

Which Factors Influence New Zealand Registered Nurses To Leave Their Profession?

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Abstract

In the context of a looming shortage, this study uses qualitative data to understand why registered nurses leave the profession in New Zealand, and identify what can be done to retain them. Our analysis points to a set of factors that is positive for retention, including the opportunity to express a value of caring, supportive relationships, and career development prospects. If not experienced, however, these factors can repel registered nurses from the profession. A second set of factors is clearly negative, such as heavy workload demands, bullying, and problems of work-life balance while a third set is economic and demographic.

Key words: nursing shortage, employee retention, occupational commitment, health sector

Introduction

A fundamental challenge for the health sector lies in the demographic shift affecting both the community (the potential patients or clients) and the workforce that serves them. As in other developed economies, the New Zealand population is aging because of increased life expectancy, advances in medical technology, and declining fertility rates (Bascand, 2007; Joumard, Andre, & Nicq, 2010). The number of New Zealanders aged 65-plus is projected to climb from 650,000 in 2014 to more than one million in the late 2020s (Statistics New Zealand, 2014). As a direct consequence, the prevalence of chronic disease is increasing dramatically, with a growing number of people experiencing multimorbidity (Banerjee, 2015). The economic effect of aging populations and the increasing prevalence of chronic disease is a major concern for health systems in all developed countries (ibid). These costs can include direct costs (subsidising providers, pharmaceuticals, providing income support), underlying costs (capital and equipment) and indirect costs (reduced employment or social productivity) (National Health Committee, 2005).

The nursing workforce plays a critical role in providing health care, not only in traditional settings, such as hospitals and long-term care institutions, but increasingly in primary care and in homecare settings. But like the population they serve, New Zealand's registered nurses (RNs) are

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aging, with 46 per cent aged 50-plus (Ministry of Health, 2014). Research has shown a steady decline in the retention of RNs from the age of 50 years (Nursing Council of New Zealand, 2011). North, Leung, and Lee (2014) reported that, in New Zealand between 2006 and 2011, one-quarter of RNs aged 50-plus left the workforce. Permanent leaving rose sharply at 64 years, as retirement fund-eligibility (at 65 years) approached. Any escalation in rates of resignation or retirement of RNs potentially threatens the viability of the health and disability system, which has prompted actions to increase the training of new RNs in combination with efforts to increase the retention of those currently in the profession.

Aging populations and an increasing prevalence of chronic disease continue to increase the demands on healthcare services and, thus, place pressure on health systems to ensure a sustainable supply of nursing staff who are willing to work in the system. Although there is a plethora of research on the career behaviours of RNs, the focus has largely been on organisational, rather than occupational, turnover. Occupational commitment is linked with various positive outcomes, including lower absenteeism and higher work engagement (Freund, 2005) and is inversely linked with intentions to leave a profession (Hackett, Lapierre, & Hausdorf, 2001). Current understandings of why RNs leave the profession remain limited (Gilmartin, 2013; van der Heijden, van Dam, & Hasselhorn, 2009), partly due to a lack of in-depth qualitative analysis. More research is needed because occupational turnover results not only in withdrawal from the specific healthcare institution but also in withdrawal from the nursing profession itself.

To some extent, the looming shortage has been alleviated by recent economic events. Following the onset of the Great Recession in 2007, the number of RNs in paid employment increased (Buerhaus, Auerbach, & Staiger, 2009). In the United States, hospital employment of RNs increased by an estimated 243,000 in 2007 and 2008, the largest increase during any two-year period in the past four decades (Buerhaus, 2012). Similarly in New Zealand, the number of practising RNs per 1000 population increased from 10.6 in 2009 to 11.5 in 2015 (Ministry of Health, 2016). However, commentators point out that RNs who re-entered or extended their involvement in the workforce because of negative economic effects on their family may be more likely to leave their jobs or reduce their hours once the family's financial situation improves (Buerhaus et al., 2009; Staiger, Auerbach, & Buerhaus, 2012). The temporary reprieve in workforce stability is not likely to last and we would be very unwise to ignore the longer-run trend.

Solutions that address the anticipated nursing shortage are likely to focus on the motivations of RNs and incentives to recruit and retain them despite their changing circumstances. Many RNs think that they are unfairly financially rewarded for their efforts, or they have conflicting expectations with their managers and cannot provide the comprehensive care expected, so are disillusioned with the profession (Buerhaus, 2009; Cohen, Stuenkel, & Nguyen, 2009). They often have intense and demanding workloads, which result in them feeling emotionally and physically exhausted (Huntington, Gilmour, Tuckett, Neville, Wilson, & Turner, 2010). Many others experience bullying by their peers (Foster, Mackie, & Barnett, 2004). It is unlikely that simply training more RNs will help avoid a shortage; therefore, policy development needs to address the 'discontents' of current RNs and consider innovative ways to retain them. Increasing the inflow into any critical profession addresses only one side of the problem. We need to

complement this with actions that reduce the outflow. Finding ways to delay the retirement of RNs, for example, is an important factor in addressing the issue of nursing shortages (Hasselhorn, Muller, & Tackenberg, 2005).

In this context, our goal is to better understand why RNs leave the profession. In this paper, we report findings from a set of qualitative interviews designed to examine the occupational commitment of New Zealand RNs: what draws them to nursing as an occupation and what repels them from it? We begin by describing our method and then explain the results of our data analysis. This leads into our discussion, limitations and conclusion.

Method

Our study adopts a critical realist perspective. Critical realism is committed to ontological realism (where there is a reality, which is structured and layered and independent of the mind), epistemological relativism (where beliefs are socially produced) and judgemental rationalism (that there are justifiable grounds for preferring one theory over another) (Bhaskar, 1989; Patomaki, 2000). Researchers working within this philosophical schema understand that there are many approaches to research, which cross the traditional quantitative–qualitative divide and that the differences between methods are not always as extreme as they are made out to be (McEvoy, 2006). This article reports an exercise in qualitative data gathering and analysis, which brings its own insights and which can help to inform subsequent quantitative research. Research commenced after ethics approval from The University of Auckland Human Participants Ethics Committee (Ref 9447).

Sample

To understand the factors that might affect the decisions RNs make around leaving the profession, we conducted interviews with purposively-selected RNs and nursing leaders (n=24) working in Auckland, New Zealand. A framework was developed to ensure that the sample was diverse in terms of hierarchical levels, different areas of nursing practice (hospital, community and residential care) and different stages of career. Interviews were held with 12 RNs working in non-leader roles, seven in operational management roles, and three in executive management roles. Seven interviews were with those working within a tertiary hospital setting, 10 within a primary care or community setting, and five within the residential care setting. Participants were from Māori, Pacific Island, Asian, Indian and European descents. Two additional interviews were conducted with health leaders from Health Workforce New Zealand and the Nursing Council of New Zealand. Two participants were men and 22 were women. Sampling continued to the point at which no new information was obtained and data saturation had been reached (Polit & Beck, 2012).

Data collection

Semistructured interviews were undertaken in 2013 at a time and place convenient to participants. Participant information and consent forms were provided in English. Written informed consent was gained on the day of the interview. Face-to-face interviews were regarded

as the best method of collecting qualitative data because of the quality of information they yield (Polit & Beck, 2012). Confidentiality was ensured.

An interview schedule comprising 12 open-ended questions guided a focussed interview exploring issues related to RN retention within the profession. The interview schedule was informed by relevant literature related to the study objectives but we were careful not to impose too much academic structure on the process. We wanted to hear in their own voices what RNs wanted to say about working in their profession and the reasons for leaving it. Examples of questions include “What do you think motivates nurses to work in nursing?” “Could nursing work be restructured to better suit nurses at different life stages?” “What do you think are the main reasons nurses choose to leave the profession?” and “What could be done to ensure that your future nursing career is effective and satisfying?” Interviews were digitally recorded and then transcribed verbatim.

Analysis

A general inductive approach was used to thematically analyse the data obtained from the interviews (Thomas, 2006). The purpose of such an approach is to condense raw textual data into a brief, summary format. The general inductive approach provides a systematic set of procedures for analysing qualitative data. Thematic analysis is not wedded to any pre-existing theoretical framework, and can be used within different theoretical frameworks, including “contextualist” methods, such as critical realism (Braun & Clarke, 2006). Qualitative data were entered into Microsoft Word, read many times to form codes and then condensed into themes. Links were then established between the research objectives and the themes. External corroboration of the thematic analysis was undertaken between the authors to validate the identified themes. Any discrepancies were discussed and the codes and themes adapted accordingly.

Findings

What, then, does our sample of New Zealand RNs have to say about the factors that affect their occupational commitment? Reflection on the voices in our data suggested a threefold categorisation of the forces influencing the retention of RNs. One set of forces, relating to work values, supportive relationships and prospects for career progression, is attractive or has the potential to be attractive. These are factors that participants see as consistent with their personal goals or supportive of their longer-term commitment to the profession. A negative experience with these factors, however, can repel them from the profession. A second set, relating to workload, bullying and work-life interference, is more obviously negative and clearly has the potential to repel: they account for why many RNs have become disillusioned with their profession. Finally, there is a set of forces that relate to the characteristics of the economic climate and the demographic profile of RNs, and where the impacts on retention are more ambiguous. More minor factors, or factors mentioned by only a small number of participants, are not reported here.

Work Values, Supportive Relationships and Career Progression

Value congruence

Many RNs choose nursing because of the opportunity to help others, which they identify with employment in a healthcare organisation. Thirteen participants from across hospital, community and residential care settings, and from across non-leader, operational management and executive management positions, made comments to this effect. For example, one RN commented “I work in nursing because I enjoy working with patients and trying to make a difference in their health outcomes,” and one executive manager said “what motivates nurses is actually making a difference.” This factor, which typically attracts altruistic people into nursing can, however, repel them from it if the lived reality of nursing does not fulfil the expectation. For example, one RN said, “We are not patient-centred anymore. We are document-centred.” Another commented that their work involves “more paperwork than patient care.”

Colleague support.

The voices across hierarchies and areas of practice were united on the importance of having good working relationships with other RNs, as well as the wider interdisciplinary team. Fourteen participants discussed how their work colleagues were supportive. For example, one RN stated that “communication with other workmates is always helpful,” and another said, “your resources are your colleagues that you’re working with because you’re always going to them if you need to know anything.” One health leader noted that, “nurses draw on the comradery, the professional identity and the professional esteem and the kinship you get from other nurses.”

The importance of teamwork was also identified. One executive manager felt that RNs get satisfaction from “working in a team of like-minded people who have a collective goal to make a difference to patients.” Another RN thought that “having that team support is really invaluable, so you do not feel isolated.” Sentiments of “valuing each other” and “caring for each other” were identified as needed in nursing teams.

Supervisor and managerial support

The other source of direct support comes from the immediate line manager and from those at higher levels of the hierarchy. Eleven participants discussed the importance of these relationships. RNs in executive management roles talked about the need to have “good strong leadership that has a collective vision toward supporting and progressing nursing,” and argued that managers “need to be passionate about what they do and share their knowledge and skills, rather than it being a very hierarchical structure.” On the negative side, one health leader commented on the lack of support for younger RNs: “nurses often expect our young to hit the floor running and we don’t cut them a lot of slack.” This was supported by one RN who said that “nurses are not getting the support and education and mentorship they need.”

Fifteen of the participants commented on the need for healthcare organisations to invest more fully in developing the leadership capabilities of nursing managers. Suggestions included “more nurse mentor figures that people could go to” and “harnessing good leaders who make things work well on the floor.”

Career progression

This attractive force came through comments from participants regarding their opportunities to advance their career. For some participants, this meant progressing into higher-level nursing roles ('moving up the ranks'), whereas for others it meant moving across specialisations or into other domains or types of organisation within the health sector. A younger RN, for example, thought she might leave nursing to move into health management or education, stating, "I do not think I could be on the floor for the rest of my life giving enemas."

Four RNs discussed their frustration at the pace with which they were able to progress into new nursing roles, which they considered a potential reason for RNs to leave the profession. Comments included "it is slow to move up in the ranks," "you have to be kind of committed to one area to earn your right to move up in the ranks and it is a bit disheartening," and "it is very hard to go up, there are not many positions you can rise to."

Workload, Bullying and Work-life Interference

A second set of factors emerged around the demands and stresses of contemporary nursing and the ways in which they affected the rest of the RN's life.

Quantitative demands

Fourteen participants across hierarchies discussed consistently heavy workloads that led to stress and feeling burnt-out by the end of the shift. They identified this as a reason to leave the profession. For example, one RN commented, "there are never any light days and you are constantly all-go from when you start to when you finish and you can get quite exhausted." Another RN noted the link between workload, decision-making and stress by stating, "...having a heavy workload seems to be the biggest challenge. It can be a stressful environment with some of the decision-making because of the type of issues we are dealing with." Participants acknowledged that RNs might leave the profession because of burnout caused by the emotional challenges of caring: "caring all the time is hard."

Nine of the participants connected workload to inadequate staffing levels. For example, one RN stated, "there never seems to be a day when you are fully staffed, so you are always playing catch-up." Participants in managerial roles described the impact increasing workloads was having on the ability of RNs to develop therapeutic relationships with patients. One operational manager stated, "...nurses frequently tell me that they do not have that time to sit down and talk to patients." Other concerns related to skill mix: "we will often have one senior nurse working with a lot of junior nurses and quite a lot of new grads."

Bullying

The issue of bullying between RNs, and between management and RNs, was identified by 15 of the participants. This was acknowledged as a problem by participants from all practice settings and all hierarchies. This was the converse or 'dark side' of the supportive relationships referred to above, and included reference to 'horizontal violence,' which participants saw as contributing

to RNs leaving the profession. Statements included “nursing is notoriously known for bullies,” “nurses are their own worst enemies,” and “bullying is everywhere.” One participant likened the bullying culture in nursing to one of domestic violence, explaining that “the cycle of bullying continues in nursing, until somebody steps in and breaks the cycle.” Suggestions for dealing with bullying included “expectations around the cultural environment” that demonstrated zero tolerance for “unsupportive derogatory negative behaviors” and a “process for consequences” when there are breaches in behavior.

Flexible working hours and work-life interference

Seventeen of the participants discussed the importance of flexible working hours. For example, one RN stated, “for me it is all about the flexibility, the fact that I can do the hours that suit me, obviously to fit in with family.” The challenges of shift work and having to work nights or weekends were reasons to consider leaving the nursing profession. One RN talked about colleagues who had left nursing because they “could not cope with the shift work” or because they had to work “hours that do not necessarily fit with their family.” The majority of comments indicated that there was insufficient flexibility around working hours to accommodate those with families and older RNs wanting to reduce their hours. The effect of greater flexibility was summed up by one RN who said, “...if you give people the hours that suit them, people stay longer.”

For many RNs, there exists the need to combine work and family demands, and with the proliferation of dual-career couples, balancing work and home responsibilities has become increasingly difficult, leading to the occurrence of work-life interference. Nine participants discussed the complications around childrearing and working, despite nursing remaining a predominantly female occupation. One RN talked about the pressure on RNs to “manage really big and busy jobs and to manage home lives,” and others discussed how their colleagues had left because the organisation was not “family-friendly.”

Economic and Demographic Factors

A final set of factors relates to the changing economic context, to the impact of pay levels, and to age profiles in the nursing workforce.

Effects of the recession

Sixteen participants commented on the impact of the economic climate. One operational manager said they had a “really high retention rate at the moment” because of “the financial crisis.” An RN suggested that the recession had slowed turnover because “once you have got a good job you kind of want to stay there because you have got a stable job and you should be grateful.” Others talked about how the recession had affected families, suggesting that women increased their hours or returned to nursing “when their husbands lost their jobs.” One RN talked about the risk of RNs leaving the profession as the economy improves because “if they do not need to put in those amounts of hours, and their husbands are back full-time and have job security, they probably will look at leaving.”

Pay

The impact of pay levels divided our participants. Four RNs said that the pay in nursing was now good, with one stating that it “pays more than anything else that I would have skills to do out there.” For seven others, pay was still an issue, with one citing that, although “the salary is a lot better than it was several years ago, it is a pretty basic salary, so it has to be something you really wanted to do.” Another RN talked about how the “step up” in pay was very slow, and one operational manager thought that primary care is “not as well paid as the hospital.”

Age

Eighteen participants across hierarchies and practice settings commented on how the age of RNs might affect their motivations to work but, again, their views on how it did so were varied. Some thought that younger RNs might be motivated by money and travel and were, therefore, likely to turn over more regularly, whereas older RNs were less motivated by pay and were challenged by the demands of work, so consequently wanted to work less. Other participants did not think that the age of RNs affected their working motivations, instead saying it was more about “teamwork, appreciation and appropriate workload.” Most participants agreed that older RNs should continue to have an important role within nursing and that attention needed to be placed on developing more innovative roles, such as mentorship. One health leader commented that they wanted to see more “innovation” in how to “use the wisdom of our older nurses without burning them out.”

Discussion

In this discussion, we seek to integrate our findings in a way that would help healthcare providers to foster better RN retention in New Zealand. On the one hand, our analysis points to positive factors, which should be capable of retaining RNs. This includes being able to fulfil a cherished sense of caring, which is in line with the concept of value congruence where the values of RNs fit with those of their employer and are able to be realised in the work environment (Dotson, Dinesh, Cazier, & Spaulding, 2014). The findings regarding the importance of good working relationships with colleagues resonates with the role of social support at work in positively improving wellbeing and performance and reducing burnout and absenteeism (Frese, 1999). Additionally, the importance of experiencing supportive relationships with managers resonates with those studies that find that RNs with supportive supervisors and senior managers are more satisfied with their work and are more inclined to stay in their job (Ogle & Glass, 2014; van der Heijden et al., 2009). As with the preceding factors, findings that highlight the desire to work in a sector in which career development is fostered can ‘cut both ways’. Where RNs do perceive advancement opportunities, rather than intimidating barriers, these opportunities can make a positive impact on job satisfaction and occupational commitment (Price, 2001). These are factors that can be expected to attract RNs to the profession and to retain them in it.

However, our results also indicate that all these factors can turn out to be negative, repelling RNs from the profession. This occurs when the altruistic promise of a nursing career is dashed by a reality of excessive bureaucracy and unrelenting pressure, making it difficult to express a care-driven ethic. Similarly, the kind of collegial support one is primed to expect from workmates and

managers can be dashed by a reality of bullying, either because RNs are deficient in interpersonal skills in conflictual situations or are simply too busy to express themselves more competently. Furthermore, a desire for career progression can be unfulfilled due to barriers such as a lack of opportunity for vertical movement, caused by tight budgets, or lack of opportunity for lateral movement, caused by excessive regulatory requirements. The difficulty with our first set of factors is not that they are a threat to professional retention but that the experience of them can become negative in a heavily constrained or poorly managed environment.

Our second set of factors is more obviously negative and threatening in terms of RN well-being. They relate to heavy workload demands and to the relatively high incidence of bullying among RNs, which is likely to be associated, at least in part, with tensions relating to sharing the workload, and to the difficulty of achieving work-life balance. As in the research of Huntington et al. (2010), who reported that RNs had intense and demanding workloads, resulting in them feeling emotionally and physically exhausted, our findings point to the impact of workload in generating job dissatisfaction and an intention to leave the profession. Likewise, the findings of this study are consistent with research demonstrating that the level of abuse RNs are subjected to by patients and/or by colleagues connects to intentions to leave the profession (Sofield & Salmond, 2003). In addition, our findings are consistent with the view that work-life interference is associated with lower job satisfaction and greater turnover from the profession (Greenhaus, Parasuraman, & Collins, 2001). These are inherently unattractive aspects of working in the nursing profession in an era in which health demands are growing and in which bureaucratic demands on professionals are escalating, making it more difficult to focus on care-giving. On top of these negative trends, RNs are often employed in organisations that have 24/7 needs for patient care, making rostering issues problematic, and potentially conflictual, in any context. The challenge is one of managing these negative features of the work environment such that their negative impact is minimised or such that RNs regard them as positively managed in their organisation and in the nursing profession more generally.

Our third set of factors may seem to stand apart from the first two kinds, but this is not necessarily the case. In respect of the impact of a changing economic context, this may become less relevant if RNs are attracted by good opportunities for ongoing career development and consider that their needs for flexible working conditions are well-handled. Older RNs may be more inclined to stay if organisational practices in the area of work-life balance are sensitive to their desire to work fewer or more convenient hours or to play a mentoring and less hands-on role (Graham et al., 2014). Similarly, pay levels will be more positively regarded if RNs see them as fair compensation in the labour market and consistent with their level of skill, responsibility and experience in the health system itself.

Clearly, there are systemic issues involved in dealing with the factors identified, which present serious governmental, managerial, professional and personal challenges. Given the centrality of workload issues, the question of the adequacy of government funding of the health system needs to be at the top of this list. The level of funding leads, via the budgets of health care organisations, to staff/patient ratios, thus determining the quality of time that RNs have available for providing the kind of care that respects patients' values, needs and preferences (Boyle, Dwinnell, & Platt, 2005; Gerteis, Edgman-Levita, Daley, & Delbanco, 1993). Our results indicate that whether RNs feel that they have the time to express patient-centred values is

directly related to their level of occupational commitment. An associated issue for government is the impact of bureaucratic models of managing healthcare providers, which involve targets and bureaucratic controls. Although often established with good intentions, these forms of control can undermine the quality of professional work (e.g. Green, 2008) and, perversely, take time away from the 'real job', as our participants indicated.

Government funding, of course, will always entail some limit and governments are entitled to believe that at least some of the problem can be addressed by actions that health managers can, and should, take with a given level of funding to reduce nursing turnover and its costs. This includes, for example, better processes for training and support of RNs working in supervisory or management positions to help them to perform well in these roles. Supervisory and managerial support, like the quality of care, is another variable that can attract or repel. In partnership with educational institutions, unions and RNs themselves, management is also in a position to develop better approaches to bullying to assist RNs with conflict management under conditions of pressure. It is also open to management and unions to review current policies affecting work-life balance, which continue to frustrate the RNs in our sample. Scheduling flexibility, and workload balancing, is a complex issue but our results indicate that it is one of the keys to retaining RNs in their profession. Two groups stand out as needing special attention. One is that group of RNs seeking to balance career development, financial needs and care-giving for dependent children, and the other is the older cohort of RNs, who may be motivated by an ongoing interest in the work but who are averse to inflexible schedules or simply to too much work. Given that work-life interference increases intention to leave the profession (van der Heijden et al., 2009), this issue should be commanding a high level of attention in the health system.

Limitations

During the data collection, the interviewer's personal attributes such as age, body language, experience, or profession could have impacted on study participants' behaviour and responses. Because of the nature of this study, employees might have been hesitant to discuss sensitive issues regarding their employment for fear of jeopardising it. Confidentiality of participants was ensured to help counter this.

Conclusion

The combination of an aging population, the increasing prevalence of chronic disease and multimorbidity, and an aging nursing workforce are contributing to a looming global shortage of RNs. Our analysis of qualitative interviews of New Zealand RNs and nursing leaders has pointed to three sets of interrelated factors affecting nursing retention. There is a set of potentially positive factors, which should be capable of improving the retention of RNs, such as the opportunity to express a cherished value of caring, the experience of supportive relationships with work colleagues and managers, and the prospects of career development within and across the health sector. In an ideal world, these inherently attractive factors would underpin healthy levels of retention of RNs in their profession. The data show, however, that all these factors, if not experienced in reality, can turn out to be negative, repelling RNs from the profession.

A second set of factors is more obviously negative and unattractive, relating to heavy workload demands, to the relatively high incidence of bullying among RNs, which is likely to be related to work pressures, and to the difficulty of achieving work-life balance. Health funders, health managers, nursing unions, educational institutions and RNs themselves all have a role to play in addressing these threats to RN retention such that their negative potential is minimised or such that RNs regard them as positively managed in their profession.

A third set of factors concerns the impact of economics, in terms of the wider economic climate and the fairness of pay within the sector, and of nursing demographics. Dealing more effectively with the first two sets of factors should reduce the risks presented by these factors. Overall, our message is that RN retention is likely to improve when the inherently attractive features of the profession and the health sector are experienced as such and when the unattractive features of the profession and the sector are managed as positively as possible.

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