wales in 2000 surveyed the state’s nurses who were not working in nursing in New South Wales at the time of their registration renewal in 1998.\textsuperscript{43} In the two years from 1998 to 2000, 11% of the 10,000 respondents to the study had moved into non-nursing careers, five percent had retired and a further 12% had moved overseas or interstate. From the results it was estimated that 16,000 of the state’s 100,000 registered nurses were not in the nursing labour force and of these 27% had been completely lost to nursing, having retired or never intending to return to the profession.\textsuperscript{43}

Retention issues start within the tertiary education process, where between 10% and 25% of students fail to complete their program.\textsuperscript{44} The figure is lower than for all of tertiary education. Clare et al. in their study for the Australian Universities Teaching Committee cite the reasons for departure range from academic to lack of clinical exposure early in the program.\textsuperscript{44}

e) Factors affecting retention and turnover

In the UK the reasons for retention problems in the NHS have been grouped under four broad headings: pay and the cost of living; the changing nature of the job; perceptions of being ‘valued’; and other employment opportunities. Other reasons for leaving the NHS include career breaks, retirement, maternity leave, nurse education, non-nursing work, and travel.\textsuperscript{18}

Certain groups of nurses have been repeatedly identified as more likely to leave the workforce (e.g. those in the youngest age groups and those in the lower paid groups). The research evidence demonstrates that there is a complex interplay between job satisfaction, career prospects, pay and household commitments. These factors are imperfectly understood for nurses in different types of labour markets. Key variables for retaining nurses are the perceived opportunities to care for people, to develop professionally, to gain autonomy and to participate in decision-making, while being fairly rewarded.\textsuperscript{45}

In the NSW Health study of nurses who were no longer working, the two main reasons respondents cited for leaving nursing were family responsibilities (28%) and to move into a role that was more suited to their lifestyle and responsibilities (10%).\textsuperscript{43} Common themes expressed were dissatisfaction with management, inflexibility of hours, low pay and lack of authority to make decisions.\textsuperscript{43}

Best Practice Australia asked nurses why they would consider leaving the profession. Pay was selected by 50% of nurses, followed by shiftwork/hours (34%), workload/staffing (33%), stress/frustration (23%), lack of recognition/respect (18%), management (15%) and career/growth opportunities (13%).\textsuperscript{42} A further 18 reasons, ranging from need to change to workplace bullying, were given by between one percent and 10% of the respondents.\textsuperscript{42}
When asked why they would consider staying in the profession, the nurses identified the following as the main influencers: the work (49%), money (28%), ‘the people I work with’ (26%), hours and shifts (19%), and current position/type of work (18%).

These data do not provide the reason why people have left (that is, they are not retrospective) however, they do provide a clear insight into the important issues pertaining to the profession.

So many factors have to be considered in the retention/turnover analysis. A major consideration would be the changes to nursing work in recent years – in particular, the impact of technology and health care restructures. It is therefore difficult to differentiate between factors that would result in turnover versus those that would primarily affect retention. Both will be dependent on the balance between factors for remaining and those for leaving. Alternative opportunities both within and outside of the profession will be key factors.

Factors that may influence the decision for change are usually broken down into categories such as personal, professional, educational, financial or workplace. It should be noted, however, that a recent paper by Morrell questioned many of the data collected to evaluate retention and turnover. He evaluated the reasons for nurses leaving based on his concept of exposure to shock, which he defined as a single, particular event that caused a nurse to think about leaving. One hundred and fifty-two nurses (out of 352 participants) from eight large NHS hospitals identified shock as a reason for leaving. He identified three broad clusters of nursing turnover. The first cluster was comprised of nurses whose decision to leave was precipitated by a work-related shock (e.g. a violent occurrence). In the second cluster were nurses whose decision to leave was precipitated by a personal shock (e.g. a spouse being relocated). Finally, there was a third cluster, which followed the conventional picture of how turnover occurs. This conventional picture follows a causal chain, in which dissatisfaction leads to an employee searching for another job, thus generating alternatives to their current job. The alternatives are then weighed against the current position and a decision taken.

Morrell noted that many analyses that are based on intent rather than action would not necessarily take into account the first two clusters and therefore have to be viewed with some caution. He concludes that it is important for management to be aware of different categories in turnover in order that plans may be put in place to minimise the occurrence or effect of shock.

**f) Remuneration**

Adequate remuneration for nurses is a topic often linked to job dissatisfaction and intention to leave. Complicating interpretation of the results of several studies of remuneration and turnover, is the fact that many studies ask nurses who are currently employed in the workforce, why they would leave. It could be argued that reasons given for intention to leave would be quite different to actual reasons for leaving. This caution on interpretation of the results extends to many studies on retention and turnover, where data are often collected on intent rather than action.
In the Best Practice Australia study, for example, 50% of the nurses who were still in the workforce stated that remuneration was a reason to leave the profession. This contrasts with the NSW Health study, which surveyed those nurses who had left the profession, and who did not rate remuneration as a major reason for leaving. The difference in perceptions of the importance of remuneration of nurses who are still in the workforce and those who have left the workforce is confirmed by Summer and Townsend-Rocchiccioli, who stated ‘the tangible reward of salary is less of an issue to those who leave’. Clare et al. citing a 1978 South Australian study investigating why graduate nurses were leaving, reported that not one respondent stated they were leaving due to salary issues, or because they did not like nursing. The key reasons given were pregnancy and childcare, travel, study, illness, work conditions, job transfers, or the unsuitability of shift work. However, in their recent study, they found the major reasons that nurses gave for leaving nursing included the lack of a career path, long working hours, poor work conditions and remuneration.

The perceived view that remuneration is the driving force to recruit and retain nurses is also questioned by Cowin and Jacobsson, who state there is ample evidence that the nursing profession has not responded to the usual strategies of wage adjustment. They believe that remuneration is not highly related to job satisfaction; however, when linked to organisational structure and career opportunities, it does become a significant factor. They note it is highly probable that a nurse will look towards the work climate and the amount of job related stress and trade off remuneration in lieu of a good working environment. Day’s research into morale in registered nurses in Queensland confirms Cowin and Jacobsson’s findings. He states that ‘while research has shown that non-monetary awards are more important, remuneration provides a tangible basis to rank [nursing] … against … [other professionals] in terms of societal worth or value.

There may be particular times and circumstances when the financial rewards become an important consideration for retention. For example, it was found that for new graduates the issue of remuneration became a significant area of dissatisfaction in the transition from student to registered nurse. Another study undertaken in Queensland in 2001 also found that within the category of extrinsic work values, newly employed nurses in the public sector in Queensland were more dissatisfied with their remuneration than the longer serving nurses.

g) Geographical factors

Retention rates differ across geographical regions; however, in general, rural and remote areas have a lower retention and higher turnover, with the more remote the community, the higher the turnover. A recent study by the Australian Nursing Federation (ANF) in Western Australia found that 50% of nurses in rural nurses planned to leave their employment in the next five years.

Canada, USA and Australia share similar problems in these geographical areas. Hegney and colleagues postulated that factors such as decreased population growth, low median income and the high rates of unemployment, which were
demonstrated to affect the retention of nurses in rural and remote areas of the USA, were likely to be similar in Australia.\textsuperscript{54} Often it is the rural environment alone which can impact upon a nurse's decision to work in a rural and remote area. For those nurses who have partners, the lack of employment opportunities for their employment can influence the decision to work in a rural or remote area.\textsuperscript{55}

As noted previously, Queensland Health was experiencing a higher than state average turnover of staff in many of their rural and remote area health service districts.\textsuperscript{40} Subsequent research was carried out by surveying nurses who had resigned from Queensland Health to determine their reasons for doing so.\textsuperscript{54,55,56} Although the subject group was limited, it provides one of the few data sets examining why nurses working in rural and remote areas have actually left their place of work. These results provide important insights that may be extrapolated to other states, national or even international situations.

Of the 146 nurses who participated in the study, 77\% indicated that they expected to return to nursing, i.e. would be retained in the profession. This was in agreement with previous data collected by the same authors, but was in sharp contrast to the results from a NSW Health Taskforce study for all geographical areas, in which only 36\% of the nurses who were not working said they would return.\textsuperscript{43,54,55,56}

The reasons given for leaving remote and rural areas in Queensland were varied; however, the most significant were related to management practices, emotional and physical demands of work, family responsibilities, workplace support and job satisfaction. The authors noted that inflexible rostering, excess administrative work, lack of education opportunities and limited progression due to lower turnover of high level staff, were contributory factors to the lower retention of staff in remote areas.\textsuperscript{54,55,56}

Results from this Queensland study agreed with previous studies that retention of nurses is closely allied to job satisfaction. However, in the rural environment it appears that this is related less to the tangible factors such as financial incentives and conditions and more to the intangibles such as quality of interactions, workplace morale, role diversity, sense of relationship with the community and the ability to offer holistic care.\textsuperscript{54,55,56} Nurses more often than not chose to work in a rural and remote area for the lifestyle and had previous association with that environment, e.g. having grown up there.\textsuperscript{54,55,56}

The results of this study suggest that the reasons why rural and remote area nurses leave their employment are many and varied. One finding from this study was that nurses who had been in employment for less than 12 months were more likely to leave employment than those who had been employed for longer periods of time.\textsuperscript{55} Additionally, the more remote the nurse, the more likely they were to cite lack of access to education and training as a reason for leaving employment.\textsuperscript{55} This concurs with work undertaken in the USA, where it has been noted that innovative distance education strategies were being used to overcome barriers of access to education and training.\textsuperscript{53}
**h) Job satisfaction**

Job satisfaction is clearly a primary key factor influencing retention. Similar to other terminology surrounding recruitment and retention, job satisfaction has many definitions; however, a simple interpretation of all of these definitions is that job satisfaction equates with a general perception of liking and enjoying one’s job. Predictors for job satisfaction are affected by personal characteristics (e.g. age, degree, tenure), work characteristics (e.g. teams, collaboration, relations, quality of care, workload, respect) and administrative characteristics (e.g. pay, responsibilities, leadership).

A North American study of paediatric intensive care units, where shortages and turnover were both high, found that job satisfaction was most highly correlated with the work characteristics of quality of care, staffing and team respect. The study found no significant relationships between job satisfaction and the personal characteristic variables of age, type of degree, and tenure in nursing. However, the organisational characteristics of leadership, recognition and confidence were of some importance. Detailed analysis revealed that the single most important factor in job satisfaction was the perception by the nurses of their ability to deliver quality individualised care.

Hegney and colleagues evaluated the effect of intrinsic and extrinsic work values on job satisfaction as perceived by the members of the Queensland Nurses’ Union (QNU). Results demonstrated differences among the nurses according to employment sector, job level and designation in their views on both intrinsic (e.g. emotional challenge, physical demands) and extrinsic factors (e.g. rate of pay, rewards for skills and experience). The findings of this study illustrate that the causal factors to job (dis)satisfaction differ within the profession and that any strategy to increase satisfaction and influence retention/turnover must recognise this. Furthermore, the results give further support to other studies that suggest that less experienced nurses are more at risk of leaving the profession.

**i) Role and responsibilities**

A research study by Chang and Hancock evaluated data on role stress on new nursing graduates from 13 institutions in New South Wales. Role stress is caused by the disparity between perceived job responsibility and actual job activities or accomplishments, and has relevance to the retention of nurses, especially of new graduates. Their results showed that role ambiguity was the most salient feature of role stress in the first few months of a graduate nurse’s career and this was replaced by role overload by the end of the first year. Similarly, a US study of cohorts of graduate nurses found that they did not feel skilled, comfortable or confident for at least one year after graduation. These studies emphasise the need for extensive orientation and support programs to facilitate successful entry into practice. In locations where resources or demands on personnel do not allow such orientation, retention may suffer.
**j) Physical and emotional demands of nursing**

Nursing is physically demanding and the nature of nursing work is manifested in work related disorders. For example, nurses have been reported to have higher rates of musculoskeletal disorders (MSDs) than most other occupational groups. The high physical demands of nursing have been linked with lack of retention. For example, Berliner and Ginzburg believe that the short working life of many nurses is related to the high physical demands of nursing. This view is shared by the Australian Council of Nursing Deans who, in their submission to the National Review of Nursing Education, stated that physical and emotional exhaustion was a principal reason for moving out of the profession.

It appears that the physical and emotional demands of nursing can vary depending upon the sector in which the nurse is employed (public acute and community, private acute and community, aged care). For example, nurses in aged care considered their place of work to be more emotionally and physically challenging, with resultantly higher work stress, than did nurses in either the private or public sectors. An additional influence on the physical and emotional demands of nursing work is the age of the nurse. The NSW nursing review findings suggested that as nurses age, paying attention to the physical and emotional demands of nursing will be an important factor in retaining the nursing workforce.

**k) Workload**

The importance of workload on retention is supported by many studies.

The International Hospital Outcomes Research Consortium led by Dr Linda Aiken surveyed 43,000 nurses from more than 700 hospitals in the USA, Canada, England, Scotland, and Germany in 1998-1999. They found that burnout levels as measured by a standardised psychological tool (Maslach Burnout Inventory Manual) were in the range of 33 to 41% in all countries except Germany (17%). Job dissatisfaction among hospital staff in the USA was five times the average for all USA workers.

The same principal author reported on data collected from 10,000 nurses in Pennsylvania and clearly demonstrated that high workload caused by low staff to patient ratios had adverse effects on nurses’ health and morale. After adjusting for nurse and hospital characteristics, each additional patient per nurse was associated with a 23% increase in the odds of nurse burnout and a 15% increase in the odds of job dissatisfaction.

Clare et al. noted that economic factors can increase workload within the public sector in Australia. Examples of the impact of economic factors given in this study included: spending time moving from ward to ward to acquire needed items due to shortages on their own ward; and reluctance by administrators to fill vacant positions.

Day (2005) found that nurses’ ability to cope (defined as staff, workloads) was associated with morale.
I) Morale and workplace stress

Several recent studies suggest that morale among nurses is low. For example, Callaghan, in a study of nurses in the UK, found that morale was low. A large number of nurses in the study were considering leaving the profession and the majority of respondents stated they would discourage others from becoming a nurse. The themes that emerged in relation to their disillusionment included low pay, lack of support for education, limited opportunity for promotion, lack of resources, and job insecurity. The study undertaken of members of the QNU in 2001, also found morale to be extremely or quite poor in 48% of the respondents. This study found that RNs in higher management positions perceived a higher level of morale and a lower level of deterioration in morale, than did registered nurses employed at the bedside.

Day's study of morale among registered nurses in Queensland found several factors associated with personal and organisational morale. In particular, he found team interaction, lack of professional recognition, workplace violence, ability to cope, ability to provide care at the registered professional level and lack of professional recognition all impacted upon morale.

McVicor undertook a review of the literature from 1985 to 2003 on workplace stress and nursing. The study found that workload, leadership/management style, professional conflict and emotional cost of caring have been the main sources of distress for nurses for many years. It was apparent that the effectiveness of organisational interventions to decrease workplace stress is often limited, hindered by a lack of understanding by employers that sources of stress can vary between different practice areas. In addition, the study noted that there was a lack of understanding by employers of how personal and workplace factors interact. Clare in their study of new graduates describe some of the factors that can lead to workplace stress.

[Nurses] state they feel increasing physical tiredness and are emotionally drained as they try to adjust to the culture of the workplace, the demanding role, client expectations, and their own focus on time management, skill acquisition and proficiency in the early months after graduation. ... coupled with the impact of a seven day roster and shift work,... they have a restricted social life and lose touch with their friends, family and other support persons. It is at this time that many start to question if this is the career they really want for the long term.

m) Nursing image

Nursing as a career of choice for young people can be seen to have a profile problem. For example, CollegeGrad.Com advertises itself as the number one Internet job search service for college students and recent graduates in the USA, and states that nursing is characterised by 'modest entry requirements, low pay, high physical and emotional demands, and lack of advancement opportunities'. Not exactly an attractive proposition. The site reports that 'numerous job openings and
excellent job opportunities are expected'. How the low pay, high demands and lack of opportunities lead to excellence is unclear.

Nurses possess their own image of nursing and also have perceptions as to the image that nursing is held by the community at large and within the health industry.

Kramer and Schmalenberg noted recently that ‘it’s a paradox that nursing-the profession consistently judged by the public as the most ethical and respected—ranks only 137th in the list of 250 most-desirable professions.’ Although nurses are trusted and respected, nursing is often undervalued. It has been pointed out that the perceived value by the public will ultimately affect the funding that nursing education receives and the level of nurse remuneration.

Perceptions of nursing obviously affect recruitment. As stated in an editorial in the Nursing Standard, ‘everyone trusts and respects nurses but relatively few want to join the profession’.

In an article reviewing the changing image of Australian nursing, Bloomfield concludes that the traditional public image of nursing is finally being eroded and slowly replaced with a more realistic and accurate one that truly reflects the unique and valuable work of nurses. The author reflects on the importance of media portrayal on public perception. She considers that the television program “All Saints” portrayal of nurses as being an integral part of the health care team, making autonomous and rational nursing decisions, is revolutionary. She warns, however, that misrepresentation of the nurses’ role has potentially serious consequences to both patients and nurses when the expectations are not met.

Self image and perceptions of value by others will influence job satisfaction and retention. In a study of nurses in Queensland it was found that nurses with less than 10 years experience had a low perception of the status of nursing as a career. Nurses’ perceptions of how nursing is valued by the community at large and by the health profession was shown to differ among nursing sectors and job designation.

n) Management structure

Team structure, leadership style and internal communications are conducive to enhanced job satisfaction. Internal leadership is an essential area to study because of the influence that unit level managers have on nurse retention. Numerous studies provide support for the relationship between effective leadership style and retention and internal leadership development through succession planning. This could ensure that suitable internal candidates are selected and trained.

In recognition of the importance of leadership issues on retention, hospitals are trialling new management styles such as changes in team leadership (e.g. from clinical nurse leader to team co-ordinator) to address nurse retention. A working environment that supports communication among all levels of hospital staff and participation of nurses in the decision making-process is being promoted as a crucial aspect of retention strategies. The quality of administrative management systems and relationships among physicians, nurse managers, peers and administrators have also been found to be essential factors for nurse retention.
Findings also suggest that the quality of nurse-physician relationships must be addressed as facilities seek to improve nurse recruitment and retention.\textsuperscript{75} The type of relationship that has been demonstrated to be most effective in contributing to job satisfaction is the collegial relationship in which nurses and physicians share equal power.\textsuperscript{76}

Power sharing is another essential strategy reported as being effective in improving job satisfaction among nurses.\textsuperscript{77} A higher inter-organisation retention rate was reported among nurses who were satisfied with their nurse managers if the latter valued staff contributions, promoted information sharing and exerted influence for a stable work environment.\textsuperscript{77}

Studies have shown that nurses want to have the freedom to use knowledge to make independent clinical decisions in the best interest of the patient. Nurses in Magnet\textsuperscript{b} hospitals reported that the conditions promoting staff nurse autonomy — being held accountable in a positive, constructive manner; acknowledgment of combined spheres of practice; organisational sanction — are present to a much greater degree in Magnet than in other hospitals.\textsuperscript{67}

In the development of strategies for recruitment and retention, the reasons nurses join an organisation are as important as why nurses leave. For example, in the BPA study, 22\% of nurses rated the type of position/role as the most important reason for joining an organisation.\textsuperscript{42} In addition, the greatest percentage of nurses (31\%) gave location of the health service as the most important factor. The results of this study suggest that in areas where location may be considered to be unattractive (rural and remote, lower socio-economic areas), other job related attractions or benefits could be used to attract staff.

\textbf{o) Organisational culture}

The characteristics of workplace culture are based on factors including management style, accountability, communication and organisational ambition. In the BPA study, organisations operating a culture of blame had more than twice as many ‘at risk’ nurses as those operating a culture of success.\textsuperscript{42} A sensitive management culture within an organisation is critical to a sense of belonging by nurses. Nevidjon and Erikson note the importance of senior executives considering nurses to be an asset rather than an expense.\textsuperscript{68}

\textbf{p) Workplace violence}

Workplace violence takes many forms such as aggression, harassment, bullying, intimidation and assault. Inconsistencies in definitions and varied terminologies make comparison studies difficult.

\textsuperscript{b}Magnet hospitals are accredited on their environment, that supports nursing practice and focuses on all aspects of professional autonomy, decision making, career development and leadership.
It is generally accepted that there may be a direct link between episodes of violence and aggression towards nurses and sick leave, burnout and poor recruitment and retention rates. Few data providing numbers on retention and turnover due to workplace aggression are to be found, although a study in South Australia reported that 19.6% of resignations were as a result of workplace bullying.78

According to New York State Nurses Association, the US Department of Justice reports that more than 400,000 nurses are subject to violent acts each year.79 Studies in the USA have indicated that staff shortages are directly related to an increased risk of violence. Insufficient staffing, overcrowding, and service cutbacks are causing patients to wait longer for care, resulting in increased patient aggression towards nurses.79

In the UK, Wells and Bower undertook a systematic literature review of the literature on workplace violence, which they noted has been attributed to be an adverse factor in recruitment and retention. They concluded that although research findings were limited and data were very difficult to compare, nurses do appear to have a high level of risk in comparison to the general workforce and other health care professionals.80 The authors estimated that at least 9.5% of general nurses working in general hospitals in the UK are the subject of violence in any one year. Aside from verbal abuse, higher rates of violence may be found in psychiatric, learning disabilities and elderly care units.79 These results concur with the findings of Hegney whose survey of Queensland nurses in 2001 noted a significant difference in the rate of workplace violence aged care (50%), public sector (47%) and private care (29%).54

A review of the literature revealed some alarming figures: up to 90% of nurses report verbal abuse and up to 50% report physical abuse in any one year. Other nurses report violence to be a daily event.81 These data, while confirming that violence is all too frequent in the health environment, illustrate the differences that are encountered due to definitions, locations and sources.

Acts are perpetrated against nurses from a variety of sources, including patients, relatives, management and other nurses, with patients consistently being the highest offenders. However, a survey of members of the Queensland Nurses’ Union in 2001 revealed that the second most common source of violence after patients, varied across sectors. Within the public sector it was visitors and relatives, while nurses in the aged care and private sectors reported other nurses as the second most common source.51 Although the authors recognise the variability in results of other studies, general trends did appear between Queensland and other studies most notably in the prevalence of violence from other members of staff on nurses. Bullying has been reported as the most common form of violence from higher ranked staff members on nurses.81

While there is evidence of an excess of assaults towards students and to those who are younger and usually the least experienced, results are not all in agreement as to the effect of experience and the source of violence.51,80 For example, in the Hegney et al. study, no statistically significant differences were found between nurse experience and patient perpetrated violence. However, nurses who had been in the
profession for 35 years reported six times lower incidence of workplace violence from other nurses as compared to those who had five years or less experience.\textsuperscript{51} Another difference between sectors evident in the same study was the increased level of workplace violence emanating from medical practitioners, reported by nurses employed in the private sector.\textsuperscript{51} Regardless of the source of the violence, these findings have major implications in retention, especially of the highest ‘at risk’ group in terms of exit from the profession. The excess risk of the most junior staff suggests that pre-registration training in dealing with violence should become mandatory in all schools of nursing.

A recent study in Queensland has linked workplace violence to levels of personal morale,\textsuperscript{49} and therefore retention:

The effect of workplace violence on retention has not been quantified however, all the evidence suggests that greater emphasis needs to be based on strategies to solve this problem. Interestingly, in the Australian study, more experienced nurses are less convinced that workplace policies and procedures for workplace violence are effective.\textsuperscript{51}

One example of a successful strategy is the highly trained security teams at King’s Health Care NHS Trust in the UK. These security staff at King’s are employed by the Trust and seem to be more effective than comparable teams run by outside contractors, whose primary allegiance is to profits.\textsuperscript{80}

In 2004 the Victorian Government set up a Taskforce on Violence in Nursing to address the issue of occupational violence in nursing, the results of which are expected in 2005. Additionally Queensland Health established a Violence Against Nurses Steering Committee in 2004. It is expected also to report in 2005.

\textit{q) Childcare}

Other conditions of employment have been identified as affecting the retention of nurses – among them childcare. In the UK, acknowledgement of the effect that lack of childcare facilities has on retention and return to work was demonstrated by the launch of the UK Childcare Strategy as part of the NHS plan. The strategy involves provision of on-site childcare and all NHS staff have access to a childcare co-ordinator. In 2004 the responsibility for funding these centres was handed over to local authorities.\textsuperscript{82}

The Queensland Health Taskforce recognised that the workforce has changed considerably in response to societal trends and, as a result, nurses (male and female) now balance paid employment with family responsibilities.\textsuperscript{40} Lack of availability of childcare or extended hours childcare was seen as an impediment to flexible rostering practices. This impacted on nurses with children, and other staff who worked the hours that parents with children could not, due to the unavailability of childcare.\textsuperscript{40}

Unfortunately, some five years later not a lot of progress has been made with regard to the provision of childcare in Queensland hospitals. The Queensland Heath
Industrial Health Policy Manual (IRM 3.10-2) states that ‘Queensland Health will facilitate the provision of childcare where appropriate, it should be noted that Queensland Health staff will not provide childcare’. It should be noted, however, that in recognition of the need to address this area the manual also states that a procedure will be followed so that ‘arrangements’ (emphasis as in the document) for Childcare facilities are considered when planning for all new works and refurbishment.\(^{\text{83}}\)

Similarly in 2001 the Victorian Government accepted the recommendation by the Nurse Recruitment and Retention Committee that, as a matter of urgency, a review of nurses’ childcare needs was required across all sections of the nursing workforce, with a view to formulating a strategy to best meet assessed needs.\(^{\text{84}}\) At the time of writing this report, there is no information available on the outcomes of the committee.

\(r\) Rostering

Work schedules have been shown to impact on many aspects of nurses’ working and domestic lives and on their retention in the workplace.\(^{\text{85,86}}\) Scheduling of nursing time on hospital wards is critical to the delivery of patient care, resource utilisation and employee satisfaction. Work schedules or rosters are often seen as inflexible, inequitable and prone to abuse such as favouritism. Rostering has been termed one of the most complex and important management functions.\(^{\text{87}}\)

It has been reported that many hospitals in the UK have moved away from the traditional planning of rosters undertaken by a single manager, towards a more participatory processes of self-rostering and team rostering.\(^{\text{86}}\) The authors compared the processes within the NHS system and found that each had its advantages and disadvantages. For example, they noted that despite self rostering in theory allowing empowerment and increased motivation, in practice the processes often favoured the more senior staff. The senior staff were self rostering, with the junior staff being allocated what was left. The authors concluded that different systems were applicable to different conditions. A combination of ward size, demand variability, demand predictability, and complexity of skill mix, needs to be taken into account. They recommended that departmental rostering be applied in large wards with complex rostering problems, while team rostering is more appropriate for medium-sized wards, and self-rostering appropriate for small wards.\(^{\text{86}}\)

In Queensland the importance of rostering in job satisfaction and retention of staff was recognised by the Queensland Taskforce.\(^{\text{40}}\) Focus groups were established, and the criticisms from participants was that full-time employees are disadvantaged in having to work the undesirable shifts that part-time employees do not wish to work.\(^{\text{40}}\)

For many nurses, rostering and childcare are linked. The NSW Health review noted that despite the increased operating hours of many childcare facilities, the ability to negotiate a set roster (allowing for the planning of days and times for childcare) remains a major obstacle for working nurses.\(^{\text{43}}\)
In Queensland, as a result of recommendations by the Taskforce, six rostering trials were undertaken in 2003. Results from those trials supported a new framework of *Best Practice Framework for Rostering Nursing Personnel*. The guidelines aim to match requirements of both staff and patients with available supply and skill mix, (i.e. competency and experience of the work force), in a fair and equitable manner. The key to success of any system, however, is good management involving transparency and good communication.

**1.2.4.3 Returners to the profession**

As Buchan and Calman noted in their report to the ICN, the average career life of a nurse tends to be short. Therefore, a partial answer to the nurse shortage situation exists within the large pool of nurses who have left the profession. In the USA in the year 2000, more than 500,000 of the 2.7 million licensed nurses were not nursing.

The NSW Health study found that the departure of many nurses was in fact temporary, and 14% were estimated to have returned to nursing between the administration of the two surveys. The survey also revealed that the longer a nurse remains out of the nursing workforce, the less inclined they are to return.

Retaining or encouraging return of nurses will boost the workforce considerably. A NSW Study demonstrated that by delaying the retirement age from 58 to 65 would have a significant result in the retention of extra nurses in an ageing nursing workforce. Perhaps as critical as the number of nurses retained is the experience of the nurses retained within the workforce.

A study for the Irish Nurses Organisation highlighted that in order to attract nurses back into the workforce there must be flexibility in working hours and adequate remuneration. The UK, Ireland and Australia have all adopted initiatives to target returners. In the UK a returner’s package was initiated that included free refresher training, cash as a financial support while retraining, and assistance with childcare support, travel and books. Yearly recruitment drives in 1999, 2000 and 2001 yielded 6000, 5797 and 713 returners up to July 2001. In January 2005 the UK Department of Health website proclaimed, ‘The success of the return-to-practice initiative has ensured that target numbers of returning nursing staff have been met two years early’.

The Australian, state and territory governments have initiated several scholarship programs aimed at assisting nurses with re-entry. Examples of some of these schemes can be found on the Royal College of Nursing Australia website (see http://www.rcna.org.au/pages/russ.php). The Victorian Government stated in 2004 that its campaign had been the most successful undertaken in Australia, with more than 2200 nurses returning to the public health system via free refresher or re-entry/supervised practice programs. Funding will continue for these programs until 2005 (see http://www.nursing.vic.gov.au/returning/index.htm).

The private sector has also commenced its own initiatives. For example, one Australian medical centre adopted a recruitment strategy that included appointing a nursing recruitment and staffing allocations manager. Interventions include an
aggressive advertisement campaign, educational opportunities, flexible working hours through development of a nurse pool, and much improved communication between management and staff. Results are reported to have been very encouraging.\textsuperscript{91}

1.2.4.4 Strategies to reduce shortages and improve retention

A search using all of the words ‘shortages, strategy, nurses’ and limited to the years 2002 to 2005 yields 450 references in Google Scholar. Inserting ‘retention, strategies, nurses’ yields 750. This indicates the wide extent of literature on this topic; much of which offers solutions to problems.

There are several ways to discuss the strategies employed to address the nurse shortage. One can centre on key themes that include employment guarantees, career structure, flexibility, leadership, training, working conditions and remuneration. Secondly strategies may also be grouped under the headings of recruitment (locally and internationally), encouraging returners and improving retention. A third method (and the one used here), is that of addressing strategy through international, government or organisational policies, initiatives or activities.

\textit{a) International}

At the international level, the report commissioned by the ICN to examine the global nurse workforce situation developed a policy-based intervention framework.\textsuperscript{13} In order to achieve sustained improvement there are four components to the intervention strategy: workforce planning; recruitment and retention; deployment and performance; and utilisation and skill mix. The necessary interventions for the recruitment and retention component have been identified as recruitment using both traditional and new sources. In order to achieve these there must be financial and non-financial incentives, career structure and opportunities, flexible working models, safe working conditions and nurse involvement in decision-making. Adoption of this model should attract and retain nurses who have been shown to want opportunities to develop, gain autonomy, participate in decision-making and be rewarded fairly. The report, complemented by a series of issue-based papers, will provide the background material for a global summit on the nursing workforce held in 2005.

An international policy on international recruitment is needed. International recruitment supports or even exceeds home-based recruitment (as it did in the UK in 2002\textsuperscript{92}) and is an active strategy to address workforce shortages in some countries. The cost of such practices in loss of human resources in predominantly developing countries must be weighed against the requirements of other work forces and the restriction on an individual’s choice. The Commonwealth Secretariat International Code of Practice, World Health Assembly Resolution 57.19 and the International Council of Nurses position statement on ethical recruitment, all support the need to assess initiatives such as national guidelines or policies on ‘ethical recruitment’, bilateral agreements and managed migration, and to research other possible interventions.\textsuperscript{13}
b) Government

In the USA the increasing crisis in the nursing workforce resulted in landmark legislation passed by the 107th Congress during 2002. The Nurse Reinvestment Act, which specifically addressed the issues of nurse shortages through the two faces of recruitment (Title I) and retention (Title II) became law in 2002, and was enacted and funded in 2003. Recruitment is being addressed through increased public awareness, advertising, utilisation of distance learning technologies, scholarships and attractive student loan repayment schemes. Activities funded to support retention emphasise the role of the workplace in retaining and enhancing the education and professional development of nurses. Priority is given to the development of career ladder programs and the design of systems that enhance the delivery of patient care, by improving collaboration and communication within the healthcare team. The ageing population is recognised through special provisions for training in aged care.

In 2000 the UK NHS Plan was introduced ‘to give the people of Britain a health service fit for the 21st century: a health service designed around the patient’. A key element to the plan is for ‘more’ and ‘better paid’ staff using new ways of working. The ‘more’ is to be achieved through increased recruitment at home and overseas, encouraging returners and improving retention. ‘Better paid’ nurses will have greater opportunity to extend their roles. For example, from 2004 nurses have the ability to dispense medicine and a new Leadership Centre will be established to develop a new generation of managerial and clinical leaders. The NHS Improvement Plan was proclaimed in 2004. It expanded on the same themes with work-based learning, accreditation schemes, increased responsibility, flexible working conditions and better remuneration for nurses.

It appears that the UK recruitment campaigns have been successful. In 2004 the UK Health Minister reported that the target of 35,000 more nurses by 2008 had been comfortably exceeded already, as was the target of 5,500 more nurses and midwives to be entering training each year by 2004.

Independent research undertaken by Buchan and Seccombe on behalf of the Royal College of Nursing in the UK revealed some of the results of these initiatives. One key feature of the NHS nursing workforce in recent years was staffing growth of between 8% and 15% in England, Scotland, Wales and Northern Ireland in the four years to 2003. The authors noted that the success in workforce numbers had been achieved by the range of policy initiatives in the four UK countries designed to increase the numbers of new nurses being trained, improve nurse retention, and attract returners. However, they noted the increases also reflected large numbers of newly registered international nurses. The driver for staffing growth had been government policy to expand and improve NHS services, and the European Working Time Directive that reduced junior doctor hours and increased the demand for advanced nurses.

Government initiatives in the UK have examined the public health sector in total and have addressed all aspects of the supply-demand continuum. The strategies to
increase the nursing workforce have succeeded. It is too soon to say whether the changes to management, remuneration, continuing education and workplace safety improve retention.

In Australia the pressures on the nursing workforce have been recognised by government with a series of committees, taskforces, review panels and action plans at both state and national level.40,96,97,98

On 30 April 2001 the Commonwealth Ministers for Education, Training and Youth Affairs and for Health and Aged Care jointly announced the National Review of Nursing Education. More than 20 literature reviews and research reports were commissioned to support the work of the Review, including Job Growth and Replacement Needs in Nursing Occupations and The Nursing Workforce – 2010.21,99 The Senate Community Affairs Reference Committee Inquiry into Nursing occurred over the same period as the Review, reporting in June 2002.100 The report of the Review which incorporated the Senate committee findings was presented to government in 2002.21

As a result of findings, the National Nursing and Nursing Education Taskforce was established in 2003 by the Commonwealth, state and territory health ministers to implement all but one of the Review’s recommendations. A National Health Workforce Strategic Framework was released in April 2004 at the Australian Health Ministers Conference. In the communiqué it was noted that:

Ministers agreed that a National Workforce Action Plan, focusing on national and cross-jurisdictional issues, will be developed for reporting back to Ministers at their July meeting. In addition to national projects, the Australian Government and States and Territories will develop their own implementation plans and responses to the Strategic Framework. Other health workforce stakeholders will also be encouraged to develop implementation plans.101

The Australian Health Workforce Officials Committee (AHWOC) is conducting projects aimed at profiling, analysing, projecting and considering the implications of current and future nursing workforce data. They produced A Guide To The Process And Methods Used By The Australian Health Workforce Advisory Committee in 2004 to provide a general resource document on nursing workforce planning in Australia for use by the Australian Health Workforce Advisory Committee (AHWAC), the National Health Workforce Secretariat and members of nursing workforce working parties established by AHWAC.102

As part of a recruitment strategy, the Australian Government announced funding for 210 more university places in 2004 for nurses in regional universities as part of the Health Minister’s higher education package. A further increase in places is planned. Another Australian Government strategy is the rural and remote nurse scholarship program which commenced in 1996.

Retention strategies have been formulated in Queensland, New South Wales and Victoria by the state governments and include: re-entry programs, scholarship based postgraduate education, targeted patient ratios, flexible rostering, family friendly workplace and childcare facilities, increases in safety and security, improvements in
career progression, and structured mentor/preceptorship programs. The success of these programs is still too early to determine.

Recommendations have been formalised that have involved the upgrading and up-skilling of enrolled nurses. This strategy is aimed at increasing retention and attracting returners to the profession. The authors conclude that, while up-skilling less qualified nurses may provide health services with some short-term nursing shortage relief (similar to that of importing nurses from overseas), such a strategy is doomed to fail as it does not address the underlying problem of why there is a shortage in the first place.

Government policies on addressing the nurse shortfall are not without critics. Buchan points out that attempts to lure back nurses who have left the health care system are doomed to fail if the health care service has not addressed the reasons why nurses left in the first place. This sentiment is echoed in a critical review of Australian policy that addresses re-entry of nurses as the solution to shortages. Cowin and Jacobsson state:

“The reason for the long-term failure of re-entry to nursing programs is simple, yet continues to be disregarded by nursing workforce planners. If the health system repels the nurse then only a reformed health system can hope to retain nurses.”

In 2001 mandatory minimum nurse-patient ratios in public sector facilities were achieved in Victoria, after negotiation between the state government and the nurses union went to arbitration before the Australian Industrial Relations Commission. The minimum ratios vary to meet the needs of different units and shifts, and range from 1:1 for an unconscious patient in a post anaesthetic care unit to 1:6 in a general ward in the night. It should be noted, however, that these ratios are not in place in all hospitals/health facilities in Victoria. In particular, small rural hospitals are excluded from this agreement. These initiatives were intended to reduce nurse workload and benefit patients. Improvements reported in the first year of implementation of the ratios include increased applications for nursing schools and decreased staff turnover and absenteeism. It is suggested that the nurse-patient ratio is the reason Victoria is the only state in Australia not experiencing a severe nurse shortage.

In 2004 the nurses of Victoria were battling with the State Legislature, who wanted to abolish the ratio system in favour of a more flexible approach. It was reported that more than half of Victoria’s nurses would resign, retire early or reduce their hours if mandated, minimum-nurse patient ratios were abolished.

California is the only other place in the world which uses nurse-patient ratios to staff its hospitals. The ratios were established by legislation following four years of negotiation. It has been reported that the California Board of Nursing is being inundated with RN applicants from other states since the nurse-to-patient ratio regulations went into effect in January 2004. These ratios are, however, currently under attack by the Californian governor and may be overturned.
Buchan presented a report in 2004 to the Royal College of Nursing reviewing the pros and cons of the practice in California and Victoria. Surveys among the nurses in the two states show that they like the system, as it leads to increased staffing and thus reduces workload. Data reported elsewhere in this review would suggest that this will also lead to improved patient outcomes. However, conventional wisdom continues to be that staffing levels is something best left to local level management, taking account of local workload and resources.

Buchan concluded that imposed ratios are:

...a blunt instrument for achieving employer compliance, where reliance on alternative, voluntary (and often more sophisticated) methods of determining nurse staffing have not been effective.

In essence what is being stated is that appropriate ratios should be the result of suitable staffing levels and not the cause.

c) Organisational Strategies

Much interest has been generated in this topic. A search of the literature over the last five years identifies hundreds of editorials, letters, briefs and full research papers on turnover and retention strategies at the organisation level. There are scores of case studies such as ‘Using a Blitz to help retention’ , ‘Gatherings as a retention strategy’ , ‘Mentoring program aims to improve nurse retention’ and ‘Career routes are the key to retention: radical approach boosts Trust’s staff numbers...’.

A recent book, entitled The Nursing Shortage: Strategies for Recruitment and Retention in Clinical Practice and Education, details strategies used in the USA for recruitment and retention. In it, the authors present strategies that operate on three fronts: a) policy making to combat the nursing shortage; b) education’s role in building collaborative work-site relationships and developing accelerated programs to increase enrolment; and c) the promotion of workplace retention through strategies to increase job satisfaction.

Another recent book, entitled Keeping Patients Safe: Transforming the Work Environment of Nurses, makes 15 recommendations that should be introduced to improve patient safety. The principles to be enacted by organisations include: governing boards that focus on safety; leadership and evidence-based management; effective nursing leadership; adequate staffing; organisational support for on-going learning and decisions support; work design that promotes safety; mechanisms that promote interdisciplinary collaboration; and an organisational structure that continuously strengthens patient safety. The writers note that ‘none of these recommendations is ‘less important’ and they stress that the implementation of these recommendations is the only way to address ‘all sources of patient safety’.

Aiken et al. noted that the literature proclaims that nurses change jobs and careers because of issues in the workplace, with culture of the hospital workplace as a principal factor. Interest in the workplace has focused attention on the value of Magnet hospitals.
**d) Magnet Hospitals**

In 1981 the American Academy of Nursing identified 41 hospitals that were good places to work and offered excellent nursing care to patients. The AAN referred to these as 'magnet' hospitals and their attributes formed the basis of the 1991 Magnet Recognition Program developed by the American Nurses Credentialing Center. There are now more than 100 designated Magnet hospitals in 37 states in the USA.

The first non-US magnet hospital was Rochdale Infirmary in England, which was accredited in March 2002. Preliminary results from Rochdale indicate an increase in job satisfaction and reduction in burnout of the nurses following implementation of the practices.\(^{113}\)

The Princess Alexandra Hospital in Brisbane is the first Magnet Accredited Hospital in Australia. Designation was achieved in January 2005. Other Australian hospitals will follow. The Senate Community Affairs Committee recommended that the Commonwealth Government support the proposal by the Royal College of Nursing to conduct a pilot project in Australia on the Magnet Hospital Recognition Program.\(^{100}\)

A Magnet hospital combines the attributes that nurses consider important to job satisfaction, with the productivity of quality care. Magnet hospital nurses are encouraged to engage in the decision-making process, staff development is promoted and facilitated, working conditions such as working hours are flexible, staffing is at an optimum to ensure maximum outcomes for patients, and communication between staff and management is practiced. As noted by Rosemary Bryant, these characteristics of the Magnet Program are in reality good management practices, with nurses treated as professionals rather than a commodity.\(^{114}\) Within these hospitals employees consistently report high levels of job satisfaction.\(^{115}\)

In a series of four articles Kramer and Schmalenberg compared Magnet, 'Magnet aspiring' and 'other' hospitals for the eight *essentials of magnetism* (EOM). These EOMs had been previously identified as eight attributes essential to quality patient care and, by extension, to high job satisfaction and improved recruitment and retention.\(^{67,76,116,117}\) The authors’ comparison revealed that the Magnet hospitals consistently scored higher in all EOMs than did the other hospitals. The EOMs are:

- support for education programs
- working with other competent nurses
- positive nurse/physician (RN/MD) relationships
- autonomous nursing practice
- a culture that values concern for the patient
- control of and over nursing practice
- perceived adequacy of staffing
- nurse-manager support.
Research in those hospitals which have been accredited as Magnet hospitals has shown there is:

- reduced mortality/morbidity rates and increased patient satisfaction
- improved image of nurses/nursing
- improved staff morale
- lower rates of nurse burnout and injury
- higher educational preparation of RN workforce
- high levels of nurse autonomy and control over practice
- positive relationships with doctors
- adequate support services and RNs to provide high quality care.

1.3 Summary

This overview of the literature provided the backdrop for the development of the questionnaire used in 2001. While there has been a focus on nursing recruitment, and retention and patient outcomes linked to nursing shortages since the 2001 QNU study, the questionnaire used in 2004 was basically the same instrument, informed by similar issues. The next section shall provide information on the study design and data analysis.
2.0 METHOD

2.1 Project Aims

The aim of the study was to identify the factors impacting upon nursing work in Queensland in 2004. The results, as well as a comparison where possible to the results of the 2001 study, will inform the strategic planning of the QNU.

2.2 Research Questions

1. From the perspective of members of the Queensland Nurses’ Union, what are the factors impacting upon nursing work in Queensland?
2. How satisfied are members of the Queensland Nurses’ Union with nursing work in Queensland?
3. Have perceptions of and satisfaction with nursing work changed during the period 2001 to 2004?

2.3 Principal Outcomes

Data will provide, from the perspective of nurses who are members of the Queensland Nurses’ Union:

a) an indication of any changes in the perceptions of and satisfaction with nursing work
b) the current perceptions of and satisfaction with nursing work
c) information that can be used by the Queensland Nurses’ Union to assist them with strategic planning.

2.4 Method

2.4.1 Inclusion criteria

All nurses who were members of the QNU at the time of the study and who worked in the public and private sectors, community health or in aged care (public and private) were eligible to participate in the study.

2.4.2 Sampling

The study involved a postal survey of financial members of the QNU in October 2004. A stratified random sampling design was employed with sampling frame restricted to financial members of the QNU. The strata included were the three largest employment sectors in Queensland: aged care (non-government and government), public (government) and private (non-government). To ensure adequate levels of precision in estimating key measures, 1000 nurses from each of the three sectors were invited to participate, with an expected response rate of around 50%.
2.4.3 The tool

The questionnaire was based on that used in the 2001 survey of QNU members. Only minor changes were incorporated, since the instrument had been validated in 2001 and a comparison of changes in responses between 2001 and 2004 was of particular interest. Piloting of the instrument was unwarranted because the data collection process was unchanged from that used for the 2001 study. Items modified or added to the 2001 questionnaire procedure, however, were pre-tested by independent experts.

The questionnaire (called ‘Your Work, Your Time, Your Life’) contained 77 questions divided into eight sections. These were:

- Section 1 – Your Current Nursing Employment – asked eight questions relating to current employment, place of main employment and if they were working for a nursing agency
- Section 2 – Your Working Hours – contained 10 questions to gain information on the number of hours worked, the type of hours worked; employment status and the days and hours worked in their employment
- Section 3 – Your Working Conditions – contained 21 questions that sought information on their ability to complete work within the paid time available, skill mix, workload, rostering practices, workplace violence, and replacement of staff. This section contained one open-ended question on workload issues
- Section 4 – Your Responsibilities Outside Work – contained eight questions that gained information on the respondents’ family commitments and childcare arrangements
- Section 5 – Your Professional Development – contained nine questions that provided information about the respondents’ professional development and professional development opportunities
- Section 6 – Your Experience in Nursing – contained eight questions that gathered data on the nurses’ perceptions of nursing work as well as the length of time they had worked in nursing, the number of breaks from nursing and the reason/s for these breaks
- Section 7 – About You – contained 11 questions on demographic information about the respondents including their qualifications, endorsements, gender, age and employment level
- Section 8 – You and the QNU – provided two open-ended questions. The first question asked respondents to identify the five most important activities that the QNU should focus on in the coming year. The second question allowed the respondents to provide other feedback to the QNU (via the researchers) on issues they believed were important to their working life.

2.4.4 Limitations of the study

To assess the possibility of non-response bias, checks where made against the QNU database in each sector regarding the distributions of gender, age and job designation. No significant difference exists between the gender distribution of the respondents and the gender distribution of the QNU database within each sector. Similarly, there were no significant differences in the distribution of job designation
when compared to the database within each sector. Concerns exist, however, regarding bias in the age distribution of respondents in the survey compared to the QNU database. In the aged-care sector, 30 to 40 year olds appear under-represented, and 50 and above over-represented. In the public sector, under 30s appear under-represented, and 40 and above over-represented. In the private sector, under 40s appear under-represented, and 40 and above over-represented. However, this issue is clouded by the QNU database being incomplete – the ages of about 20% of members are unknown.

Some evidence of bias exists in the age of respondents in relation to the order of receipt of the questionnaires. In particular, in the aged care and private sectors, on average, surveys from younger respondents, and hence less experienced nurses, were received earlier than surveys from older respondents. Relatively weak evidence exists of a reverse trend in the public sector. Although the effect is statistically significant the size of the effect is small. The inference from this: that older, more experienced nurses are under-represented in the aged-care and acute-care sectors, is not supported in comparing the overall age distributions of respondents and QNU members.

2.4.5 Ethics approval

The study was approved by the Human Research and Ethics Committee of the University of Southern Queensland. Accompanying the questionnaires was a covering letter outlining the study (see Appendix 1) and a Plain Language Statement and Consent Form (see Appendix 2). Informed consent was implied if the participant completed the questionnaire (see Appendix 3) and returned it for inclusion in the study.

In order to assure confidentiality, the following processes were adopted:

- The QNU provided a set of codes that they could link to names and addresses of specific members. These were the codes used for the random sampling procedure previously outlined
- The USQ established a database of the codes. All survey packages (these included a covering letter from USQ and QNU, the questionnaire, a reply paid envelope, the Plain Language Statement and an overview of the outcomes of the previous study) were sealed at USQ, the code affixed to the top right-hand corner, and sent to the QNU
- The QNU, by use of the external code, affixed labels and posted the packages to the participants. This ensured any ‘return to sender’ packages were returned to the QNU
- The QNU notified USQ of the codes of nurses who had packages returned so that the reminder package was not sent by to them
- USQ noted the codes of the returned surveys (these were on the questionnaire) so that only non-respondents were sent a reminder package.
- At no stage did USQ have access to any information which could link the respondent code to the respondent name
- At no stage did the QNU have access to data that was identified by respondent codes
To conform with National Health and Medical Research Council Guidelines, the questionnaires were stored in a locked facility only accessible to the investigators on the project. On completion of the project all computer files were written to a CD-ROM, which is kept in a secure area within the chief investigator’s offices. All data on the ‘H’ drive of USQ has therefore been deleted. After a five-year period all paperwork will be treated as confidential waste (shredded) and the CD-ROMs will be destroyed.

2.5 Data Analysis

Unlike in 2001, when data were manually entered, the questionnaires were formatted to allow automatic scanning and data entry using Teleform. While quantitative data were scanned in, all qualitative data were typed in manually. All scanned questionnaires were manually checked and adjustments made of any scanning errors.

2.5.1 Quantitative data

The data were extensively screened and anomalies logged, checked and corrected where appropriate.

Comparisons between sectors in the 2004 survey have been made on an item-by-item basis using descriptive and inferential statistical tools as appropriate to the scale of measurement. In most instances, categorical or ordinal data is involved and contingency tables, clustered bar charts, measures of association (both nominal and ordinal) and chi-square tests have been employed. Exact chi-square tests have been used where the asymptotic test results may be compromised through small numbers. In addition, ordinal-scaled data and interval-scaled data involving heavily skewed distributions have been analysed using the Kruskall-Wallis test to compare median responses. Interval-scaled data have been summarised using means, medians, standard deviations, IQRs, multiple boxplots and histograms. For such data, inference has relied on $F$ and $t$ procedures except where heavy skewness or outliers compromise such analyses, in which case the Kruskall-Wallis test has been used to compare median responses.

Similar techniques have been used to compare the 2001 and 2004 surveys, except that a loglinear analysis encompassing both the sector and year factor has preceded a sector-by-sector analysis of categorical or ordinal data. Similarly an omnibus F test has preceded a sector-by-sector analysis of interval data. Only if an omnibus test indicates a significant result has further inferential analysis been undertaken.

The use of omnibus testing helps to contain the false positive (Type I) error rate. Furthermore, only inferences supported at the 1% level of significance are reported, except where more than one sector exhibits a similar trend or where there is a prior expectation of an effect. In these cases the threshold has been lowered to the 5% level. On rare occasions, when sample sizes otherwise compromise the available power and an effect is of particular prior interest, the threshold has been set at 10%. This approach is consistent with the 2001 survey analysis. It should be noted that containing the false positive error rate is bound to increase the false negative (Type II) error rate. It follows inevitably that some differences between sectors and
between years are not due to sampling variation but have nonetheless been reported as non-significant. To put this into perspective, typically, sample sizes are such that it is not possible to discriminate between percentages that are less than 5% apart, and in many instances margins need to be considerably larger than that before being declared statistically significant.

Because the numbers in each of the sectors in the QNU database are not proportional to the numbers of respondents in each sector, measures averaged over the three sectors must be weighted to be valid. The appropriate weights are 17.8%, 65.8% and 16.4% respectively for the aged care, public sector and private sectors respectively. In this report, these weights have only been used in analysing the results for Question 9 involving the number of hours worked for an agency. However, the reader may use them to combine proportions or means across sectors if a measure averaged across the sectors is desired.

For completeness, detailed tabular summaries of responses to each item are presented in the supplementary data. Graphical summaries and brief descriptors of significant effects are presented in the main body of this report.

### 2.5.2 Qualitative data

There were three major qualitative data questions in the survey (Q31 – ‘If you wish, please comment on how workload related issues are addressed at your workplace’, Q76 – ‘In terms of QNU activities over the coming year, please describe up to five of the most important activities you believe the QNU should be involved in’ and Q77 – ‘Is there any other information you would like to share with us regarding your working life? If so, please write in the space provided below [and over the page]’). The data from each returned questionnaire were typed verbatim into a word processing file. Analysis for each question was carried out separately for each of the sectors. Thus, for each question there were three files.

A thematic analysis was then undertaken on each of the files. This involved:
- studying each transcript individually as well as by sector to give a sense of the whole
- identifying, themes and categories that arose from each question and from each sector
- developing summative themes and research findings from this analysis.
3.0 RESULTS

3.1 Your Current Employment

3.1.1 Current paid employment in Queensland

Of the 1349 participants in the 2004 study, 1342 provided information that allowed their allocation to a sector. A total of 1306 (97%) were in paid employment in nursing in Queensland at the time of the study. The participants who were not currently in paid employment were asked to proceed to question 57 of the survey.

3.1.2 Nurses with one or more paid jobs (Q2)

Figure 3.1 provides a comparison between the 2001 and 2004 surveys. A highly significant (p < 0.001) difference exists among the sectors as regards the proportions or respondents in each of the categories. Main source of this effect: relatively fewer nurses in the aged care sector have more than one job.

No significant changes have occurred, however, in any of the sectors between 2001 and 2004.

3.1.3 The main reason for more than one paid job (Q3)

Of those respondents with more than one paid job, the reasons for more than one job are displayed in Figure 3.2 broken down by sector and year of survey. No significant differences exist across the sectors or within any sector between 2001 and 2004.
The participants who had more than one employer were asked to answer the remaining questions in the survey with regard to their main job.

### 3.1.4 Length of time employed in current position (Q4)

Participants were asked to indicate how long they had been employed in their main job. The distribution of times is not significantly different across sectors in either 2001 or 2004 (see Figure 3.3).

Strong evidence (p < 0.001) exists, however, in the private sector of a change in distribution of time in employment between 2001 and 2004. Main source of effect: in
2004 there are relatively fewer nurses with less than 12 months and relatively more with two to five years in main job. No such effect exists in the other two sectors.

### 3.1.5 Postcode of place of employment (Q5)

No analysis on the postcode of the place of employment has been carried out for this report. Further analysis will take place and be used to report on geographical locality of the participants.

### 3.1.6 Type of workplace (Q6)

The distribution of places of work of the respondents in 2004 is displayed in Table 3.1. The responses to this question, rather than the QNU database, were used where possible to identify sector membership.

<table>
<thead>
<tr>
<th>Type of Workplace</th>
<th>Aged care</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>351</td>
<td>422</td>
<td></td>
</tr>
<tr>
<td>Community health</td>
<td>36</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private domiciliary nursing</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public aged care</td>
<td>57</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private aged care</td>
<td>348</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>32</td>
<td>23</td>
</tr>
</tbody>
</table>

*It should be noted that in all reported data in this study there were some missing cases.*

### 3.1.7 Agency work (Q7)

Questions regarding work for nursing agencies were included in the 2004 survey but not in the 2001 survey. Figure 3.4 shows the percentages of nurses from each sector who had worked for a nursing agency in the previous 12 months. No significant differences exist in the percentages across the sectors.

**Figure 3.4 Percentages of nurses who have worked for a nursing agency in the last 12 months**

Only one respondent (in the aged care sector) specified an agency as their main current employer.
3.2 Your Working Hours

3.2.1 Hours worked by agency nurses (Q9)

Participants employed by one or more nursing agencies in the previous four weeks were asked to specify the number of hours in total worked in each of public hospitals, private hospitals, public aged care facilities, private aged care facilities, community health (public), and domiciliary nursing (private). Statistics for the total number of hours worked in these various sectors are summarised in Table 3.2. Because these figures are aggregations over the three sectors, weightings have been applied as appropriate in calculating the mean and median measures. This information was not collected in the 2001 survey.

Table 3.2 Hours worked in nursing agencies in last four weeks

<table>
<thead>
<tr>
<th>Where worked</th>
<th>n</th>
<th>mean</th>
<th>median</th>
<th>min</th>
<th>max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital</td>
<td>52</td>
<td>115.4</td>
<td>128</td>
<td>8</td>
<td>200</td>
</tr>
<tr>
<td>Private hospital</td>
<td>53</td>
<td>69.2</td>
<td>61</td>
<td>4</td>
<td>172</td>
</tr>
<tr>
<td>Public aged care</td>
<td>9</td>
<td>152.0</td>
<td>148</td>
<td>32</td>
<td>304</td>
</tr>
<tr>
<td>Private aged care</td>
<td>29</td>
<td>86.4</td>
<td>90</td>
<td>10</td>
<td>168</td>
</tr>
<tr>
<td>Community health (public)</td>
<td>7</td>
<td>79.4</td>
<td>60</td>
<td>32</td>
<td>160</td>
</tr>
<tr>
<td>Domiciliary nursing (private)</td>
<td>2</td>
<td>52.0</td>
<td>52</td>
<td>40</td>
<td>60</td>
</tr>
<tr>
<td>Agency hours other</td>
<td>7</td>
<td>66.5</td>
<td>40</td>
<td>16</td>
<td>160</td>
</tr>
<tr>
<td>Total hours in agency work</td>
<td>136</td>
<td>113.2</td>
<td>128</td>
<td>0</td>
<td>332</td>
</tr>
</tbody>
</table>

3.2.2 Hours worked in all paid positions, whether this was typical of their normal hours and the type of employment contract (Q10)

Participants were asked to identify, for each paid employment position in which they were currently employed: the total number of ordinary hours worked; the number of hours of paid overtime; the number of hours of unpaid overtime; the amount of Time Off In Lieu (TOIL) accrued and taken; and the number of hours on call in the last four weeks of employment. They were also asked to state if this was less than, about, or more than the usual hours worked. Additionally, they were asked if they were employed in a permanent full-time; permanent part-time; casual; temporary full-time; or temporary part-time capacity.

For the purpose of this study, employment was defined thus:

- permanent full-time: an employee who is engaged in a permanent capacity for 38 hours per week
- permanent part-time: an employee who is engaged in a permanent capacity for less than 38 hours per week
- casual: an employee who is engaged on a daily basis (i.e. should not appear on a roster)
- temporary full-time: an employee who is engaged on a fixed term contract for 38 hours per week
- temporary part-time: an employee who is engaged on a fixed term contract for less than 38 hours per week.
3.2.2.1 Comparison across sectors for permanent full-time employees

Comparisons of the distribution of the various categories of working hours across the aged care, public and private sectors for permanent full-time employees in 2004 are displayed in Figure 3.5.

Figure 3.5 Comparison across sectors of hours worked by permanent full-time employees in previous four weeks

![Comparison across sectors](image-url)
The median number of hours of unpaid overtime is significantly greater (p < 0.001) in the aged care sector for permanent full-time nurses than in the other two sectors. Similarly, the median number of hours of time off in lieu (TOIL) is significantly greater (p < 0.01) in the aged care sector for permanent full-time nurses than in the other two sectors. As regards TOIL taken over the previous four weeks, the three sectors differ significantly (p < 0.01) with the median of respondents in the aged care sector being greater than that for the private sector, which is greater than that of the public sector. No significant differences exist across the sectors for the other types of work time.

### 3.2.2.2 Comparison across sectors for permanent part-time employees

The distributions of time spent over the previous four weeks in the various work time categories are displayed in Figure 3.6 for permanent part-time nurses.

**Figure 3.6 Comparison across sectors of hours worked by permanent part-time employees in previous four weeks**
The median level of unpaid overtime is significantly greater for permanent part-time nurses in the aged care sector (p < 0.001) compared to the other two sectors. No other median measures of work times for permanent part-time nurses differ significantly across the sectors.

### 3.2.2.3 Comparisons across sectors for casual employees

Of the other categories of employment, only casually employed respondents have sufficient numbers to warrant summarising and comparing work times, and even then only for paid ordinary hours. The distributions are compared in Figure 3.7. No significant differences exist in the median number of hours of ordinary paid work, although it should be noted that with the moderately small numbers involved, the power of discrimination is reduced compared to many of the previous analyses in this section.

**Figure 3.7 Comparison across sectors of hours worked by casual employees in previous four weeks**
3.2.2.4 Comparison of work times between 2001 and 2004

A comparison between 2001 and 2004 of the medians of the number of hours worked for each category of work for permanent full-time employees, permanent part-time employees and casuals in each of the sectors reveals no significant differences. It should be noted, however, some comparisons involve relatively small numbers, thereby compromising the discriminating power available.

3.2.2.5 Second and third jobs

In the aged care sector, 31 respondents in 2001 and 29 in 2004 had a second job in nursing; two in 2001 and five in 2004 had a third job. In the public sector 50 respondents in 2001 and 51 in 2004 had a second job in nursing; four in 2001 and six in 2004 had a third job. In the private sector 70 respondents in 2001 and 68 in 2004 had a second job in nursing; nine in 2001 and five in 2004 had a third job.

3.2.2.6 Typical hours worked over last four weeks (Q11)

There is no reason to suspect that the previous four weeks employment is atypical or gives a biased impression of the working hours of nurses in the three sectors judging by the responses (see Figure 3.8) to the question of whether or not the number of hours recorded in the survey is typical of a four-week period for the respondent’s main nursing job.

Figure 3.8 Typical hours worked in the last four weeks

3.2.3 Type of employment (Q12)

As in 2001, very significant differences exist in 2004 across sectors with regard to the type of employment (p < 0.001). The sources are primarily (but not only): relatively more permanent full-time nurses in aged care and relatively fewer permanent part-time nurses in aged care compared to the other two sectors; and
relatively more permanent full-time and more temporary part-time in the public sector than in the other two sectors.

No significant change has occurred between 2001 and 2004 in any of the sectors (see Figure 3.9).

**Figure 3.9 Type of employment**

![Type of employment chart](chart)

**3.2.4 Minimum number of shifts worked (Q13)**

For those nurses who were not permanently employed on a full-time basis, a further question sought to ascertain if they regularly worked a minimum number of shifts (Figure 3.10).

**Figure 3.10 Respondents who indicated whether they worked a minimum number of shifts.**

![Minimum number of shifts chart](chart)

No significant statistical differences exist across the sectors or within sectors between 2001 and 2004.
3.2.5 Number of hours contracted to work each week (Q14)

Nurses who did not work full-time were asked to identify the number of hours they work each week in their main nursing position. It should be noted that the data below do not include nurses who are employed on a permanent full-time basis, or the number of hours that may be worked by nurses who have more than one position.

Summaries for each of the sectors in 2001 and 2004 can be found in Tables 3.3, 3.4 and 3.5.

### Table 3.3 Number of hours worked: Aged care

<table>
<thead>
<tr>
<th>Year</th>
<th>n</th>
<th>mean</th>
<th>median</th>
<th>std deviation</th>
<th>std error of mean</th>
<th>min</th>
<th>max</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>266</td>
<td>30.61</td>
<td>30</td>
<td>15.02</td>
<td>.92</td>
<td>6.00</td>
<td>75.00</td>
</tr>
<tr>
<td>2001</td>
<td>292</td>
<td>26.66</td>
<td>28</td>
<td>8.27</td>
<td>.48</td>
<td>7.50</td>
<td>40.00</td>
</tr>
</tbody>
</table>

### Table 3.4 Number of hours worked: Public

<table>
<thead>
<tr>
<th>Year</th>
<th>n</th>
<th>mean</th>
<th>median</th>
<th>std deviation</th>
<th>std error of mean</th>
<th>min</th>
<th>max</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>188</td>
<td>27.29</td>
<td>28.0</td>
<td>10.25</td>
<td>.74</td>
<td>8.00</td>
<td>80.00</td>
</tr>
<tr>
<td>2001</td>
<td>207</td>
<td>25.25</td>
<td>24.0</td>
<td>6.98</td>
<td>.48</td>
<td>2.00</td>
<td>40.00</td>
</tr>
</tbody>
</table>

### Table 3.5 Number of hours worked: Private

<table>
<thead>
<tr>
<th>Year</th>
<th>n</th>
<th>mean</th>
<th>median</th>
<th>std deviation</th>
<th>std error of mean</th>
<th>min</th>
<th>max</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>260</td>
<td>29.18</td>
<td>29.0</td>
<td>12.54</td>
<td>.78</td>
<td>6.00</td>
<td>97.00</td>
</tr>
<tr>
<td>2001</td>
<td>293</td>
<td>25.76</td>
<td>26.5</td>
<td>7.27</td>
<td>.42</td>
<td>8.00</td>
<td>40.00</td>
</tr>
</tbody>
</table>

3.2.6 Preference to work more contracted shifts (Q15)

Respondents who were not employed in a permanent full-time position were asked to identify if they would like to work more shifts per week in their main position. A summary of responses for 2001 and 2004 across sectors is shown in Figure 3.11.
A highly significant difference ($p < 0.001$) exists across the sectors in the proportion of non-permanently employed nurses preferring to be permanently contracted to work more shifts. This applies in both 2001 and 2004. The primary source in 2004 is the relatively higher number of nurses in the aged care sector who would prefer to be permanently contracted to work more shifts.

Within the private sector but not the aged or public sectors, there is evidence of a change ($p = 0.01$) in proportions between 2001 and 2004. In the private sector there are relatively more nurses in 2004 than 2001 who would prefer to be permanently contracted to work more shifts.

### 3.2.7 Preference for permanent employment (Q16)

Those nurses who were employed on a temporary or casual basis or by a nursing agency were asked to indicate if they would prefer to be permanently employed. Only 24 nurses in 2001 and 33 in 2004 across all sectors answered this question, so there are insufficient numbers to allow useful comparisons to be made (see Figure 3.12).

![Figure 3.12 Preference for permanent employment](image)

### 3.2.8 Shifts worked (Q17)

All participants were asked to indicate the type of shifts they worked in their main nursing position. Highly significant differences exist among the sectors with respect to types of shifts worked in the main nursing position over all employee types ($p < 0.001$), in both 2001 and 2004. In 2004 the main source of differences is the relatively fewer continuous shift workers in the aged care sector and relatively more in the public sector compared to the private sector. Also, among other differences, there are relatively fewer morning and evening shift workers in the public sector and relatively more evening shift workers in the aged care sector than in the other two sectors (see Figure 3.13).

No significant change was observed within any of the sectors between 2001 and 2004.
Further analysis of this question was undertaken to ascertain if there were any similarities and differences between permanent full-time staff, between sectors. Once again, in both 2001 and 2004 significant differences (p < 0.001) exist among the sectors with respect to types of shifts worked in the main nursing job for participants who were employed on a permanent full-time basis. As in 2001, the main source of differences in 2004 is the relatively fewer continuous shift workers in the aged care sector and relatively more in the public sector compared to the private.

Among other differences, there are relatively more morning and evening shift workers in the private sector than in the other two sectors (see Figure 3.14).

No significant change between 2001 and 2004 has occurred.
### 3.2.9 Work patterns (Q18)

All participants were asked to indicate if they worked weekends only, Monday to Friday only, or shifts that encompassed the seven days of the week. The responses for 2001 and 2004 across the three sectors are summarised in Figure 3.15.

![Figure 3.15 Work patterns of respondents](image)

Highly significant differences exist among the sectors with respect to work times during the week in the main nursing job across all employee types \( (p < 0.001) \), in both 2001 and 2004. In 2004 the main source of the effect is the relatively higher proportion in the private sector and lower proportion in the aged care sector who have worked only Monday-Friday in the last four weeks. Of course, there is a commensurately lower proportion in the private sector and higher proportion in the aged care sector relative to the public sector who have worked over all seven days in the last four weeks.

For nurses employed full-time, a different pattern emerged as shown below (see Figure 3.16).

![Figure 3.16 Full-time employees and work patterns](image)

For these nurses, differences among the sectors are no longer significant.
3.3 Your Working Conditions

3.3.1 Ability to complete work in the paid time available (Q19)

Participants were asked to indicate, on a five-point Likert scale, whether they were able to complete their job to their satisfaction within the paid time available. A summary comparison of 2001 with 2004 in each sector is displayed in Figure 3.17.

Highly significant (p < 0.001) differences exist among sectors in both 2001 and 2004. In 2004 there is little difference in the average response of nurses in the public and private sectors. However, nurses in the aged care sector on average find it relatively more difficult than public or private nurses to complete their job to their satisfaction (p < 0.001).

In the aged care sector, but not in the other two sectors, there is significant evidence (p=0.01) of a change between 2001 and 2004. Although the average response is still significantly inferior to that of the other two sectors, a significant improvement on average for aged care nurses is indicated between 2001 and 2004 (p = 0.01).

This effect, on average, appears strongest for permanent part-time employees, but it persists in both the public and private aged care sectors for Assistants in Nursing (AINs), Enrolled Nurses (ENs) and RNs, and for permanent full-time and non-permanent staff.

3.3.2 Sufficient staff employed in work unit (Q20)

There is a highly significant difference (p < 0.001) across the sectors in the proportion of nurses who believe sufficient staff were employed in their work unit over the last 6 months to meet the patient/client needs (including physical, social and mental health). This applies in both 2001 and 2004. The major source of this
difference in 2004 is the relatively high proportion of aged care nurses who believe there is 'never', or 'very seldom', sufficient staff to meet needs. In terms of average response, the perception of nurses in the aged care sector is that they are worse off than nurses in the public and private sectors (p < 0.001). On average no significant difference exists between the public and private sectors (see Figure 3.18).

**Figure 3.18 Sufficient staff to meet patient/client needs?**

![Figure showing percentage of nurses' perceptions across sectors and years](image)

Between 2001 and 2004 an improvement in average response to this issue has occurred in the aged care (p < 0.01) and public (p = 0.001) sectors. No such change is apparent in the private sector.

In the aged care sector, this average improvement appears to exist in both the public and private sectors regardless of the type of nurse or conditions of employment. Likewise, in the public sector the effect appears to persist regardless of the type of nurse and conditions of employment.

### 3.3.3 Skill mix (Q21 and Q22)

All participants were asked if, in their professional opinion as a nurse, the skill-mix of the nursing staff employed in their working unit over the last six months was adequate to meet the daily needs of patients/clients. The data reveal that in both 2001 and 2004 there is a highly significant difference across sectors in the proportion of nurses who believe the skill mix of staff is adequate (p < 0.001). In 2004 the major source of this effect is the relatively high proportion of aged care nurses who never or very seldom believe there is sufficient skill mix to meet patient needs.

There is good evidence in the aged sector (p = 0.002) and weaker evidence in the public sector (p = 0.03) of differences between 2001 and 2004. In the aged care sector, on average, there is significant evidence (p = 0.001) of an improvement in the perceived adequacy of skill mix support. This effect persists for both the public...
and private aged care sectors across AINs, ENs and RNs, regardless of whether the nurses are permanent full-time, permanent part-time or otherwise.

In the public sector the main reason for the difference between 2001 and 2004 is the relatively higher response of ‘always or nearly always’ to this question. However, in terms of average response, there is little change between 2001 and 2004 (see Figure 3.19).

Figure 3.19 Skill mix adequate?

Nurses who indicated the responses ‘never or very seldom’ and ‘seldom’ were asked to indicate from a list of variables (with a choice of an ‘other’ category) the factors they believed influenced the skill mix in their facility. Summaries of the 2001 and 2004 responses can be found in Tables 3.6 and 3.7.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Aged care</th>
<th></th>
<th>Public</th>
<th></th>
<th>Private</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Too many inexperienced staff</td>
<td>83</td>
<td>38.2</td>
<td>96</td>
<td>53.3</td>
<td>68</td>
<td>36.4</td>
</tr>
<tr>
<td>Too few experienced staff</td>
<td>103</td>
<td>47.5</td>
<td>122</td>
<td>67.8</td>
<td>64.7</td>
<td></td>
</tr>
<tr>
<td>Too many unlicenced care providers</td>
<td>19</td>
<td>8.8</td>
<td>4</td>
<td>2.2</td>
<td>12</td>
<td>6.4</td>
</tr>
<tr>
<td>Too many agency staff used</td>
<td>39</td>
<td>18.0</td>
<td>30</td>
<td>16.7</td>
<td>57</td>
<td>30.5</td>
</tr>
<tr>
<td>Too many casual staff used</td>
<td>25</td>
<td>11.5</td>
<td>56</td>
<td>31.1</td>
<td>38</td>
<td>20.3</td>
</tr>
<tr>
<td>Too few relief/agency staff available</td>
<td>50</td>
<td>23.0</td>
<td>62</td>
<td>34.4</td>
<td>61</td>
<td>32.6</td>
</tr>
<tr>
<td>Lack of funding</td>
<td>94</td>
<td>43.3</td>
<td>41</td>
<td>22.8</td>
<td>29</td>
<td>15.5</td>
</tr>
<tr>
<td>Employer policy on the minimum skill mix for the facility</td>
<td>72</td>
<td>33.2</td>
<td>26</td>
<td>14.4</td>
<td>47</td>
<td>25.1</td>
</tr>
<tr>
<td>Other</td>
<td>22</td>
<td>10.1</td>
<td>19</td>
<td>10.6</td>
<td>17</td>
<td>9.1</td>
</tr>
<tr>
<td><strong>Total number of respondents</strong></td>
<td><strong>217</strong></td>
<td><strong>10.1</strong></td>
<td><strong>19</strong></td>
<td><strong>10.6</strong></td>
<td><strong>17</strong></td>
<td><strong>9.1</strong></td>
</tr>
</tbody>
</table>

*Respondents could choose more than one response to this question.
Table 3.7 Reasons for inadequate skill mix: 2001

<table>
<thead>
<tr>
<th>Factor</th>
<th>Aged care</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Too many inexperienced staff</td>
<td>113</td>
<td>41.4</td>
<td>90</td>
</tr>
<tr>
<td>Too few experienced staff</td>
<td>131</td>
<td>48</td>
<td>122</td>
</tr>
<tr>
<td>Too many unlicenced care providers</td>
<td>42</td>
<td>15.4</td>
<td>7</td>
</tr>
<tr>
<td>Too many agency staff used</td>
<td>53</td>
<td>19.4</td>
<td>49</td>
</tr>
<tr>
<td>Too many casual staff used</td>
<td>55</td>
<td>20.1</td>
<td>58</td>
</tr>
<tr>
<td>Too few relief/agency staff available</td>
<td>60</td>
<td>22</td>
<td>74</td>
</tr>
<tr>
<td>Lack of funding</td>
<td>130</td>
<td>47.6</td>
<td>75</td>
</tr>
<tr>
<td>Employer policy on the minimum skill mix for the facility</td>
<td>94</td>
<td>34.4</td>
<td>30</td>
</tr>
<tr>
<td>Other</td>
<td>29</td>
<td>10.6</td>
<td>35</td>
</tr>
<tr>
<td>Total number of respondents*</td>
<td>273</td>
<td></td>
<td>215</td>
</tr>
</tbody>
</table>

*Respondents could choose more than one response to this question.

Each source of skill mix inadequacy is examined individually in the following subsections. Percentages are expressed as a fraction of those respondents who believed skill mix was sometimes or often compromised in the previous six months.

3.3.3.1 Too many inexperienced staff?

Significant differences exist across sectors in 2004 (p < 0.01) in the percentage of nurses who perceive the presence of too many inexperienced staff as a reason for inadequate skill mix in the workplace. The proportion of public sector respondents perceiving too many inexperienced staff is greater than that of the other two sectors. No significant differences existed in 2001 (see Figure 3.20).

In the public sector there is some evidence of deterioration in the perceived level of this factor from 2001 to 2004 (p < 0.05).

Figure 3.20 Inexperienced staff as reason for inadequate skill mix
3.3.3.2 Too few experienced staff?

Highly significant differences exist across sectors in 2004 (p < 0.001). The proportion of nurses in the aged care sector perceiving a lack of experienced staff is lower than that of the other two sectors. A similar significant effect existed in 2001 (p < 0.05).

In the public sector a significant deterioration has been perceived in this factor from 2001 to 2004 (p < 0.05) (see Figure 3.21).

Figure 3.21 Too few experienced staff as reason for inadequate skill mix

3.3.3.3 Too many unlicenced care providers?

Significant differences exist across sectors in both 2004 (p < 0.05) and 2001 (p < 0.001). In both 2004 and 2001, the proportion of nurses in the aged care sector, citing too many unlicenced care providers, is higher than that in the private sector, which is higher than that in the public sector.

There is evidence in the aged care sector (p < 0.05) of a decrease between 2001 and 2004 in the importance of this factor. No significant changes in time exist in the other sectors (see Figure 3.22).

Figure 3.22 Unlicenced care providers as reason for inadequate skill mix
### 3.3.3.4 Too many agency staff?

Significant differences exist across sectors in 2004 ($p < 0.01$) and in 2001 ($p = 0.001$). In both 2004 and 2001, the proportion of nurses in the private sector perceiving the presence of too many agency staff, is greater than that of the other two sectors. There is no significant evidence of a change between 2001 and 2004 (see Figure 3.23).

![Figure 3.23 Too many agency staff as reason for inadequate skill mix](image)

### 3.3.3.5 Too many casual staff?

Highly significant differences exist across sectors in 2004 ($p < 0.001$) but not in 2001. In 2004 the proportion of nurses perceiving the presence of too many casual staff is greater in the public sector than in the private sector, which in turn is greater than in the aged care sector (see Figure 3.24).

There is evidence in the aged care sector that the proportion of nurses noting too many casual staff has decreased significantly from 2001 to 2004 ($p = 0.01$).

![Figure 3.24 Too many casual staff as reason for inadequate skill mix](image)
3.3.3.6 Too few relief/agency staff available?

Significant evidence exists to argue for differences across the sectors, in 2004 (p < 0.05) and 2001 (p < 0.01), in the proportion of nurses who perceive a lack of availability of relief or agency staff. In both years the proportion of nurses who perceive the presence of too few relief or agency staff is lower in the aged care sector than in the private and public sectors (see Figure 3.25).

There is evidence in the public and private sectors that the proportion noting the availability of too few relief and agency staff has increased significantly from 2001 to 2004 (p < 0.01).

Figure 3.25 Too few relief/agency staff as reason for inadequate skill mix

3.3.3.7 Lack of funding?

Highly significant evidence exists in both 2001 and 2004 (p < 0.001) of differences across sectors regarding the perceived lack of funding as a cause of poor skill mix. In both years the proportion of nurses in aged care is greater than that of nurses in the public sector, which is greater than that in the private sector.

In the public sector there has been a significant reduction from 2001 to 2004 in the percentage of nurses who perceive lack of funding as a factor contributing to inadequate skill mix (see Figure 3.26).

Figure 3.26 Lack of funding and inadequacy of skill mix
3.3.3.8 Employer policy on skill mix?

In both 2001 and 2004 highly significant differences (p < 0.001) exist across sectors with regard to the proportions of nurses who perceive employer policy regarding skill mix as a source of inadequate skill mix in the workplace. In both years the proportion of nurses in the aged care sector is greater than that in the public sector, which is, in turn, greater than that in the private sector (see Figure 3.27).

A significant increase from 2001 to 2004 in the proportion of nurses citing this factor has occurred in the private sector (p < 0.05).

Figure 3.27 Employer policy and inadequacy of skill mix

The next question focused on the type of rostering system operating within the respondent’s workplace.

3.3.4 Type of roster in work unit or ward (Q23)

There is a highly significant difference across sectors in the types of rosters employed (p < 0.001) in both 2001 and 2004. There are substantial differences in all categories of response. The most statistically significant is the relatively low proportion of nurses who report request-based rostering, and the relatively high proportion who report fixed non-rotating rostering in the aged care sector, compared to the other two sectors (see Figure 3.28). There is no evidence of a change between 2001 and 2004.
3.3.5 Satisfaction with rostering practices in the workplace (Q24)

Participants were asked to indicate their level of satisfaction with the rostering practices in their workplace. The data indicate that a highly significant difference exists in the level of satisfaction across the sectors with regard to rostering practices ($p < 0.001$) in both 2001 and 2004 (see Figure 3.29). In 2004 the main reasons for these differences are the relatively low proportion of nurses responding ‘often’ and relatively high proportion responding ‘never’ in the aged care sector, compared to the other two sectors. No significant change has occurred between 2001 and 2004.
In the aged care sector in 2004 there is a highly significant correlation between age and satisfaction with rostering practice in the workplace. In particular, older nurses are relatively more satisfied with rostering practices than younger nurses. No significant association exists in the other sectors in either 2004 or 2001 (see Figure 3.30).

**Figure 3.30 Satisfaction with rostering practices and estimated mean age of nurse**

Further analysis of the data revealed no significant correlations within any sector in 2001 and 2004 between whether a nurse has a significant family responsibility or whether or not there is a dependent child and their satisfaction with the rostering practices (see Figures 3.31, 3.32, 3.33, 3.34).

**Figure 3.31 Significant family responsibility and satisfaction with rostering practices (2004)**
Figure 3.32 Significant family responsibility and satisfaction with rostering practices (2001)

Figure 3.33 Dependent child and satisfaction with rostering practices (2004)

Figure 3.34 Dependent child and satisfaction with rostering practices (2001)
In the aged care sector in 2004, RNs are significantly more satisfied with rostering practice in their workplace than ENs or AINs (p=0.01). In the public sector, RNs are significantly more satisfied with rostering practices in their workplace than ENs (p<0.001). No significant association exists in the public sector (see Figure 3.35).

**Figure 3.35 Satisfaction with rostering practices and job designation (2004)**

**Figure 3.36 Satisfaction with rostering practices and job designation (2001)**
### 3.3.6 Input into roster (Q25)

A scale was also used to determine respondents’ frequency of input into their rosters. Once again, there are highly significant differences ($p < 0.01$) across the sectors in the degree of input nurses have into rostering, in both 2004 and 2001. These differences occur in all response categories. The most statistically significant differences are in the aged care sector where nurses have less say in their rostering than nurses in the other two sectors. There is no evidence of a significant change between 2001 and 2004 (see Figure 3.37).

**Figure 3.37 Input into roster**

![Input into roster](image)

Younger nurses in the public sector are relatively more likely than older nurses to have input into their rosters. A non-significant correlation with the same direction existed in the public sector in 2001 (see Figure 3.38).

**Figure 3.38 Level of input into roster and estimated age of the nurse**

![Level of input into roster and estimated age of the nurse](image)

Further analysis of the data revealed no significant correlations within any sector in 2001 and 2004 between whether a nurse has a significant family responsibility or whether or not there is a dependent child and their level of input into their roster (see Figures 3.39, 3.40, 3.41, 3.42).
In the aged care sector, RNs have significantly more input into their rosters than ENs or AINs ($p<0.001$). Similarly, RNs in the public sector have significantly more input into their rosters than ENs. While not significant in the private sector, the same trend is apparent with RNs reporting more input into their rosters than ENs (see Figure 3.43, Figure 3.44).

**Figure 3.43 Roster input and job designation (2004)**
3.3.7 Working of double shifts (Q26)

Few nurses (a total of 26 across sectors) worked double shifts ‘always’ or ‘often’. On average, however, in both 2004 and 2001 the requirement to work double shifts is significantly higher in the public and private sectors than in the aged care sector (p < 0.001). In 2004 there is no significant difference between the public and private sectors in this regard (see Figure 3.45).

With regard to the percentage of nurses working double shifts, on average, conditions have deteriorated significantly in the aged care sector between 2001 and 2004 (p < 0.01) and there is a some evidence that conditions may have also deteriorated on average in the public sector (p = 0.05).
3.3.8 Standard minimum and maximum hours per shift (Q27)

Participants were asked to indicate the standard rostered minimum and maximum hours per shift worked in their workplace. This estimate was to exclude overtime. Only responses from those who specified lengths of time between two and 12 hours inclusive are included in the analysis. Summary statistics of minimum and maximum rostered shift length are presented in Tables 3.8 - 3.13 for 2001 and 2004 for each sector.

Table 3.8 Minimum standard rostered shift length (hours): Aged care

<table>
<thead>
<tr>
<th>Year</th>
<th>n</th>
<th>mean</th>
<th>median</th>
<th>std deviation</th>
<th>std error of mean</th>
<th>min</th>
<th>max</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>297</td>
<td>5.01</td>
<td>4.0</td>
<td>1.58</td>
<td>.092</td>
<td>3.0</td>
<td>9.25</td>
</tr>
<tr>
<td>2001</td>
<td>384</td>
<td>5.05</td>
<td>4.0</td>
<td>1.62</td>
<td>.083</td>
<td>2.0</td>
<td>10.0</td>
</tr>
</tbody>
</table>

Table 3.9 Maximum standard rostered shift length (hours): Aged care

<table>
<thead>
<tr>
<th>Year</th>
<th>n</th>
<th>mean</th>
<th>median</th>
<th>std deviation</th>
<th>std error of mean</th>
<th>min</th>
<th>max</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>297</td>
<td>8.04</td>
<td>8.00</td>
<td>.82</td>
<td>.048</td>
<td>3.0</td>
<td>12.0</td>
</tr>
<tr>
<td>2001</td>
<td>384</td>
<td>8.23</td>
<td>8.00</td>
<td>.77</td>
<td>.039</td>
<td>4.25</td>
<td>12.0</td>
</tr>
</tbody>
</table>

Table 3.10 Minimum standard rostered shift length (hours): Public

<table>
<thead>
<tr>
<th>Year</th>
<th>n</th>
<th>mean</th>
<th>median</th>
<th>std deviation</th>
<th>std error of mean</th>
<th>min</th>
<th>max</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>312</td>
<td>6.99</td>
<td>8.00</td>
<td>1.60</td>
<td>.091</td>
<td>3.0</td>
<td>12.0</td>
</tr>
<tr>
<td>2001</td>
<td>411</td>
<td>6.78</td>
<td>8.00</td>
<td>1.73</td>
<td>.085</td>
<td>2.0</td>
<td>9.00</td>
</tr>
</tbody>
</table>

Table 3.11 Maximum standard rostered shift length (hours): Public

<table>
<thead>
<tr>
<th>Year</th>
<th>n</th>
<th>mean</th>
<th>median</th>
<th>std deviation</th>
<th>std error of mean</th>
<th>min</th>
<th>max</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>312</td>
<td>8.78</td>
<td>8.00</td>
<td>1.29</td>
<td>.073</td>
<td>4.0</td>
<td>12.0</td>
</tr>
<tr>
<td>2001</td>
<td>411</td>
<td>8.47</td>
<td>8.00</td>
<td>0.92</td>
<td>.046</td>
<td>7.36</td>
<td>12.0</td>
</tr>
</tbody>
</table>

Table 3.12 Minimum standard rostered shift length (hours): Private

<table>
<thead>
<tr>
<th>Year</th>
<th>n</th>
<th>mean</th>
<th>median</th>
<th>std deviation</th>
<th>std error of mean</th>
<th>min</th>
<th>max</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>372</td>
<td>5.85</td>
<td>6.00</td>
<td>1.95</td>
<td>.101</td>
<td>2.0</td>
<td>12.0</td>
</tr>
<tr>
<td>2001</td>
<td>425</td>
<td>5.64</td>
<td>6.00</td>
<td>1.90</td>
<td>.092</td>
<td>2.0</td>
<td>9.00</td>
</tr>
</tbody>
</table>

Table 3.13 Maximum standard rostered shift length (hours): Private

<table>
<thead>
<tr>
<th>Year</th>
<th>n</th>
<th>mean</th>
<th>median</th>
<th>std deviation</th>
<th>std error of mean</th>
<th>min</th>
<th>max</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>372</td>
<td>9.29</td>
<td>9.50</td>
<td>1.45</td>
<td>.075</td>
<td>4.0</td>
<td>12.0</td>
</tr>
<tr>
<td>2001</td>
<td>425</td>
<td>8.94</td>
<td>8.00</td>
<td>1.16</td>
<td>.056</td>
<td>5.0</td>
<td>12.0</td>
</tr>
</tbody>
</table>

On average the minimum shift length varies significantly across sectors, with the public sector being longer than the private sector, which in turn is larger than the aged care sector. This holds for both 2004 and 2001. In the public and private
sectors, however, there is significant evidence of an increase in average minimum shift length (public, $p = 0.001$; private, $p < 0.01$).

For maximum shift length, on average the private sector is longer than the public sector which is longer than the aged care sector, and this holds for 2004 and 2001. Once again an increase in the private and public sectors between 2001 and 2004 is evident (public, $p < 0.001$; private, $p < 0.001$).

In contrast, in the aged care sector, the average minimum and maximum length of shift has decreased ($p < 0.01$).

### 3.3.9 Factors influencing working hours (Q28)

The prevalence of factors affecting the type of shifts and hours worked by the participants over the previous four weeks of employment is shown in Tables 3.14 and 3.15.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Aged care</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Not applicable</td>
<td>137</td>
<td>35.0</td>
<td>121</td>
</tr>
<tr>
<td>Family responsibilities</td>
<td>69</td>
<td>17.6</td>
<td>112</td>
</tr>
<tr>
<td>Study commitments</td>
<td>25</td>
<td>6.4</td>
<td>23</td>
</tr>
<tr>
<td>Sporting commitments</td>
<td>6</td>
<td>1.5</td>
<td>16</td>
</tr>
<tr>
<td>Staff turnover</td>
<td>54</td>
<td>13.8</td>
<td>39</td>
</tr>
<tr>
<td>Your leave/absence</td>
<td>73</td>
<td>18.7</td>
<td>64</td>
</tr>
<tr>
<td>Other staff leave/absence</td>
<td>150</td>
<td>38.4</td>
<td>158</td>
</tr>
<tr>
<td>Others</td>
<td>17</td>
<td>4.3</td>
<td>32</td>
</tr>
<tr>
<td><strong>Total number of respondents</strong></td>
<td>391</td>
<td></td>
<td>399</td>
</tr>
</tbody>
</table>

*Respondents could choose more than one response to this question.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Aged care</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Not applicable</td>
<td>231</td>
<td>54.7</td>
<td>196</td>
</tr>
<tr>
<td>Family responsibilities</td>
<td>98</td>
<td>23.2</td>
<td>172</td>
</tr>
<tr>
<td>Study commitments</td>
<td>26</td>
<td>6.2</td>
<td>46</td>
</tr>
<tr>
<td>Sporting commitments</td>
<td>5</td>
<td>1.2</td>
<td>18</td>
</tr>
<tr>
<td>Leave</td>
<td>60</td>
<td>14.2</td>
<td>88</td>
</tr>
<tr>
<td>Other</td>
<td>39</td>
<td>9.2</td>
<td>44</td>
</tr>
<tr>
<td><strong>Total number of respondents</strong></td>
<td>422</td>
<td></td>
<td>477</td>
</tr>
</tbody>
</table>

*Respondents could choose more than one response to this question.

A highly significant difference exists across the sectors in 2001 (but not in 2004) in the proportions of nurses whose work hours or shifts in the previous four weeks have not been affected by the cited factors. In each sector there has been a
significant increase between 2001 and 2004 in the proportion of nurses who whose hours or shifts in the previous four weeks are affected by one of other of the cited factors (see Figure 3.46).

Figure 3.46 Not applicable responses to factors affecting hours and type of shifts worked.

The factors influencing the number of hours or type of shift worked in the previous four weeks are further examined in the following subsections.

3.3.9.1 Family responsibilities

In both 2001 and 2004, the proportion of nurses citing family responsibilities as a factor is significantly lower in the aged care sector, than in the public or private sectors ($p < 0.001$). No significant change exists, however, between 2001 and 2004 in any of the sectors (see Figure 3.47).

Figure 3.47 Family responsibilities affecting shifts worked
In the aged care sector in 2004, nurses without significant family responsibilities are significantly older (p < 0.001) than those with significant family responsibilities in the other sectors. No such significant differences exist in the other two sectors. A similar effect existed in 2001.

In the private sector there is a significant relationship between employment status (permanent full-time, permanent part-time or casual) and the impact on hours or shifts worked and family responsibilities (p < 0.001). In particular, a substantially higher proportion of permanent part-time or casual employees are affected than permanent full-time employees. This same trend exists to a lesser degree in the public sector (p < 0.05) and in turn to a lesser, non-statistically significant extent in the aged care sector.

### 3.3.9.2 Study commitments

No significant differences exist across the sectors in either 2001 or 2004 as regards the importance of study commitments as a factor in influencing work. A significantly diminished proportion of nurses in the private (p < 0.01) and public (p < 0.05) sectors cite this factor in 2004 compared to 2001 (see Figure 3.48).

![Figure 3.48 Study commitments affecting shifts worked](image)

### 3.3.9.3 Sporting commitments

The proportions are small, but a significant difference exists across sectors in 2001 (p < 0.01) but not 2004 in the percentage of nurses citing sporting commitments as a factor. No significant differences exist between 2001 and 2004 (see Figure 3.49).
3.3.9.4 Staff turnover

This factor was not presented in the 2001 survey. No significant difference exists among the sectors for nurses in the 2004 survey (see Figure 3.50).

3.3.9.5 Leave/absence

In the 2001 survey this factor was simply described as ‘leave’, without specifying whether it was the respondent’s leave or otherwise (see Figure 3.51). In the 2004 survey ‘your leave/absence’ (see Figure 3.52) and ‘other staff leave/absence’ (see Figure 3.53) were separated. Consequently response proportions cannot be compared between years. No significant differences were observed across the sectors in 2004 for either of these factors.
3.3.10 Workload workplace processes (Q29)

Participants were asked to indicate if there was a committee and/or process in place that dealt with workload related issues. The data indicate a highly significant difference (p < 0.001) across sectors concerning knowledge about, and existence of, a process to deal with workload related issues for 2001 as well as 2004. The reasons for this effect are the relatively high ‘yes’ response in the public sector and relatively low ‘yes’ response in the private sector (see Figure 3.54).

Figure 3.54 Workplace committee/process dealing with workload related issues

A change is apparent between 2001 and 2004, particularly in the public sector (p < 0.001) and to a lesser extent in the aged care and private sectors (p < 0.05). The main reason for the change in the public sector is that the ‘no’ response is substantially lower in 2004 compared to 2001.

When the ‘don’t know’ respondents are excluded from the data, the difference in the proportions of ‘yes’ across the sectors remains highly significant in 2004 (p < 0.001), unlike in 2001 (see Figure 3.55). Also the change over time is now significant (p < 0.001) for the public sector only. The reasons for these effects are the same as described earlier with the ‘don’t knows’ included.
3.3.11 Effectiveness of workload committee/process (Q30)

Participants were asked to indicate on a five-point Likert scale if, in their experience, the workload committee and/or processes were effective (see Figure 3.56). The data indicate there is evidence of a difference across the sectors in the perceived effectiveness of the committee/process ($p = 0.01$) in 2001 but not in 2004 ($p = 0.30$). There is some evidence ($p = 0.01$) of a change in perception between 2001 and 2004 in the private sector. This is because there were relatively more respondents in the ‘never or seldom’ category and relatively fewer in the ‘sometimes’ category in 2004 than in 2001.

The respondents were then given an opportunity to provide qualitative comments on workload issues within their workplace.
3.3.12 Qualitative comments on workload (Q31)

A total of 547 respondents (189 in aged care sector, 158 in public and 200 in private) provided a response to this question. This compares to a total of 605 respondents in 2001 (190 in the aged care sector, 209 in the public sector and 206 in the private sector). Table 3.16 provides an outline of the themes that arose from this question.

A variety of formal mechanisms were identified throughout each of the sectors to deal with workload related issues, namely, reporting directly to management, regular meetings, workload committees and completing incident forms. Other informal strategies commented on by nurses in each of the sectors were related more to changing work practices, flexible rostering, changing shift times and hours, and hiring agency staff. However, these were all identified as strategies to address workload related issues, overall across the sectors ‘very little’ to ‘no action’ or ‘not addressed’ were common phrases.
Table 3.16 Themes and sub-themes arising from analysis of the qualitative data relating to workload

<table>
<thead>
<tr>
<th>Theme</th>
<th>2001 Aged Care</th>
<th>%</th>
<th>2004 Aged Care</th>
<th>%</th>
<th>2001 Public</th>
<th>%</th>
<th>2004 Public</th>
<th>%</th>
<th>2001 Private</th>
<th>%</th>
<th>2004 Private</th>
<th>%</th>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>a) Reported to manager</td>
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<td>24</td>
<td>62</td>
<td>33</td>
<td>55</td>
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<td>31</td>
<td>71</td>
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<td>33</td>
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<td>b) Reported at meetings</td>
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<td>23</td>
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<td>16</td>
<td>15</td>
<td>9</td>
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<td>• Put up with it</td>
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### 3. Influences on workload issues

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<th>%</th>
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<th>%</th>
<th>2004 Public</th>
<th>%</th>
<th>2001 Private</th>
<th>%</th>
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<th>%</th>
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<td>b) Short staffed</td>
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<td>c) Heavy workloads</td>
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<td>d) Hour cuts / staff cuts / no funding</td>
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<td>e) Agency / casuals</td>
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<td>j) Trend care</td>
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<td>0</td>
<td>0</td>
<td>8</td>
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<td>3</td>
<td>17</td>
<td>8</td>
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<td>k) Flexible rostering</td>
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<td>3</td>
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73
It is apparent that there were some differences in responses across the sectors. Each sector response is now discussed.

3.3.12.1 Aged care sector

Thirty-five percent (n=189) of nurses from the aged care sector provided a response to the question. Similar to other sectors, nurses in this sector noted that workload issues were reported verbally, documented and that action was or was not taken. They also noted specific influences on workload issues as well as commenting on the outcomes of reporting workload issues (both verbally or by documentation).

a) Reporting workload issues

i) Reported to manager

Thirty-three percent (n=62) of these nurses stated they reported any workload related issues to a senior member of staff such as the Director of Nursing (DON), Nurse Unit Manager (NUM) or Clinical Nurse Consultant (CNC), Case Manager, RN in charge, Shift Supervisor or an Administrative Officer. Three nurses (2%) commented their facility did not have a DON at that point in time so there were no mechanisms in place to deal with workloads. One such comment was:

At the moment nothing. DON on stress leave... Do not know who is running facility at the moment.

ii) Reported at meetings

Reporting or addressing workload issues at meetings was mentioned by 23% (n=43) of nurses across the aged care sector. The frequency of these meetings ranged from regularly, weekly to mostly monthly. The types of meetings where workload issues were reported and discussed were general staff meetings (16%:n=30) or at safety, work or service improvement team meetings (7%:n=13). There were no comments to suggest that workload issues were reported or addressed on a day-to-day or shift-by-shift basis as is the case in both the public and private sectors.

iii) Documented

Seven percent (n=13) of nurses working in the aged care sector commented on 'specific improvement log forms'. Ironically, completing these forms created further workload issues, as one respondent noted:

There is paperwork that states they deal with workload issues but the reality is we have to work overtime to get it done.
Committees such as workplace health and safety and work improvement teams were only mentioned by 7% (n=14) of respondents as avenues whereby workload issues were reported, but not necessarily addressed. For example:

*Committee talks about a solution but does not commit to fixing the problem. All talk, no action.*

**b) Outcome of reporting of workload issues**

**i) Nothing is done - reported but not addressed**

Thirty-three percent (n=62) of the nurses who stated workload related issues were reported, noted that the issues were not addressed. Some of the many comments made were:

*Staff often address these issues to management but nothing is ever done.*

*Meetings which never get results… issues discussed and then forgotten about.*

*We are told there are no workload related issues and to ‘just do it.’*

**ii) Action is taken - reported addressed/attempted**

In contrast, seven percent (n=14) of respondents noted that workload related issues were addressed, or at the very least acknowledged, at their place of employment. For example:

*Supervisor advised of issue, addressed immediately by either discussion or meeting with appropriate staff depending on issue raised.*

*If there is a problem it is addressed straight away. We feel comfortable going to management with issues and find we are listened to.*

**iii) Action is taken**

Flexible rostering, changing shift hours, employing staff for short periods during the busy times of the day were examples of other ways workloads were managed in the aged care sector. For example:

*Workload on the morning shift… a four hour nurse to lighten the workload and provide better quality care to our residents.*
iv) **Adverse outcomes**

Some respondents reported adverse outcomes that they believed were associated with workload issues. Two percent (n=4) of respondents noted that if they raised concerns about workloads they felt bullied and intimidated by management. As one respondent stated:

> You complain to ADON [Assistant Director of Nursing] or DON and are usually told that if we aren't happy there is a long list of job seekers out there waiting to take our jobs.

**c) Influences on workload**

With regard to influences on workload issues, several sub-themes were apparent. These were:

- 9% (n=17) mentioned staff shortages. An example of this theme was:

  *Grossly understaffed, insufficient lifting equipment, staff need to use hoists on their own and position heavy patients on their own.*

- 6% (n=11) recalled no available replacement staff to cover staff either on sick leave or on leave. This resulted in heavy workloads. As one respondent suggested:

  *Continual heavy workload, inadequate staffing and subsequent increasing sick leave place staff morale on the ground at all times.*

The issues raised by the 2004 respondents were similar to those raised in 2001. There were, however, some differences in the frequency in which the respondents raised issues between 2001 and 2004. In particular, it should be noted (see Table 3.16) that in 2004:

- more workload issues were reported to managers but fewer were reported at meetings
- there appeared to be less documentation of workload issues
- a higher percentage of respondents in 2004 believed that no action was being taken by management to address the issues
- there was an increase (but caution is advised due to small numbers of respondents) in the percentage of respondents who believed their facility was short staffed; had heavy workloads; and that there were no replacement staff available
- there were fewer respondents (again small numbers) who believed that funding was an influence on workloads.

Generally the comments from the 2004 surveys were negative and the respondents appeared to be constantly faced with insurmountable workloads and were attempting to have these issues addressed. However, for the majority, there appeared to be no resolution.
3.3.12.2 Public sector

A smaller percentage, 29% (n=158) of nurses from the public sector offered a comment to this question. This compared to a total of 209 respondents in 2001.

a) Reported

i) Reported to manager

Reporting workloads to management was commented on by 31% (n=49) of the respondents. They reported workload related issues to a senior member of staff, mostly the Nursing Unit Manager (NUM), Clinical Nurse Consultant (CNC) or Level 3, Level 2, After Hours Manager, or the DON.

ii) Reported at meetings

A further nine percent (n=14) of respondents noted they raised workload issues at meetings such as workload management committees.

iii) Documented

Nineteen percent (n=30) of respondents stated they documented workload issues on 'a form'.

b) Outcomes

i) Not addressed / nothing is done

Twenty-two percent (n=34) of the forty-nine respondents who stated workload related issues were reported went on to say they were not addressed or that nothing was done. Some examples of this were:

- Reported to CN/NPC – usually nil action taken.

- We fill out forms and management ‘fudge’ the issues and report that staffing levels are adequate.

- There is a workload committee – however we never hear from them and they never respond to issues that occur.
ii) Action is taken

A similar number of respondents believed that when they reported workload issues through various formal mechanisms, positive action resulted. Additionally, the same number of respondents suggested that even though a workable solution was not possible, management certainly tried to address the issue at the time it was raised (n=21:13%). As some respondents noted:

Most requests for more staff are approved as long as rostering is viable and skill mix is appropriate.

Issues are passed on to our shift coordinator and unit manager, who then endeavours to fix the problem if able.

Other action taken included:
- six percent (n=10) of respondents reported that staff were called in from days off
- five percent (n=7) stated that staff were deployed or a casual pool of staff were used
- three percent (n=4) suggested double shifts or split shifts were another mechanism used to decrease workload pressure
- two percent (n=3) stated that surgery was cancelled or patients were transferred to other facilities.

iii) Personal outcomes

- Four percent (n=6) of nurses were told either to sort it out themselves or just ‘put up with it’
- Five percent (n=7) of the public sector nurses described their working environments as ‘exhausting’ and ‘stressful’. For example:

  Our staff are constantly sick and stressed which I believe is because of the immense pressure we are under.

- Five percent (n=7) stated morale was being affected.

c) Influences on workload issues

Several respondents raised specific influences on workloads:
- Eight percent (n=13) made a comment that workloads were heavy. For example:

  My last rotation finished 4/52 ago in a busy acute surgical ward where workload related issues were treated with ‘sink or swim’ attitude. On one shift I was given seventeen (Trended) hours. It was extremely stressful. I’m only a new grad!
• Seven percent (n=11) believed that workloads were influenced by staff shortages. For example:

There are constant issues with nursing shortages and overcrowding of patients in the department. Chronic bed blockage where patients stay waiting in corridors for days waiting for a bed on the ward, a disgusting situation to work in.

• Four percent (n=6) stated that inexperience staff and inappropriate skill mix were the cause of increasing stressful working conditions. For example:

Unsafe patient workloads, overcrowding in E/Dept... due to decreased skill mix and increased workloads. Current union intervention awaits outcomes. Management unaware of unsafe OH&S concerns. Disaster waiting to happen.

Similar to the aged care sector, there were some differences in responses to the overall themes and sub-themes within the study. However, it should be noted that the major themes did not change over the three-year period. Differences between the 2004 and 2001 study were:
• fewer nurses in 2004 reported taking workload concerns to meetings
• more respondents in 2004 were documenting workload issues
• fewer nurses in 2004 stated that workload issues were reported, but not addressed/or ignored
• more nurses in 2004 believed that action to address workload issues was implemented
• more nurses believed that staff were called in (but numbers were small and therefore this result should be treated with caution)
• more nurses in 2004 identified heavy workloads and being short-staffed as an issue affecting workload (again small numbers mean results should be treated with caution).

3.3.12.3 Private sector

A total of 200 (37%) of the respondents in the private sector provided a response to this question. This was a similar number to those who provided a response in 2001 (n=206).

a) Reported

i) Reported to manager

Thirty-three percent (n=65) of the respondents said they reported any workload related issues to a senior member of staff in the hospital sector such as the NUM, CNC, DON, Hours Nurse Manager. In contrast to the other sectors, four (2%) respondents stated they reported workload issues to a
practice manager or business manager, suggesting that these nurses worked outside the acute hospital environment.

ii) **Reported at meetings**

Similar to the aged care and public sectors, the other formal mechanism used by respondents in the private sector included a variety of meetings where workload issues were presented (n=26:13%). Four respondents (2%) specifically noted that workload issues were reported to a workload committee within their organisation.

iii) **Documented**

A further eight (4%) of the respondents noted that documentation was a major tool used within their organisation to monitor workload issues.

**b) Outcomes**

i) **Reported but not addressed/ ignored**

Twenty-four percent (n=48) of respondents stated they reported workload related issues to a manager and believed that these issues were not addressed. For example:

> You complain – they listen and nod and comment but rarely is anything actually done.

> Workload issues are ignored by management.

ii) **Action is taken**

By contrast, 29 respondents (15%) who stated they reported workload issues through various formal mechanisms such as workplace committees/documentation/reporting to a manager, believed that either a solution occurred or that management were unable to address the issue at the time, believed action was being taken.

Similar to the public sector, some respondents noted that the organisation in which they worked addressed workload issues on a day to day basis (n=5:3%). Mechanisms included:

> CNC contacted and extra staff engaged ASAP.

> Immediate discussion with CNC in relation to inadequate staffing levels. They do try and get extra staff from other wards or agency staff, otherwise no new acute admissions to the ward.
iii) Personal outcomes

A major theme within the private sector was that respondents believed they were told that staff would just have to ‘put up with’ heavy workloads (n=10:10%). Comments varied and included: ‘put up with it if you want a job’, ‘do the best you can’ and ‘just get in and do the work’. Other respondents were told to ‘manage time more effectively’ or ‘if you don’t like it find another job’.

Other personal effects on workloads reported were:

- four percent (n=7) of the nurses believed that there was an increase in sick leave being taken, mostly due to heavy workloads
- three percent (n=5) believed that stress and burnout were a direct result of current workloads.

c) Influences on workload issues

There were several issues raised by private sector nurses that could be seen to be influences on workload issues. These were:

- **TrendCare.** Eighteen (eight percent) of the respondents believed that TrendCare dictates how workloads are addressed and managed. All of these comments were negative and related to how this rostering system did not adequately predict the correct hours and skill mix needed for each shift. Comments included: ‘workloads are not based on acuity of patients – merely on numbers’. Others were more vocal:

  *The computer package ‘TREND’ is used to calculate staffing requirements… every shift is ‘under’ and it is known that nursing coordinators are given bonuses from executive if they are regularly ‘under’ on TREND.*

  *Management are only interested in the predicted required hours according to a computer program ‘TrendCare’ They don't listen to people working in the ward who deal with new admissions/emergencies/patient deterioration that weren’t predicted by the computer. This happens nearly every day.*

- Seven percent (n=14) of the respondents complained of staff shortages
- It seemed that agency and casual staff were relied on (when available) to assist staffing issues which in turn helped eased heavy workloads. This was recalled by ten percent (n=19) of the respondents, as well as undertaking double shifts (n=4:2%) and overtime (n=6:3%) as a solution to heavy workloads:

  *Most times you just work under pressure if not adequate staff available. If a colleague off sick very hard to replace, with a number of staff doing double shifts to take their place (No agency staff available).*

  *The biggest problem area of increased workload is sick leave and the inability of replacing staff.*
We are expected to do overtime whenever the need arises.

- A further five percent (n=10) of the respondents believed that staff cuts or funding issues were impacting on workloads. For example:

  Each year I find we are expected to do our care with less staff - the squeeze just gets tighter and the patients miss out more and more.

  There is a huge focus on customer service but little is done in equipping those at the coalface [for example] money for thousands of dollars of artwork but one commode with two wheels?

  My CNM thinks it’s great when we are $50,000 under budget at our weekly meetings; we’ve had five staff in the past week break down and cry due to stress and being overworked. We got a cake from the DON to say good job… nice hey.

These findings reflect the 2001 data. There were no major new themes or sub-themes between the 2001 and 2004 data. However, there were differences in the percentage of respondents commenting on some of the themes. Notable results are:

- an increase in the percentage of nurses in 2004 who believed that workload issues were being addressed
- a decrease in the number of respondents in 2004 reporting double shifts as a mechanism of dealing with workload (small numbers mean that these results should be dealt with cautiously)
- a large increase in the percentage of respondents who have reported that a response to workload concerns is to be told to ‘put up with it’ (again small numbers)
- there appears to be an increase in the percentage of respondents who believe that agency or casual workers are impacting upon workload issues within their workplace (similar small numbers).

3.3.13 Violence in the workplace (Q32)

Respondents were asked if they had experienced any incidents in the last three months related to bullying, threats, harassment, attacks or other abuse. There are highly significant differences across sectors in 2004 (p < 0.01). The main source of these differences is the relatively higher proportion of ‘no’ responses in the private sector compared to the other two sectors (see Figure 3.57). There is evidence also that the incidence of violence has increased in each of the sectors between 2001 and 2004 (p = 0.02 aged; p < 0.01 public; p < 0.001 private).
Respondents who reported experiencing workplace violence in the previous three months were asked to identify the sources of these incidents. The prevalence of these sources is summarised below according to sector and year. The subsections following explore the differences across the sectors and between the years for the most prominent sources.

### 3.3.13.1 Sources of workplace violence (Q33)

Tables 3.17 and 3.18 list the sources of workplace violence from the 2004 and 2001 surveys.

#### Table 3.17 Sources of workplace violence: 2004

<table>
<thead>
<tr>
<th>Source</th>
<th>Aged care</th>
<th></th>
<th>Public</th>
<th></th>
<th>Private</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Clients/patients</td>
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<td>75.8</td>
<td>175</td>
<td>74.8</td>
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<tr>
<td>Visitors/relatives</td>
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<td>105</td>
<td>44.9</td>
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<tr>
<td>Other nurses</td>
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<td>38.1</td>
<td>86</td>
<td>36.8</td>
<td>72</td>
<td>36.7</td>
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<tr>
<td>Nursing management</td>
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<td>26.7</td>
<td>57</td>
<td>24.4</td>
<td>71</td>
<td>36.2</td>
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<tr>
<td>Other management</td>
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<td>5.9</td>
<td>13</td>
<td>5.6</td>
<td>7</td>
<td>3.6</td>
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<tr>
<td>Doctors</td>
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<td>5.5</td>
<td>38</td>
<td>16.2</td>
<td>60</td>
<td>30.6</td>
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<tr>
<td>Allied Health Professionals</td>
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<td>6</td>
<td>2.6</td>
<td>4</td>
<td>2.0</td>
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<tr>
<td>Other staff</td>
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<td>11</td>
<td>4.7</td>
<td>17</td>
<td>8.7</td>
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<tr>
<td>Others/unknown</td>
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<td>0</td>
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<td></td>
<td><strong>234</strong></td>
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<td><strong>196</strong></td>
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</table>

*Respondents could choose more than one response to this question.*
### Table 3.18 Sources of workplace violence: 2001

<table>
<thead>
<tr>
<th>Source</th>
<th>Aged care</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>%</td>
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<tr>
<td>Clients/patients</td>
<td>154</td>
<td>74.8</td>
<td>138</td>
</tr>
<tr>
<td>Visitors/relatives</td>
<td>24</td>
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<td>74</td>
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<tr>
<td>Other nurses</td>
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<td>18.4</td>
<td>54</td>
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<td>Nursing management</td>
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<td>33</td>
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<td>Other management</td>
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<td>15</td>
</tr>
<tr>
<td>Doctors</td>
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<td>4.4</td>
<td>35</td>
</tr>
<tr>
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<td>1.0</td>
<td>6</td>
</tr>
<tr>
<td>Other staff</td>
<td>9</td>
<td>4.4</td>
<td>7</td>
</tr>
<tr>
<td>Others/unknown</td>
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<td>0.5</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total number of respondents</strong></td>
<td><strong>206</strong></td>
<td><strong>219</strong></td>
<td><strong>138</strong></td>
</tr>
</tbody>
</table>

*Respondents could choose more than one response to this question.

**a) Clients/patients**

Very significant differences exist across the sectors in both 2001 and 2004 ($p < 0.001$). In both 2004 and 2001, of those nurses experiencing violence in the previous three months, a lower percentage in the private sector compared to the other sectors cited the source as clients or patients. Also in 2001, but not 2004, the percentage within the aged care sector is greater than that within the public sector (see Figure 3.58). In the public sector there has been a significant increase ($p = 0.001$) in the proportion of reported incidents involving clients or patients between 2001 and 2004.

**Figure 3.58 Clients/patients as a source of workplace violence**

**b) Visitors/relatives**

Highly significant differences exist across the sectors in both 2001 and 2004 ($p < 0.001$). In both 2004 and 2001, the reported rate of incidents involving
visitors or relatives was considerably higher in the public sector than in the other two sectors. A significant increase between 2001 and 2004 in the reported rate of incidents involving visitors or relatives has occurred in the aged care (p < 0.001), public (p < 0.01) and private sectors (p < 0.01) (see Figure 3.59).

Figure 3.59 Visitors/relatives as a source of workplace violence

![Figure 3.59 Visitors/relatives as a source of workplace violence](chart)

c) Other nurses

In 2001, but not 2004, there were significant differences across the sectors (p < 0.001) in the proportion of nurses specifying this source. In particular in 2001, the proportion in the aged and public sectors was greater than that of the private sector.

Data in Figure 3.60 indicate that there has been a significant increase from 2001 to 2004 in the percentage of nurses citing other nurses as a source of incidents in the aged care (p < 0.001) and public (p < 0.01) sectors.

Figure 3.60 Other nurses as a source of workplace violence

![Figure 3.60 Other nurses as a source of workplace violence](chart)


d) Nursing management

There is some evidence in 2004 (p < 0.05) but not 2001, of a difference across the sectors in the proportion of nurses citing this source of violence (see Figure 3.61). In particular a higher percentage is associated with the private sector than the other two sectors. In all sectors there is significant evidence of an increase between 2001 and 2004 in the reported proportion of incidents involving nursing management (aged care, p < 0.01; public, p = 0.01; private sectors, p < 0.001).

Figure 3.61 Nursing management as a source of workplace violence

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e) Medical practitioners

There is very significant evidence (p < 0.001) in both 2004 and 2001 of a difference across the sectors in the proportion of nurses citing this source of violence (see Figure 3.62). In particular a higher percentage is associated with the private sector than the public sector, which in turn is higher than the aged care sector. There is no significant evidence of a difference between 2001 and 2004 in the reported proportion of incidents involving medical practitioners.

Figure 3.62 Medical practitioners as a source of workplace violence

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### 3.3.14 Workplace violence and gender

Except for the private sector in 2004, the proportion of male nurses experiencing workplace violence is substantially higher than the proportion of female nurses in all sectors in both 2001 and 2004. In the public sector, the difference is significant (2004, p < 0.01; 2001, p = 0.01) despite the relatively small number of male nurses surveyed (see Figure 3.63).

In all sectors the percentage of female nurses experiencing violence has increased significantly between 2001 and 2004 although the corresponding percentage for male nurses has not.

![Figure 3.63 Workplace Violence and Gender](image)

### 3.3.15 Workplace violence and designation of the nurse

Although power is compromised because of small numbers in some samples, there is evidence to suggest that in 2004, but not in 2001, AINs and ENs in the aged care sector (both public and private), experienced more violence than other nurses in this sector (see Figure 3.64).

Additionally, ENs (p < 0.05) and RNs (P < 0.001) in the private sector have experienced highly significant increases in workplace violence (p < 0.001) from 2001 to 2004.
3.3.16 Workplace violence and work patterns

Permanent part-time employees in the private sector reported a highly significant increase in workplace violence from 2001 to 2004 ($p < 0.01$). Although not significant, the trend across all work patterns in all the sectors is one of increase since 2001 (see Figure 3.65).
3.3.17 Workplace violence and age of the nurse

In the aged care sector only, the reported level of workplace violence in 2004 increases significantly with the age of the nurse (p < 0.01) (see Figure 3.66). This effect applied to both private and public sections of the aged care sector. No such correlation is present between the incidence of reported violence and length of time in the job for nurses in this sector.

Figure 3.66 Workplace violence and mean age of nurse

3.3.18 Workplace safety and workplace violence

In each sector such an association exists and is highly significant (p < 0.01). The relation for 2004 is displayed in Figure 3.67. In each sector there is a highly significant (p < 0.001) tendency for a poorer perception of workplace safety to be associated with a higher incidence of reported violence.

Figure 3.67 Respondents have experienced abuse in the workplace in the last 3 months according to their perceived level of workplace safety
### 3.3.19 Workplace Safety and Morale

Those who had been subjected to workplace violence in the last three months rated workplace morale as being poorer than those who were not subjected to workplace violence ($p < 0.001$). This relationship was evident across all three sectors, however, in the aged care sector those nurses who believed morale was ‘extremely poor’ (33.5%) were more likely to report being subjected to workplace violence in the previous three months than those in the private (23.5%) or public (19.5%) sectors (see Figure 3.68).

Figure 3.68 Respondents have experienced abuse in the workplace in the last 3 months according to their perceived level of morale (2004)

![Graph showing percent experiencing abuse by perceived morale level in 2004](image)

Figure 3.69 Respondents have experienced abuse in the workplace in the last 3 months according to their perceived level of morale (2001)

![Graph showing percent experiencing abuse by perceived morale level in 2001](image)
Respondents were then asked if their workplace had a policy for dealing with aggressive behaviour of other staff.

3.3.20 Workplace policy for aggressive behaviour of other staff (Q34)

Knowledge of the existence of a workplace policy dealing with aggressive behaviour of other staff (defined as nurses, management, doctors and allied health professionals) was requested in Question 34. A comparison of the responses across sectors and for 2001 and 2004 is given below (see Figure 3.70).

Figure 3.70 Existence of a workplace policy for aggressive behaviour of other staff

![Diagram showing the existence of a workplace policy for aggressive behaviour of other staff across sectors and years.]

Highly significant differences exist among sectors ($p < 0.001$) mainly due to the relatively lower proportion of ‘don’t knows’ in the aged care sector compared to the other two sectors. Also, highly significant changes in responses to this question occur between 2001 and 2004 in each of the sectors. In the aged care ($p = 0.001$) and public ($p < 0.001$) sectors this was mainly because of a drop in the proportion of ‘no’ responses. In the private sector ($p < 0.01$) the changes were due to a drop in the ‘no’ response and a drop in the ‘don’t know’ response.

The 2004 responses across sectors are only marginally different ($p = 0.04$) if the ‘don’t knows’ are ignored. Differences between 2001 and 2004 are still significant in all sectors because of a decrease in the proportion of ‘no’ responses in each case.

3.3.21 Adequacy of policy for dealing with aggression of other staff (Q35)

Respondents were then asked to indicate if they believed the policy in place was adequate to deal with this issue. There was very strong evidence ($p < 0.001$) in 2004 of differences among the sectors regarding the perception of adequacy of the policy towards aggressive behaviour of other staff. The
source of the difference is mainly the relatively higher ‘always or nearly always’ response rate in the aged care sector and correspondingly lower response rate in the public sector compared to the private sector. On average the public sector fares worse than the other two sectors, and this effect is also evident in the 2001 survey (see Figure 3.71). No evidence of a change exists between the 2001 and 2004 surveys.

Figure 3.71 Adequacy of policy for aggressive behaviour of other staff

![Chart showing adequacy of policy for aggressive behaviour of other staff](chart)

3.3.22 Policy for aggressive patients/clients/visitors (Q36)

Respondents were asked to indicate if there was a workplace policy that dealt with aggressive behaviour of patients/clients/visitors. There is a significant difference (p < 0.001) between the sectors with regard to knowledge of the existence of a policy regarding aggressive behaviour of patients/clients/visitors. This is the case in both 2001 and 2004. The major reason for the difference is the relatively high ‘don’t know’ response rate in the private sector compared to the other two sectors (see Figure 3.72). Differences among sectors are still significant (p = 0.01) if the ‘don’t knows’ are ignored, mainly because there are relatively fewer ‘no’ responses in the public sector than the other sectors. Overall, nurses in the private sector were more satisfied than nurses in the other two sectors regarding the effectiveness of these policies both in 2004 and in 2001.

Also, significant changes in response to this question occurred between 2001 and 2004 in each of the sectors. In the aged care sector (p < 0.001) the percentage of ‘don’t knows’ increased and percentage of ‘nos’ decreased from 2001 to 2004. Also, in both the public (p < 0.001) and private (p < 0.01) sectors, the percentage of ‘nos’ decreased. Overall though, the average response in each sector is little changed. These effects remain significant after ignoring the ‘don’t knows’, with the ‘no’ response rate diminishing in all sectors between 2001 and 2004.
3.3.23 Adequacy of policy for aggressive behaviour of patients/visitors/clients (Q37)

The perceived adequacy of the policy dealing with aggressive behaviour of patients/visitors/clients was examined in this question. Strong evidence (p < 0.01) of differences among the sectors regarding the perception of adequacy of the policy for aggressive behaviour of patients/visitors/clients exists in 2004. The main differences are the relatively low proportion of the 'sometimes' response in the private sector and the relatively low proportion of ‘always or nearly always’ response in the public sector compared to the other sectors. Only weak evidence of such differences existed in the 2001 survey. Little evidence exists of a change occurring in any of the sectors between 2001 and 2004 (see Figure 3.73).
3.3.23 Replacement of staff on leave (Q38)

Nurses were asked to indicate on a three point scale (never, sometimes, always) the frequency of replacement of staff in their workplace for the various types of leave (sick, long service, annual, accrued days off, training/study leave, TOIL).

3.3.23.1 Sick leave

There is a highly significant difference across the sectors in 2004 in the level of replacement of staff on sick leave (p < 0.001). Differences exist across all categories, the major source of significance being in the ‘always’ category, in which there is a relatively high rate in the aged care sector and a relatively low rate in the private sector compared to the public sector. On average, staff on sick leave were replaced less often in the private sector than the public sector, in which staff are replaced less often than in the aged care sector (see Figure 3.74). In 2001, on average the private sector performed better than the public sector. Despite this, on average, there has been an improvement in all sectors (aged care, p < 0.001; public, p < 0.001; private, p < 0.05).

3.3.23.2 Long service leave

Similar to the previous question, there is a highly significant difference across the sectors in the level of replacement of staff on long service leave (p < 0.001). The main source of significance is in the ‘never‘ category where the response rate is relatively low in the aged care sector and relatively high in the private sector. Also, the ‘always’ category is relatively high in the aged care sector compared to the other two sectors. These results also hold in the absence of the ‘don’t knows’. On average, in both 2004 and 2001 the aged care sector is more likely to provide staff replacement for long-service leave than the other two sectors (see Figure 3.75).
Highly significant changes \( (p < 0.001) \) have also occurred between 2001 and 2004. The proportion of ‘don’t knows’ has decreased in all sectors. In the aged care sector, there are relatively more ‘sometimes’ and relatively fewer ‘always’ respondents in 2004 than in 2001. In both the public and private sectors there are relatively more ‘sometimes’ responses in 2004 than in 2001. These latter descriptions also hold if the ‘don’t knows’ are excluded. On average in all sectors there has been a highly significant deterioration in the likelihood of staff replacement for long-service leave.

3.3.23.3 Annual leave

A similar pattern exists for annual leave as in the previous questions. Once again, there is a highly significant difference \( (p < 0.001) \) across the sectors in the level of replacement staff on annual leave for both 2001 and 2004 (see Figure 3.76). In 2004, there are differences across all categories. The main differences are the relatively low rate of ‘never’ responses and high rate of ‘always’ responses in the aged care sector compared to the other two sectors. Overall, annual leave replacement is more likely to be accommodated in the aged care sector than the other two sectors and this holds in both 2001 and 2004. No significant changes occurred between 2001 and 2004 in any sector.
3.3.23.4 Accrued days off

A similar pattern emerges with these data (see Figure 3.77), with a highly significant difference \((p < 0.001)\) across the sectors for each of the years, in the level of replacement of staff on accrued days off. In 2004 there are differences across all categories. The main differences are the relatively low rate of ‘never’ responses and high rate of ‘always’ responses in the aged care sector compared to the other two sectors. On average, the aged care sector is significantly better than the other two sectors in both 2001 and 2004. There is evidence of a change from 2001 to 2004 in the private sector \((p < 0.01)\) but not in the other two sectors. In the private sector there are more ‘never’ responses and fewer ‘don’t knows’ in 2004 than in 2001, indicating an overall decrease in this sector’s performance on this indicator.

Figure 3.77 Replacement of staff on accrued days off

3.3.23.5 Training/study leave replacement

Highly significant \((p < 0.001)\) differences exist across the sectors for 2004 (and for 2001) in the level of replacement of staff on training/study leave. There are differences across all categories in 2004 in particular (see Figure 3.78). The main differences are the relatively low rate of ‘never’ responses and high rate of ‘always’ responses in the aged care sector compared to the other two sectors, indicating that on average the aged care sector is more likely to replace staff on training or study leave.

Significant differences exist in the private sector \((p = 0.001)\) between 2001 and 2004. The main source of these differences is the increased proportion of ‘never’ responses in 2004 compared to 2001. An overall deterioration in performance is indicated in this sector. No significant differences between 2001 and 2004 exist in the aged care or public sectors.
3.3.23.6 Time off in-lieu (TOIL) replacement

A highly significant difference across the sectors for each year in the level of replacement of staff on TOIL is apparent (p < 0.001). There are differences across all categories in 2004 (see Figure 3.79). The main differences are the relatively low rate of ‘never’ responses and high rate of ‘always’ responses in the aged care sector compared to the other two sectors. On average the aged care sector performs better than the private sector, which performs better than the public sector, and this holds for both 2001 and 2004. Once again there is some evidence (p = 0.01) in the aged care sector of a change between 2001 and 2004. The difference is due to a decrease in the ‘don’t know’ rate in 2004 compared to 2001. No significant difference on average can be confirmed.
3.3.24 Annual leave availability (Q39)

Respondents were asked to indicate their ability to access accrued annual leave when they so wished. A three-point scale was used: ‘never’; ‘sometimes’; ‘always’. There are highly significant differences (p < 0.001) among sectors in 2004 (and in 2001). The main reasons for these differences are the relatively high proportion of ‘sometimes’ responses and relatively low proportion of ‘always’ responses in the public sector compared to the other two sectors. On average this suggests that in both 2001 and 2004 the public sector is less flexible as regards annual leave than the other two sectors (see Figure 3.80). Insufficient evidence exists to claim a difference exists within any sector between 2001 and 2004.

Figure 3.80 Ability to take annual leave when required

The aim of the next section of the questionnaire was to ascertain the respondent’s responsibilities outside of work (such as dependent family members) and their access to employer assistance.

3.4 Responsibilities Outside Work

3.4.1 Family responsibilities (Q40)

Tables 3.19 and 3.20 display the type of significant family responsibilities identified by participants in the 2004 and 2001 surveys.
Unlike in 2001, in 2004 there is significant evidence of a difference among sectors in the percentage of nurses without significant family responsibilities. The proportion in the aged care sector is significantly higher than that for the other two sectors (p < 0.001). Overall, no significant differences exist between female and male nurses regarding the existence of significant family responsibilities.

### 3.4.1.1 Dependent spouse

The percentage of nurses with a dependent spouse in the aged care sector in 2004 is significantly more than that for nurses in the other two sectors (p = 0.01) as shown in Figure 3.81. Although the difference is not statistically significant, approximately 18% of permanent full-time nurses compared to about 13% of permanent part-time nurses in both the public and private sectors cited a dependent spouse as a significant responsibility in the 2004 survey. However, in the public sector, a significantly higher percentage of males than females cited a dependent spouse as a significant responsibility (see Figure 3.82). A similar trend in the aged care sector is marginally significant. As this question was not asked in 2001, it is not possible to note any change over time. The mean age of nurses with a dependent disabled or ill family member is similar in the aged care sector (around 49 years) to the
mean age without a dependent spouse. These nurses in the aged care sector with a dependent disabled or ill family member are two to three years older than nurses in the public and private sectors that have dependent disabled or ill family members.

Figure 3.81 Dependent spouse by employment status across sectors

Figure 3.82 Dependent Spouse according to gender

3.4.1.2 Dependent children

The aged care sector also differs significantly from the other two sectors regarding dependent children, there being a significantly smaller fraction of nurses in both 2001 and 2004 (p < 0.001) who regard this as a significant family responsibility. Further, in the aged care sector the prevalence of this responsibility has dropped significantly from 2001 to 2004 (p < 0.01).

3.4.1.3 Dependent disabled or ill family members

Nurses in the public sector were significantly less likely to report this as an issue as shown in Figure 3.83. While there were no significant differences
between the sectors, there was a slight increase in the percentage in the public (6.4% in 2004 and 4.9% in 2001) and private sectors (5.1% in 2001 and 8.4% in 2004) and a slight increase in the aged care sector (9.7% in 2001 and 8.9% in 2004). No significant differences or indicative trends in the percentage of full-time and part-time nurses with dependent disabled or ill family members exist.

Figure 3.83 Dependent disabled or ill family members by employment status

3.4.1.4 Dependent elderly relative

Similar percentages of nurses across all sectors reported caring for a dependent elderly relative. The mean age of nurses in the aged care sector who were caring for a dependent elderly relative was higher than the mean age of nurses caring for dependent elderly relatives in other sectors. The percentage of nurses reporting this factor is not significantly different between the 2001 and 2004 studies (see Figure 3.84).

Figure 3.84 Dependent elderly relative by age
3.4.1.5 Dependent other relative
Only a small percentage responded they cared for a person in this category. There is no significant difference across the sectors.

3.4.2 Adequacy of care arrangements (Q41)

The majority of respondents believed there were adequate care arrangement in place for dependent family members, Figure 3.85 summarises the responses of participants for whom this question is relevant.

Figure 3.85 Adequacy of care arrangements for dependent family members

In the private and public sectors there is a significant relationship between employment status (working full-time, part-time and casually) and the perception of the adequacy of support. In particular a higher proportion of nurses employed permanent part-time or casual are more likely to report family support as inadequate. The same trend exists in the aged care sector, but is not statistically significant (see Figure 3.86).

Figure 3.86 Adequacy of care arrangements for dependent family members and nurse employment status
In 2004, nurses who reported inadequate care arrangements for family members were, on average, younger by two to three years than those nurses who report adequate care arrangements. This trend occurs across the three sectors (see Figure 3.87).

There is some evidence that the issue of adequate care arrangements is more relevant to permanent part-time nurses than to permanent full-time nurses. However, the effect is not significant in any one sector but is consistent across sectors and significant if all three sectors are combined. No gender effects are apparent; although small samples render these tests weak (see Figure 3.88).
3.4.3 Effect of inadequate support or assistance on the number of hours available for work (Q42)

In the 2004 survey, a follow-up question for those participants who consider support or assistance regarding family responsibilities to be inadequate revealed significant differences ($p = 0.001$) exist among the sectors as indicated in Figure 3.89. The major source of these differences is the relatively lower rate of the ‘extremely’ response of respondents in the aged care sector compared to the other two sectors. On average nurses in the aged care sector are least affected, followed by nurses in the private and public sectors.

![Figure 3.89 Inadequate support or assistance and its effect on hours able to work](image)

3.4.4 Access to family leave (Q43)

A comparison across sectors and years regarding the accessibility of family leave to care for family members is provided in Figure 3.90. In both 2001 and 2004, highly significant ($p < 0.001$) differences exist across the sectors. The main sources of this significance are the relatively low ‘don’t know’ responses in the public sector, and the relatively high rate of the ‘no’ responses in the aged care sector compared to the other two sectors. Significant differences do not exist within any sector between 2001 and 2004.

![Figure 3.90 Access to family leave](image)
3.4.5 Age of youngest dependent children (Q44)

For those who had dependent children, the distribution of the age of the youngest dependent child differed significantly across sectors (p < 0.001) in both 2001 and 2004 (see Figure 3.91). The age of the youngest dependent child is relatively older for respondents in the aged care sector compared to the other two sectors in both 2001 and 2004. No significant changes occurred between 2001 and 2004 in any of the sectors.

Figure 3.91 Age of youngest dependent children

3.4.6 Employer provision of childcare (Q45)

The question of whether the employer provided support or assistance with childcare resulted in the data in Figure 3.92. No significant difference exists across sectors in each year, or between years in any sector.

Figure 3.92 Employer provision of childcare
3.4.7 Adequacy of employer provided childcare support (Q46)

A follow-up question asking whether the support is adequate elicited the following responses (see Figure 3.93). There are no significant differences among sectors in 2004. Evidence exists, however, suggesting a change has occurred between 2001 and 2004 in the aged care (p = 0.01) and public sectors (p = 0.01). In both sectors the percentage of ‘yes’ responses increased from 2001 to 2004.

Figure 3.93 Employer assistance or support for childcare adequate?

3.4.8 Inadequacy of childcare facilities (Q47)

Very few nurses without dependent children commented on issues of the availability or adequacy of childcare support. Analysis indicated that approximately 67% of nurses in the private and public sectors had dependent children. This was significantly more than the 50% of the nurses in the aged care sector. The various factors influencing dissatisfaction with childcare and their relative importance are displayed in Tables 3.21 and 3.22 for each sector in each year. Percentages are of those respondents for whom the issue of childcare facilities is applicable.

| Table 3.21 Factors influencing perceptions of the adequacy of childcare: 2004 |
|-----------------------------------------------|---------------|---------------|---------------|
| Factor                                      | Aged care     | Public        | Private       |
|                                              | n  | %  | n  | %  | n  | %  |
| Inadequate or limited hours of operation     | 12 | 52.2 | 37 | 44.6 | 37 | 56.1 |
| Cost too high                                | 11 | 47.8 | 42 | 50.6 | 32 | 48.5 |
| Inconvenient location                        | 5  | 21.7 | 3  | 3.6  | 11 | 16.7 |
| Inflexible                                   | 10 | 43.5 | 21 | 25.3 | 16 | 24.2 |
| Poor care                                    | 1  | 4.3  | 2  | 2.4  | 3  | 4.5  |
| Emergency care not available                 | 4  | 17.4 | 23 | 27.7 | 22 | 33.3 |
| Vacation care not available                  | 3  | 13.0 | 15 | 18.1 | 6  | 9.1  |
| Other/s                                      | 6  | 26.1 | 14 | 16.9 | 9  | 13.6 |
| Total number of respondents*                 | 23 | 83  | 66 |      |     |     |
Table 3.22 Factors influencing perceptions of the adequacy of childcare: 2001

<table>
<thead>
<tr>
<th>Factor</th>
<th>Aged care</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Inadequate hours</td>
<td>13</td>
<td>31.0</td>
<td>38</td>
</tr>
<tr>
<td>Cost too high</td>
<td>23</td>
<td>54.8</td>
<td>51</td>
</tr>
<tr>
<td>Inconvenient location</td>
<td>7</td>
<td>16.7</td>
<td>7</td>
</tr>
<tr>
<td>Inflexible</td>
<td>5</td>
<td>11.9</td>
<td>31</td>
</tr>
<tr>
<td>Poor care</td>
<td>1</td>
<td>2.4</td>
<td>2</td>
</tr>
<tr>
<td>Emergency care not available</td>
<td>9</td>
<td>21.4</td>
<td>33</td>
</tr>
<tr>
<td>Vacation care not available</td>
<td>5</td>
<td>11.9</td>
<td>10</td>
</tr>
<tr>
<td>Limited hours of operation</td>
<td>19</td>
<td>45.2</td>
<td>55</td>
</tr>
<tr>
<td>Other/s</td>
<td>7</td>
<td>16.7</td>
<td>22</td>
</tr>
<tr>
<td><strong>Total number of respondents</strong></td>
<td><strong>42</strong></td>
<td></td>
<td><strong>107</strong></td>
</tr>
</tbody>
</table>

*Respondents could choose more than one response to this question.

Because sample numbers are moderately low, percentages are relatively unreliable. For example, the inflexibility of childcare facilities may well be a more important factor for aged sector nurses than other nurses in 2004 based on the percentages, but the difference is not statistically significant.

There is evidence in 2004 that in the private sector, inadequate or limited hours of operation is a less important factor than in the other two sectors ($p = 0.05$). Also the cost of childcare has significantly increased in importance between 2001 and 2004 for private sector nurses ($p = 0.01$).

Inconvenience of location is a significantly less important issue for public sector nurses than aged care or private nurses in 2004 ($p = 0.01$). The importance of this issue has increased significantly between 2001 and 2004 for private sector nurses ($p < 0.01$).

The importance of inflexibility appears to have increased in the aged care sector between 2001 and 2004 ($p < 0.01$) and possibly also in the private sector ($p = 0.05$).

In the private sector, the absence of emergency care has become more of an issue between 2001 and 2004 ($p = 0.01$).

Also, the importance of the non-availability of vacation care appears to have increased between 2001 and 2004 for public sector nurses ($p < 0.05$).

3.5 Your Professional Development

This section aimed to gather data on nurses’ professional development such as enrolment in formal programs as well as short courses. The data collected also aimed to identify the barriers nurses experienced when wishing to access education and training related to their work.
In addition to individual education and training, this section also gathered data on new graduates and new members of staff and their support within the workplace.

### 3.5.1 Access to training and/or professional development (Q48)

Nurses were asked if they had access to training and/or professional development opportunities through their workplace. Figure 3.94 summarises the responses across the sectors for the 2001 and 2004 surveys. In the 2004 survey there is some evidence (p = 0.01) of differences among the public, private and aged care sectors with regard to access to training and professional development opportunities through the workplace. The reason for this is the relatively low percentage of public nurses who do not have access to training. No such evidence exists in the 2001 survey.

![Figure 3.94 Access to training and/or professional development opportunities through the workplace](image)

### 3.5.2 Level of employer support for study (Q49)

Participants who were currently involved in a course of study related to their job (e.g. university or TAFE), were asked to indicate the level of support they received from their employer with regard to this study. Tables 3.23 and 3.24 summarise the responses for the 2001 and 2004 surveys. No significant differences exist across sectors or over time.

**Table 3.23 Type of support provided by employer for study: 2004**

<table>
<thead>
<tr>
<th>Type of Support</th>
<th>Aged care</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>No support</td>
<td>57</td>
<td>54.8</td>
<td>66</td>
</tr>
<tr>
<td>Some time off during work</td>
<td>22</td>
<td>21.2</td>
<td>25</td>
</tr>
<tr>
<td>Payment of some or all of course fees</td>
<td>27</td>
<td>26.0</td>
<td>35</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>8.7</td>
<td>15</td>
</tr>
<tr>
<td><strong>Total number of respondents</strong>*</td>
<td>104</td>
<td></td>
<td>127</td>
</tr>
</tbody>
</table>

*Respondents could choose more than one response to this question.
Table 3.24 Type of support provided by employer for study: 2001

<table>
<thead>
<tr>
<th>Type of Support</th>
<th>Aged care</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>No support</td>
<td>62</td>
<td>47.3</td>
<td>74</td>
</tr>
<tr>
<td>Some time off during work</td>
<td>29</td>
<td>22.1</td>
<td>27</td>
</tr>
<tr>
<td>Payment of some or all of course fees</td>
<td>34</td>
<td>26.0</td>
<td>34</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>13.0</td>
<td>22</td>
</tr>
<tr>
<td>Total number of respondents*</td>
<td>131</td>
<td>144</td>
<td>121</td>
</tr>
</tbody>
</table>

*Respondents could choose more than one response to this question.

3.5.3 Types of work-related education and training activities in the last 12 months (Q50)

The following five questions were answered only by nurses who had been employed in their main job for at least 12 months. Tables 3.25 and 3.26 describe the work-related education or training activities attended in the last 12 months.

Table 3.25 Work-related education and training activities in the previous 12 months: 2004

<table>
<thead>
<tr>
<th>Type of education and training activity</th>
<th>Aged care</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Watched a training video</td>
<td>252</td>
<td>66.0</td>
<td>202</td>
</tr>
<tr>
<td>Attended lectures/talks within the health facility</td>
<td>322</td>
<td>84.3</td>
<td>296</td>
</tr>
<tr>
<td>Attended a conference/seminar outside the health facility</td>
<td>137</td>
<td>35.9</td>
<td>150</td>
</tr>
<tr>
<td>Attended a course/program</td>
<td>108</td>
<td>28.3</td>
<td>130</td>
</tr>
<tr>
<td>Attended a workshop</td>
<td>127</td>
<td>33.2</td>
<td>172</td>
</tr>
<tr>
<td>Attended a satellite broadcast</td>
<td>21</td>
<td>5.5</td>
<td>51</td>
</tr>
<tr>
<td>Others</td>
<td>21</td>
<td>5.5</td>
<td>25</td>
</tr>
<tr>
<td>Total number of respondents*</td>
<td>382</td>
<td>365</td>
<td>410</td>
</tr>
</tbody>
</table>

*Respondents could choose more than one response to this question.

Table 3.26 Work-related education and training activities in the previous 12 months: 2001

<table>
<thead>
<tr>
<th>Type of education and training activity</th>
<th>Aged care</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Watched a training video</td>
<td>260</td>
<td>68.6</td>
<td>268</td>
</tr>
<tr>
<td>Attended lectures/talks within the health facility</td>
<td>348</td>
<td>91.8</td>
<td>366</td>
</tr>
<tr>
<td>Attended a conference/seminar outside the health facility</td>
<td>174</td>
<td>45.9</td>
<td>222</td>
</tr>
<tr>
<td>Attended a satellite broadcast</td>
<td>14</td>
<td>3.7</td>
<td>89</td>
</tr>
<tr>
<td>Others</td>
<td>35</td>
<td>9.2</td>
<td>51</td>
</tr>
<tr>
<td>Total number of respondents*</td>
<td>379</td>
<td>414</td>
<td>399</td>
</tr>
</tbody>
</table>

*Respondents could choose more than one response to this question.
Very significant differences exist across sectors in 2004 and 2001 ($p < 0.001$) with respect to the proportion of nurses who watched a training video in the last year as part of their main job. In particular, in 2004 the proportion in the aged care sector is greater than that in the public sector, which is greater than that in the private sector. There is evidence of a decrease in the public sector ($p = 0.01$) between 2001 and 2004.

Unlike in 2001 when there were significant differences, there is no significant evidence in 2004 of a difference across sectors in the proportion of nurses attending lectures or talks within their health facility in the last 12 months. A significant decrease in the proportion occurred within the aged care ($p < 0.01$) and public ($p = 0.01$) sectors between 2001 and 2004.

Additionally, in the aged care and public sectors there has been a significant decrease in the reported percentage of nurses who attended a conference or seminar outside the health facility (aged care, $p < 0.01$; public, $p = 0.001$). A non-significant decrease ($p = 0.16$) also occurred in the private sector.

In 2004 a significantly higher proportion of nurses from the public sector attended a workshop ($p < 0.001$). Similarly there is evidence that a higher proportion of nurses from this sector also attended a course or program ($p < 0.05$). These questions were not asked in the 2001 survey.

In 2001 and 2004 there was also a significantly higher proportion of public sector nurses who attended a satellite broadcast ($p < 0.001$). In the public sector, however, the proportion dropped significantly between 2001 and 2004 ($p = 0.01$).

### 3.5.4 Work-related educational activities and employer support for time off in the last 12 months (Q51)

The level of financial support for time off provided to employees in undertaking the educational activities outlined in the previous question, is described in the summary of responses given in Figure 3.95. Excluding those who ‘don’t know’ (about 2% of all respondents), for both the 2001 and 2004 surveys there is strong evidence of a difference across the sectors in the level of paid time off from employers for work-related education/training activities ($p = 0.001$ and $p < 0.001$ respectively). In 2004 the main reasons for the differences are the relatively low proportion of nurses in the aged sector who have fully paid time off from the employer and the relatively low proportion in the public sector who are not paid. Little evidence exists to suggest a change occurred in any of the sectors between 2001 and 2004.
3.5.5 Hours of education and training activities fully or partially reimbursed by the employer (Q52)

Only those nurses who indicated that employers partially or fully contributed to paid time off for their education and training activities responded to this question.

3.5.6 If fully or partially paid time off – how many hours (Q52)

Although the difference is not large, the estimated time that was fully or partially paid by the employer in the previous 12 months was significantly higher in the public sector than in the other two sectors in both 2001 and 2004 (p = 0.01) (see Tables 3.27, 3.28, 3.29).

Table 3.27 Training hours paid by employer: Aged care

<table>
<thead>
<tr>
<th>Year</th>
<th>n</th>
<th>mean</th>
<th>std deviation</th>
<th>std error of mean</th>
<th>min</th>
<th>max</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>235</td>
<td>13.21</td>
<td>17.672</td>
<td>1.153</td>
<td>0</td>
<td>96</td>
</tr>
<tr>
<td>2001</td>
<td>171</td>
<td>11.38</td>
<td>15.852</td>
<td>1.212</td>
<td>0</td>
<td>170</td>
</tr>
</tbody>
</table>

Table 3.28 Training hours paid by employer: Public

<table>
<thead>
<tr>
<th>Year</th>
<th>n</th>
<th>mean</th>
<th>std deviation</th>
<th>std error of mean</th>
<th>min</th>
<th>max</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>256</td>
<td>14.81</td>
<td>15.001</td>
<td>.938</td>
<td>0</td>
<td>80</td>
</tr>
<tr>
<td>2001</td>
<td>240</td>
<td>15.09</td>
<td>19.451</td>
<td>1.256</td>
<td>0</td>
<td>162</td>
</tr>
</tbody>
</table>

Table 3.29 Training hours paid by employer: Private

<table>
<thead>
<tr>
<th>Year</th>
<th>n</th>
<th>mean</th>
<th>std deviation</th>
<th>std error of mean</th>
<th>min</th>
<th>max</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>275</td>
<td>12.54</td>
<td>14.713</td>
<td>.887</td>
<td>1</td>
<td>96</td>
</tr>
<tr>
<td>2001</td>
<td>229</td>
<td>12.69</td>
<td>13.894</td>
<td>.918</td>
<td>0</td>
<td>170</td>
</tr>
</tbody>
</table>
3.5.7 Type of education and training support (Q53)

Respondents were asked to identify the other types of education and training support they had received from their employer (see Tables 3.30 and 3.31). The inclusion of a ‘no support’ option in the 2004 survey but not the 2001 survey renders a direct comparison between 2001 and 2004 invalid. The percentage of nurses reporting that they received no support compared with some type of support were similar across sectors.

No significant differences exist across sectors in 2004, with regard to the proportion of nurses who were given no employer support when attending work-related education and training activities. The level of employer support for accommodation expenses, however, is significantly higher in the public sector than the aged care or private sectors (p < 0.01).

Table 3.30 Type of education and training support provided: 2004

<table>
<thead>
<tr>
<th>Type of support</th>
<th>Aged Care</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Leave</td>
<td>61</td>
<td>18.8</td>
<td>79</td>
</tr>
<tr>
<td>Registration fees</td>
<td>57</td>
<td>17.5</td>
<td>80</td>
</tr>
<tr>
<td>Travel</td>
<td>36</td>
<td>11.1</td>
<td>49</td>
</tr>
<tr>
<td>Meals</td>
<td>50</td>
<td>15.4</td>
<td>38</td>
</tr>
<tr>
<td>Accommodation</td>
<td>22</td>
<td>6.8</td>
<td>37</td>
</tr>
<tr>
<td>No Support</td>
<td>175</td>
<td>53.8</td>
<td>154</td>
</tr>
<tr>
<td>Others</td>
<td>18</td>
<td>5.5</td>
<td>15</td>
</tr>
<tr>
<td><strong>Total number of respondents</strong></td>
<td><strong>325</strong></td>
<td><strong>318</strong></td>
<td><strong>340</strong></td>
</tr>
</tbody>
</table>

*Respondents could choose more than one response to this question.

Table 3.31 Type of education and training support provided: 2001

<table>
<thead>
<tr>
<th>Type of support</th>
<th>Aged care</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Leave</td>
<td>80</td>
<td>43.5</td>
<td>102</td>
</tr>
<tr>
<td>Registration fees for workshop conference</td>
<td>105</td>
<td>57.1</td>
<td>93</td>
</tr>
<tr>
<td>Travel</td>
<td>36</td>
<td>19.6</td>
<td>66</td>
</tr>
<tr>
<td>Meals</td>
<td>42</td>
<td>22.8</td>
<td>33</td>
</tr>
<tr>
<td>Accommodation</td>
<td>19</td>
<td>10.3</td>
<td>44</td>
</tr>
<tr>
<td>Other</td>
<td>25</td>
<td>13.6</td>
<td>30</td>
</tr>
<tr>
<td><strong>Total number of respondents</strong></td>
<td><strong>184</strong></td>
<td><strong>211</strong></td>
<td><strong>173</strong></td>
</tr>
</tbody>
</table>

*Respondents could choose more than one response to this question.

3.5.8 Barriers to undertaking education and training activities (Q54)

A comparison of the 2001 and 2004 responses across the sectors in this regard is given in Tables 3.32 and 3.33.
Table 3.32 Barriers to undertaking education and training activities for nurses employed for greater than 12 months: 2004

<table>
<thead>
<tr>
<th>Type of support</th>
<th>Aged Care</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Lacked the time</td>
<td>66</td>
<td>32.8</td>
<td>67</td>
</tr>
<tr>
<td>Lacked the information on what was available</td>
<td>33</td>
<td>16.4</td>
<td>35</td>
</tr>
<tr>
<td>Could not afford the fee involved</td>
<td>92</td>
<td>45.8</td>
<td>93</td>
</tr>
<tr>
<td>Could not afford to take unpaid leave</td>
<td>75</td>
<td>37.3</td>
<td>67</td>
</tr>
<tr>
<td>Family commitments prevented</td>
<td>43</td>
<td>21.4</td>
<td>71</td>
</tr>
<tr>
<td>Access was difficult because of distance</td>
<td>40</td>
<td>19.9</td>
<td>46</td>
</tr>
<tr>
<td>Relief staff were not available</td>
<td>50</td>
<td>24.9</td>
<td>70</td>
</tr>
<tr>
<td>Employer could/would not provide leave</td>
<td>30</td>
<td>14.9</td>
<td>57</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>3.5</td>
<td>14</td>
</tr>
<tr>
<td>Total number of respondents*</td>
<td>201</td>
<td></td>
<td>215</td>
</tr>
</tbody>
</table>

*Respondents could choose more than one response to this question.

Table 3.33 Barriers to undertaking education and training activities: 2001

<table>
<thead>
<tr>
<th>Type of support</th>
<th>Aged Care</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Lacked the time</td>
<td>110</td>
<td>40.3</td>
<td>111</td>
</tr>
<tr>
<td>Lacked the information on what was available</td>
<td>35</td>
<td>12.8</td>
<td>47</td>
</tr>
<tr>
<td>Could not afford the fee involved</td>
<td>129</td>
<td>47.3</td>
<td>150</td>
</tr>
<tr>
<td>Could not afford to take unpaid leave</td>
<td>91</td>
<td>33.3</td>
<td>92</td>
</tr>
<tr>
<td>Family commitments prevented</td>
<td>63</td>
<td>23.1</td>
<td>102</td>
</tr>
<tr>
<td>Access was difficult because of distance</td>
<td>78</td>
<td>28.6</td>
<td>90</td>
</tr>
<tr>
<td>Relief staff were not available</td>
<td>77</td>
<td>28.2</td>
<td>110</td>
</tr>
<tr>
<td>Employer could/would not provide leave</td>
<td>32</td>
<td>11.7</td>
<td>79</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
<td>4.8</td>
<td>21</td>
</tr>
<tr>
<td>Total number of respondents*</td>
<td>273</td>
<td></td>
<td>337</td>
</tr>
</tbody>
</table>

*Respondents could choose more than one response to this question.

In 2004 there are few differences across the sectors regarding the importance of these issues as impediments to undertaking training or educational activities. However, a significantly higher percentage of nurses in the private sector than the other two sectors, cite affordability of fees as an issue ($p = 0.01$). In the aged care sector there is some evidence ($p < 0.05$) that family commitments are less of an issue than in the other two sectors.

3.5.9 Support for new nursing graduates (Q55)

The data in Figure 3.96 indicate a significant difference across the sectors with regard to the nurses’ perceptions of the level of support given to new graduates both in 2001 ($p < 0.01$) and in 2004 ($p < 0.001$). In particular, in the
In the aged care sector there is a relatively better perception of support for new graduates. In the private sector there is a relatively poorer perception than in the public sector. No significant differences exist between 2001 and 2004 in any sector.

**Figure 3.96 Perceptions for support for new nursing graduates**

In 2004, in the aged care sector the mean age of nurses who believe new graduates are given adequate support in the workplace is significantly higher (p=0.001) than that of nurses who do not believe new graduates are given adequate support in the workplace. A similar trend is apparent in the other two sectors in 2004 and in all sectors in 2001, however these differences only reach significance at the 5% level in two of these cases (see Figure 3.97).

**Figure 3.97 Perceptions or support for new nursing graduates by estimated age**

In the public sector a significantly higher proportion of RNs than ENs do not have an opinion regarding the adequacy of support (see Figure 3.98 and Figure 3.99).
3.5.10 Orientation for both experienced and inexperienced nurses into new clinical areas (Q56)

In the final question in this section, nurses were asked to indicate whether they believed that nurses commencing work in new clinical areas were appropriately oriented to them. There are significant differences across the sectors with regard to orientation of new staff in 2004 (p < 0.001) and 2001 (p < 0.01). In 2004 the main reason for this difference is in the aged care sector, where there is a relatively better perception than in the other sectors of new staff receiving orientation when commencing (see Figure 3.100).
There is also some evidence ($p = 0.01$) that a change in perception has occurred between 2001 and 2004 in the aged care sector but not the other sectors, mainly due to the 'sometimes' response decreasing between 2001 and 2004.

In the aged care sector in 2004 the mean age of nurses who believe appropriate orientation is provided to newly employed nurses in clinical areas is significantly higher than that of those nurses who do not believe appropriate orientation is provided. The same effect is apparent across all sectors in both 2001 and 2004, and in some cases the effect is significant. After adjusting for time in the current position, this relationship between age and perception of support persists. (see Figure 3.101, Figure 3.102)
In the aged care sector, but not in the others sectors, there is a significantly higher proportion of RNs than ENs or AINs who believe nurses received appropriate orientation when commencing work in new clinical areas. A similar significant trend existed in 2001.
3.6 Your Experience in Nursing

In this section the respondents were asked several questions related to their perceptions of nursing work, the length of time they have worked in nursing, how long they expected to work in nursing in the future, if they had had a break from nursing and how long was that break, and if they had received any retraining if they had had a break from nursing and if they had taken any training before re-entering the workforce.

3.6.1 Perceptions of nursing work (Q57)

The first question in this section aimed to ascertain respondents’ perceptions of their nursing work. On a seven-point Likert scale, where both negative and positive statements were presented, the respondents were asked to identify if they ‘extremely’, ‘quite’ or ‘slightly’ agreed with either the negative or positive statement. The seventh option was ‘neither’.

3.6.1.1 Work is emotionally challenging

There is evidence of a difference across the sectors with respect to the level of emotional challenge presented by nursing in 2001 (p < 0.001) and in 2004 (p < 0.01). In particular in 2004, a relatively higher percentage of nurses in the aged care sector find the work extremely emotionally challenging compared to the other sectors (see Figure 3.105). On average in the aged care sector nurses report their work is considerably more emotionally challenging than nurses in the public or private sectors (p = 0.001). No significant change has occurred between 2001 and 2004 in any sector.
3.6.1.2 Workload is heavy or light

Nurses were asked to nominate their perceptions of their workload from options ranging from ‘workload is heavy’ to ‘workload is light’ (see Figure 3.106). There is very strong evidence ($p < 0.001$) of a difference across the sectors with respect to perceived workload in nursing in both 2001 and in 2004. In 2004 the major reason for this difference is the relatively high percentage of aged care nurses reporting an extremely heavy workload compared to the other two sectors. On average, aged care nurses report a substantially heavier workload than private sector nurses ($p < 0.001$), whose average response does not differ significantly from public sector nurses. There is no indication of a change between 2001 and 2004 in any sector.
3.6.1.3 The physically demanding nature of nursing work

There is very strong evidence (p < 0.001) of a difference across the sectors with respect to the physical demands of nursing work in both 2001 and 2004 (see Figure 3.107). The main reason for the difference in 2004 is the relatively high proportion of aged care nurses reporting the work is extremely physically demanding. On average aged care nurses report their work is relatively more physically demanding than private nurses, who in turn report their work is relatively more physically demanding than public nurses (p < 0.001). Changes between 2001 and 2004 are not significant.
3.6.1.4 Remuneration

There is strong evidence of a difference across the sectors in 2001 ($p < 0.001$) and 2004 ($p < 0.001$) with respect to the perception of adequacy of pay rate (see Figure 3.108). In particular, a relatively higher proportion of aged care nurses than public nurses are ‘quite’ or ‘extremely’ dissatisfied with remuneration. Respondents in the public sector, on average, are substantially more satisfied with remuneration than the other two sectors ($p < 0.001$). No significant change occurred between 2001 and 2004 in any sector.

Figure 3.108 Perceptions of the adequacy of pay rates

3.6.1.5 Working hours

There is evidence of a difference across the sectors in 2001 ($p = 0.001$) and 2004 ($p = 0.01$) with respect to the inconvenience of working hours (see Figure 3.109). The main reason is the relatively high proportion of public sector nurses who find the work hours quite inconvenient. On average across the seven-point scale, public sector nurses report a higher level of inconvenience than the other two sectors ($p < 0.01$). No change between 2001 and 2004 in any sector is apparent.
3.6.1.6 Career prospects

Nurses were asked to respond to a choice between ‘limited’ and ‘good’ career prospects. There is strong evidence of a difference across the sectors in 2001 (p < 0.001) but little evidence in 2004 with respect to feelings about career prospects in nursing (see Figure 3.110). No significant change occurred between 2001 and 2004 in any sector.

Figure 3.110 Perceptions of career prospects in nursing
3.6.1.7 Reward for skills and experience

Respondents were asked to indicate if they believed that skills and experience were or were not rewarded. Insufficient evidence exists to conclude that differences exist across sectors in either 2001 or 2004 regarding rewards for skill and experience (see Figure 3.111). No significant changes between 2001 and 2004 exist in any sector.

Figure 3.111 Reward for skills and experience

3.6.1.8 The status of nursing as a career

This question elicited responses around the statement that nursing was seen as either a ‘high’ or ‘low’ status career. There is strong evidence of a difference across the sectors in 2001 (p < 0.001) and 2004 (p < 0.001) with respect to the perception of the status of nursing as a career. The main reason for the difference in 2004 is the relatively high proportion of nurses in the aged care sector who perceived nursing as a ‘quite’ or ‘extremely’ high status career compared to the respondents in the other two sectors (see Figure 3.112). On average the status of nursing is perceived as being higher among aged care nurses than among public or private sector nurses (p < 0.001). No change between 2001 and 2004 in any sector is apparent.
3.6.1.9 Work stress

This question asked respondents to indicate if work stress was ‘high’ or ‘low’. There is strong evidence of a difference across the sectors in 2001 (p < 0.001) and 2004 (p < 0.001) with respect to the level of stress at work. In particular, nurses in the aged care sector report relatively higher levels of extremely high work stress than nurses in the other two sectors (see Figure 3.113). On average also this relationship holds with aged sector nurses reporting a significantly higher work stress level than public or private sector nurses. No change between 2001 and 2004 in any sector is apparent.
3.6.1.10 Teamwork and support from colleagues

Respondents were asked to indicate if there was ‘good teamwork and support’ or if their workplace lacked ‘teamwork and support’. There is evidence of a difference across the sectors in 2001 (p = 0.003) and 2004 (p < 0.001) with respect to the level of teamwork and support from colleagues. In 2004 it is the relatively high percentage of aged care nurses reporting extremely unsupportive colleagues, compared to the other two sectors, that is the main source of this effect (see Figure 3.114). On average nurses in the public and acute care sectors perceive a higher level of support from colleagues than nurses in the aged care sector (p < 0.001). No change between 2001 and 2004 in any sector is apparent.

Figure 3.114 Teamwork and support from colleagues

3.6.1.11 Safety of the workplace

Respondents were asked to indicate if they perceived the workplace as safe or unsafe. There is evidence of a difference across the sectors in 2001 (p = 0.001) and 2004 (p < 0.001) with regard to safety in the workplace (see Figure 3.115). In 2004, the main source of the difference is the relatively high percentage of nurses in the aged care sector reporting an extremely safe workplace compared to nurses in the other two sectors. On average, aged care nurses see their workplace as safer than private sector nurses who see their workplace as safer than public sector nurses (p < 0.001). No change between 2001 and 2004 in any sector is apparent.
3.6.1.12 Autonomy in nursing

Nurses were asked to indicate if they felt that autonomy was encouraged or discouraged. There is evidence in 2004 ($p = 0.002$), but only weak evidence in 2001 ($p = 0.05$), of differences across sectors regarding perceptions of autonomy in nursing. The reason for the difference in 2004 is mainly the relatively higher proportion of nurses in the public sector, compared to the other two sectors who believe autonomy is slightly discouraged (see Figure 3.116). The average responses across the sectors, however, do not significantly differ. No change between 2001 and 2004 in any sector is apparent.
3.6.1.13 Morale within the workplace

This question gathered data from the respondents on the perceived level of staff morale and whether they believed morale was improving or deteriorating. No significant evidence exists of differences among sectors in 2001 or 2004 with regard to the level of staff morale (see Figure 3.117) or changes in staff morale (see Figure 3.118). Also no significant changes between 2001 and 2004 exist in any sector.

Figure 3.117 Morale within the workplace

![Bar chart showing the distribution of perceived staff morale levels in 2001 and 2004 for private, public, and aged care sectors.]

Figure 3.118 Changes in staff morale within the workplace

![Bar chart showing the percentage of respondents indicating improvements or declines in staff morale from 2001 to 2004 for private, public, and aged care sectors.]

127
Across all sectors in both 2001 and 2004, staff morale is significantly associated with autonomy, perception of the value of nursing work within the health system, workplace equipment levels, safety in the workplace, status of nursing as a career, level of teamwork and support from colleagues, career prospects, work stress, remuneration, rewards for skills and experience, perception of the value of nursing work within the community, workload and the physical demands of work.

There is no significant difference in the perceived level of staff morale amongst RNs, ENs and AINs (Figure 3.119 and 3.120) or between male and female nurses in any sector or year (see Figure 3.121, Figure 3.122).

**Figure 3.119 Staff morale by job designation (2004)**
3.6.1.14 Adequacy of Workplace equipment

This question gathered information on the nurses’ perception of the adequacy of equipment within the workplace. There is evidence in 2004 ($p = 0.001$), but not in 2001, of differences across sectors regarding the level of workplace equipment. The reason for this difference is mainly due to the relatively high percentage of aged care sector nurses stating that their workplaces are very well-equipped, and a relatively lower percentage stating their workplace is quite poorly equipped, compared to the public and private sectors (see Figure 3.123). On average the aged care sector reports a better-equipped workplace than the other two sectors ($p = 0.004$). No change between 2001 and 2004 in any sector is apparent.

Figure 3.123 How adequately was the workplace equipped?
3.6.1.15 The value of nursing work by the community

Nurses were asked if they believed that nursing work was valued by the community. There is evidence in both 2001 ($p = 0.004$) and 2001 ($p = 0.01$) of differences across sectors regarding perceptions of the value of nursing work in the community. The reason for this is the relatively high proportion of nurses in the aged care sector who perceive their nursing work as extremely highly valued within the community compared to the other two sectors (see Figure 3.124). On average, aged care nurses see their work as more highly valued within the community than private sector nurses who in turn see their work more highly valued than public sector nurses ($p = 0.004$).

Figure 3.124 Perceptions of how the community values nursing work

3.6.1.16 Value of nursing work by the health system

In this question nurses were asked to indicate how valued they believed nursing work was within the health system. Strong evidence exists of differences across sectors ($p < 0.001$) in both 2001 and 2004 regarding the value of nursing work within the health system. Once again the aged care sector differs from the other two sectors with a relatively higher proportion of aged care nurses perceiving their work as extremely highly valued within the health system. On average there is little difference between the public and private sectors. No change between 2001 and 2004 in any sector is apparent (see Figure 3.125).
3.6.2 Length of time in nursing (Q58)

Nurses were asked to indicate how long they had worked in nursing overall. Differences exist in the distributions of time spent overall in nursing across the sectors in both 2001 (p < 0.01) and 2004 (p < 0.01). The average length of time in nursing does not differ significantly among the three sectors (see Figure 3.126). However, the profile of the distribution differs within the aged care sector compared to the other two sectors. There is greater variation in the time spent overall in nursing for aged care sector nurses than for public and private sector nurses. In particular, there are relatively more nurses in aged care whose length of time in nursing is from two to less than 10 years and relatively more with length of time 35 years and above. No significant changes between 2001 and 2004 exist in any sector.
3.6.3 Future time in nursing (Q59)

This question sought to ascertain from nurses how long they expected to continue to work in nursing. A significant difference exists across the sectors in both 2001 and 2004 in the distribution of future time respondents expected to work in nursing (p < 0.001). In particular, relatively more nurses in the aged care sector did not expect to work in nursing for another five years, and relatively fewer nurses expected to continue for another 15 years or more, compared to the other two sectors (see Figure 3.127). This difference applies whether or not the ‘unsure’ respondents are included. On average the expected future time in nursing for aged care nurses is significantly less than for private sector nurses (p < 0.001) which in turn, is significantly less than for public sector nurses (p < 0.001). No significant changes occurred from 2001 to 2004 in any sector.
Highly significant inverse correlations exist in all sectors in both 2001 and 2004 between nurses’ ages and their expected future time working in nursing. Between 13% and 36% of the variability in future time in nursing can be explained by the age of the nurse (see Tables 3.34, 3.35 and 3.36).

Table 3.34 Relationship (correlation coefficient) between age and future time in nursing

<table>
<thead>
<tr>
<th>Year</th>
<th>Aged care</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>-0.60</td>
<td>-0.43</td>
<td>-0.38</td>
</tr>
<tr>
<td>2001</td>
<td>-0.49</td>
<td>-0.46</td>
<td>-0.36</td>
</tr>
</tbody>
</table>

No significant differences exist between ENs or RNs within each sector as regards this relationship.

Table 3.35 Relationship (correlation coefficient) between age and future time in nursing according to nursing level

<table>
<thead>
<tr>
<th>Year</th>
<th>Aged care</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EN</td>
<td>RN</td>
<td>EN</td>
</tr>
<tr>
<td>2004</td>
<td>-0.54</td>
<td>-0.63</td>
<td>-0.62</td>
</tr>
<tr>
<td>2001</td>
<td>-0.31</td>
<td>-0.58</td>
<td>-0.57</td>
</tr>
</tbody>
</table>

Also no significant differences exist between full-time permanent and part-time permanent employees within each sector except in the private sector in 2004 where no significant relationship exists for full-time permanent nurses.
Table 3.36 Relationship (correlation coefficient) between age and future time in nursing according to employment status

| Year | Aged care | | Public | | Private | |
|------|-----------|---|---------|---|---------|
|      | FT        | PT | FT      | PT | FT      | PT    |
| 2004 | -0.60     | -0.60 | -0.52 | -0.37 | -0.07 | -0.48 |
| 2001 | -0.35     | -0.51 | -0.45 | -0.48 | -0.32 | -0.34 |

3.6.4 Break from nursing (Q60)

There were five questions that elicited information regarding breaks from nursing. Participants who had not had a break from nursing were instructed not to answer these questions.

3.6.4.1 Had a break from nursing during nursing career

The significantly higher proportion of ‘yes’ responses in the 2001 survey may be the result of explicitly excluding paid leave in the 2004 question. In 2004, no significant difference exists across the sectors in the proportions of nurses who have taken a break from nursing other than paid leave (see Figure 3.128).

Figure 3.128 Breaks from nursing

3.6.4.2 Number of breaks from nursing (Q61)

Those who indicated they had a break from nursing were asked to indicate how many breaks they had. There is no significant difference evident in the 2004 survey of a difference across sectors in the average number of breaks of nurses who have had a break from nursing during their career (see Figure
Nurses in the aged care sector have taken a mean of 1.3 breaks from nursing during their career, while nurses in both the public and private sectors a mean of 1.4 breaks. These means include all nurses, those who have taken a break as well as those who have not (see figure 3.130 for 2001 results).

Figure 3.129 Number of breaks from nursing (2004)

![Figure 3.129 Number of breaks from nursing (2004)](image)

Figure 3.130 Number of breaks from nursing (2001)

![Figure 3.130 Number of breaks from nursing (2001)](image)

3.6.4.3 Length of longest break from nursing (Q62)

The length of the longest break taken from nursing varies very significantly across sectors in both the 2001 and 2004 surveys (p < 0.001). In particular, the proportion of nurses in the aged care sector whose longest break is less than one year, is less than that of the other two sectors, the proportion whose longest break is five years or more, is substantially greater in the aged care sector than in the other two sectors (see Figure 3.131). The average longest break is significantly longer for nurses in the aged care sector, than for nurses in the other two sectors (p < 0.001).
The estimated mean lengths of the longest break in 2004 by sector are: aged care, 5.1 years; public, 2.6 years; and private 2.9 years. The corresponding figures in 2001 were: aged care, 5.0 years; public, 2.9 years; and private 3.0 years. No significant evidence exists to suggest a change occurred in any sector between 2001 and 2004.

Figure 3.131 Length of longest break in nursing

3.6.4.4 Retraining following the longest break from nursing (Q63)

Again, those nurses who had indicated they had a break from nursing were asked if they received any retraining before or after re-entering the health care field after their longest break. The majority of nurses indicted they had received no training. In 2001 there was evidence of a difference across the sectors in the proportion of nurses who received retraining on re-entering the nursing (p = 0.007). This evidence is weaker in 2004 (p = 0.05). No evidence exists of a change between 2001 and 2004 in any sector (see Figure 3.132).
3.6.4.5 Reasons for breaks from nursing (Q64)
The relative importance of the reasons for taking breaks from nursing is displayed in the Tables 3.37 and 3.38.

Table 3.37 Reasons for breaks in nursing: 2004

<table>
<thead>
<tr>
<th>Reason for Break</th>
<th>Aged Care</th>
<th></th>
<th>Public</th>
<th></th>
<th>Private</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Parental/maternity leave</td>
<td>131</td>
<td>52.6</td>
<td>174</td>
<td>66.2</td>
<td>185</td>
<td>63.6</td>
</tr>
<tr>
<td>Burn-out</td>
<td>33</td>
<td>13.3</td>
<td>37</td>
<td>14.1</td>
<td>37</td>
<td>12.7</td>
</tr>
<tr>
<td>Lack of motivation or encouragement to pursue career in nursing</td>
<td>25</td>
<td>10.0</td>
<td>15</td>
<td>5.7</td>
<td>26</td>
<td>8.9</td>
</tr>
<tr>
<td>Never intended to stay in nursing</td>
<td>2</td>
<td>.8</td>
<td>4</td>
<td>1.5</td>
<td>3</td>
<td>1.0</td>
</tr>
<tr>
<td>Nothing to gain financially</td>
<td>10</td>
<td>4.0</td>
<td>3</td>
<td>1.1</td>
<td>8</td>
<td>2.7</td>
</tr>
<tr>
<td>Left to pursue further education</td>
<td>20</td>
<td>8.0</td>
<td>19</td>
<td>7.2</td>
<td>19</td>
<td>6.5</td>
</tr>
<tr>
<td>Travel</td>
<td>43</td>
<td>17.3</td>
<td>56</td>
<td>21.3</td>
<td>67</td>
<td>23.0</td>
</tr>
<tr>
<td>Family responsibilities</td>
<td>114</td>
<td>45.8</td>
<td>61</td>
<td>23.2</td>
<td>85</td>
<td>29.2</td>
</tr>
<tr>
<td>Had a job with better pay</td>
<td>19</td>
<td>7.6</td>
<td>3</td>
<td>1.1</td>
<td>8</td>
<td>2.7</td>
</tr>
<tr>
<td>Had a job more suited to my lifestyle and responsibilities</td>
<td>26</td>
<td>10.4</td>
<td>17</td>
<td>6.5</td>
<td>31</td>
<td>10.7</td>
</tr>
<tr>
<td>Nursing salary was too low</td>
<td>22</td>
<td>8.8</td>
<td>5</td>
<td>1.9</td>
<td>19</td>
<td>6.5</td>
</tr>
<tr>
<td>Lack in flexibility in nursing</td>
<td>15</td>
<td>6.0</td>
<td>25</td>
<td>9.5</td>
<td>36</td>
<td>12.4</td>
</tr>
<tr>
<td>Dissatisfaction with the profession</td>
<td>32</td>
<td>12.9</td>
<td>30</td>
<td>11.4</td>
<td>40</td>
<td>13.7</td>
</tr>
<tr>
<td>Wanted a change</td>
<td>45</td>
<td>18.1</td>
<td>28</td>
<td>10.6</td>
<td>49</td>
<td>16.8</td>
</tr>
<tr>
<td>No jobs in preferred area of nursing</td>
<td>9</td>
<td>3.6</td>
<td>11</td>
<td>4.2</td>
<td>6</td>
<td>2.1</td>
</tr>
<tr>
<td>No jobs near where I lived</td>
<td>15</td>
<td>6.0</td>
<td>14</td>
<td>5.3</td>
<td>15</td>
<td>5.2</td>
</tr>
<tr>
<td>No part-time work available</td>
<td>7</td>
<td>2.8</td>
<td>8</td>
<td>3.0</td>
<td>11</td>
<td>3.8</td>
</tr>
<tr>
<td>Shiftwork requirements</td>
<td>20</td>
<td>8.0</td>
<td>19</td>
<td>7.2</td>
<td>31</td>
<td>10.7</td>
</tr>
<tr>
<td>Health reasons</td>
<td>32</td>
<td>12.9</td>
<td>18</td>
<td>6.8</td>
<td>21</td>
<td>7.2</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
<td>6.0</td>
<td>18</td>
<td>6.8</td>
<td>16</td>
<td>5.5</td>
</tr>
<tr>
<td><strong>Total number of respondents</strong>*</td>
<td><strong>249</strong></td>
<td></td>
<td><strong>263</strong></td>
<td></td>
<td><strong>291</strong></td>
<td></td>
</tr>
</tbody>
</table>

*Respondents could choose more than one response to this question.
Table 3.38 Reasons for breaks in nursing: 2001

<table>
<thead>
<tr>
<th>Reason for Break</th>
<th>Aged Care</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Burn-out</td>
<td>28</td>
<td>9.9</td>
<td>32</td>
</tr>
<tr>
<td>Lack of motivation or encouragement to pursue career in nursing</td>
<td>12</td>
<td>4.2</td>
<td>23</td>
</tr>
<tr>
<td>Never intended to stay in nursing</td>
<td>6</td>
<td>2.1</td>
<td>2</td>
</tr>
<tr>
<td>Nothing to gain financially</td>
<td>5</td>
<td>1.8</td>
<td>3</td>
</tr>
<tr>
<td>Left to pursue further education</td>
<td>7</td>
<td>2.5</td>
<td>21</td>
</tr>
<tr>
<td>Travel</td>
<td>36</td>
<td>12.7</td>
<td>59</td>
</tr>
<tr>
<td>Family responsibilities (including parental leave)</td>
<td>221</td>
<td>77.8</td>
<td>238</td>
</tr>
<tr>
<td>Had a job with better pay</td>
<td>10</td>
<td>3.5</td>
<td>7</td>
</tr>
<tr>
<td>Had a job more suited to my lifestyle and responsibilities</td>
<td>30</td>
<td>10.6</td>
<td>22</td>
</tr>
<tr>
<td>Nursing salary was too low</td>
<td>15</td>
<td>5.3</td>
<td>9</td>
</tr>
<tr>
<td>Lack in flexibility in nursing</td>
<td>27</td>
<td>9.5</td>
<td>23</td>
</tr>
<tr>
<td>Dissatisfaction with the profession</td>
<td>20</td>
<td>7.0</td>
<td>38</td>
</tr>
<tr>
<td>Wanted a change</td>
<td>46</td>
<td>16.2</td>
<td>50</td>
</tr>
<tr>
<td>No jobs in preferred area of nursing</td>
<td>3</td>
<td>1.1</td>
<td>10</td>
</tr>
<tr>
<td>No jobs near where I lived</td>
<td>18</td>
<td>6.3</td>
<td>18</td>
</tr>
<tr>
<td>No part-time work available</td>
<td>6</td>
<td>2.1</td>
<td>8</td>
</tr>
<tr>
<td>Shiftwork requirements</td>
<td>23</td>
<td>8.1</td>
<td>34</td>
</tr>
<tr>
<td>Health reasons</td>
<td>31</td>
<td>10.9</td>
<td>19</td>
</tr>
<tr>
<td>Other</td>
<td>25</td>
<td>8.8</td>
<td>21</td>
</tr>
<tr>
<td>Total number of respondents*</td>
<td>284</td>
<td>100.0</td>
<td>309</td>
</tr>
</tbody>
</table>

*Respondents could choose more than one response to this question.

Some significant differences exist across sectors and between 2001 and 2004.

In the aged care sector there has been a significant increase between 2001 and 2004 in the proportion of nurses who cite lack of motivation or encouragement to pursue their in nursing as an impediment (p = 0.01). Also in the aged care sector an increased proportion of nurses left to pursue further education (p < 0.01).

Family responsibilities were a far more significant issue in the aged care sector than in the other two sectors in 2004 but not in 2001 (p < 0.001). A very significant decrease in the importance of this issue occurred between 2001 and 2004 in each sector (p < 0.001).

In 2004 a significantly higher proportion of nurses in the aged care sector than the other sectors cited a job with better pay as a reason for a break from nursing (p < 0.001).
The importance of nursing salary differed significantly across the sectors in 2004 (p < 0.01) with the aged care sector seeing this as more important than the private sector, which in turn saw this as more important than the public sector.

Health reasons feature more prominently for aged care sector nurses than nurses in the other two sectors in both 2001 (p < 0.01) and 2004 (p < 0.05).

### 3.7 Demographic Data on Respondents

This section of the questionnaire gathered data on the level of nurse, their formal qualifications, endorsements, gender, age, ethnicity and if they had a disability.

#### 3.7.1 Job designation – private sector (Q65)

In Queensland, due to industrial agreements, there are now two different classifications for registered nurses. Additionally, within the public sector (both acute and aged care) there are advanced practice positions for both ENs and AINs.

A comparison of the distribution of job designation between 2001 and 2004 for nurses in the aged care private and private sectors is displayed below in figure 3.133. No significant difference exists in the distributions between 2001 and 2004.

**Figure 3.133 Designation of nurses employed in the private aged care and acute sectors**
3.7.2 Job designation – public sector (Q66)

The designation of nursing jobs in the public sector has changed since 2001, so no direct comparison is possible between 2001 and 2004 (see Figure 3.134).

A combination of the data from Q65 and Q66 results in the following percentages of nurses in the study (see Tables 3.39, 3.40).

Table 3.39 Job designation across all sectors for 2004 (in percent)

<table>
<thead>
<tr>
<th>Designation</th>
<th>Aged care</th>
<th>Public</th>
<th>Private</th>
<th>Overall</th>
<th>SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIN</td>
<td>39.9</td>
<td>0.5</td>
<td>1.3</td>
<td>7.6</td>
<td>3.1</td>
</tr>
<tr>
<td>EN</td>
<td>11.0</td>
<td>13.2</td>
<td>12.9</td>
<td>12.7</td>
<td>3.1</td>
</tr>
<tr>
<td>RN</td>
<td>43.0</td>
<td>85.7</td>
<td>82.2</td>
<td>77.5</td>
<td>1.4</td>
</tr>
<tr>
<td>Other</td>
<td>6.2</td>
<td>0.7</td>
<td>3.6</td>
<td>2.2</td>
<td>3.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 3.40 Job designation across all sectors for 2001 (in percent)

<table>
<thead>
<tr>
<th>Designation</th>
<th>Aged care</th>
<th>Public</th>
<th>Private</th>
<th>Overall</th>
<th>SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIN</td>
<td>39.0</td>
<td>1.2</td>
<td>1.2</td>
<td>8.6</td>
<td>3.0</td>
</tr>
<tr>
<td>EN</td>
<td>12.8</td>
<td>14.1</td>
<td>11.0</td>
<td>13.3</td>
<td>3.0</td>
</tr>
<tr>
<td>RN</td>
<td>45.9</td>
<td>82.2</td>
<td>85.9</td>
<td>75.7</td>
<td>1.4</td>
</tr>
<tr>
<td>Other</td>
<td>2.3</td>
<td>2.5</td>
<td>1.8</td>
<td>12.3</td>
<td>2.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
No significant change in overall percentage has occurred between 2001 and 2004 for any designation.

Further analysis to ascertain a “goodness of fit” between the results of the 2004 study and the QNU database suggests RNs appear over-represented (p < 0.05) and AINs under-represented (not significantly so but the small numbers compromise power) in the 2004 survey compared to the QNU database (see Table 3.41).

<table>
<thead>
<tr>
<th>Designation</th>
<th>Aged care</th>
<th>Public</th>
<th>Private</th>
<th>Overall</th>
<th>SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIN</td>
<td>51.5</td>
<td>4.3</td>
<td>1.7</td>
<td>12.3</td>
<td>2.1</td>
</tr>
<tr>
<td>EN</td>
<td>9.9</td>
<td>11.9</td>
<td>12.2</td>
<td>11.6</td>
<td>2.0</td>
</tr>
<tr>
<td>RN</td>
<td>37.0</td>
<td>81.6</td>
<td>84.0</td>
<td>74.1</td>
<td>1.0</td>
</tr>
<tr>
<td>Other</td>
<td>1.6</td>
<td>2.2</td>
<td>2.1</td>
<td>2.1</td>
<td>2.2</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

3.7.3 Formal nursing qualifications (Q67)

In this question nurses were asked to list all the formal nursing qualifications they had completed outside of a university or Technical and Further Education (TAFE) which were directly relevant to their work. The courses with ten or above respondents are displayed, by rank, in Table 3.42. A total of 1349 nurses provided a response to this question. It should be noted that many of the courses listed are continuing professional education programs rather than formal hospital qualifications. The full responses to this question can be found in the supplementary documentation.
## Table 3.42 Nursing Qualifications gained outside a University or TAFE

<table>
<thead>
<tr>
<th>Rank</th>
<th>Formal nursing qualifications outside university or TAFE</th>
<th>n</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>General nursing in hospital</td>
<td>336</td>
<td>24.91%</td>
</tr>
<tr>
<td>2</td>
<td>Midwifery</td>
<td>203</td>
<td>15.05%</td>
</tr>
<tr>
<td>3</td>
<td>Life support courses (includes first aid and pre hospital trauma course)</td>
<td>124</td>
<td>9.19%</td>
</tr>
<tr>
<td>4</td>
<td>Cardiac/intensive care/critical care</td>
<td>49</td>
<td>3.63%</td>
</tr>
<tr>
<td>5</td>
<td>Enrolled nursing</td>
<td>48</td>
<td>3.56%</td>
</tr>
<tr>
<td>6</td>
<td>Mental health nursing</td>
<td>38</td>
<td>2.82%</td>
</tr>
<tr>
<td>7</td>
<td>Child/adolescent and family health</td>
<td>36</td>
<td>2.67%</td>
</tr>
<tr>
<td>8</td>
<td>Aged care</td>
<td>32</td>
<td>2.37%</td>
</tr>
<tr>
<td>9</td>
<td>Palliative care</td>
<td>32</td>
<td>2.37%</td>
</tr>
<tr>
<td>10</td>
<td>Wound management</td>
<td>29</td>
<td>2.15%</td>
</tr>
<tr>
<td>11</td>
<td>Emergency nursing</td>
<td>25</td>
<td>1.85%</td>
</tr>
<tr>
<td>12</td>
<td>Dementia</td>
<td>23</td>
<td>1.70%</td>
</tr>
<tr>
<td>13</td>
<td>Immunisation</td>
<td>22</td>
<td>1.63%</td>
</tr>
<tr>
<td>14</td>
<td>Neonatal</td>
<td>20</td>
<td>1.48%</td>
</tr>
<tr>
<td>15</td>
<td>Infection control/infectious disease</td>
<td>16</td>
<td>1.19%</td>
</tr>
<tr>
<td>16</td>
<td>Operating theatre</td>
<td>16</td>
<td>1.19%</td>
</tr>
<tr>
<td>17</td>
<td>Perioperative</td>
<td>16</td>
<td>1.19%</td>
</tr>
<tr>
<td>18</td>
<td>Anaesthetics/recovery room</td>
<td>14</td>
<td>1.04%</td>
</tr>
<tr>
<td>19</td>
<td>Continence</td>
<td>14</td>
<td>1.04%</td>
</tr>
<tr>
<td>20</td>
<td>Manual handling/no lift</td>
<td>14</td>
<td>1.04%</td>
</tr>
<tr>
<td>21</td>
<td>EEN</td>
<td>13</td>
<td>0.96%</td>
</tr>
<tr>
<td>22</td>
<td>Rural and remote area nursing</td>
<td>13</td>
<td>0.96%</td>
</tr>
<tr>
<td>23</td>
<td>Preceptor program</td>
<td>12</td>
<td>0.89%</td>
</tr>
<tr>
<td>24</td>
<td>Cannulation/phlebotomy</td>
<td>10</td>
<td>0.74%</td>
</tr>
<tr>
<td>25</td>
<td>ECG</td>
<td>10</td>
<td>0.74%</td>
</tr>
<tr>
<td>26</td>
<td>Oncology</td>
<td>10</td>
<td>0.74%</td>
</tr>
</tbody>
</table>

### 3.7.4 Formal qualifications completed at university or TAFE (Q68)

In this question respondents were asked to identify all completed university or TAFE programs which were directly relevant to their work. A total of 1349 respondents provided an answer. The courses that 10 or more respondents indicated they had completed are found in Table 3.43. The full responses to this question can be found in the supplementary documentation.
Table 3.43 Qualifications completed at university or TAFE

<table>
<thead>
<tr>
<th>Rank</th>
<th>Qualification</th>
<th>n</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>BN (nursing, applied science)</td>
<td>348</td>
<td>25.80%</td>
</tr>
<tr>
<td>2</td>
<td>AIN – Cert 2 and Cert 3</td>
<td>112</td>
<td>8.30%</td>
</tr>
<tr>
<td>3</td>
<td>Cert 4 Workplace Assessment and Training</td>
<td>59</td>
<td>4.37%</td>
</tr>
<tr>
<td>4</td>
<td>EN Medication Endorsement</td>
<td>49</td>
<td>3.63%</td>
</tr>
<tr>
<td>5</td>
<td>Diploma in Nursing (pre-reg)</td>
<td>29</td>
<td>2.15%</td>
</tr>
<tr>
<td>6</td>
<td>Grad Dip Midwifery</td>
<td>18</td>
<td>1.33%</td>
</tr>
<tr>
<td>7</td>
<td>Cert 4 Aged Care/Community</td>
<td>17</td>
<td>1.26%</td>
</tr>
<tr>
<td>8</td>
<td>B Arts</td>
<td>12</td>
<td>0.89%</td>
</tr>
</tbody>
</table>

3.7.5 Endorsements (Q69)

The number and percentage of respondents with endorsements in the 2001 and 2004 surveys are displayed in Tables 3.44 and 3.45. It should be noted that the isolated practice endorsement changed to a rural and isolated practice endorsement during the period 2001 to 2004.

Table 3.44 Endorsements: 2004

<table>
<thead>
<tr>
<th>Endorsement</th>
<th>Aged Care</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Midwifery</td>
<td>56</td>
<td>13.1</td>
<td>131</td>
</tr>
<tr>
<td>Immunisation</td>
<td>3</td>
<td>0.7</td>
<td>33</td>
</tr>
<tr>
<td>Sexual health</td>
<td>1</td>
<td>0.2</td>
<td>5</td>
</tr>
<tr>
<td>Mental health</td>
<td>9</td>
<td>2.1</td>
<td>33</td>
</tr>
<tr>
<td>Rural and Isolated Practice</td>
<td>3</td>
<td>0.7</td>
<td>7</td>
</tr>
<tr>
<td>EN Medication</td>
<td>47</td>
<td>11.0</td>
<td>49</td>
</tr>
<tr>
<td><strong>Total number of respondents</strong></td>
<td>119</td>
<td></td>
<td>258</td>
</tr>
</tbody>
</table>

*Respondents could choose more than one response to this question.

Table 3.45 Endorsements: 2001

<table>
<thead>
<tr>
<th>Endorsement</th>
<th>Aged Care</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Midwifery</td>
<td>74</td>
<td>29.0</td>
<td>157</td>
</tr>
<tr>
<td>Immunisation</td>
<td>3</td>
<td>1.2</td>
<td>26</td>
</tr>
<tr>
<td>Sexual health</td>
<td>1</td>
<td>0.4</td>
<td>5</td>
</tr>
<tr>
<td>Mental health</td>
<td>22</td>
<td>8.6</td>
<td>37</td>
</tr>
<tr>
<td>Isolated Practice</td>
<td>2</td>
<td>0.8</td>
<td>8</td>
</tr>
<tr>
<td>EN Medication</td>
<td>30</td>
<td>11.8</td>
<td>47</td>
</tr>
<tr>
<td><strong>Total number of respondents</strong></td>
<td>132</td>
<td></td>
<td>280</td>
</tr>
</tbody>
</table>

*Respondents could choose more than one response to this question.

In both 2001 and 2004, very significant differences exist across the sectors in the percentage of nurses holding a midwifery endorsement (p < 0.001), with the aged care sector being significantly less than the other two sectors. A significant decrease is noted in the private sector from 2001 to 2004 (p < 0.001). Immunisation endorsements are significantly more prevalent in the public sector than the other two sectors in both 2001 and 2004 (p < 0.001).
In 2004 there is a significantly lower percentage of nurses in the aged care sector with a mental health endorsement than in the other two sectors (p = 0.01) and some evidence that this proportion has dropped since 2001 (p < 0.05).

3.7.6 Gender (Q70)

There is evidence that the proportion of males differs across the sectors both in the 2004 survey (p < 0.01) and the 2001 survey (p < 0.05). In 2004 the proportion of males in the private sector is less than that in the aged care sector, which is less than that in the public sector (see Figure 3.135). No significant change in gender distribution occurred between 2001 and 2004 in any sector.

Figure 3.135 Gender

No significant differences exist in the gender distribution between 2001 and 2004 or between the 2004 survey and the QNU database. However, male sample sizes are small so only large differences in percentages can be detected as significant (see Tables 3.46, 3.47 and 3.48).

<table>
<thead>
<tr>
<th>Gender</th>
<th>Aged care (%)</th>
<th>Public (%)</th>
<th>Private (%)</th>
<th>Overall (SE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>93.4</td>
<td>90.1</td>
<td>95.5</td>
<td>91.6 (1.0)</td>
</tr>
<tr>
<td>Male</td>
<td>6.6</td>
<td>9.9</td>
<td>4.5</td>
<td>8.4 (3.2)</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 3.47 Gender across all sectors for 2001 survey

<table>
<thead>
<tr>
<th>Gender</th>
<th>Aged care (%)</th>
<th>Public (%)</th>
<th>Private (%)</th>
<th>Overall (SE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>96.3</td>
<td>92.6</td>
<td>95.1</td>
<td>93.7 (0.8)</td>
</tr>
<tr>
<td>Male</td>
<td>3.7</td>
<td>7.4</td>
<td>4.9</td>
<td>6.3 (3.0)</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 3.48 Gender according to QNU database 2004

<table>
<thead>
<tr>
<th>Gender</th>
<th>Aged care (%)</th>
<th>Public (%)</th>
<th>Private (%)</th>
<th>Overall (SE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>93.4</td>
<td>88.4</td>
<td>94.8</td>
<td>90.4 (0.7)</td>
</tr>
<tr>
<td>Male</td>
<td>6.6</td>
<td>11.6</td>
<td>5.2</td>
<td>9.6 (2.1)</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>
**3.7.7 Age distribution (Q71)**

The age distribution differs significantly across the sectors (p < 0.001) both in 2001 and in 2004. In 2004 the main reason for the difference is the lower percentage of nurses aged less than 50 years and higher proportion of nurses aged 50 or more in the aged care sector compared to the other two sectors (see Figure 3.136). No significant difference exists between the average age of nurses in the public and private sectors, but nurses in the aged care sector are significantly older on average than those in the other sectors (p < 0.001).

![Age distribution chart](image)

There is also a very significant (p < 0.001) change of age distribution in the aged care sector between 2001 and 2004. The main change is the increase in the percentage of nurses of 60 years or more in 2004 compared to 2001. Consequently the average age of nurses in the aged care sector has increased significantly from 2001 to 2004 (p < 0.001).

In both 2001 and 2004 the differences among the mean ages of nurses in the three sectors are highly significant (p < 0.001). In both 2001 and 2004 the mean age of nurses in the aged care sector is significantly greater than that in the public and private sectors. Estimated means have increased in all sectors between 2001 and 2004, although the differences are statistically significant only in the aged care sector (p < 0.01).
On average, over all sectors, the mean age has increased (p < 0.10) from 43.4 years in 2001 to 44.1 years in 2004 (see Table 3.49).

### Table 3.49 Estimated mean age by year and sector

<table>
<thead>
<tr>
<th>Year of survey</th>
<th>Aged care</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>49.7</td>
<td>42.8</td>
<td>43.6</td>
</tr>
<tr>
<td>2001</td>
<td>48.0</td>
<td>42.2</td>
<td>42.6</td>
</tr>
</tbody>
</table>

#### 3.7.8 Aboriginal, Torres Strait or South Sea Island origin (Q72)

The breakdown for 2004 is displayed in Table 3.50.

### Table 3.50 Aboriginal, Torres Strait or South Sea Island origin: 2004

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Aged care</th>
<th>public</th>
<th>private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Aboriginal</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Torres Strait Islander</td>
<td>1</td>
<td>0.2</td>
<td>0</td>
</tr>
<tr>
<td>South Sea Islander</td>
<td>5</td>
<td>1.1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total number of respondents</strong></td>
<td>6</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>
3.7.9 Non-English speaking background (Q73)

No significant differences exist the sectors in the proportions of nurses with a non-English speaking background. Further, there are no significant differences in the proportion of nurses with a non-English speaking background between 2001 and 2004 in any of the sectors (see Figure 3.97).

3.7.10 Identification as a person with a disability (Q74)

The two disability questions were reversed in order from the 2001 survey. There is no evidence of a difference in the proportion of respondents across sectors who identify as having a disability in either the 2001 or 2004 surveys.
Despite the small numbers involved, there is some evidence, however \((p = 0.02)\) in the private sector of a change between 2001 and 2004, with the proportion of nurses identifying as having a disability increasing from 2001 to 2004 (see Figure 3.140).

### Figure 3.140 Identification as a person with a disability

![Chart](chart1.png)

**3.7.11 Work-acquired disability (Q75)**

There is weak evidence \((p = 0.08)\) in the 2001 survey of a difference among sectors in the proportion of nurses with work-acquired disabilities. However, this is not supported by the 2004 survey. Weak evidence exists of a reduction in the rate of work-acquired disability from 2001 to 2004 in the aged care \((p = 0.07)\) and private sectors \((p < 0.05)\) but this may be a result of the reordering of the two disability questions (see Figure 3.141).

### Figure 3.141 Work-acquired disability

![Chart](chart2.png)
The final two questions were open-ended and have been analysed qualitatively.

3.8 Five Most Important Activities for the QNU in the coming Year

Table 3.40 outlines the major themes which arose from analysis of the qualitative data in this question. Following Table 3.51 is an outline of the nine major themes arising from the data as well as a comparison between 2001 and 2004.

Table 3.51 Major themes from data analysis of question 76

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Remuneration and conditions</td>
<td>249</td>
<td>70</td>
<td>256</td>
<td>79</td>
<td>200</td>
<td>59</td>
</tr>
<tr>
<td>Workloads/staffing/skill mix</td>
<td>101</td>
<td>28</td>
<td>155</td>
<td>48</td>
<td>88</td>
<td>25</td>
</tr>
<tr>
<td>Parity</td>
<td>68</td>
<td>19</td>
<td>89</td>
<td>27</td>
<td>23</td>
<td>6</td>
</tr>
<tr>
<td>Industrial support</td>
<td>52</td>
<td>15</td>
<td>75</td>
<td>23</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Education and training / professional development</td>
<td>100</td>
<td>28</td>
<td>67</td>
<td>21</td>
<td>106</td>
<td>30</td>
</tr>
<tr>
<td>Recruitment and retention</td>
<td>83</td>
<td>23</td>
<td>51</td>
<td>16</td>
<td>50</td>
<td>14</td>
</tr>
<tr>
<td>Support from QNU</td>
<td>37</td>
<td>10</td>
<td>36</td>
<td>11</td>
<td>18</td>
<td>5</td>
</tr>
<tr>
<td>Workplace violence</td>
<td>21</td>
<td>6</td>
<td>34</td>
<td>10</td>
<td>48</td>
<td>13</td>
</tr>
<tr>
<td>Aged care</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

An overview of the results of the data analysis is now presented. The full data analysis is available in the supplementary documentation of this report.

3.8.1 Public sector

A total of 279 respondents gave one or more indications of activities of the QNU. The five most common themes arising from the data were: wages and conditions (n=221:79%); workloads/staffing/skill mix (n=143:51%); education, training and/or professional development (n=55:20%); workplace violence (n=42:15%); and the QNU to provide support to nurses (n=38:14%). These themes are now discussed.

3.8.1.1 Remuneration and conditions

Two hundred and twenty-one (79%) respondents listed aspects of remuneration and conditions they wished the QNU to address.
a) Remuneration

The most respondents believed that the wages paid do not reflect the complexity of nursing work. The majority of respondents just wrote ‘wages’ as the issue they wished the QNU to address. Many respondents believed that there should be an:

...improvement of pay to reflect the stress and life changing decisions nurses have to make.

There were also many respondents who commented on how the current pay structure disadvantaged nurses above Nursing Officer (NO) 1.

Ensure there is a greater pay difference between NO1 and NO2 – at least 15% increase from NO1 Yr 8 to NO2 Yr 1.

Other respondents believed that the pay differentials between NO2 and NO3 had not been addressed in the previous Enterprise Agreement and noted that this anomaly meant that nurses currently employed at NO2 did not wish to be promoted to NO3 as they ‘would receive less pay’.

Currently L2 [NO2] nurses who work shifts can earn up to $6,000 per year more than NUMS [nursing unit managers]. There is no incentive for CNs [clinical nurses] to act up as NUMs. The career structure should address this as a matter of urgency.

As this respondent noted:

...pay increases for level 3 and above (no incentive to go for promotion as this means a pay drop – what other profession is there where you receive less pay for promotion).

This pay differential was also a problem for NO3 nurses wishing to encourage NO2 nurses to relieve them for leave.

Anomalies for NO3 pay (Level 2 not willing to relieve as they go down in pay).

There were many varied comments on what the respondents believed should be remunerated. These included:

- double time for public holidays
- review of entitlements for remote area nurses
- increased shift allowances for morning shifts
- pay for being on-call
- double time for Sundays
- meal breaks remunerated when not taken
- increased penalty rates for working night duty
• shift allowances to be added to superannuation and not just the flat rate as at present
• the cost of food for night duty staff
• overtime.

However, one respondent stated that:

*I feel the QNU focuses too heavily on pay and ignores the working conditions, especially in the area of nurse-to-patient ratio (or hours on TREND).*

b) Conditions

The respondents also suggested that a wide range of conditions could be improved. Some believed that there should be incentives to remain in nursing:

_Incentives for experienced staff to remain in workforce i.e. workload in community based care._

While others suggested that untaken leave should be accumulated and paid out on retirement. This respondent, like several others, believed that there should be an:

…_incentive to reduce sick leave taken, e.g. financial or leave incentives to bank sick leave or have it paid out on resignation or converted to annual._

Many of the respondents just wrote ‘conditions’; however, there were many and varied suggestions for the QNU to address with regard to working conditions in the public sector, such as:

- laundry allowance
- more paid annual leave
- maternity/family leave
- SARAS leave
- paid conference leave
- support services for nurses such as counselling
- health services for nurse such as gyms
- maintaining leave loading
- increased leave to compensate for public holidays
- better hours
- study leave
- a paid sleep day after night duty
- a 36 hour working week.

The second theme that arose from the data collection was that of workloads/staffing/skill mix. A total of 143 (51%) nurses raised issues relating to this theme.
3.8.1.2 Nursing workloads/staffing/skill mix

The majority of respondents just wrote ‘workloads’ as their response to what the QNU should address. Other respondents wrote a little more. For example:

*I believe the QNU needs to investigate ways to expose the lack of nurses working in the health sector. New workload reports and making them work.*

*Ensuring safe workloads and practices.*

It is apparent that many of the respondents believed that one way of decreasing current workloads was to increase the number of nurses employed on each shift. As this respondent noted:

*Maybe the QNU could focus more on getting more nurses on the floor and less on increasing wages. If there were more people to carry the workload job satisfaction would be a lot higher. High wages do not really compensate for lack of job satisfaction and we don’t realistically appear to be able to have both. MAYBE THE QNU COULD BE THE FIRST UNION TO PUSH FOR HIGHER JOB SATISFACTION INSTEAD OF HIGHER WAGES.*

Other respondents noted that workloads are inequitable within the work unit. For example:

*Don’t let a certain few get the heavy workloads.*

Several respondents believed that there should be a nurse-patient ratio of 1:4. For example:

*Attain nurse/patient ratio of 1 to 4.*

Impacting on the ability of nurses to provide care is the skill mix available. Several respondents noted that rostering systems do not take into account the mix of experienced versus inexperienced staff working on any particular shift. This respondent noted that a major issue was for the QNU to:

*Resolve skill mix issues (patient care management system do not allow for different hours for lesser trained staff).*

Other respondents believed that the level of RNs on each shift should not be eroded by replacing them with ENs or AINs.

*Ensure skill mix of RNs to ENs/AINs is not altered to the detriment of RN employment.*

In most cases, the respondents believed that cost containment was the major reason for lack of staffing, inappropriate skill mix and high workloads. They urged the QNU to:
Push for adequate funding from State gov. Therefore adequate staffing.

The themes of workplace violence and education and training were ranked third, with 15% (n=42) of the respondents raising them as issues to be addressed by the QNU.

3.8.1.3 Workplace violence

Workplace violence towards the respondents in this study came from two major sources: management and the general public (patients and/or relatives). Respondents were often brief in their notes about management’s role in workplace violence, often just noting that there was harassment ‘by management’. Several respondents noted they were subject to:

…abuse mostly verbal, mostly clients, relatives.

One respondent noted some feeling of helplessness about violence from patients and relatives, stating that:

Patient and public are protected by the patient’s charter and can be as rude, aggressive and obstructive as they wish. Staff appear to have no rights and are often asked to explain/account for complaints, causing them to feel as though they (the staff members) are at fault.

Other respondents believed that the QNU had a role to play in decreasing workplace violence: for example, respondents believed that the QNU should run a:

…mandatory workplace bullying seminar to all nurses for a couple of hours every year.

Others believed the QNU should continue with their policy of:

…‘zero tolerance’ to workplace violence.

3.8.1.4 Education and training

This theme encompasses comments by respondents (n=42:15%) about formal education and training programs as well as in-service programs offered within the health facility. Many respondents expressed the wish for:

…more paid leave to further education.

Others requested that:

…professional development days to be built into award (two per year).
Some respondents believed that the employer had a responsibility to contribute (if not fully pay) for the costs incurred by employees for education and training. For example:

...better support for nurse completing/studying post graduate qualifications, e.g. financial and leave.

Several respondents from rural areas noted that on-site training was preferable:

...to eliminate long distance travelled, and utilise modern technology (lots of staff unable to attend courses because of limited staff coverage in smaller facilities).

Other rural respondents noted that the QNU should:

...encourage health facilities especially larger areas and metropolitan to have places for staff to stay/reside doing exchange/training in larger centres. ... Often lack of cheaper accommodation is a deterrent from studying away from home.

Respondents also provided some guidance on the focus of training programs to be offered by their employer:

...education – require supports for clinical education not just corporate issues.

Another respondent believed that clinical education and training should be provided to nurses who, for various reasons, were unable to keep up-to-date clinically. They believed the QNU should ensure that these programs were available.

...re-training/refreshed programs for nurses like myself who now work casually and infrequently due to family-life commitments and to ensure that they remain confident and safe in the workplace, thus ensuring that they stay in the workforce. In my age group (41 years) I know several people no longer working in nursing at all! I am keen to hang in there! Just.

Another respondent believed that casually employed nurses should also have access to education and training within the health facility:

...in-service training for casual staff on a paid to attend basis.

In addition to these comments, a further 13 (5%) respondents believed that the QNU should provide education and training to its members. While some respondents wanted to be provided with information on education and training opportunities, others wanted to be informed on scholarships that might be available.
Areas that were considered to be education and training activities of the QNU were:

- international unionism
- assertiveness training
- effective communication
- information technology.

The fifth most common theme was that of the support that respondents believed should be offered by the QNU.

### 3.8.1.5 Support from the QNU

A total of 38 (14%) respondents' perceptions could be allocated within this theme. Many respondents noted that they require the QNU to provide:

...support to nursing staff when required.

Others noted they had requested support and that this had not been provided to their level of satisfaction. As one respondent stated:

[I] had little and limited support from QNU in a dispute I had with my employer.

Other respondents believed that the QNU should be:

...advocating for a healthier nursing workforce – get into hospitals re their lack of flexibility on nursing hours and rosters.

...[providing] teamwork and care for the carers workshops.

...[providing] staff assistance – as seem to be inadequate representative in this area. So no assistance when needed at short notice.

...[seen in the workplace more often as] I pay my QNU fees. [I] may see a QNU rep once a year, no other involvement, only if a work-related need arises.

Additionally, several respondents noted that the QNU should:

... continue as they are – fighting for nurses.

### 3.8.2 Private sector

A total of 326 private sector respondents provided some comments in this section of the questionnaire. The five major themes from this sector were: wages and conditions (n=256:79%); workloads/staffing/skill mix (n=155:48%);
parity (n=89:27%); industrial support (n=75:23%) and education and training (n=67:21%). It should be noted that there were commonalities between the public and private sector (remuneration, conditions, workloads, education and training) there were also differences (parity; industrial support).

3.8.2.1 Remuneration and conditions

a) Remuneration

Similar to respondents in the public sector, many respondents just wrote ‘wages’. Others, however, were more specific, wanting:

...pay rate equal to work and responsibility held/ performed.

Several respondents noted that there were limitations with the current pay rates for Level 1 nurses:

...increase the top wage levels as in level 1 year 8. ... does not encourage experienced nurses who do not want or get opportunity for promotion to increase their salary. ... Staff I work with have collective experience of 90 years! That is three nurses still on level 1 year 8 pay scales – not good enough.

Unlike the public sector, there were no comments related to pay anomalies for Level 2 and above nurses.

b) Conditions

There were many and varied comments relating to working conditions within the private sector. Several respondents believed that they should be given financial incentives or decreased workload when they were working as a preceptor.

...increased pay rate or decreased patient workload when acting as preceptor for student nurses.

Many respondents stated that they wished to be paid for ‘meal breaks’ and for the ‘overtime [they are] expected to perform’. One respondent noted that the QNU should:

...support claim it/no breaks conditions in private sector.

Other areas raised were related to:

- leave (increase in paid maternity leave; the ability to transfer long service leave from the private to the public sector; more paid sick leave)
• shift work (not working an early shift after a late shift; being given insufficient notice of rostered hours to be worked; increased penalty rates for night shift; working double shifts; 12 hour shifts; being able to take two days off in a row; improved allowance for Christmas Day)
• on-call (the amount of on-call work required)
• recreation leave (should be increased; more needed for shift workers; increased for on-call staff; the fact that nurses are required ‘to work “20” of every shift to get our 6th week annual leave – in Victoria you only need work a certain number of weekends/year to get the same’)
• incentives (for ENs who are undertaking a conversion to RN; in-charge allowance for Level 1s who are relieving in charge of a unit; salary sacrifice)
• patient load (nil when co-ordinating a shift).

3.8.2.2 Workloads/staffing/skill mix

Similar to nurses in the public sector, the respondents in the private sector mentioned ‘workload’ as an issue to be addressed by the QNU. Many respondents believed that the QNU should have a role of monitoring workloads. These respondents wanted the QNU to examine:

…patient-nurse ratio…watched by the union, e.g. in some wards in the private hospital I work at, the patient-nurse ratio is one nurse to 15 patients. Very dangerous.

…lack of staff, and staff per patients. I look after up to 15 patients on my own.

Other respondents commented on what they saw were issues with deployment:

…skilled nursing staff levels, i.e. staff sent to speciality areas ICU, recovery, endoscopy and they are in charge and not buddied up with an experienced member (out of scope of practice).

And in areas of speciality:

…advocate for more staff – especially in higher risk areas, i.e. A&E, lock up dementia units/psychiatric units and to generally improve patient care – aged care units are chronically understaffed at patient meal times.

Many of the respondents believed that current staffing levels in their facility were unsafe:

…hospitals should be penalised if understaffed on shifts per ‘Trendcare’ – executives continually get away with it, and sit in their cosy offices as us (nurses) are ‘drowning’ in work, deeming it unsafe, that’s when mistakes are made.
And similar to a respondent in the public sector, one respondent noted that the QNU should:

…stop requesting pay increases and look at ways to keep nurses on the floor. Improve numbers doing patient care.

Other respondents were concerned about the growth of AINs or Personal Care Attendants (PCAs), in acute areas as the employment of PCAs was seen to increase the load on experienced nurses.

…allocation of eight hours of nursing (on Trendcare programs) to PCAs in acute hospital wards and therefore large patient loads for RNs in team nursing situation (e.g. one RN and one PCA).

However, one respondent believed that one way to decrease the need for more RNs was to replace them with ENs:

…the QNU should investigate using more enrolled nurses to provide direct patient care to allow RNs to provide overall management and co-ordination.

3.8.2.3 Parity

Respondents in the private sector were particularly concerned about parity of remuneration and conditions: (1) between the public and private sectors; (2) with other Australian states; and (3) between nursing and other similar professions.

a) Parity between the public and private sectors.

The majority of respondents wanted to know:

Why is there a difference between the private and public sectors?

b) Parity with other Australian states.

Other respondents noted that other nursing industrial agreements in other states gave better conditions (annual leave); had a better clinical career structure; and wage parity.

Why do Queensland nurses have less annual leave and PH [public holidays] than other states?

Why is experience in specified fields not recognised in Queensland i.e. CNS [Clinical Nurse Specialists] and CNC as in NSW. Level 2 positions are management and not area-specific qualified positions.
wage parity between states i.e. national rates of pay.

c) Parity with other professions.

Similar to the public sector, several respondents believed that other professionals were remunerated better than nurses:

...casual teachers are paid much, much more than casual RNs – why the discrepancy?

3.8.2.4 Industrial support

This was another theme that was more apparent in the private than the public sector. Many respondents simply wrote ‘EB’. However, there were other aspects to this theme.

For example, some respondents believed that it was a QNU responsibility to:

...follow up on employers – that they are implementing the terms specified in the enterprise bargaining agreement and show proof that they are to the union.

...audit private hospital pay offices to make sure employees are getting paid what their entitled to. My employer is successfully paying people casual rates of pay when they should be paid overtime.

Others believed that the union representative should be more visible in the workplace:

...making union rep [representative] more available in workplace.

In particular, it was apparent that several of the respondents believed that the QNU was ‘not interested in the private sector’ and that:

I believe the QNU need to show more active interest in making headway in membership and pay parity issues in the private sector. Council or union officials/delegates should make at least one visit a year to those private hospitals etc. even where membership is low and no ‘industrial’ activities are occurring. There always seems to be more ‘public nursing outcomes’.

Several other respondents felt unsupported in their EB negotiations:

...our hospital is undergoing EBA and we are finding the support as minimal and discouraging.

...the QNU are involved in the enterprise bargaining agreement negotiations with my employer. However, regardless of the content of
the EB, the employer will hold (as with the last EB) a meeting to
discuss how to ‘interpret’ the document. Obviously those who
negotiated on the EB have no input nor does anyone from or in the
QNU. Is it any wonder that only a third of staff eligible to vote in the last
EB even bothered voting? The QNU have no real input.

Several other respondents believed that the QNU had a role in:

…negotiations in disputes.

3.8.2.5 Education and training

The respondents in the private sector also discussed education and training in
terms of: (1) areas they would like the QNU to provide; and (2) as well as
making overall comments about employer support and the availability of
education and training.

Areas for the QNU to provide education and training were:
- workplace violence
- law
- stress management workshops
- education of members generally.

One respondent noted that courses offered by QNU should be ‘at reasonable
prices’.

Respondents provided varying suggestions to the QNU. These included:
- training and support for post-graduate nurses
- re-training to allow nurses to re-enter the workforce
- access to employer funded education and training
- education programs for ENs (including conversion programs)
- ensuring nurses were given time to attend education and training
  programs (both in-service and external to the organisation) – this
  included back-filling of positions to allow nurses to be released
- inform members of programs available nationally
- lobby to eliminate Post-graduate Education Loans (PELs) for post-
  graduate study
- education and training that is accessible (especially for night staff).

3.8.3 Aged care sector

A total of 257 nurses provided a response to this question. The five major
themes within this sector were: wages and conditions (n=191:81%);
workloads/skill mix/staffing (n=94:37%); issues specific to aged care (n=112;
44%); recruitment and retention (n=63:25%); and education and training
(n=55:21%).
3.8.3.1 Remuneration and conditions

Many of the respondents noted that the QNU should focus on ‘improved wages/salaries for aged care nurses’ and ‘working conditions’. As one respondent noted:

*Much improved wage structure achieved without forgoing already achieved benefits such as reduction in penalty rates.*

The major sub-theme in the data relating to working conditions was that respondents were expected to work unpaid overtime. That is, there were ‘expectations to start early or work late and don’t claim’.

As one respondent noted:

*On the couple of occasions when I felt that payments for overtime worked was demanded, I felt that my request was met with contempt.*

Other issues raised relating to working conditions raised by the respondents were:

- employer superannuation (paid on taxable income)
- maternity leave
- adequate notification of days working (i.e. roster availability)
- uniforms (‘specific uniforms for different categories of nursing, e.g. AIN, EN, RN Level 1, RN Level 2, RN Level 2’).
- leave (‘having annual leave and sick hours put on our pay slips’)
- penalty rates (being paid more for public holidays).

A major sub-theme could be parity (n=46: 18%). Similar to the other sectors, the respondents in the aged care sector sought parity with the public sector. They also noted that unskilled labour was paid more than nurses. The majority of respondents stated they wanted:

*Equality of wages for aged care private sector staff to that of public sector.*

*Improved funding for aged care nurses’ pay to meet public sector – this may provide incentive for RNs to gain permanent/casual employment rather than the current trend for RNs to joint nursing agencies for ‘better pay’.*

Others noted that:

*People working in our local citrus industry packing citrus have a higher rate of pay than nurses.*
3.8.3.2 Workloads/skill mix/staffing

Similar to the respondents from the private and public sectors, many of the respondents wrote ‘staffing levels’, ‘safer workloads’, ‘workloads’, ‘staffing ratio’, and ‘more staff’.

_Aged care nurses – appropriate hours to fit with working ADLs [activities of daily living]. Nurses need more time to attend to individual needs of residents. Emotionally, socially and physically. Nurses are spending more time on documentation than hands on with residents and their care. There always seems to be not enough time spent with patients, rushing off to another resident. Leaving work late as there is always documenting to be done after the shift._

Respondents commented on staff to resident ratios as being inadequate.

_The ratio of staff to residents. I have the above residents (40) and three of those require two staff members. There are only two staff members on duty at any time. I feel that the residents aren’t getting enough one-on-one and are being rushed._

This respondent expresses the concern many raised with the replacement of RNs by other less qualified staff and its impact on the care of residents.

_EENs are rostered in some aged care facilities to work ‘as RNs’ and identify themselves as ‘the RN on duty’ knowing that they are in charge of 35-45 residents._

Other respondents noted the difference between staffing between the private and public aged care sectors.

_Improved funding for aged care so that private sector aged care can provide more AINs/resident ratio. My previous employment was with [name of organisation] and currently I am in public sector of aged care, which is much better staffed._

3.8.3.3 Aged care

Reflecting the different context of practice, many respondents in this study raised specific issues that could be related to aged care. Sub-themes within this theme include:
a) Medications being given out by unlicenced personnel

A total of 40 (16%) respondents raised the issue of unregulated care providers administering medications in aged care facilities. Some respondents noted that the QNU was to:

Stop AINs being able to administer medications.

Others provided more detailed information. For example:

I feel the main activity QNU needs to be involved in is the suggestion that AINs and carers should give medications to elderly folk in residential care. I feel this practice is foolhardy and dangerous. I am committed to the welfare and wellbeing of the residents I care for. I take my job and responsibilities very seriously and am horrified at the suggestion of untrained staff taking on such a role. I am continually updating my knowledge on medications.

Stamping out of ‘personal carers’ giving medication, i.e. pre-packed or bottled regular medication, as there are clear black areas, and areas of rule. PCs do not know what the medication prescribed does or why they are giving it. They do not have the knowledge or skill level to be responsible for this.

Stop the passing of the Bill to let personal carers give drugs under directions.

b) QNU to change government policies

The respondents in this sector also believed that the QNU had a role in lobbying the Australian and Queensland governments with regard to aged care policy. For example:

Pushing our government to make management in aged care facilities more accountable for where money is being spent.

Increase flexibility between federal and state funding.

To be more actively lobbying against the private, public nursing home operators and private nursing home chief executives/managers, as well as the government/state governments towards removing the current RCS – resident classification system. The RCS is an RN’s administrative nightmare. It is far too complex with too much writing, duplicity. It places the RN under extreme high pressure and takes them away from their direct patient care and supervision, as well as staff supervision. It is too open to interpretation by accreditors. It needs to
be simplified, e.g. use of appropriate boxes/answers as this survey does.

Respondents urged the QNU to be proactive:

Be alert – what is the plan being put in place by providers to counteract the shortage of RNs in the aged care sector?

c) Paperwork

A sub-theme within the aged care sector was the amount of paperwork associated with working in an aged care facility (n=10; 3%). The respondents who raised this noted that the paperwork required in residential aged care meant they had less time to provide care to the resident.

Aim to cut out paperwork which now far exceeds bedside care.

Others asked for the documentation system to be simplified:

Repetitive documentation (if the care plans are done well why repeat, repeat, repeat?).

Finally, one respondent would like the QNU to:

Promote aged care in a positive light to the media and community. Negative and misleading media reports cause anxiety and distress for the whole community and affects staff morale.

3.8.3.4 Recruitment and retention

The respondents provided a broad overview of how they believed the QNU should work to recruit and retain nurses. There were three areas of discussion. The first area focused on retaining RNs in aged care:

Not allowing RNs to be removed from aged care.

The second focused on recruiting nurses into aged care:

Getting/keeping more staff.

The third area also focused on recruitment, but recruitment back to nursing of people who had left and were no longer registered.

Re-training nurses who have been out of the workforce for longer than five years, by having more re-training programs available (for enrolled nurses) and more scholarships available.
3.8.3.5 Education and training

Similar to the other sectors, the respondents saw two roles for the QNU in education and training. The first role was one of the QNU offering direct support in the form of scholarships and courses. For example:

Scholarships for rural nurses.

...continue to offer education opportunities to nurses.

...bereavement courses; stress management; communication.

Other respondents saw a role for the QNU in influencing the availability and type of programs provided by external providers. For example, several respondents believed that the QNU could assist nurses by increasing their:

...access to studies i.e. UNI, QTAC, or TAFE. Nursing is such a demanding field. Yet they make it so hard for people to enter or qualify for the course!

Other nurses saw other roles such as:

Professional development in rural areas.

In hospital/facility education (diploma and degree level).

Push to improve educational and professional development opportunities for all nurses in all sectors by making these more flexible with work/family/financial commitments.

More education course for enrolled nurses – such as gerontological nursing. Nurses in other States are able to access more study than in Queensland. TAFE programs need to be improved greatly.

Finally, other respondents noted that employers who hold funds to provide education must ‘demonstrate accountability for the use of it on education’.

3.8.4 Comparison with 2001 study

The data in Table 3.40 demonstrate some changes between the survey carried out in 2001 compared to the survey in 2004.

The data analysis from the public sector suggests:

- There was an increase in the percentage of respondents raising issues of: remuneration/working conditions; workloads/staffing/skill mix; QNU support; parity; and industrial support
- There was only one theme where the percentage of respondents decreased – education and training/personal development
• There were several new issues raised. The most significant of these were issues surrounding enrolled nurses, new graduates/re-entry; and valuing nursing skills.

In the private sector, the differences in thematic analysis are:
• A small increase in the percentage of respondents raising remuneration and working conditions; parity; industrial support and workplace violence
• A large increase in the percentage of respondents raising workloads/staffing/skill mix
• A decrease in the percentage of respondents mentioning education and training and recruitment and retention
• New themes emerging from the analysis were: new graduates/re-entry; paperwork and other professional issues; the need for the QNU to be stronger and recruit more members; AINs replacing RNs and ENs; and EN issues.

In the aged care sector, there were:
• percentage increases in: remuneration and working conditions; education and training/professional development; workplace violence; recruitment and retention and issues surrounding aged care
• several new themes emerging from the data, the most significant was that of paperwork; and unregulated carers administering medications.

3.9 Further Comments

Similar to the preceding data, this question has been analysed by the public, private and aged care sector and the five major themes arising from the data are presented. An overview of similarities and differences from 2001 and 2004 is also provided. This open-ended question allowed an opportunity for respondents to provide any other information they would like to share with the QNU/USQ regarding their working life. A total of 470 nurses provided a response to this question. This comprised a total of 183 respondents in the private, 153 respondents in the public and 134 respondents in the aged care sectors. The data analysis is presented under four headings: the public sector, the private sector, the aged care sector and a comparison of findings between 2001 and 2004. Table 3.52 outlines the analysis of this question under major emergent themes.
### Table 3.52 Major thematic analysis of question 77

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### 3.9.1 Public sector

#### 3.9.1.1 Low morale/stress/workloads/staffing

Fifty-two respondents (or 34%) raised the issues of workloads, staffing and how these issues led to low morale and stress. Some of their comments were preceded by what could be seen as a positive image of nursing; however, these positive images were influenced by their ability to deliver nursing care at a level they believed was adequate. As one respondent noted:

> Although I love my job and appreciate the support my colleagues give each other I often finish my shift frustrated because basic nursing care...[has] often been neglected due to the acute requirements of patients.
Others noted how their satisfaction with nursing had changed over time:

_**Nursing has never been an easy job, but it has become more stressful, with less camaraderie and support in recent years, plus heavy workloads.**_

In many other statements, the respondents’ frustration and anger with the current levels of staffing and workloads were evident. For example:

_…the acuity rate has increased, patients are sicker, requiring more one on one within the ward. Standards of care hence decrease, leaving nurses feeling frustrated with the care they can deliver._

Other respondents believed that issues surrounding inadequate staff led to unsafe working conditions:

_…dangerous overcrowding of our [nursing unit] due to budgetary shuffling are leaving us working in dangerous overcrowded and overwhelming conditions. Effect on morale is high with staff leaving, which compounds the problem._

Other respondents believed that skill mix was an issue, particularly with high levels of junior staff:

_…junior and new staff could be functioning in their roles more efficiently, quicker, if given more support by senior staff. This doesn’t happen often._

All of these comments related to workload, morale, stress and staffing levels. However, the tone of these comments was reflected in the second most common theme – what has been called ‘images of nursing’. We were unable to categorise these images into a central theme, and therefore believed that the theme within them was the image of nursing.

### 3.9.1.2 Images of nursing (n=39:24%)

Several respondents made comparisons to how their perception of nursing had changed over time. For example:

_In my opinion, nursing has gone back to the dark ages. The way we are treated is worse than when I originally started 28 years ago._

_When I came back to nursing in 1994 I found that whilst the basics of nursing had not changed, nurses had. No more do you readily find happy smiling faces in hospital corridors or in the tea rooms. Now you are most likely to find people in tears or debrief sessions happening about the toll on staff._
When I first started my nursing career I felt so proud to put on my uniform. The prestige that went with the job lifted my self confidence greatly. Now I have a job to get myself to put on the uniform as it makes me a target for abuse, harassment, workplace bullying, very little job satisfaction.

Many of these nurses believed that high levels of dissatisfaction meant that as nurses became more experienced they left nursing. This resulted in a: 

...workforce...full of ‘old’ nurses and ‘young’ nurses. There is not enough of the in-between type to carry nursing into the future.

These images contrasted with the theme - ‘love nursing / positive comments about nursing’ which were expressed by 14% (n=14) of the respondents.

Some respondents did not believe that time had eroded their perception of nursing. One respondent noted:

I found nurses much better at supporting each other than in the past. I love the girls I work with, most of my patients and the privilege of being a part of people’s lives in their most intimate/vulnerable moments. It would be good to spend as much time celebrating the good in nursing as bemoaning or trying to fix the negative (not that I suggest we give up trying, but recognition is important).

Many other respondents were happy to ‘be a nurse’ and loved the work they did for their patients/clients – sometimes in their own time. For example:

I love my job, and I love to help my clients. Realistically there are never enough hours in the day, but I find it personally satisfying to stay behind and make sure my job is done and my clients are maintained.

Others just talked about their love of nursing.

I believe my working life is better than some other colleagues because I am good at my job and I value the intrinsic rewards of personal achievement and progression. I do not get extrinsically rewarded by my employer for extra study or hard work or contributing to education and training in my unit.

I enjoy my working life – it is a challenging role, seeing improvement in clients and their meeting of /achieving their goals is rewarding.

In many of the comments – both negative and positive, it was apparent that how local management dealt with the respondents influenced how they felt about nursing work.
3.9.1.3 Support by management (n=27:18%)  

Similar to the private sector, several respondents in this study believed that management decisions driven by cost control were detrimental to the care nurses could provide to patients:

* Nurses are fed up, no respect working, working to care for people and they [management] just cut costs. It’s all money in the private and public sectors.  

Some respondents believed that cost control was inevitable in the 21st century. They noted, however, that:

* …most struggles are put down to a lack of funding but genuine encouragement and recognition doesn’t always cost money.  

This, respondents believed, resulted in nurses who were angry and frustrated with the lack of support provided:

* NURSING is hard enough as it is without all the bureaucratic problems being added to the fire. Support and appreciation for our job from our employer is desperately SOUGHT but unfortunately NEVER DELIVERED.  

Other respondents commented on how they saw that as nurses became more senior and more removed from the clinical area, they became less sensitive to the needs of nurses delivering clinical care.

* Nursing management is entrenched in brown nosing bureaucracy. Management only cares about profits or budgets or administrative outcomes. They certainly don’t care about us.  

This lack of care towards nurses and their ability to work, was also expressed as dissatisfaction with the rostering system and/or the lack of a ‘family friendly’ work environment.

3.9.1.4 Rostering/family/friendly workplace  

This was the fourth ranked-theme in the analysis. A total of 25 respondents (16%) raised this as an issue. There were two sub-themes within this theme. The first related to what were seen as inequities in rostering systems. Some nurses spoke positively about rostering systems at their workplace. For example:

* Overall, staff bend over backwards to assist each other in requests as far as rosters go.
Others were not so positive about rostering and rostering systems. They believed that there was:

...inequitable treatment of workers in regard to rostering.

And that:

The current business planning framework is unrealistic when put into practice and subsequently puts unnecessary pressure on nurses attempting to provide quality patient care as there is insufficient time to do so and to all act as team leader, especially when there is staff who are either unfamiliar or inexperienced on the ward/team.

Others noted that their inability to work shift-work affected their ability to continue nursing.

I am an experienced employee with eight years plus exemplary service who will now be made redundant as I cannot accept full time 8 – 5 Mon – Fri employment.

Other nurses talked about issues related to being ‘on call’. For example, one respondent believed that on call work ‘is dangerous’. S/he noted that working for eight hours and then being on call for a further 10 hours ‘is quite detrimental to the health of the worker and results in an unsafe environment for patients’.

However, the majority of comments in this theme related to shift work and its ability to be ‘family friendly’. Some comments were positive about attempts to make rosters ‘family friendly’:

My husband and I are both registered nurses and both work in the same hospital but in different areas…Our respective nurse managers are very helpful in rostering our shifts so we can work opposite shifts and don’t need to worry much about childcare.

Other respondents expressed dissatisfaction:

But it’s to the detriment of family time together because when children are not at school one of us is always working…. It would be nice if nursing could be a bit more family friendly with more support for casual childcare.

Despite this comment, it should be noted that only two respondents specifically mentioned childcare as an issue affecting their ability to work in nursing.
Other nurses noted the physiological effects of working shiftwork:

*Shift work … health problems such as lack of sleep, never getting a regular period – different day each month. Body clock gets mucked around too much, can’t sleep when supposed to.*

Another aspect of nursing often reported upon is the exposure of nurses to workplace violence – from other nurses, from management, as well as from patients and their relatives.

### 3.9.1.5 Workplace violence

A total of 23 respondents (15%) of nurses chose to mention their exposure to workplace violence.

Mention was made of violence from:

- **Other nurses:**
  
  *Nurses eat their young.*

  *Professional culture of abuse and violence tolerated by our unions, state and federal governments, allied health, and perpetuated by our own colleagues.*

- **Management:**
  
  *Nursing directors … question to the point of harassment why work isn’t completed in the allocated time. [I am] expected to just hand over to the next person – this is at times not [possible].*

  *The DM of the district I work for is intimidating to say the least. … I feel it is only a matter of time before I am at the receiving end of his bullying – but where do you go?*

- **Patients/relatives:**

  Some nurses noted that the Privacy Act was one of the causes of workplace violence from relatives:

  *A lot of the stress and abuse received from relatives both via the phone or face to face relates to the ‘Privacy Act’. Not being able to give simple pieces of information to people already undergoing a degree of stress and frustration.*

Others noted that aggression from relatives and clients was caused by a lack of understanding of the stress placed on the nurses by lack of staffing or other cost-cutting exercises.
Nurses take the brunt of the patients’ understandable anger and frustration [about their surgery being delayed or cancelled].

For some nurses in this study, the outcome of inequitable and unmanageable workloads, lack of staffing, poor skill mix, the lack of a family friendly environment, and lack of support (or praise) from management, was to leave nursing.

3.9.2 Private sector

3.9.2.1 Low morale/stress/workloads/staffing

Thematic analysis of the private sector respondents revealed this as the most important issue, with 86 (47%) respondents writing about these issues. There were several aspects raised.

The first was patient to nurse ratio and the high acuity of this allocation.

It is frightening, the lack of experience, the workload we are given and expected to do. [It is frightening] when we have a busy 44 bed surgical ward with a workload of 6/10 patients each. Our employers don’t believe in hiring agency [staff] and go by [the] number of patients in bed at midnight to work out staffing, not patient acuity. As [they believe that] acuity and numbers don’t go together.

The respondents noted how the inability to provide nursing care to clients to their level of satisfaction affected how they felt about nursing work.

The main issue I have with nursing is the constant frustration feeling that I am not able to provide the best care available. I would like to feel that I could consistently provide the care I was trained to provide. Ultimately I would rather have better working conditions than better pay.

[I am] feeling overwhelmed by what I can’t achieve with care and compassion because I’m flat chat trying to do basics! Please help us change this trend!

Experienced nurses noted how the already high workload was increased by the need to supervise students or inexperienced staff, which was leading to a higher level of errors occurring.

We have lots of students from colleges and this is an ongoing stress. Due to heavy workloads and trying to teach I have made an error in judgment on one of my patients.

Many respondents noted that the workload had increased.
In my 25 years of nursing the workload and stress levels have escalated, especially in the past five years.

Other nurses believed that the staffing levels resulted in unsafe practice.

Very poor staffing, nurses working very hard, not enough staff working especially night shift … we feel this is very unsafe practice.

The workers will never be convinced that these levels are ‘safe’. The patients deserve more and so do the staff!!!

Nurses believed that a compounding issue was the lack of support staff, resulting in nursing time being taken up undertaking these duties on top of what they saw as nursing work.

Cost-cutting is rife, nurses are not being replaced, doing non-nursing duties, all time-consuming and putting extra stress …

I love working in [name of unit] but feel very stressed as often have to look after stage 1 recovery and day patients and make tea and sandwiches and escort patients to car on discharge and push heavy beds to wards as no wardie available for assistance.

3.9.2.2 Support by management

Forty-nine (27%) respondents believed that there was a lack of management support within the private sector. The overall interpretation of this theme was that respondents believed that private sector hospitals are driven by economics rather than patient care or any care for their employees.

Nurses noted that in this sector, management were more interested in cost-reduction than patient care.

Extremely disillusioned by the health system in Qld. [name of hospital] has become a business. I have seen a huge change in ‘the care of the patient’ and level of nursing care.

Several respondents noted that a focus on cost-efficiencies rather than valuing staff was in fact counterproductive.

Hospital boards and topline managers … are still in the dark ages, seeing nurses as a means to an end. It is a money-making facility not focused on staff happiness/conditions but the bottom fiscal line. Immediate managers realise unhappy nurses = no staff but this doesn’t seem to be heard or indeed cared about at the top.

Due to lack of staff I receive phone calls all the time to work extra shifts. I refuse due to lack of backup from management.
Many respondents noted that the lack of value placed on nursing work has negative outcomes.

*Management need to appreciate their staff – show gratitude, be caring/concerned. Show loyalty to staff – be compassionate and understanding. Be supportive.*

*There is no respect, managers treat us as lackeys. De-value our skills and then wonder why we don’t want to be nurses.*

Other respondents commented on how, in an effort to cut costs, many Level 3 nurses had been replaced by business managers. They noted that health service delivery is no longer about ‘patient care it is about the almighty dollar’.

### 3.9.2.3 Remuneration/conditions

A total of 44 (24%) respondents wrote about their perceptions of wages and employment conditions. Most of the respondents had positive comments about nursing work but believed that the remuneration for the work carried out was inadequate.

*I love my job, and I enjoy going to work… but that does not mean I think I am adequately paid. We should be ashamed of the hourly rate we get, and make more demands from private institutions and government.*

Other respondents raised individual issues which they believed the QNU should address. These were:
- extra payment for preceptoring university students and/or new graduates
- free parking
- payment for hospital-based qualifications (such as mental health)
- re-imbursement of costs of travel for education and training.

The majority of respondents believed that wages and conditions were poor and that there were no real incentives for nursing work.

*I am disappointed at the lack of incentive to remain a nurse.*

### 3.9.2.4 New graduate/re-entry

A total of 33 (18%) respondents raised issues surrounding the employment of new graduates or younger nurses.

Many of the respondents noted that new graduates were unprepared for the reality of nursing work.
The other problem is staff coming from the university. Have not enough clinical experience and although counted as fully qualified, flounder for the first twelve months at least. In an acute setting there is not enough time to give them the extra direction when the staff are already stretched.

Others noted that there was insufficient support given to new graduates when they entered the workplace.

I am sorry to write that I am often disappointed at the lack of encouragement for young or new nurses in the nursing profession (I realise this is often a staffing problem).

This lack of support was not only for newly graduated RNs. As a newly graduated EN noted:

As an EEN, have had a patient load of up to 11 in first six months of work.

There were two distinct outcomes with regard to new graduates. First, as one nurse reports, experienced nurses who work with new graduates are disappointed when the new graduate does not continue to stay in nursing.

Frustration at teaching novices only to have them leave at end of graduate program and then start the whole process over again.

Other respondents believed that the outcome of the lack of preparation of the new graduate was that new graduates would leave nursing.

Nurses trained in university programs are not well prepared for the “real world”. They become a liability even though they are in post grad programs, and are often put off nursing when they find themselves in a stressful, emotional setting.

Many new graduates leave nursing after a short time because they don’t like it.

Another respondent noted that the outcome, when new graduates were not supported adequately, was:

…young graduate nurses out a couple of months are in charge of surgical wards and have made mistakes and ‘feel out of their depth’ and have left and undergone other studies as nursing experience was not a good one.

Several respondents in this study commented how new graduates become ‘disillusioned’ when ‘they see what they have to do and their non-nursing friends have to do’.
3.9.2.5 Occupational health and safety

Thirty-three (18%) of the respondents in this study believed that their health was affected by the excessive workloads. For example:

...exhaustion – too tired to cook dinner some nights. Worry about exhaustion affecting driving skills (e.g. driving home and not remembering parts of the journey).

Some nurses referred to ‘burnout’ as an outcome of the excessive workloads they were experiencing.

Overall if I could find a way out of nursing I would, but I am a single parent who struggles and although enjoy my actual clinical job, am very burnt out.

On average I probably take one sick day per three weeks due to burnout both physically and mentally.

Other nurses talked about expressing harmful levels of stress.

...stress levels will increase due to staff shortages, and burnout is going become more common.

As would be expected, many nurses spoke about the effect of shift work and suggested that overall working hours should reflect the health effects of shift work. For example:

Due to the harmful effects of shift work I feel that 4 x 8.5 hour shifts per week (on .8 fortnight) should be classified as full-time employment.

Other nurses noted that their current health status affected their ability to work. For example, one nurse with a health problem noted that she could not: ‘meet my employer’s criteria of being able to work all three shifts’. This, she says, limits her job opportunities.

Many respondents noted that the lack of a ‘no lift’ policy in the past had resulted in damage to their health. This, they noted, limited their ability (and wish) to continue to work in nursing. For example:

...as for the amount of... damage to backs, necks and shoulders... there are better alternatives [to nursing].

3.9.3 Aged care sector

3.9.3.1 Low morale/stress/workloads/staffing

Sixty-three respondents (47%) commented on how stressful and heavy the workloads are in aged care, particularly in relation to staff/resident ratios.
Usual story in aged care, one RN to 167 residents at night is dreadful!

Because of this there was the issue of time constraints to complete the work required in a shift.

You rush your care and toss people around like a sack of potatoes because of heavy workloads and time constraints just to get the job done.

A number of respondents commented that heavy workloads meant having to stay back after the end of a shift and not having any time to talk to residents.

I would be thrilled to complete a shift on time, satisfied I had done a good job for the day and actually had time to talk to a resident.

That is the main thing I dislike about my job, the rushing and no time for conversation with residents.

There was obvious frustration among some of the respondents, who felt workloads were resulting in an inability to perform quality nursing care.

Basic care is often not completed, hence the rise in pressure area numbers. I have to work very hard in dealing with the stress of not being able to fulfil my duty of care.

Heavy workloads were blamed for some respondents suffering stress.

I personally recently had two weeks stress leave as I could not handle the workload and I consider myself a very experienced registered nurse but felt unable to provide the care that meets my standard.

Then there was an issue that a lack of staff and reducing nursing hours increased workloads and decreased morale.

Nurses are expected to do more in less time. Not enough staff if anything goes wrong.

Morale is very low.

Is it any wonder we are tired and worn out and stressed.

The respondents commented negatively on a variety of issues specific to employment in the aged care sector and some of which also contributed to the heavy workloads. One such theme was the amount of paperwork and documentation with RCS standards.
3.9.3.2 Aged care issues

Another theme in the aged care sector and commented on by many was, as one respondent put it, the ‘dollar driven’ sector. Thirty-seven nurses (28%) commented on issues specific to aged care but especially the funding and how it impacts negatively on their day-to-day work.

I feel, aged care today, is all about money.

I now believe, especially in aged care as that is where I have worked most of the time of late, care is now provided by what a dollar provides, not by what a resident requires.

I believe the Government need to reassess the amount of funding they provide. There is not enough money to supply deserving care and needs for residents.

3.9.3.3 Paperwork/non-nursing duties

Thirty respondents (22%) commented on the excessive paperwork and some blamed conflict, stress, burnout, taking away valuable time from residents, having to reduce hours to part-time and doing unpaid overtime on the paperwork expected in aged care. As one respondent stated:

The amount of documentation in aged care can cause conflict, as often there is a choice, do full documentation and not have enough time for the residents, or do documentation in own time, working unpaid overtime, taking documentation home.

Another respondent confessed that:

The only way I can cope with the level of paperwork attached to my job is to take it home… I would probably lose my job if my employer knew.

A consistent theme related to the time spent keeping up with documentation was the time not spent caring for the residents.

Having worked in aged care continuously for past 20 years, I find the ever increasing documentation requirements extremely alarming. Time spent on documentation is taking away hands-on time and forces nurse to lower their standard of care….

Some respondents expressed concern about the future of nursing because of lack of support from their managers who insisted they keep up with the paperwork, as one comment suggested:
When management threatens loss of jobs or cut back in hours if the paperwork doesn’t get done, the future of nursing is less hopeful.

There was much negativity and dissatisfaction the respondents about nursing in aged care, and the issue of little or no support for nurses from their managers was a strong theme.

3.9.3.4 Remuneration and conditions

Twenty-seven (20%) nurses expressed dissatisfaction with their pay and conditions at their place of employment. One example of this was:

*In our facility, several of the longer employed personal carers are paid under one award, the rest of us are paid under a different award, and different pay scale.*

Many respondents commented that the amount of work and responsibilities nurses endure was not reflected in remuneration. The following statements supported this theme:

*We just want to be recognised for the work we do and paid accordingly.*

*For the workload and responsibilities the pay is terrible.*

*The pay rate for nursing (AIN, EN) has never been adequate to suit the type of work especially compared with other professions (e.g. retail worker can earn as much).*

3.9.3.5 Education and training

A noticeable difference from the previous study was that twenty-five (n=25:19%) made comments about the limitations in furthering education. In particular, Enrolled Nurses and Assistants in Nursing made comments such as:

*The government is screaming out for ENs and RNs, but there is no incentive for anyone to further their career. I am currently studying for my ENs and when I went searching for financial assistance to my surprise there is nothing available, I feel that is disgusting.*

*As I have to work full time, I found it very difficult when I tried to do my RN training. Everywhere I rang to see if they could let me do training part time or by correspondence, I was told it would take six years and my endorsed enrolled nurse training would not be taken into account.*

*Being looked down on as ‘only00’ an EEN. After completing my studies I went into aged care - now am trying to get into acute setting nursing but find it almost impossible. There is no support [given to EENs to
allow them to] gain further knowledge or training. [Rather the only opportunities in education and training are to become] an RN.

Even though education is being conducted throughout some aged care facilities, some nurses believed that it was inconvenient to attend the sessions, and that it interrupted their work. For example:

Lectures/talks = time taken at work on shift so therefore work unpaid overtime at end of shift to finish the minimum work necessary.

They take you off the floor for compulsory education sessions and interrupt your routine, which is dangerous.

3.9.4 Comparison between 2001 and 2004

Within the private sector there were several differences between the thematic analysis of the 2001 and 2004 data. For example:

- increase in low morale/stress/workloads/staffing, education and training, new graduates/re-entry, occupational health and safety
- decrease in negative comments about nursing, support by management, remuneration/conditions.

In the public sector there were also some differences between the data analysis in 2001 and 2004. For example:

- There was an increase in the percentage of respondents raising issues of: staff turnover/retirement/leaving; education and training; images of comments on nursing
- There were several themes where the percentage of respondents decreased. These were: occupational health and safety; remuneration / working conditions; support by management, paperwork/non-nursing duties
- The major new theme emerging from the data was about new graduates/re-entry nurses.

In the aged care sector there were changes from the 2001 and 2004 study. For example:

- There was concern raised by respondents regarding the work of unregulated care providers, especially with regard to the administration of medications. This was a new finding of the 2004 study in both Questions 76 and 77
- Another new theme in this study was the need for nurses to be able to provide a comfortable environment for their residents as well as the ability to work within an environment which promoted the health and safety of the nursing workforce
- There was an increase in nurses commenting on their inability to access affordable education and training
- There was also an increase in issues raised that were specific to the aged care working environment

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• There was a decrease in respondents raising issues of morale, stress and workload or staffing and remuneration and working conditions.


4.0 DISCUSSION

This section provides an overview of the significance of the study findings. It does so by making some comparison between the 2001 and 2004 studies, and discussing the relationship between the findings and the published national and international literature.

4.1 Personal demographics of the respondents in the study

This section presents the results of a combination of questions from the survey. It provides the reader with a description of the type of respondent in this study as well as their nursing history. Comparisons are made across each of the three sectors as well as between the 2001 and 2004 studies. To enable the reader to link the result discussion to the questionnaire, each heading in this chapter contains (in brackets) the number of the question in the questionnaire.

4.1.1 Nursing designation (Q65 and Q66)

Respondents to the study included:

- 172 Assistants in Nursing (AIN)
- 157 Enrolled Nurses (EN)
- 913 Registered Nurses (RN).

In addition, 37 nurses in the private sector (acute and aged care nurses) described their nursing designation as ‘other’. There is an apparent employment difference across the public and private sectors. For example, there are more AIN and EN respondents from the private (acute, domiciliary and aged care) sector than from the public (acute, community health and aged care) sector. Thus, there was a greater percentage of RN respondents from the public (77.2% of total public respondents) than the private (66%) sector.

It appears that in the 2004 study that RNs are over-represented when compared to the QNU database for 2004. There is also some indication that AINs are under-represented, although the small numbers compromise power.

4.1.2 Gender (Q70)

No significant differences exist in the gender distribution between the 2001 and 2004 surveys. Additionally, there are no significant differences between the surveys and the QNU database. A sector difference is apparent with male nurses more likely to be employed in the public sector. The smallest percentages of male nurses are employed in the private sector.
4.1.3 Aboriginal and Torres Strait Islander and South Sea Islander (Q72)

Very few respondents noted they were from an Aboriginal, Torres Strait or South Sea Islander background. Of interest is the fact that all the South Sea Islander descent respondents are employed in aged care.

4.1.4 Non-English speaking background (Q73)

Similarly, few respondents stated they came from a non-English speaking background. There were no statistically significant differences between the sectors. Further, there were no statistically significant differences in the percentage of respondents in the 2001 and 2004 studies.

4.1.5 Disability (Q74 and Q75)

Forty-five nurses stated they identified themselves as a person with a disability. There was no difference in the percentage of nurses with a disability across the three sectors, however, there was a statistically significant increase in the number of respondents with a disability employed in the private sector between 2001 and 2004.

There appears to be some inconsistency in the data in that while only 45 nurses stated they identified themselves as a person with a disability, 106 nurses stated they had acquired a disability from nursing work. These findings suggest that almost half of the nurses who had acquired a disability at work did not consider themselves to be a person with a disability.

There was weak evidence of a reduction in the number of nurses with a work-acquired disability from 2001 to 2004 in the aged care and private sectors.

4.1.6 Qualifications (Q67 and Q68 and Q69)

It appears very difficult to obtain reliable statistics on the formal qualifications held by the nursing workforce. In this study it is apparent that the respondents held a wide range of formal qualifications (for a full list see supplementary documentation). Additionally, they had been active in undertaking continuing professional education activities in the form of short courses.

As would be expected, the most common post-registration qualification was that of midwifery, followed by mental health. The Queensland advanced practice endorsements of immunisation, sexual health and rural and isolated practice were held by a relatively small percentage of the registered nurse participants. This small number may reflect the short time that the advanced practice endorsements have been available and would be expected to...
increase over time. A greater proportion of enrolled nurses stated they held the medication endorsement than they did in 2001. In excess of 80% of enrolled nurses in the study held a medication endorsement (n=47 in aged care, 49 in public and 43 in private sectors). This compared with less than 35% in 2001 (30 in aged care, 47 in public and 30 in private).

As would be expected, midwives were more likely to be employed in the public and private sectors (although 56 aged care nurses held a midwifery qualification). Similarly, other endorsements were also more likely to be held by nurses working in the public and private sectors, with nurses holding endorsements such as immunisation and rural and isolated practice more likely to be employed in the public sector, as this is the major employer outside capital cities or large regional centres. Of note is the decrease in the percentage of nurses holding a mental health endorsement employed in the aged care sector. This decrease is statistically significant.

4.1.7 Age of the nurse (Q71)

As would be expected, the results of this study show an ageing nursing workforce. The mean age of the nurses employed in each of the three sectors differs significantly (49.7 aged care, 42.8 public and 43.6 private sectors). The mean age of all nurses in the study has increased from 43.4 years in 2001 to 44.1 years in 2004, however, this may be due to a sampling variation rather than an actual increase in mean age.

4.1.8 Summary

The respondents in this study are similar to the Australian nursing Workforce: ageing; predominantly female; and more likely to be a registered nurse.

4.2 Work profile of the respondents

This series of questions provided information on the work profile of the respondents. As well as the length of time the respondents had been working with their current employer and in nursing overall, the data also provide some information on how long the respondents believed they would continue to work in nursing. Sector differences and significant changes between the 2001 and 2004 study are highlighted.

4.2.1 Length of time employed in nursing (Q58)

While the average length of time that the respondents in the study have spent in nursing is not statistically significant across the sectors, there are some specific differences when the data are analysed in more detail. For example, in the aged care sector there are more respondents who have worked in nursing from two to less than 10 years compared with the other sectors. The
aged care sector also has more nurses who have worked in nursing for 35 years or more.

Unfortunately, the numbers of new graduate respondents in this category are small (three in aged care; six in public; four in private). Similarly few respondents have worked in nursing for more than one but less than two years (eight in aged care; six in public; seven in the private sector).

4.2.2 Length of time employed in current position (Q4)

The majority of nurses in this study had been employed by their current employer for less than 10 years. Almost one-quarter (24.5%) had been with their current employer for 15 years or more. A statistically significant change has occurred between the 2001 and 2004 studies in the percentage of nurses employed in the private sector. The percentage of nurses employed in the aged care and private sectors who had been employed for less than 12 months declined. In the same sectors the percentage of those employed for between two and five years increased.

4.2.3 Future time expected to work in nursing (Q59)

It is established that the nursing workforce is ageing. A study in New South Wales found that 48% of nurses were at risk of leaving nursing and 41% of the same respondents were at risk of leaving the organisation. A new finding of our study is that nurses employed in aged care were more likely to expect to leave nursing sooner (less than five years) compared to nurses in the acute environment. This finding may reflect the greater age of nurses working in aged care (and therefore the possibility of retirement) or it may reflect the higher levels of workplace stress identified in this sector (see section 4.8.4). As would be expected, highly significant inverse correlations exist in all sectors in both 2001 and 2004 between nurses’ ages and their expected future time to work in nursing. Between 13% to 36% of the variability in future time in nursing care can be explained by the age of the nurse. There was no difference in the designation of the nurse (RN or EN) within each sector as regards this relationship. There was, however, an indication that nurses who were over 50 years of age and who were employed full-time in the private sector, envisaged working for 20 or more years. The need to continue working past 65 years of age may reflect the poor superannuation preparation previously identified amongst nurses.

There appears to be no significant difference in the perceptions of the respondents of the time that they believed they would continue to work in nursing in 2001 and 2004.
4.2.4 Type of workplace (Q6)

As would be expected from the design of the study (two-thirds of the respondents were from the acute sector which included both community health and hospital employed nurses) and reflecting the fact that the hospital sector is the largest employer of nurses, the majority of respondents in the study are employed in the private and public sectors (n=773). There are small numbers of respondents working in community health (n=36) and domiciliary nursing (n=7). Again reflecting the workforce distribution there are larger numbers of respondents employed in private aged care (n=348) than in public aged care (n=57).

4.2.5 Type of employment category (Q12)

Nurses employed in the aged care sector are less likely to be employed on a permanent full-time basis and more likely to be employed on a permanent part-time basis than nurses in the other sectors. Nurses who are employed in the public sector are more likely to be employed on a permanent full-time basis than nurses in the other sectors. In the aged care and private sectors, nurses are more likely to work permanent part-time than permanent full-time. This is a different work pattern to nurses in the public sector where full-time and part-time work patterns were equivalent.

4.2.6 Hours and shifts worked (Q10 and Q13 and Q14 and Q15)

It is apparent that nurses in the aged care sector who are permanent full-time are more likely to work unpaid overtime and TOIL. Reflecting the finding that nurses in the aged care sector are more likely to take accrued leave, these nurses were the most likely than public sector nurses to take accrued TOIL. Nurses in the public sector were least likely to take TOIL.

Permanent part-time nurses in aged care also work more unpaid overtime. The number of hours worked, unpaid and paid overtime and TOIL and on-call has not changed significantly from the 2001 to the 2004 study. There is no difference across the sectors with regard permanent part-time employees and TOIL taken.

Nurses who were not employed on a permanent basis indicated that they worked a regular minimum number of shifts. There was no significant difference in the responses across the sectors. The hours these nurses worked varied across sectors with the minimum hours six in the aged care and private and eight in the public sectors. The maximum number of hours worked per week by this group of non-permanent employees ranged from 75 in the aged care sector to 80 in the public sector and 97 in the aged care sector.
Non-permanent nurses were also asked if they wished to be permanently contracted to work more shifts. There was a difference across sectors with nurses in the aged care sector most likely to wish to work more shifts. While there was no change across the two studies in the percentage of nurses in the aged care and public sectors wishing to be permanently contracted to work more shifts, there was an increase in the percentage of nurses in the private sector indicating they wished to work more shifts.

4.2.7 Standard minimum and maximum hours per shift (Q27)

The minimum shift length varies statistically across sectors with the public sector having the longest minimum shifts followed by private sector and then aged care. In all sectors there has been a statistically significant increase in the average minimum shift length reported in the public and private sectors in the 2001 and the 2004 studies.

For maximum shift length, the private sector is longer than the public sector which is longer than the aged care. There is an increase in each sector in maximum length of shifts reported in the 2001 and 2004 studies. It is possible that the increase in the maximum length of shifts over this period has been influenced by the availability of nurses for work. The effect of increasing length of shifts and its impact on patient safety and outcomes has been previously documented. In particular, this report noted that fatigue caused by insufficient breaks from work did affect patient safety.

4.2.8 Working hour pattern (Q17 and Q18)

As would be expected the majority of nurses in this study worked continuous shifts. This pattern did vary statistically between the sectors, with nurses employed in the public sector most likely and nurses in the aged care sector least likely to work continuous shifts. Nurses in the public sector were least likely to work morning and evening shifts. In comparison in the aged care sector there were relatively more nurses working evening only shifts compared to nurses in the other sectors. There was no statistically significant change between the 2001 and 2004 studies.

Nurses employed on a permanent full-time basis in the public sector are more likely and nurses in aged care least likely to be work continuous shifts. In the private sector, permanent full-time nurses are more likely to work morning and evening shifts. This cohort, regardless of whether they are employed full-time or part-time, are more likely to work Monday-to-Friday than nurses in the other sectors.

4.2.9 Number of paid jobs (Q10)

Sixteen percent of nurses (n=203) have more than one paid job. For the majority of these nurses (70%:n=142) all additional jobs are in nursing.
nurses in the aged care sector are less likely than nurses in the public and private sectors to have more than one paid job. This finding was consistent with the 2001 study where 17.9% of respondents stated they had more than one paid job.

The main reason given by nurses in all sectors in 2004 for having more than one paid job (Question 3) was to maintain clinical skills (32.6%). The second ranked factor influencing more than one job was that the respondents stated they earned insufficient income from their main job (18.4%).

Further analysis of the 2001 and 2004 data revealed no relationship between the need to work more than one job and: the mean age of the nurses; the job designation of the nurse’s main job; the perception of pay rates in nursing; the level of satisfaction with rostering practices in the main nursing job; the level of input into the roster in the main nursing job or the frequency of working double shifts.

4.2.10 Agency work (Q7 and Q9)

One of the ways in which a nurse can be employed in more than one job is to undertake agency work as the second job. Additionally, the nurse’s main job can be working for an agency. In this study only 71 nurses indicated they had worked for an agency in the last 12 months. Of these, only one nurse (in the aged care sector) indicated that an agency was the main employer. Analysis of these data suggests that the majority of nurses who have more than one job (203 in this study) are more likely to have two institutional employers rather than have a nursing agency as the second employer.

4.2.11 Break from nursing and number of breaks (Q60 and Q61)

In 2004, 61.3% of the respondents in the study reported a break from nursing sometime in their nursing career. There are little differences in the percentages of nurses taking a break among the three sectors. For example, nurses in the aged care sector had taken a mean of 1.3 breaks while nurses in the public and private sectors had taken a mean of 1.4 breaks.

4.2.12 Length of break, reason for break, re-entry programs after break (Q62, Q63 and Q64)

The length of the break and the reasons for taking this can be linked. In the public and private sectors the length of the break is less than those taken by nurses employed in the aged care sector (2.6 years in the public, 2.9 years in the private and 5.1 years in the aged care sectors). It is highly possible that the reason is that younger nurses employed in the public and private sectors have taken short breaks for parental/maternity leave.
Reflecting the longer length of the break, nurses in the aged care sector also are more likely to undertake a re-entry program prior to re-entering the workforce. There was no significant difference in the length of the break reported in the 2001 and 2004 data for any sector.

Of interest is the fact that more nurses from the aged care sector cite health reasons as a factor for their break (12.9% compared with 6.8% in public and 7.2% in private sectors). This may reflect the findings that nurses in the aged care sector are older and more likely to report nursing both physically and emotionally demanding.

There were some statistically significant changes in the results between the 2001 and 2004 studies. In particular, nurses in the aged care sector in 2004 were more likely to state that the reason for their break was that they lacked motivation or encouragement to continue with their nursing career. Reflecting the perception of poor remuneration there were more aged care nurses in 2004 who cited that the reason they had a break from nursing was to pursue a position with better remuneration. Additionally, nurses in the 2004 survey employed in aged care were less likely to cite parental/maternity leave but more likely to cite family responsibilities as a reason for a break from nursing.

4.2.13 Summary

Nurses in this study indicated that the shift lengths they were required to work (both Maximum and minimum) had increased. This increase along with the percentage of nurses working as part time or as casuals, suggests that Queensland’s workforce is similar to other nursing workforces. It is well recognised that staff losses are expensive. Thus, the percentage of nurses indicating they will exit nursing in the next five years is disturbing, a reflection in the aged care sector of the physical and emotional demands of the work and the age of the nursing workforce.

4.3 Working hours

The number and type of hours that nurses work can be influenced by many factors. In this section, the influences identified by the respondents in this study are discussed. Sector differences as well as significant differences between the 2001 and 2004 study are highlighted.

4.3.1 Factors influencing working hours (Q28)

As has been demonstrated Australian nurses are opting increasingly to work part-time rather than full-time. This study sought to ascertain the factors that respondents believed had influenced the hours they were available to work during the last four weeks. It should be noted that in each sector there has been a significant increase between 2001 and 2004 in the proportion of nurses whose hours or shifts in the previous four weeks are affected by one or more of the following factors.
4.3.1.1 Other staff leave/absence

This was the major reason affecting working hours with 39.5% stating this was a factor. There were no statistically significant differences across sectors and as this was a new question in the 2004 study, no comparison with the 2001 can be made. The findings suggest that a major influence on the hours that nurses work is the work pattern of other staff within the work unit. These results suggest that staff shortages are impacting upon the hours worked by nurses as reflected in the increasing hours of length of shifts, overtime and TOIL as noted previously.

4.3.1.2 Family responsibilities

This was the second most influential factor overall with 26.9% citing it as a reason. Nurses in the aged care sector (17.6%) were less likely to cite this as a factor (possibly due to their age and the age of their dependent children). However, this was a significant factor for nurses in the private (31.8%) and public (28.1%) sectors.

None of the other factors in this question had such a major influence.

4.3.1.3 Study commitments

This was not a major influence on working hours with only 5.7% of respondents citing this as a factor. The number of nurses citing this as a reason decreased from 9% in 2001 to 5.7% in 2004. The decrease is significant in the public and private sectors.

4.3.1.4 Staff turnover

This was a new factor added for the 2004 study. Approximately 11% (10.9%) of the overall respondents cited this as a factor. There was no significant difference across the sectors.

4.3.1.5 Your leave/absence

This factor was cited by 16.1% of all nurses. This again was a new question of this study, and there were no significant differences between the sectors.

4.3.1.6 Summary

While it would have been expected, family and personal responsibilities were not the major influence on working hours or the nurses in this study. Rather, the absence/availability of other staff was the major influence on the hours the
nurses in this study worked. This finding could reflect an increasingly flexible workforce using large numbers of casual and part-time staff. It could however, also reflect the increasing unavailability of replacement staff. The latter theory is confirmed by the fact that in the public and private sectors in particular, staff are not often replaced when on leave.44

4.3.2 Perceptions of working hours (Q57)

This Likert scale question asked the nurses to describe if their working hours were convenient or inconvenient. Nurses employed in the public sector were more likely to be dissatisfied with their working hours than nurses from other sectors. There is no significant change over time with regard to these results.

The qualitative data from questions 76 and 77 contained further information – especially with regard to the impact of family responsibilities on working hours. This will be discussed in the next section.

4.3.3 Responsibilities outside of work (Q40)

It has been noted that employers often do not understand how personal and workplace factors interact and influence the way nurses feel about their work.65 This section therefore discusses the influence of outside responsibilities and their effect on working hours. As demonstrated by the data previously reported, family responsibilities do impact upon the hours that nurses wish to work, as well the number and length of breaks they take from nursing work. These data therefore provide some information on the type of family responsibilities being currently experienced by the respondents as well as some comparison with the data collected in the 2001 study.

4.3.3.1 Type of dependents

a) Dependent children

The most common family responsibility overall was dependent children with over 50% of nurses in the public and private sectors reporting this factor. Nurses in the aged care sector were significantly less likely to report dependent children (less than 30%) possibly because both they (and their children) were older. For all sectors there were significant age effects in with younger nurses more likely to note that children were a responsibility. Of note, is that nurses in the aged care sector in 2004 were less likely to have dependent children than they were in the 2001 study. This again, may reflect an ageing workforce.

b) Dependent spouse

There were significant differences across the sectors. Nurses in the aged care sector were more likely to have a dependent spouse. Although the difference
was not significant, nurses who were employed on a permanent full-time basis in the acute sector (both public and private) were more likely to have a dependent spouse. There were also differences found in the gender of the nurses and the likelihood of a dependent spouse, with male nurses employed in the public and aged care sectors, more likely to have a dependent spouse. As this question was not asked in 2001, it is not possible to note any change over time.

c) **Dependent disabled or ill family members**

Nurses in the public sector are less likely to report this as an issue and although not significant the aged care sector nurses have the highest reported incidence (8.9% in aged care as compared to 6.4% in public and 8.4% in the private sectors). While there were no significant differences between the two survey years, there was a slight increase in the percentage in the public sector (4.9% in 2001 and 6.4% in 2004) and private sectors (5.1% in 2001 and 8.4% in 2004) and a slight decrease in the aged care (9.7% in 2001 and 8.9% in 2004). Work patterns (part-time or full-time) were not influenced by having a dependent disabled or ill family member.

d) **Dependent elderly relative**

Similar numbers across sectors reported caring for dependent elderly relatives. The mean age of nurses in the aged care sector who were caring for a dependent elderly relative was higher than the mean age of nurses caring for a dependent elderly relative in the other sectors.

e) **Dependent other relative**

Only a small percentage responded they cared for a person in this category. There is no difference between the nurses in the sectors.

f) **Summary**

These data show similar factors affecting responsibilities outside work across sectors and between years. The one major difference was found with respect to dependent children in that fewer nurses reported this responsibility as a factor in the aged care sector which has the oldest mean age for nurses. For all other dependencies there were trends for all nurses with any dependant to be older than those without a dependent, however this was only significant for aged care nurses and dependent elderly relatives.

The nurses were then asked about the adequacy of care available for family members.
4.3.3.2 Adequacy of care for family members (Q41)

Over 80% of all respondents believed that there were adequate care arrangements in place. Those nurses who did report inadequate care arrangements were more likely to be younger and there was some evidence that the issue of adequate care arrangements is more relevant to permanent part-time nurses than to permanent full-time nurses. The latter effect is not significant in any one sector but is consistent across sectors and significant with all three sectors combined.

4.3.3.3 Impact of care arrangements on the number of hours worked (Q42)

A follow-up question in the 2004 study asked respondents if they considered care to be inadequate how did it affect the hours they were available for work. The responses significantly differed across sectors. It was apparent that nurses working in the aged care sector (who have fewer dependent children and report less need for childcare) were the least likely to be affected, and those working in the public and acute sectors the most likely.

4.3.3.4 Access to family leave (Q43)

There is a significant difference across the sectors with regard to access to family leave. Nurses in the public sector are more likely to have access (88.3%), than nurses in the private (78.2%) and aged care (72.2%) sectors. This result may reflect a greater knowledge of the Queensland Family Leave Award 2003 in this sector. Access has increased in all three sectors since 2001.

4.3.3.5 Age of dependent children (Q44)

Those respondents who had dependent children were asked to identify the ages of their youngest dependent child. As would be expected from previous results, there is a significant difference between the sectors in the response. Nurses in the aged care sector (who are older) tend to have older dependent children and nurses in the private and public sectors had younger children (56.1% in the public and 54.1% in the private sector with children less than 12 years of age as compared to 35.3% in the aged care sector). Almost twice as many aged care nurses had children over 18 than did nurses in the other sectors. These findings were consistent with the 2001 data.

4.3.3.6 Employer support or assistance with childcare (Q45)

There is an apparent lack of employer provided childcare in all sectors with less than 5% of nurses reporting that their employers provided support or assistance. There was no significant difference between the sectors in the response and no significant change between the 2001 and 2004 surveys.
4.3.3.7 Adequacy of employer support or assistance with childcare (Q46)

In the United Kingdom there is recognition of the impact of lack of childcare facilities on nursing retention and re-entry. Additionally, childcare facilities have been noted to be inadequate in previous Queensland studies and there is no indication that these issues have been addressed. The finding that in this study, the majority of nurses stated that the support they were given was inadequate is not unexpected.

There are no significant differences across sectors. There was some significant change between the responses in 2001 and 2004 in the aged care and public sectors with an increase in nurses answering ‘yes’. However, despite this increase there are still 69.6% in the aged care and 79.8% of nurses in the public and 78.8% in the private sectors who consider the support/assistance to be inadequate.

4.3.3.8 Factors affecting adequacy of childcare facilities (Q47)

A very small number of nurses responded to this question (n=23 aged care; n=83 public; n=66 private) and therefore results are not necessarily reliable indicators of the general population. However, trends or themes can be reported. The main inadequacies identified are: the cost of childcare; the hours of operation; and inflexibility. The percentage of nurses mentioning the inadequacy or limited hours of operation of childcare facilities has increased from 2001. Additionally, the cost of childcare facilities was identified by more nurses in the private sector and the percentage of nurses in this sector identifying this as an issue has increased from 2001.

a) Qualitative Data

In the qualitative data, it is apparent that several nurses in all sectors believed that shift work was not ‘family friendly’ and that current rostering systems were unrealistic. However, it should also be noted that there were some positive comments in the qualitative data regarding the cooperation of staff around rostering so that there could be some family friendly activity.

4.4 Professional development

As life-long learners, it is important for nurses to be able to remain current with their skills as well as having the ability to change focus within nursing or to develop new career pathways within nursing. Access to professional development (formal and informal) is therefore very important. Additionally, maintaining skills and knowledge in the workforce has a direct impact on patient safety and outcomes.
4.4.1 Ability to access training and/or professional development (Q48)

While a large majority of nurses in each sector report access to education and training activities, nurses in the public sector are more likely to report this access. This trend has increased slightly since the 2001 survey.

4.4.2 Level of employer support for a formal course of study (Q49)

Of the 336 respondents who reported current involvement in a course of study 181 indicated they received employer support. The most common support is payment of some or all of course fees, followed by support for some time off work for study. There is no significant change in the perceptions of the respondents between the 2001 and 2004 studies.

4.4.3 Type of work-related education and training activities in last 12 months (Q50)

There are significant differences across the sectors with regard to the type of education and training activities in which they have participated in the last 12 months. For example, nurses in aged care are more likely to watch a training video than nurses from the public and private sectors. Of note is that there was a 10% decrease in the percentage of nurses in the public sector watching a training video between the 2001 and 2004 studies.

There are no significant differences across sectors in 2004 (unlike in 2001) of nurses attending talks or lectures within the health facility. However, there was a decrease in the percentage of nurses attending talks or lectures in the health facility in all three sectors with a significant drop in both the aged care and public sectors from the 2001 to the 2004 study.

In 2004 there was a significant difference between the nurses in the aged care sector attending a conference or seminar (35.9%) compared with nurses from the public (41.1%) and private (43.9%) sectors. Similarly, there was a significant decrease in the percentage of nurses who attended a conference or seminar in both the aged care and public sectors and a non-significant decrease in the private sector from 2001 to 2004.

Additionally, in 2004 public sector nurses were more likely to attend a workshop, satellite broadcast and a course/program than nurses in other sectors. Of note is that the number of nurses in the public sector attending a satellite broadcast decreased from the 2001 to the 2004 survey.

Overall training and education activities have reduced across all sectors since 2001.
4.4.4 Financial support for the aforementioned activities (Q51)

Nurses were asked if any of the abovementioned activities were fully, partially or not paid by their employer. There were significant differences in the responses across sectors with only 41% in aged care as compared to 56.6% in public and 52% in private sectors stating the activities were fully paid. Nurses in the public sector were more likely to have time off fully or partially paid by their employer than nurses in the other sectors. There is no evidence of any change in the responses from 2001 to 2004.

4.4.5 Other employer support (Q53)

Nurses were then asked, in relation to the education and training activities they had undertaken, what other employer support was given other than being full or partially paid. There are significant differences in results across the sectors. Nurses in public and private sectors were more likely to have leave and registration fees paid whereas nurses in the aged care sector were more likely to have their meals paid for. Furthermore nurses in aged care were more likely to report no support.

4.4.6 Barriers to education and training (Q54)

Nurses were asked what factors prevented them from undertaking any training or educational activities. Again there are significant differences across the sectors with fewer nurses in aged care citing family commitments as a barrier (21.3% aged care, 32.2% public and 30.2% private sectors). This confirms previous responses by aged care nurses to the influences of family on their working life. In the private sector, nurses were more likely to state they could not afford the fee involved (45.7% aged care, 43.6% public and 56% private sector). In the public sector, nurses were more likely to state that their employer would not provide leave (15.2% aged care, 27% public and 16.8% private sectors). All the factors had a response rate of 15% or more, and so none could be considered to be unimportant.

4.4.7 Qualitative Data

Education and training was a major theme for nurses as evidenced from the free text Questions 76 and 77. The major points made with regard to education and training were:

- Workloads affect the ability of nurses to attend education and training as they are often not backfilled. In this study, over one quarter (26.7%) of the respondents stated that relief staff were not available. Thus, the quantitative data appear to reinforce the qualitative data.
- The cost of education and training was a major reason for the lack of uptake. The cost of education and training was also a significant factor in the quantitative data.
• Financial remuneration for education and training was inadequate, whether it was for postgraduate study or for conversion from AIN to EN or EN to RN. Similarly to the preceding comment, cost was an identified barrier in education and training.

4.4.8 Adequate support for new graduates (Q55)

An essential part of the transition of new graduates to the workplace is the amount of support they receive. Previous studies have noted that new graduates have faced difficulties adjusting to the workplace and that this lack of adjustment can result in poor retention,\textsuperscript{44, 59} or threats to patient safety and outcomes.\textsuperscript{5} Nurses in this study were therefore asked if they believed that there was adequate support for new graduates. There was a significant difference across sectors with the aged care sector respondents more likely to perceive adequate support than the public and private sectors. The nurses who perceived this in the aged care sector were older than the nurses in the same sector who perceived there was inadequate support.

There were differences in the perceived level of support given to new graduates by AINs, ENs and RNs, though this was not consistent across the sectors. Similarly, RNs in the public sector were less likely to have an opinion of the level of support for new graduates than were ENs.

New graduates were also a focus in the qualitative data analysis from Questions 76 and 77. The major points arising from the data from those nurses who were not new graduates were:

• Preparation of new graduates of current university and TAFE programs was unsuitable. This lack of preparation had an impact on the new graduate (work organisation) as well as the more experienced nurses on the ward/unit (having to ‘carry’ the new graduate thus increasing the workload of more experienced nurses)
• Support for new graduate was inadequate resulting in culture shock experienced by new graduates. There was also a lack of graduate programs. Respondents reported that the lack of support was resulting in high turnover
• Retention rates of new graduates are low. Many respondents noted a large workload involved in being preceptor to new graduates each year. They expressed frustration and a sense of wasted time when these new graduates did not remain in the nursing workforce.

There were some comments from the small number of new graduates in the study. It was apparent that they compared their working conditions to that of other tertiary graduates (such as law and teaching) and the outcome of this comparison affected decisions to stay or leave nursing.
4.4.9 Orientation of new staff (Q56)

Again there were significant differences across the sectors with aged care sector respondents more likely to believe that orientation was appropriate (43.3%). The respondents in the public sector were least likely to see orientation as appropriate (31.2%). There was a significant change in the responses in the aged care sector from 2001 to 2004 with the ‘yes’ response increasing. However for all sectors in 2004 there more respondents who believed that orientation was inadequate when compared to the 2001 results. This finding is similar to one in the USA where it was noted that due to funding cuts the availability of orientation programs for new staff in a workplace had decreased. This, these authors noted, had a direct impact on patient safety and outcomes.

Data indicate that the age of the nurse is related to the perceptions of adequate orientation of new staff. In particular, the older the nurse the more likely they are to perceive orientation as adequate. Similar to the findings of adequacy of support for new graduates, there is a difference in perceptions of the adequacy of orientation among RNs, ENs and AINs with a higher proportion of RNs in the aged care sector believing that orientation was adequate.

4.5 Workload

There were several questions across different sections in the questionnaire which could be seen to gather data about nursing workload within the three sectors. These will be discussed along with the results of the qualitative data analysis, where workload was a major factor raised by all the respondents.

4.5.1 Ability to complete work in paid time available (Q19)

Over the three sectors, nurses in the aged care sector were significantly more likely to state they ‘sometimes’, ‘seldom’ or ‘never or very seldom’ could complete their work to their satisfaction in the paid time available. It should be noted however that there was an improvement in the aged care sector between 2001 and 2004 mostly in nurses employed on a permanent part-time basis.

In the aged care sector, 45% of nurses reported they ‘mostly, nearly always or always’ were able to complete their work in the paid time available. This compared with approximately 60% in the other sectors.
4.5.2 Sufficient staff employed in work unit (Q20)

Related to the ability to complete work in the paid time available is the number of staff employed in the work unit on each shift. Nurses employed in the aged care sector were more likely to report insufficient staff than those in the other sectors.

Over the three years there was a significant improvement in nurses’ opinions of staff sufficiency in the aged care and public, and a non significant improvement in the private sector (aged care 28.8% to 37.3%; public 38.0% to 47.6%, private 38.0% to 41.5%). In the aged care sector this was apparent in both public and private sector aged care facilities. The type of nurse (RN, EN, AIN) as well as their employment status (part-time, full-time, permanent, temporary, casual) did not influence the significance of the result. The same pattern is apparent in the public sector, but not the private sector.

4.5.3 Skill mix (Q21)

There were significant differences in the responses across the sectors, with nurses in aged care more likely to perceive insufficient skill mix than nurses from the other two sectors. When compared to 2001 in both the aged care and public sectors all levels of nurse (RN, EN, AIN) and employment status (e.g. full-time, part-time) perceived an improvement. Although a similar trend occurred in the private sector this was not significant.

4.5.4 Reason for inadequate skill mix (Q22)

The reasons for inadequate skill mix significantly differed across the sectors.

4.5.4.1 Too many inexperienced staff

Nurses in the public sector are more likely to cite this as a factor than the nurses in other sectors (38.2% aged care, 53.3% public and 36.4% private sectors). Statistically there is evidence of an increase in this perception in the public sector since 2001 when an equal percentage in all sectors (41%) reported this as a factor.

4.5.4.2 Too few experienced staff

Sector differences are again significantly different with nurses in the public and private sectors more likely to perceive this as a factor than nurses employed in aged care (47.5% aged care, 67.8% public and 64.7% private sectors). Similar to the previous finding, nurses in the public sector were
significantly more likely to perceive this as a factor in 2004 than they were in 2001. There is no evidence of such a change in the other sectors.

4.5.4.3 Too many unlicensed care providers

Although the percentages were small the nurses in the aged care sector were more likely to perceive this as an issue than nurses in the other sectors (8.6% aged care, 2.2% public and 6.4% private sectors). This finding was expected as there were more unlicensed care providers employed in the aged care sector. However, there appears to be some improvement in this perception since 2001, with only half as many aged care sector nurses citing this as a factor.

4.5.4.4 Too many agency staff

Significant differences were apparent across the sectors in 2004. These differences were the result of nurses employed in the private sector more likely to raise this as a factor influencing skill mix than nurses from the other sectors (18% aged care, 16.7% public and 30.5% private sectors). The results reflect that, in contrast to the public and aged care sectors, the private sector is more likely to use agency staff. There was no significant change in response in any sector from 2001 to 2004.

4.5.4.5 Too many casual staff

Nurses in the public sector were more likely to raise this as a factor than nurses in the other sectors (11.5% aged care, 31.1% public and 20.3% private sectors). This result is consistent with the ‘too many agency staff’ result for the public sector as they are more likely to employ casual staff than agency staff. In contrast to 2001, there was no significant difference across the sectors in 2004.

A further change in these data from 2001 to 2004 was the decrease in the percentage of nurses from the aged care sector citing too many casual staff as a factor influencing skill mix.

4.5.4.6 Too few relief/agency staff

In contrast to the previous questions which gave the option of nominating too many ‘outside’ staff within the work unit as an influence on skill mix within the unit, this question raised the issue of insufficient staff within the unit and if the source of insufficient staffing numbers were relief or agency staff rather than permanent staff of that unit.

In the three sectors, respondents were more likely to report there were too few staff available rather than too many. However, fewer respondents from
the aged care sector raised this as an issue (23%), compared with nurses from the public (34.4%) and private (32.6%) sectors.

4.5.4.7 Lack of funding

Nurses in the aged care sector are more likely to see this as an the reason for inadequate skill mix (43.3%) compared to nurses in the public (22.8%) and private sectors (15.5%). In the public sector there was a significant reduction of perceived lack of funding from 2001 (34.6%) to 2004 (22.8%).

4.5.4.8 Employer policy on skill mix

Nurses in the aged care sector are more likely to see this as a factor (33.2%) than nurses in the private (25.1%) and public sectors (14.4%). While the percentage of nurses in the aged care and public sectors has remained relatively stable from the 2001 to the 2004 survey, the percentage in the private sector increased from 16.9% in 2001 to 25.1% in 2004.

4.5.4.9 Summary

The results of this question illustrate the complexity of the workforce. Large numbers of nurses identified inexperience or lack of experience as being problematic. However they differed across sectors as to the effectiveness of solutions (relief, agency, casual staff) or to the causes (funding and policy). The findings of this study reinforce the findings of studies undertaken in the USA which note that lack of funding, poor teamwork, lack of nurses with the necessary skills and experience and poor RN-to-patient ratios have outcomes such as increased length of stay and decrease in patient safety and patient outcomes.5,6

Results on staffing sufficiency and skill mix indicate an improvement over the three years between studies however the belief that there are insufficient staff and an inadequate skill mix are still disturbingly high.

4.5.5 Working of double shifts (Q26)

The usual cause of the need to work double shifts is a staff shortage (lack of staff or skill mix) issues. In this study only 248 nurses reported that they worked double shifts 'sometimes' but only 13 reported that they did this 'often' or 'always'. The results suggest that the working of double shifts is not a major issue in this study.

All but three of those who did report frequent double shifts were from the private sector. However, there are some trends evident in the data when the 2001 and 2004 survey results are analysed, with an increasing tendency of nurses in the aged care and public sectors to work double shifts 'sometimes'.
4.5.6 Replacement of staff on leave (Q38)

Replacement of staff on leave can also affect the workload of existing staff. A question was asked of the respondents about the replacement of staff under a variety of leave situations. The results suggest that for all the factors replacement is more likely to occur in the aged care sector. A possible explanation for this is the smaller RN workforce in the aged care sector. If an RN is on leave in the aged care sector, it is more likely that they are replaced by another RN rather than backfilled. This is different in the acute sectors which have large numbers of qualified staff.

There have been some changes between the 2001 and 2004 studies. Namely:
- in all sectors, staff are more likely to be replaced when on sick leave
- in all sectors, staff are less likely to be replaced when on long service leave
- private sector staff are less likely in 2004 than in 2001 to be replaced when on accrued days off and when on training/study leave.

4.5.7 Workload committee/process (Q29, Q30 and Q31)

Respondents were asked to identify if there were processes/committees in place to deal with workload issues within their workplace. Again there is evidence of sector differences, with public sector nurses more likely to state that these processes were in place. Only 20% of public sector nurses reported that there was no formal mechanism. This is in contrast to over 40% of nurses in both the private and aged care sectors who reported that formal mechanisms were not available within their workplace. Equally alarming, approximately one-third of the respondents in both the public and private sectors did not know if such formal processes were available. There is evidence of a significant change in the responses from the 2001 to 2004 survey with a halving in the ‘no’ response in the public sector.

The respondents were asked to comment on the effectiveness of the committee/process. Between 30% and 40% of the nurses said that this was ‘never, very seldom or seldom’ effective. In 2001 there was evidence of a difference across sectors in the perceptions of effectiveness of these processes however, this difference was not exhibited in the 2004 study. The change appears to be driven by the respondents in the private sector who are two times as likely to believe that the processes are ineffective in 2004 than they were in 2001.

4.5.8 Qualitative Data

In addition to the quantitative comments, respondents were also given the opportunity to comment on workloads. The comments suggest that while processes may be in place, that many nurses in this study believe that no
action is taken to address workload inadequacies. There appears to be a difference across the sectors, with 33% of nurses in the aged care sector believing that no action was taken. This compared with 22% in the public and 24% in the private sector.

In contrast to these responses, 20% of the nurses from the aged care sector reported that something was done – that action was taken including referral to a committee. Similarly in the public sector, 45% of the respondents believed that some action was taken, compared with 30% in the private sector.

Other qualitative comments provided in Questions 76 and 77 were:

- High workloads and inadequate staffing lead to low morale and high stress
- Due to workloads, nurses are unable to complete their work to the level of their satisfaction, resulting in ‘frustration’
- High workloads have led to feelings of dissatisfaction with nursing and are reported to be a major factor in a nurse’s decision to stay or leave nursing
- Inadequate staffing levels directly affect patient outcomes (increase errors)
- Overcrowding of units has an impact on the nurse’s safety
- The availability of support staff has decreased leading to nurses now taking on the work of the support staff. The respondents described this as ‘non-nursing work’
- The wish to complete work meant that many nurses were working paid or unpaid overtime.

4.5.9 Summary

Workload and its effect on nursing retention is supported by many studies. In a study in the USA each additional patient was associated with a 23% increase in the odds of nurse burnout and a 15% increase in the odds of job dissatisfaction. The findings of this study support the USA study. In Australia, funding cuts have also been linked with increased workloads and decreasing levels of job satisfaction. The major effect of funding cuts appears to be an increase to patient load (due to lack of staff) as vacant positions are not filled. Further, the use of deployment (as noted as one mechanism to cope with workload) is also used to cover nursing shortages.

4.6 Rostering systems (Q23 and Q24 and Q25)

Work schedules impact upon family life and therefore the availability for work, particularly for people with dependent children or other family members. Several previous studies have noted that organising a roster around staff who have dependent children requiring childcare is difficult, as the needs of all staff have to be taken into consideration. There is evidence that nurses without dependent family members and nurses who work full-time believe that their working hours are dictated by nurses who work part-time and/or have
dependent family members. In this study, there was no difference between nurses who had dependent children or other significant family responsibilities and those who did not, with regard to their level of input into rosters at their workplace.

Similar to the 2001 study there is a significant difference in the type of rosters used in the different sectors and the amount of input nurses have into the roster. The aged care sector is less likely to use request-based rostering and more likely to use fixed non-rotating rostering than the other sectors. Nurses in this sector, therefore, are more likely to report they have less input in the roster than nurses in the other sectors. The difference in the type of rostering systems used are consistent with the findings of other studies.

There was a correlation between the age of the nurse and satisfaction with rostering practices in the aged care sector where the older the nurse, the higher the satisfaction with the rostering system. In contrast, younger nurses in the public sector were more likely to report input into their roster.

In the aged care and public sectors in 2004, RNs were more satisfied with rostering practices than ENs or AINs. This higher level of satisfaction may reflect that RNs in these two sectors report having more input into their rosters than ENs or AINs.

4.7 Violence in the workplace (Q32)

Workplace bullying has been linked in previous studies to poor retention rates. One of the most significant findings in this study is the high rate of workplace violence and the increase since 2001. For example, the data indicate that half of the nurses in this study have experienced workplace violence in the last three months (57.8% aged care; 56.1% public and 43.4% private). There has been an increase in the reports of workplace violence in all three sectors. The private sector, although reporting a lower overall incidence in workplace violence, reported the greatest increase. The five major sources of workplace violence in each sector are discussed below.

4.7.1 The source of the violence (Q33)

4.7.1.1 Clients/patients:

Consistent with the findings of previous studies, patients/clients are the most common source of workplace violence. There is a significant difference in the percentage of nurses reporting this across the sectors with 54.1% of respondents in the private citing this as a source compared to 74.8% in the public and 75.8% in the aged care sector. While the percentages of workplace violence from patients/clients have remained relatively stable in the private and aged care sectors, there has been a significant increase in the public sector from 2001 to 2004. It is possible that an explanation of the increase of this source of workplace violence from patients is cost containment. A study in
the USA has noted that funding cuts, which resulted in increased waiting lists for admission to hospital, had resulted in increased patient aggression towards nurses.  

4.7.1.2 Nursing management

Violence (defined to include aggression, harassment and bullying) perpetrated by nursing management has almost doubled from 2001 to 2004 across all three sectors. Additionally, the pattern across the sectors has changed with significant differences now apparent in the 2004 data that were not in the 2001 data. Nurses in the private sector are more likely to identify nursing management as a source (36.2% - an increase from 14.6% in 2001) than nurses in the public (24.4% in 2004 and 14.5% in 2001) and aged care sectors (26.7% in 2004 and 16.3% in 2001).

There are a number of possible explanations for the increases. It may be that the larger workload and shortage of nurses has resulted in increased bullying by senior management towards nurses to ‘work harder with less’. Certainly the qualitative data suggest that this is one factor, and bullying by higher ranked staff has been reported to be the most common form of workplace violence by other studies. Another explanation is that nurses have become more aware of workplace bullying and are more likely to recognise it. This has been suggested in other studies as a cause for the increase in the incidence of workplace violence.

4.7.1.3 Other nurses

Other nurses are the second most common source of workplace violence reported overall by 37% of nurses. From 2001 to 2004 there was a significant increase in this category in the public and aged care sectors from this source but no differences occur between sectors.

4.7.1.4 Medical practitioners

Previous studies have noted that a collegial working relationship between medical practitioners and nurses does impact upon the job satisfaction of nurses. Similar to the results in 2001, is a significant difference across sectors in 2004. In the private sector respondents are more likely to report workplace violence from medical practitioners (30.6%), compared with 16.2% in the public and 5.5% in the aged care sectors. There is no significant change in the percentage of nurses reporting medical practitioners as a source of workplace violence between the 2001 and 2004 study.

There are several possible causes for this difference across the sectors. In Australia in the private sector, hospitals must ensure that medical practitioners have the freedom they need to treat their patients within each hospital environment. In many cases, if the medical practitioners are not satisfied they will transfer their services to a competing private hospital. Thus the very
viability of private hospitals is linked to the level of satisfaction by the visiting medical practitioners. This dependence often means that nurses are expected to tolerate inappropriate behaviour by medical practitioners (as exhibited in the results of the 2001 and 2004 study). In Queensland many medical practitioners are salaried in the public sector and therefore have less power than in the private sector.

Another influence could be that the income of the medical practitioner is influenced by their ability to admit and treat within the private hospital system. If there are barriers to this practice within the system, it is not unusual for some medical practitioners to abuse nurses.

Aged care facilities in general have less interaction by doctors than hospitals and results from this sector reflect this.

4.7.1.5 Visitors/relatives

This is a major source of workplace violence in all three settings. However, nurses in the public setting are much more likely to report experiencing workplace violence from visitors and relatives. Reports from this source have increased in all three sectors from the 2001 to the 2004 study. It is possible that one influence on this change is cost containment. Although there have been no published studies on how cost containment may result in increases in workplace violence from visitors/relatives, there are studies that have linked cost containment to increases in abuse from patients. The qualitative data do support this theory with some nurses noting abuse from relatives that was linked to the nurse’s inability to provide care to a patient (due to workload).

Similarly, there was also some indication from respondents in this study that the Privacy Guidelines/Legislation meant that they were now more contained in the information they could provide to next of kin. The nurses believed that lack of information about restrictions resulting from the legislation was resulting in an increase of abuse from visitors/relatives.

4.7.2 Gender and workplace violence

In 2004 the proportion of male nurses reporting more workplace violence was higher than female nurses reporting workplace violence in the public and aged care sectors. In the public sector the difference is statistically significant despite the small number of male nurses in the survey. In contrast to 2001, male nurses in the private sector were no more likely than female nurses to report workplace violence. In all sectors the percentage of female nurses experiencing workplace violence has increased significantly in 2004.

There is conflicting evidence with regard to workplace violence and gender in previous studies. For example, the Queensland Government reported that workplace harassment was more likely to occur in females than males. In contrast, Rippon stated that male nurses experience more workplace violence.
than female nurses. The results from both the 2001 and 2004 studies appear to confirm Rippon’s findings.

4.7.3 Workplace violence and designation of the nurse

There is evidence to suggest that in 2004, but not in 2001, ENs and AINs in the aged care sector (both public and private aged care) are more likely to report workplace violence than RNs. This is an expected finding as it is the ENs and AINs who provide clinical care within this sector.

Additionally, RNs and ENs in the private sector experienced significant increases in workplace violence between 2001 and 2004. These findings confirm this new evidence that there is a difference in workplace violence across sectors.

4.7.4 Workplace violence and employment type

The data suggest that permanent part-time respondents in the private sector also report a significant increase in workplace violence from 2001 to 2004.

4.7.5 Workplace violence and age of the nurse

In the aged care (both public and private) but not in other sectors the reported incidence of workplace violence increases with the age of the nurse. This is a new finding that has not been reported in previous research.

4.7.6 Workplace violence and perceptions of the level of safety of the workplace

The study investigated if the perceived level of safety of the workplace was correlated with reported levels of workplace violence. In each sector there is a highly significant tendency for a poorer perception of workplace safety to be associated with a higher incidence of reported workplace violence. This finding is consistent with Spurgeon and Barwell who also found that perceptions of a safe workplace was linked to workplace violence.

4.7.7 Workplace violence and morale

Several authors have associated workplace violence with morale. In this study, those who had been subjected to workplace violence in the last three months rated workplace morale as being poorer than those who were not subjected to workplace violence. This relationship was evident across all three sectors.
4.7.8 Workplace violence policy

4.7.8.1 Policy on workplace violence from other staff (Q34 and Q35)

Between 15 and 20% of nurses in the private and public sectors did not know if there is a policy for workplace violence from other staff. Significantly fewer aged care sector nurses (8.8%) fell in this category. Only 6.8% in the private, 3.5% in public and 4.4% in the aged care sectors said there was no policy in place. For each sector there was a trend for fewer ‘don’t knows’ and less ‘nos’ than in 2001. This finding may reflect the QNU activity over the three year period aimed at increasing awareness of workplace violence. Nurses in the aged care sector were more likely to believe that the policy was ‘always or nearly always’ effective. In contrast, nurses in the public sector were the least likely to believe that the policy was effective.

When compared with the percentage of nurses reporting workplace violence from other staff, these results suggest that while there are policies in place they are not as effective as they should be.

4.7.8.2 Policy for patients/clients visitors (Q36 and Q37)

There were significant differences across the sectors in 2001 and 2004 in their response to the existence of workplace policies for dealing with this type of behaviour. The category ‘don’t know’ is much higher in the private sector than in the aged care and public sectors (27% private; 16% aged care and 14% public). The respondents least likely to say ‘don’t know’ were from the public sector. This may be a result of the workplace violence campaign undertaken by the QNU over the last three years.

There appears to be a reduction in the number of nurses who say there is no workplace violence policy for patients/clients/visitors between 2001 and 2004. This finding suggests there has been an either an increase in workplace policies or the knowledge of the existence of these policies, mostly in the public sector (64.4% to 81.8%).

Respondents were asked if they perceived the policy to be adequate. Similar to the previous findings, nurses in the public sector were least likely to believe that the policy was ‘always or nearly always’ effective.

4.7.8.3 Qualitative Data

There were also many comments made in Questions 76 and 77 with regard to workplace violence. The major themes from the sectors were that:

- Workplace violence from nursing management appears to be associated with increased nursing workloads
• A major cause of workplace violence from relatives is also related to nursing workloads. It is well documented that increased workloads and low patient/nurse ratios do impact on patient outcomes. The lack of understanding by relatives of the Privacy legislation and guidelines was a cause of workplace violence.
• As the carers at the bedside, nurses who must deal with the anger of patients and relatives who have procedures cancelled due to cost containment exercises on the part of the organisation.
• Unfortunately, the workplace violence between nurses continues.
• In the private sector nurses experience workplace violence from medical practitioners. This behaviour is often tolerated by management.
• Often a solution to workplace violence is for the victim to leave their place of work.

4.7.8.4 Summary

The results of the 2001 and 2004 studies have confirmed previous findings of workplace violence as well as provided new evidence of influences on workplace violence not previously reported. One of the major findings is that the sources of workplace violence differ across the three sectors. The results suggest the context of practice is an important consideration, and that a ‘one size fits all’ education program or policy would not be effective to manage these differences.

The studies confirm workplace violence remains an issue within nursing. The data from the 2004 study appear to indicate an increase. Whether this is an increase in actual workplace violence, or an increase in awareness of what workplace violence is, cannot conclusively be stated.

4.8 Nursing work (Q57)

The results for this section are also discussed with a merging of the qualitative and quantitative data where this is appropriate.

4.8.1 The emotionally challenging nature of nursing work

The majority of nurses in this study believed that nursing work was emotionally challenging. Nurses in the aged care sector were more likely to report this as a factor than nurses from the other sectors (aged care 81.2%, public 75.9%, private 78.2%). Of note is that less than 6% of nurses indicated that nursing was unchallenging in any degree (slightly, quite or extremely). The results are consistent with those from 2001.
4.8.2 Physically demanding

As would be expected, a large majority of the respondents believed that nursing work was physically demanding (aged care 43.2%; public 19.8%; private 23.8%). There was a difference across sectors however, with twice as many nurses from the aged care sector likely to report ‘extremely’ than nurses from the other sectors.

Previous studies have identified the physical and emotional demanding nature of nursing work. Some of these studies identified the adverse health outcomes of nursing work due to, for example, the higher rates of musculo-skeletal disorders and generalised ‘wear and tear’ on nurses during their working life. These demands on the emotional and physical health of nurses have been linked to retention of the nursing workforce as well as its impact on the length of the working life of a nurse. However, when the results from the 2004 and 2001 studies were analysed there was no significant relationship between the physical and emotional demands of nursing and the predicted future time in nursing in any sector. Nor did such a relationship exist when all of the nurses in the study were considered together.

4.8.3 Heavy workload

Similar to the previous question, nurses in the aged care sector were more likely to report that nursing involved a heavy workload with over 50% reporting it to be ‘extremely’ heavy as compared to less than 30% for each of the other two sectors. Overall 81% of nurses reported that nursing workloads were ‘quite’ or ‘extremely’ heavy.

4.8.4 Work stress

Work stress could be seen to be related to the emotional and physical nature of nursing work. Similar to the findings above, nurses in the aged care sector were more likely to report higher levels of stress than nurses from the other sectors (52.2% aged care; 33.3% public; 33.3% private). There was no significant change in this perception from 2001 to 2004.

Heavy workload and work stress are factors that have been linked to both adverse patient outcomes and lack of retention.

4.8.5 Career prospects

Across the sectors only 20 and 25% of nurses believing career prospects were ‘extremely’ or ‘quite good’. These data are consistent with 2001. At the
other end of the spectrum the sector difference which was evident in 2001 of fewer private sector nurses stating that prospects were extremely or quite limited disappeared in 2004. In 2001 this response by private sector nurses was responsible for a significant difference across the sectors. However, in 2004 private sector nurses responses were similar to the other sector responses, thus there were no significant differences in 2004. The lack of a career pathway has been identified as a factor influencing retention of nurses in the Australian workforce in previous studies. The qualitative data confirmed the quantitative data with many nurses noting that there was a lack of incentive for nurses to be promoted past Nursing Officer 2. The main reason for this was the decrease in pay (mostly lost penalty rates) and other award entitlements at higher levels.

4.8.6 Nursing seen as a high status career

This question elicited difference responses across the sectors in both 2001 and 2004, with nurses in the aged care sector twice as likely to see nursing as an ‘extremely’ or ‘quite’ high status career. The figures were low with only 20% of aged care nurses and 10% in the other sectors making these choices. The status of a career could be seen to influence recruitment as well as retention. In Australia, one author has stated that the traditional image of nursing as a low status career is being eroded. Our data do not report this contention.

4.8.7 Value of nursing work within the community

Studies in the USA have indicated that while nursing is seen as a most ethical and respected profession, it is undervalued within the community. The same study argues that the level of remuneration of nurses reflects the value the community places upon the profession. In this study, although most nurses did not consider their profession to be high status, over 50% of the responses believed that nursing was ‘extremely or quite’ valued by the community. Less than 10% overall believed that nursing was ‘extremely or quite’ poorly valued within the community. Similar to the findings relating to the status of nursing, aged care sector nurses were more likely to believe that nursing work is valued by the community than the nurses from the other sectors. No changes were observed between the two surveys.

4.8.8 Value of nursing work within the health system

Consistent with the previous findings, nurses employed in the aged care sector were more likely to believe that nursing work was valued within the health system (31.4% compared with 23.7% public and 25% private). No significant change is apparent in the findings from 2001 to 2004.
4.8.9  Teamwork and support from colleagues

Good teamwork has previously been linked to retention. Furthermore, a supportive environment where managers value their staff and promote information sharing will also result in retention of the workforce. The results of this study indicate that twice as many private and public sector nurses indicate workplace colleagues as supportive than unsupportive. However, within the aged care sector the same number of nurses considered colleagues to be supportive and unsupportive. Comparing across the sectors, nurses from aged care were significantly more likely to report unsupportive colleagues than nurses in the other two sectors (31.5% compared to 20% in public and 19.6% private sectors). There was no significant change over time.

4.8.10  Autonomy in nursing

Several studies have noted that nurses want the freedom to use their knowledge to make independent clinical decisions. The ability to make independent decisions has been linked to retention and is a characteristic of the Magnet Hospital model. In 2004, while the evidence was weak, there is a difference across sectors. This difference is bought about by the relatively higher number of nurses in the public sector who believe that autonomy is discouraged. In 2004 few nurses believed that autonomy was 'extremely' encouraged but over 60% believed that there was some encouragement albeit 'slight' or 'quite'. No differences were found between sectors in comparison to 2001.

4.8.11  Morale

Morale was seen as high by only around 20% of nurses across all sectors and was seen as poor by 39.5% of nurses from the aged care, 36.2% of nurses in public and 34.9% of nurses in private sectors. There was no significant difference between the sectors in the 2004 study.

Although no significant change occurred from 2001 to 2004 in the level of morale the degree of deterioration was considered high. This deterioration was seen as 'extremely' or 'quite deteriorating' by 44.3% of nurses in the aged care sector, 40.6% in the public and 38.8% in the private sectors. There are no significant differences in the results between sectors or over time.

In the qualitative data were many comments on nursing were identified as either positive or negative. These comments could be interpreted along with the quantitative data as reflecting the current perceptions of nursing and their attitude to nursing work. Major themes were negative and included the following:

- There has been a deterioration in the way that nurses are valued within the health system and by the patients/clients/visitors using the health system
• Many nurses are stressed, angry, frustrated and unhappy
• Staff turnover is resulting in an ageing nursing workforce
• Shift work, long hours, being on call and lack of staff are all factors mentioned by nurses as influencing their decision to leave nursing (or retire early).

Several studies have previously indicated low levels of morale in nursing.49, 55, 64. The reasons associated with low morale were poor remuneration, lack of support for education, limited opportunities for promotion, experiences of workplace violence, lack of resources and job insecurity.49, 64 Similar findings were evident in both 2001 and 2004, with low morale associated with poor remuneration, workplace equipment levels, safety in the workplace, and the status of nursing as a career. Findings that are consistent with Day’s study of Queensland nurses levels of morale were: perceptions of the lack of recognition of nurses as a professional; experiences of workplace violence; and effective teamwork increases levels of morale.49 New variables in these studies which were associated with morale, were the level of autonomy in nursing work, nursing workload, and the physical demands of work.

By contrast to the 2001 study, there was no significant difference in the perceived level of staff morale among different levels of nurses (RN, ENs or AINs) or gender.58

There was also evidence within the qualitative data of some workplaces that had been able to provide an atmosphere where nurses wished to work. Other nurses believed that there was too much focus on the negative aspects of nursing work and that a more positive image should be promoted.

4.9 Occupational health and safety (Q57)

Many previous studies have highlighted the health outcomes of nursing work.20, 43, 61

4.10 Safety of workplace

Nurses in the aged care sector report an ‘extremely’ or ‘quite’ safe (63%) workplace compared to 45.3% in the public and 54.4% in private sectors. Between 8 and 12% of nurses indicated that their workplaces were ‘extremely’ or ‘quite’ unsafe. No significant change between sectors is apparent from 2001 to 2004.

4.10.1 Adequacy of workplace equipment

Reflecting the results above, nurses in the aged care sector were more likely to believe their workplace was ‘extremely’ or ‘quite’ well equipped (42.8% compared with 33.8% in public and 35.9% in private sectors). No change is apparent from 2001 to 2004.
4.11 Working conditions and remuneration (Q57)

This section discusses the findings of both the qualitative and quantitative data. The majority of the qualitative data have been generated from the last two open-ended questions of the survey.

4.11.1 Remuneration (Q57)

There were significant differences between the nurses in this study who believed that they were adequately remunerated, with nurses in the aged care and private sectors least likely to believe that remuneration is ‘extremely or quite’ good (15.3% in the aged care; 23.4% in the public, 15.9% in the private sectors). At the other end of the scale there were larger numbers of nurses who believed that remuneration is inadequate (45.6% aged care, 25.2% public, 38.1% private). Similar to the findings in 2001, in general nurses in the aged care sector were more likely to be dissatisfied with pay, than those in the public and private sectors.

In the qualitative data overall themes from both questions suggested that the respondents believed:

- pay rates do not reflect the complexity of nursing work
- the current classification structures and processes do not encourage nurses to be promoted within the system. This finding is reinforced by the quantitative data on perceptions of career pathways
- pay differentials between RN Level 1 and above discourage nurses from seeking career advancement as if they do so they are disadvantaged financially. The quantitative data indicating that nurses perceive a poor career pathway also supports this finding
- the lack of parity in nursing pay rates between sectors, between the Australian states and territories should be addressed
- nursing work should be remunerated at a level that reflects its status as a profession. The data suggest that nurses, particularly those in the public and private sectors do not believe that nursing is seen as a high status career. This, in turn, reflects the level of remuneration seen to be appropriate.

The effect of remuneration of retention and recruitment has been discussed in many studies, nationally and internationally.\(^{42,43,48,49,50,90,93,94}\) The conclusions of these studies is that salary appears to be a more important influence on nurses who are considering leaving nursing than for those who have already left. It is suggested that in many cases the level of remuneration is traded off in lieu of a good working environment – if the working environment is poor then nurses expect a higher level of remuneration in compensation for this.\(^{49}\) The qualitative data suggest that this is the case in this study.
4.11.2 Rewards for skills and experience (Q57)

Less than 16% of nurses believed that they were ‘quite or extremely’ well rewarded. There were no significant differences across sectors and no changes over time with regard to this factor with nurses more likely to believe that they were inadequately compensated (40%) for their skills and experience. These responses were reflected in the qualitative data from Questions 76 and 77 where respondents believed they were not adequately remunerated for their skills and experience and the level of responsibility they were required to take. The finding also reflects the results of other studies which suggest that inadequate remuneration of skills and experience is linked to poor retention.17,42,43,49,50 Additionally, employing nurses who do not have the necessary skills and experience or who cannot maintain their skills and experience has adverse outcomes with regard to patient safety.5

4.11.3 Conditions of employment (Q76, Q77)

There were many and varied statements made within the qualitative data on conditions of employment. Many of these comments were directed at the QNU as actions needed to be taken. For example:
- Parity of wages and conditions between nurses across the sectors
- Redefining what constitutes permanent full time work because of work intensification
- More paid leave for education and training
- Increase in maternity/family, annual and study leave
- Ensuring employers provide opportunities for health promoting activities (such as gyms, counselling).

However, other comments that arose in the data analysis of Questions 76 and 77 were general and included comments about:
- The amount of unpaid overtime they currently worked
- The difficulty in accessing TOIL
- Parking (should be free)
- Allowances for preceptoring of new graduates
- How different awards meant different payment and working conditions (particularly among unregulated care providers in aged care).

4.11.4 Activities for the QNU to pursue

Nurses were asked to describe up to five most important activities that the QNU should engage in over the next 12 months. There were many and varied comments provided by the respondents and the full analysis of these comments is outlined in the supplementary documentation. Reflecting the quantitative data major themes included: wages and conditions, workloads/staffing/skill mix, parity of conditions and remuneration, education
and training issues, and workplace violence. Specific to the activities of the QNU many respondents believed that the QNU should focus on providing industrial support for Enterprise Bargaining as well as general support for members. There was also a focus (though less in 2004 than in 2001) on issues that could be seen to impact upon recruitment and retention (e.g. lobbying for more undergraduate places, better articulation for ENs/AINs to RN). Additionally, several respondents in the aged care sector raised specific issues related to their sector of employment. In particular for this study, there was considerable concern and anger surrounding the introduction of legislation to allow unregulated care providers to administer medications to residents/clients.

4.12 Sector analysis

The results suggest that there are major differences between the three sectors.

4.12.1 Aged Care Sector

Reflecting the nature of work in aged care, these nurses were more likely to report that nursing work is emotionally challenging and physically demanding and that the workload is heavy. They also believed that an insufficient skill mix is impacting upon their workload. They were the most likely to believe they cannot complete their work to their satisfaction within the paid time available, however this has improved since 2001. They also believe that ‘very seldom' are there sufficient staff employed to meet patient/resident needs. Similarly, these perceptions have improved since 2001. Additionally, nurses in this sector were more likely to believe that too many unregulated care providers (has improved since 2001), lack of funding, employer policy on skill mix and too few experienced staff impact upon skill mix in their facility. They were the most likely of nurses in the three sectors to be replaced when on leave. They were more likely to report the workplace is safe and well-equipped. Nurses in this sector were more likely to indicate that a workload committee/process was in place than they were in 2001. However, nurses in this sector were more likely to believe that the committee or process was effective than nurses in other sectors.

Similar to the other sectors, nurses in this sector have reported an increase in workplace violence since 2001. In the aged care sector, the most common sources of this violence are clients/patients, medical practitioners, nursing management, other nurses, and visitors/relatives. The last three of these sources have all increased since 2001. They believe that workplace violence impacts upon workplace safety. The older the nurse in this sector, the more likely they are to report experiencing workplace violence. AINs and ENs were more likely to report workplace violence than RNs. Nurses who report low morale are more likely to have reported workplace violence, with those nurses reporting ‘extremely’ poor morale more likely to have been subjected to workplace violence than other nurses. Male nurses were more likely to report experiencing workplace violence than female nurses.
Permanent full-time nurses in this sector were more likely to work unpaid overtime or Time Off in Lieu (TOIL). However, they were also more likely than nurses in the other sectors to be able to take accrued TOIL. They are more likely to work on fixed non-rotating rosters and least likely to work on a request-based rostering system. They were least likely to be satisfied with rostering practices. Older nurses in this sector were more likely to be satisfied with the rostering system. Reflecting the fact that RNs have more input into the roster in their work unit, RNs, rather than ENs or AINs were the most satisfied with rostering practices.

The fact that the nurses in this sector are older (and the average age of nurses in this sector has increased since 2001) and they were less likely to have dependent children (decreased since 2001). In those nurses who indicated they had dependent children, these children were likely to be older than dependent children in the other sectors. In all sectors, childcare was seen to be inadequate, however, in the aged care sector nurses were more likely in 2004 than they were in 2001, to see the reason for this inadequacy as the inflexibility of childcare services. Nurses in this sector have reported a slight improvement in their perception of the adequacy of childcare since 2001.

They were most likely to indicate that family responsibilities influenced the hours they were available for work. However they were most likely to say that support for family responsibilities was adequate. Nurses in this sector were more likely to have a dependent spouse, dependent elderly relative or dependent disabled or ill family members.

Nurses in this sector were more likely to have had a longer break from nursing and, as a consequence, were more likely to have undertaken a re-entry program. Compared to nurses in the other sectors, they are more likely to have taken a break from nursing because of family responsibilities and are less likely to have taken this break as paternity/maternity leave. They are also more likely to have taken a break from nursing: due to ill-health, because they have lacked motivation or encouragement to continue their nursing career; or to go to a better paid position. While similar to the percentages of nurses in other sectors, the numbers leaving left to pursue further education, have increased since 2001.

These nurses have the most (over 35 years) or least (less than 10 years) experience in nursing. Reflecting the older workforce in this sector, these nurses are more likely to indicate they will leave nursing earlier than nurses in the other sectors.

With regard to education and training, the nurses in this sector are more likely to participate in workplace training by watching a training video but less likely to receive funding from their employer to attend a conference or seminar. While they often attend a talk or lecture within the facility, the number doing so has decreased since 2001. They are the least likely to have education and training activities funded by their employer. In contrast to the other sectors,
nurses in this sector identified that the most common support given for education and training was in the form of meals. Possibly reflecting their older dependent children, they are less likely to identify family commitments as a barrier to education and training.

Aged care sector nurses are more likely to believe there is adequate support for new graduates and orientation for new staff. In particular, older nurses in this sector are more likely to believe this than younger nurses. They are also most likely to believe that nursing is a high status career and one that is valued by both the health system and the community. However, like nurses in the other sectors, half of the aged care sector nurses perceived morale to be low and over half considered morale to be deteriorating. Reflecting their low morale, they have the highest levels of reported workplace stress, believe their colleagues are unsupportive and are most dissatisfied with remuneration.

The nurses in the aged care sector, while working the shortest minimum and maximum shifts (these lengths have reduced since 2001), are more likely to be employed on a permanent part-time basis than a permanent full-time basis. They are the least likely of all nurses to work double shifts, though working double shifts has increased since 2001. Permanent part-time nurses in this sector work more paid overtime, and are most likely to indicate they wish to be permanently contracted to work more shifts. They are least likely to work continuous shifts or Monday to Friday shifts only. They are more likely to be employed on evening only shifts.

4.12.2 Public Sector

With regard to skill mix, nurses in the public sector are more likely to believe that too many inexperienced staff (this has decreased since 2001), too many casual staff and too few relief/agency staff (increased since 2001) and lack of funding (decreased since 2001) are all affecting skill mix. The perception of too few experienced staff has increased since 2001. Despite these views on what affects skill mix the public sector nurses in 2004 reported skill mix as adequate and more respondents were likely to say, in 2004, there were sufficient staff to meet patient needs. Nurses in this sector are more likely to state that nurses are replaced when taking leave since 2001, however, this sector was the least flexible with regard to annual leave been taken at a time suitable to the nurse. In this sector, however, it is more likely that a workplace committee/process for workload is in place. Although there has been an increase in workplace committees/process since 2001 nurses in this sector were the most likely to believe that the committee was 'never, very seldom or seldom' effective.

Similar to other sectors, there has been an increase in reports of workplace violence since 2001. Clients/patients are the most common source of workplace violence in this sector (this has increased since 2001). Other sources of workplace violence in this sector are: visitors/relatives (highest of the three sectors and an increase since 2001); nursing management (increase since 2001); medical practitioners (no change since 2001); and
other nurses (increased since 2001). Nurses in this sector associate the level of safety in the workplace with workplace violence. Male nurses are more likely than female nurses to report experiencing workplace violence. Those nurses who reported low morale were more likely to experience workplace violence. Nurses in this sector are most likely not to know if there is a workplace violence policy in place to manage workplace violence from other staff. In this sector, there has been an increase in the percentage of nurses who are aware of a workplace policy for clients/patients/visitors/relatives since 2001.

Morale in this sector is also not high. More nurses in this sector believe that autonomy is discouraged. They are also more likely to state that their workplace is unsafe. They are least likely to believe that their work is physically demanding.

The mean age of nurses in this sector, in line with other sectors, has increased since 2001. There are more male nurses employed in this sector. Nurses in this sector are also more likely to hold endorsements such as midwifery (though this has decreased substantially since 2001), mental health, immunisation, sexual health and rural and isolated practice than nurses in the other sectors.

Nurses in the public sector are more likely to be continuous shift workers and be employed on a permanent full-time basis than nurses in the other sectors. There are also a higher proportion of nurses employed on a temporary part-time basis in this sector than other sectors. Nurses in this sector work the longest minimum shifts, and are the least likely to take accrued TOIL. There has been an increase in nurses in this sector reporting they work double shifts since 2001. Nurses in this sector are the most dissatisfied with their working hours.

RNAs in this sector are more satisfied with, and have more input into rostering practices than ENs. Younger nurses in this sector are more likely to have input into their roster than older nurses.

This cohort is more likely to state they have accessed family leave. This may be a result of the age of nurses in this sector, or it may be that the entitlement to family leave is promoted/advertised more widely. Nurses employed on a casual or part-time basis are more likely to report that the support they have available to care for family members is inadequate. They have the youngest dependent children. Similar to the aged care and private sectors, nurses with dependent children saw childcare support as inadequate. However, there has been some slight improvement in this perception since 2001. In this sector nurses were more likely in 2004 than in 2001 to identify this inadequacy with the non-availability of vacation care and the childcare centre being in an inconvenient location.

Public sector nurses report more access to education and training (this has increased since 2001) and are more likely to report that employers have fully or partially contributed to their education and training. Nurses in this sector
are more likely to be funded for registration fees, accommodation and travel than nurses in the other sectors. Since the 2001 study, there has been an overall decrease in the percentage of nurses watching a training video, a satellite broadcast, attending talks or lectures within the health facility and attending a conference or seminar. However, in 2004, public sector nurses are more likely to attend a workshop, watch a satellite broadcast and enrol in a course/program than nurses in other sectors. Fewer nurses in 2004 than in 2001 are stating that study commitments are impacting upon working hours.

4.12.3 Private sector

With regard to workload and skill mix, the nurses in this sector report too many agency staff, lack of funding, too few relief/agency staff (this has increased since 2001) as impacting upon skill mix. Nurses in this sector are more likely to say that employer policy on skill mix is affecting skill mix in 2004 than they were in 2001. With the exception of leave for education and training which has decreased, nurses in this sector are more likely to be replaced when on leave in 2004. These nurses are less likely to have a workload committee/process in place than nurses in the other sectors. There has been an increase in the percentage of nurses reporting the availability of a workload committee/process, however, nurses in this sector are less likely in 2004 than they were in 2001 to believe that this committee is effective.

Similar to the other sectors, the nurses also report an increase in workplace violence since 2001. The source of the increased reports is from patients/clients, visitors/relatives and nursing management. In contrast to the other sectors, nurses in the private sector are more likely to report workplace violence from medical practitioners (although this has not increased since 2001). Both RNs and ENs in this sector report an increase in workplace violence from 2001. Nurses who are employed on a permanent part-time basis are more likely to report an increase in workplace violence from 2001. Similar to nurses in the other sectors, there is an association between perceptions of the level of safety of the workplace and workplace violence. The lower the morale of these nurses, the more likely they were to report incidences of workplace violence. Nurses in this sector are more likely to not know if there is a workplace violence policy in place for dealing with violence from other staff.

The mean age of nurse in this sector has increased since 2001. Nurses in this sector are also more likely to hold a midwifery (this has substantially decreased since 2001) and mental health endorsement than nurses in the aged care sector. The percentage of nurses employed in this sector who have a disability has increased since 2001.

Nurses in this sector are more likely to work Monday to Friday shifts only. They work the longest maximum shifts, and length of both maximum and minimum shifts has increased since 2001. The nurses in this sector are more likely to cite family responsibilities as affecting the hours they are available for work. Those who are employed on a part-time or casual basis are more likely
to report that the support they have available to care for family members is inadequate. Childcare was seen to be inadequate and for nurses in this sector the cost of childcare has become a greater issue than it was in 2001. Similarly, the absence of emergency childcare has also increased as an issue since 2001.

With regard to education and training these nurses are more likely to attend a conference or seminar. They report access to more paid leave than nurses in the other sectors. They are more likely to state they cannot afford the fee for education and training than nurses in the other sectors.

This cohort of nurses has the poorest perception of support for new graduates.
5.0 CONCLUSION

The results of this study suggest that recruitment and retention issues will continue to face nursing in Queensland for some considerable time in the future. The data suggests that patient workloads remain problematic. There is clear evidence that the patient to nurse ratio is not only related to patient outcomes\textsuperscript{4,5,6,7} but also to the length of stay (shorter when lower)\textsuperscript{5,7}, and job satisfaction.\textsuperscript{6}

It is apparent that there are many variables in this study which will have an adverse affect on nurses’ job satisfaction. In particular many of the nurses in this study do not believe that they have the ability to deliver quality individualised care.\textsuperscript{58}

The increasing levels of workplace violence would be the most significant change in the data from 2001 and 2004. Workplace violence also affects recruitment and retention within the nursing workforce.\textsuperscript{49,51}

The many factors that have been found in other studies to influence a nurse’s decision to leave are also identified in this study. These are:

- family responsibilities – including pregnancy and lack of childcare;\textsuperscript{17,40}
- remuneration\textsuperscript{42,43,44,45,48,49,50,90,946,47}
- workloads and staffing\textsuperscript{6,44,63,65,104}
- stress/frustration\textsuperscript{34,48,58,59,65}
- travel\textsuperscript{17,16,44}
- career opportunities\textsuperscript{44,48,56,58,92}
- lack of recognition of nursing work\textsuperscript{42,66}
- lack of authority to make decisions\textsuperscript{45,67}
- working conditions\textsuperscript{44,54,55,56,67,82,94}

As has been stated before, recruitment strategies will fail if the workforce issues that make nurses leave are not addressed. This study suggests that urgent attention is needed to areas such as workload and workplace violence.

There are also sector differences in the data that require some attention. In particular, there was a large level of concern raised by the aged care nurses about unregulated care providers being allowed to administer medications.

A major concern surrounding the results of this study is that poor staffing numbers and skill mix do impact on patient safety, length of stay and patient outcomes.\textsuperscript{5,6,7} Unless these factors are addressed, not only will the nursing workforce continue to leave nursing, but it is possible that there will be increasing litigation against employers of nurses who continue to ignore the international evidence on registered nurse to patient ratios.
6.0 REFERENCES


38. Office of Workforce Economics. (2003). Workforce Survey Results for Nursing Staff, Midwives and health visitors.
42. Best Practice Australia Pty Ltd. (2003). Benchmarking Study into Nursing Attraction and Retention.


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26 October 2004

Dear Nurse,

You may be aware that the Queensland Nurses’ Union (QNU) undertook a survey of nurses in 2001. You may have been one of the nurses we surveyed or this might be the first time you have been surveyed. The survey targets nurses employed in the public (hospital, aged care and community health) and private (hospital, aged care and domiciliary nursing) sectors. The data from the previous survey has been used extensively by the QNU in the last two years in many different forums. The QNU has provided us with an outline of how the previous survey data were used and this outline is enclosed in this package and we urge you to read it.

The University of Southern Queensland (USQ) undertook the last survey for the QNU and we have been asked to undertake this survey for them as well. Most of the questions on this survey form are the same as the form we used in our last survey.

As you can see from the information contained in the attached Plain Language Statement, every effort has been made to ensure that confidentiality is maintained. At no stage will the QNU have access to information that could identify respondents or the health facility at which they work. Similarly, at no stage will the USQ have access to personal membership information contained on the QNU database.

You have been randomly selected to complete the survey. The attached Plain Language Statement provides details of how the survey will be conducted. It would be greatly appreciated if you could take the time to read this document before deciding whether to participate in this important study.

Completion of the survey is estimated to take around 30 minutes.

Those members participating in the survey will go in to a draw to win $250 towards the purchase of any goods through Union Shopper. This is provided in appreciation for the time and effort taken to participate in the study.

We encourage you to complete the enclosed survey and return it in the enclosed reply paid envelope by 11 November 2004.

Thank you for giving consideration to our request.

Yours sincerely,

Gay Hawksworth  
Professor Desley Hegney  
Secretary  
Chair of Rural Nursing  
Queensland Nurses’ Union  
University of Southern Queensland
The University of Southern Queensland (USQ) is working as a consultant to the Queensland Nurses Union (QNU) to carry out research of its members in the public (hospital, aged care and community health) and private (hospital, domiciliary nursing and aged care) sectors. The aim of this study is to collect data which will inform the QNU of the workplace conditions and needs of its members.

We ask you to participate in this important study to help the QNU set a strategic direction for the next few years. Participation will involve completion of the attached questionnaire. You do not have to participate in this study. If you do not wish to participate, please do not return the questionnaire. Your participation or otherwise will in no way effect your entitlements as a member of the QNU.

To ensure that your responses are confidential and anonymous we are using the following system.

1. The QNU will provide a code which relates to all of their individual members in these sectors.
2. The participants in the study will be randomly selected by USQ from the list of codes sent to us from the QNU.
3. USQ will then advise the QNU of the codes selected.
4. USQ will send the survey packages in a Plain Envelope with the code number marked on the outside of the envelope to the QNU.
5. The QNU will affix the name and address of the participant to each of the survey packages.
6. The ‘return to sender’ address will be the QNU.
7. Participants will complete the survey form and return it in the reply paid envelop supplied to the USQ.
8. After three weeks, the USQ will note the codes who have not returned questionnaires and we will send a second package to the QNU for postage to non-respondents.
9. At no stage will the QNU have access to the raw data which could link your survey to their database with names and addresses.
10. The QNU will notify USQ of any ‘return to sender’ mail by code, to allow us to remove this from the database.
11. At no stage will USQ have access to personal information of participants from the QNU database.

At no time will the QNU have access to any information which could identify you or the health facility in which you are employed. The report which USQ will supply to the QNU and any publications of the research results will contain no data which would identify individual respondents or health facilities.

If you wish to withdraw from the study at any time, you can do so by contacting Professor Desley Hegney or Dr. Ashley Plank, who will remove any information you have given the research team from the study. You will need to identify yourself by the code used on the questionnaire as we have no database of names.

All of the questionnaires will be kept in a locked filing cabinet in the SimStat (USQ) office for a period of five years, after which they will be shredded and disposed of as confidential waste.

If you have any questions with regard to this project please feel free to contact Professor Hegney or Dr. Plank on the numbers listed below. If you wish to participate could you please return the enclosed questionnaire by 6 December 2004.

Any questions with regard to this project may be directed to:
Professor Desley Hegney, Chair of Rural Nursing, University of Southern Queensland, Department of Nursing, Toowoomba, QLD, 4350, Telephone: 4631 5456; FAX: 4631 5452; Email: hegney@usq.edu.au

Dr. Ashley Plank, SimStat, Faculty of Sciences, University of Southern Queensland, Toowoomba, QLD, 4350. Telephone 4631 5538. Email: plank@usq.edu.au