INVESTIGATING FLEXIBLE WORK ARRANGEMENTS

FOR NURSES AND MIDWIVES IN THE ACUTE HOSPITAL SECTOR

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Investigating flexible work arrangements

For nurses and midwives in the acute hospital sector

The Australian Workplace Innovation and Social Research Centre (WISeR) focuses on work and socio-economic change. WISeR is particularly interested in how organisational structure and practices, technology and economic systems, policy and institutions, environment and culture interact to influence the performance of workplaces and the wellbeing of individuals, households and communities.

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ACKNOWLEDGEMENTS

CONTENTS

LIST OF FIGURES

LIST OF TABLES

EXECUTIVE SUMMARY

PROJECT BACKGROUND

Achieving work life balance and spending quality time with our families is a target in South Australia's current strategic plan. SafeWork SA endorses this by encouraging the promotion of a work life balance culture and environment in the workplace. When this occurs, employers can improve their ability to attract and retain employees, which in turn enriches our health and wellbeing and builds stronger communities. Employers can help staff achieve work life balance by implementing flexible work arrangements.

SafeWork SA and the Australian Nursing and Midwifery Federation (SA Branch) commissioned this research project as part of the Work Life Balance Strategy. This work investigates strategies and cutting edge initiatives to implement and support flexible working arrangements in South Australian hospitals providing acute medical and surgical care.

LITERATURE OVERVIEW

Internationally recognised factors related to nurse and midwife shortages and high turnover include: work and the nature of the work environment (such as unit size and safety concerns, leadership style, other managerial and organisational factors and workplace stress and location); personal reasons (such as home and family, age and generation related, values and ethics and personal career opportunities and professional development); and economic reasons such as level of remuneration[1]. It is acknowledged that turnover rates vary dramatically between different types of nursing and midwifery units with turnover rates greatest for critical or intensive care units followed by surgical, paediatric and medical units.

Health Workforce Australia conducted a workforce planning analysis of supply and demand trends for doctors, nurses and midwives, noting the "likely continuation of health workforce shortages out to 2025 for doctors and nurses, with the magnitude of shortage likely to be highly significant for nurses and less so for doctors, with the midwifery workforce more likely to be in balance" (Health Workforce Australia, 2012, p.1).

Many nurses and midwives report that overwhelming workload, unclear career progression, inflexible working hours and low salary contribute to stress, dissatisfaction, burnout and injury in the workplace. Other implications of job stress and dissatisfaction include increased absenteeism and tardiness as well as poorer patient care. O'Brien-Pallas and colleagues commented, "excessive and unrelenting workload has been identified as the major cause of stress and dissatisfaction in the nursing workforce in Australia and overseas" (O'Brien-Pallas, Duffield, & Alksnis, 2004, p.299). This is because it interferes with a nurse's ability to provide a high quality of patient care. Heavy workloads can also lead to unsafe work environments and errors or near-misses in patient care. Particularly for more experienced, older nurses, high workload can also result in increased musculoskeletal problems.

Emerging from focus groups of Australian nurses, Buchanan and Considine found that increased patient turnover and acuity without adjusting staffing levels was a great source of stress for RNs. Patient safety and staff workload are inextricably linked with skill mix. Skill mix is defined as the proportion of RNs to total clinical nursing staff. It is argued that a lesser qualified skill mix may result in increased nurse turnover and unproductive time. Other factors of note to have an impact on nursing retention include unsafe work environments (often characterised by bullying and harassment by staff and patients), lack of recognition for work done, lack of autonomy, lack of support from managers and colleagues, lack of rewards, lack of leadership roles for nurses, and limited control over practice and scheduling (O'Brien-Pallas, et al., 2004).

According to Chang and colleagues, the lack of a 'family friendly' workplace is one of the major personal issues identified in Australia as influencing nursing retention. Having flexibility in work hours may improve a nurse's ability to cope with the demands of family roles and participating in a 7 day per week/24 hour coverage roster. Exploring flexibility in work arrangements - what this means, how it works, and what the implications are – is attracting increasing interest in the context of recruitment, retention and productivity in pressured workforces. Part time work is an increasingly attractive option for many workers, particularly older workers, striving to balance family and caring roles, and to manage mental and physical workloads across the life

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[1] Please refer to Appendix A for the complete literature review with full references.

course. Although, concerns have been expressed that increased flexible work arrangements or more part time staff can create a sense of staff being 'transient' which can reduce the perception of cohesiveness of ward staff which may impact on job satisfaction (Adams & Bond, 2000).

Leadership and management style and supervisory relationships are all themes frequently raised as enablers of, or indeed barriers to, nurse and midwife recruitment and retention, job satisfaction and successful implementation of flexible work arrangements and quality part time work.

O'Brien-Pallas and colleagues provide reflections on the Canadian nurse experience and acknowledge that many existing retention strategies are aimed at the needs of more junior staff members (e.g. scholarships, additional education, childcare facilities) and are less relevant and appealing to older nurses. At the same time, the composition of a senior nurse's workload is different to that of junior colleagues and usually entails providing direct patient care, managing the activities of the unit and mentoring junior or relief staff. Reconfiguring the work effort of older nurses (e.g. 50 years of age and older) could reduce stress, maintain interest in the work and increase career longevity thereby extending the benefits and experience older staff bring to the role. Some mechanisms that could help achieve this include: rotation through clinical areas where the workload is known to be lighter; offer extended breaks to cope with physical demands; offer financial incentives to compensate for increased responsibility; permit flexible self-rostering in order to achieve a balance between work and family commitments; and provide job sharing as an option, giving staff the autonomy to decide on how they split the position (O'Brien-Pallas, et al., 2004).

More broadly, Chang and colleagues proposed several strategies to support nurses with their role stress and high workloads. These included: use of stress education and management strategies, team building strategies, balancing priorities, enhancing social and peer support, flexibility in work hours, protocols to deal with violence and retention and attraction of nursing staff strategies. The findings from Parker and colleagues' mixed-method study looking at the challenges confronting Australian clinicians in acute care also suggest a need for management styles that focus on staff empowerment, participation and team building. Participatory management or shared decision making has been found to be an effective retention strategy increasing nurse job satisfaction.

Job satisfaction is a strong and consistent predictor of retention but it is a complex concept combining both work and individual determinants and has been found to differ across generations. Reasons for turnover are likely to fluctuate over time depending on the health professional's stage of life/career and the general labour market environment. Therefore, as acknowledged by Currie and Carr Hill, strategies identified to address shortages and turnover need to be numerous, multifaceted and flexible.

STUDY FINDINGS

This report presents the perspectives and experiences about flexible work arrangements (FWA) in the public and private acute care hospital sector in metropolitan and regional South Australia for 1,365 nurses and midwives completing an online survey. Interviews with senior management (Directors of Nursing) provided information about hospital policy and processes. Participants were predominantly female and half of the respondents were Baby Boomers (aged 48+ years).

WORK-RELATED STRESS

- One third of nurses and midwives reported they experienced *high workload*, *high self-expectations*, *negative communication* (with co-workers, patients or their family members) and pressure to *meet patients' needs* to a great extent.
- Stress, illness or injury did not usually result in nurses or midwives taking more than one day off work.
- Public hospital staff reported higher levels of work-related stress (e.g. due to workload too high, colleagues' inexperience and lack of management support) than private hospital staff.

ATTITUDES ABOUT WORK

- Most nurses and midwives agreed that *they are trusted and can work autonomously,* they *have good working relationships with people they work closely with*, and that they *communicate well with their nurse or midwifery manager/supervisor*.
- There remain a small proportion of nurses and midwives who did not feel adequately supported, satisfied or valued in the work environment.

- Three quarters of nurses and midwives reported they *experience many interruptions in their daily work routine* and/or they *perform many non-nursing or midwifery tasks.*
- Nurses and midwives in management roles were more likely than others to feel their *workload was too heavy* and that they have the *opportunity for career progression*; they were also more likely to believe there was *adequate patient care supplies and equipment*.

PERSPECTIVES ABOUT FWA

- Half of nurses and midwives had ever asked their manager to access FWA, with this more common in staff working in private hospitals.
  - More than one third of these did so principally to accommodate parenting responsibilities;
  - Around one tenth requested FWA due to personal illness, injury, disability or work stress; and
  - Less than one fifth asked for FWA because they preferred to work fewer hours or wished to increase leisure time.
- Approximately, one quarter of recent FWA requests were refused, most believed this was due to inflexible management, although there was recognition of the role *patient care requirements and workload constraints* played in decisions, in addition to *setting a precedent that others would want to follow* and *hospital policy limitations*.
- One quarter of those who were refused FWA reported they would not be willing to ask again.
- Of nurses and midwives who had not made a FWA request, one third were satisfied with the current arrangements. Very few were negatively impacted by hearing of other requests that had been refused – or the belief it would negatively impact on their career.
- Around one third of nurses and midwives indicated they managed staff in their current role, with more than half of these having been asked by staff for FWA. They indicated very few (4%) of the most recent requests had been refused.
  - Around half indicated the number of requests, the need to treat all staff equally and the impact on full time staff were broad-based barriers to implementing flexible work practices.
- Three quarters of nurses and midwives agreed *models of care need to change* if staff flexibility was to increase. Moreover, 5% of nurses and midwives indicated incompatibility with the model of care as a reason they have never asked for a FWA (nearly all of these employees worked in the public sector).

WORKPLACE CULTURE

- Nurses and midwives indicated a sense of equality in their workplace in terms of support and opportunities for part time and full time staff, with most believing both part and full time staff have the *same protections* (81.7% agreed[2]), access to *training* (69.2% agreed) and are *treated equitably* (63.2% agreed).
- However, many did not feel that they would be able to transition between full and part time work or have the opportunity to job share (or work part time if they wanted).
- More than half of respondents (58.6%) were *aware of the concept of quality part time work* but almost a third did not believe the concept was promoted in their workplace. However, the statement regarding promotion of quality part time work also generated the highest proportion of 'unsure or not applicable' responses (14.4%).
  - This discrepancy was also highlighted by Directors of Nursing who felt that they most certainly do apply the concept of quality part time work/FWA but that this is not always apparent to staff.

CAREER INTENTIONS

- More than 15% (n=216) of nurses and midwives planned to leave the profession within 5 years and 29% (n=397) within 5 to 10 years. The most common reasons for leaving within 5 years were: retirement (n=120), job dissatisfaction (n=91), physicality of nursing work (n=80), work-related stress (n=80), low staff morale (n=74) and lack of flexible work conditions (n=60).

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[2] Agreement includes the positive responses 'agree' and 'somewhat agree'.

- Directors of Nursing in publicly and privately funded hospitals from both regional and metropolitan areas recognised that being 'family friendly' and providing good flexible work arrangements (e.g. part time work, job sharing, compressed hours) were important strategies to minimise staff turnover and attract staff.
- A Director of Nursing at one public metropolitan hospital observed increased turnover in medical wards compared to other areas because they tended to be busier and the work was more demanding.
- Regardless of their geographical location or whether they are publicly or privately funded, many hospitals reported that it was a daily management issue to provide safe staffing levels and achieve the mandated staffing model set out in the applicable Enterprise Bargaining Agreement.
- Nursing/midwifery hours per patient day for inpatient wards are used as the general staffing method by most hospitals. This provides them with staffing which reflects patients' nursing and midwifery care requirements. Hospitals then tend to adjust the workload to reflect changes in the acuity of patients and additional clinical care requirements such as patients requiring a ratio of 1:1 clinical care.
- Hospitals had multiple strategies or resources for minimising staff health, safety and welfare issues related to high workloads. These ranged from basic, practical measures such as having good availability of resources and equipment to more successful evidence-based approaches focussed on improving teamwork, communication and safety.
- Hospitals also provided a range of workforce development, training and education programs.
- Staff satisfaction wasn't always formally or overtly monitored – particularly when it wasn't a key performance indicator. One hospital indicated the reason for this was, in part, because they didn't want to ask about things they couldn't deliver.
- There were regular opportunities for staff to provide feedback, including ward meetings, open hospital forums, anonymous feedback and exit surveys. Directors of Nursing conducted regular rounds of the hospital to increase their availability to staff.
- All hospitals agreed FWAs were available to all nursing and midwifery staff – but that it did need to be negotiated and fit the requirements of hospital, staff and patients.
- FWA were available in the form of part time work, compressed hours (mainly for those in management positions), shorter shifts, time off in lieu (TOIL), job sharing, purchased leave and access to leave at short notice.
- Most hospitals did not allow staff to have set shifts due to the issues this generates around needing to fill all shifts in a 24 hour period and fairness of shift allocation to full time staff – although night shift tended to be the exception to this. Most also accommodated shift requests recognising this was in everyone's best interests.
  - o The 'standard' alternative to not being able to offer set shifts is to employ that staff member as part of the casual pool where they can accept or decline any shift offered.
- Directors of Nursing tend to have final approval of any flexible work arrangement requests, but base decisions on the recommendation of the nurse or midwives' direct manager.
- While generally supported, FWAs were seen as impacting on other staff and on the hospital's ability to staff night duty. Moreover there was recognition that it is difficult to achieve a precise fit to accommodate both staff and hospital needs, that communication needs to be very good, and that clear accountability for specific tasks is more necessary.

CONCLUSION

- Turnover rates described by Directors of Nursing were generally lower than indicated in the literature (20%) although this may be a result of the current global economic conditions. Turnover did not seem to vary by location or staff position but there was general acknowledgement from Directors of Nursing of higher turnover in medical or surgical wards where the workloads tend to be greater.
- Regardless of the specific reasons why 45% of the participants intend to leave the nursing/midwifery profession within 10 years, this rate supports the likely nursing shortages projected by Health Workforce Australia (2012, p.iii): "Australia is likely to experience limitations in the delivery of high quality health services as a consequence of workforce shortages – highly significant in the case of nurses (109,000 or 27%)".
- The literature suggests job satisfaction and staff retention are negatively impacted by overwhelming workload, unclear career progression, inflexible working hours, low salary, limited autonomy, poor

communication and job dissatisfaction. However, these were not major factors for the nurses and midwives responding to our survey, most of whom reported being reasonably satisfied with their workplace, feeling valued by colleagues and recognised for their accomplishments with the opportunity for career progression.

- Factors of more concern included *experiencing many interruptions in daily work routines* and *performing many non-nursing or midwifery tasks* (more than 70% of nurses and midwives reported these aspects). Furthermore, at least half of the nurses and midwives reported that their *workload is too heavy* and they do not have *adequate patient care supplies and equipment*. These factors can result in the perception that patients are not receiving a high quality of care.

- There appears to be some disparity between how FWA are perceived by managers and other staff members. Some of this difference may be accounted for by a distinction between 'formal' and 'informal' requests. For example, a nurse or midwife may (informally) ask their line manager for a FWA with the discussion leading to the perception that the request would be denied and a formal application not being made.

- All senior management interviewed recognised that being 'family friendly' and providing good flexible work arrangements were important strategies to minimise staff turnover. Almost half of survey respondents had asked their manager for flexible work arrangements (FWA). Requests were more commonly made by private hospital staff compared to public hospital staff and parenting responsibilities were reported by one third as the main reason for the request. Although Directors of Nursing observed that nurses and midwives of all ages and backgrounds are interested in working reduced hours.

- Common responses from nurses and midwives about why a FWA had *not* been requested included they were *satisfied with current arrangements* or that they were working in a casual role where flexible hours are already built in. Interviews supported these findings by suggesting that a high proportion of nursing and midwifery staff (reported as between 45-80%) were already in part time positions and when certain requests could not be accommodated (e.g. working less than 2 days a week or wanting set shifts), Directors of Nursing recommend working as part of the casual pool.

- Concerns have been expressed in the literature that increased FWA or more part time staff can create a sense of staff being 'transient'. This notion was upheld by several Directors of Nursing who felt that high proportions of part time staff could interfere with continuity of care for patients as well as place greater responsibility and shift limitations on full time workers. Although it wasn't clear what 'high proportions' meant in a context where more than half the nursing and midwifery positions were already part time or casual.

- Fairness of requests and possible impacts on the workloads of others were key issues reported by managers in both the survey and interviews regarding barriers to implementing FWA – although 'fairness' appeared to be geared more toward full time than part time staff.

- Interviewees were not always able to articulate what is best practice when it comes to implementing flexible work arrangements. However several focused on the central role of management such as good management who shares the organisation's values and organisational leaders who have a vision

RECOMMENDATIONS FOR FUTURE WORK

- To address the perceived disconnect between leadership, middle management and workers in the context of 'formal' and 'informal' requests for FWA we suggest the development of management tools to better handle and manage requests and the provision of more information and training to middle management.

- Almost one quarter of nurses and midwives in private hospitals and 10% of those in public hospitals employed self-rostering techniques. We suggest further investigation of self-rostering, what it looks like and how nurses and midwives experience them.

- To complement the knowledge provided by Directors of Nursing regarding the nature of flexible work arrangements and how they work in their hospital, it would be useful to develop specific, real case studies around successful FWA.

- Three quarters of nurses and midwives agreed *models of care need to change* if staff flexibility was to increase. This is a significant finding and warrants exploration of current models and possible alternatives.

- The physicality of nursing and midwifery as well as the adverse effects of shift work are some factors which take a greater toll on older nurses and midwives. Interviews with Directors of Nursing suggested no real formal strategies or policies were in place to assist older workers. Thus we suggest the development

of practical policies and guidelines for the work, health and safety of the ageing nurse and midwifery population.

- Findings also suggest the need to improve transition to retirement policies and succession planning in general.
- Directors of Nursing identified career progression and choice of tasks as particularly important to Generation Y staff. We suggest building in such characteristics to workforce planning in order to optimise recruitment and retention of younger nurses and midwives.
- Managers were twice as likely as other staff to be employed full time. Investigation of how managers perceive their work life balance and their experience of flexible work arrangements in senior positions would be informative.
- Upwards of half the nurses/midwives surveyed felt they experience many interruptions in their daily work routine, they perform many non-nursing or midwifery tasks, their workload is too heavy and they do not have adequate patient care supplies and equipment. These factors can culminate in perceptions that patients are not receiving a high quality of care. We recommend strategies be developed to address these issues to prevent staff stress and job dissatisfaction and prevent poor patient outcomes.
- Quality part time work (QPTW) is part of a whole of organisation approach. We recommend improving awareness and promotion of the QPTW concept, perhaps through staff development training or the provision of guidelines at staff meetings for negotiating and managing QPTW.

1   QUALITY PART-TIME WORK

By promoting a work life balance culture and environment in the workplace, employers can improve their ability to attract and retain employees, in turn enriching our health and wellbeing and building stronger communities (SafeWork SA, 2012).

Achieving work life balance and spending quality time with our families is a target in South Australia's current strategic plan (Government of South Australia, 2011). 'Quality jobs' whether they are part time or full time provide benefits to employers that include increased labour productivity, healthier workforces, greater workforce stability, reduced sickness and absenteeism, safer workplaces, and more engaged employees. Quality employment can also bring enhanced recruitment and retention of experienced and skilled staff, increased workforce morale, productivity and efficiency and a range of benefits associated with becoming an employer of choice (Barnett & Hordacre, 2011).

People choosing or working part time should not be disadvantaged in comparison to their full time colleagues. They should have equivalent (pro rata) access to entitlements and opportunities, as indicated in Figure 1.

FIGURE 1: EQUALITY OF FULL AND PART TIME WORK

Source: Barnett & Hordacre 2011.

Part time work is a key means of achieving flexibility in work hours and in balancing caring and work responsibilities, particularly for working mothers. At the same time this flexibility can assist employers to adjust to the ebb and flow of demands in particular work environments. Quality part-time work provides a critical mechanism for smoothly managing major transitions across the life course. It can mean the difference between working and not working, and for successfully balancing work and other key life responsibilities. Across the life course, individuals seek part time work because it allows them greater flexibility and opportunity to deal with personal commitments such as study, raising children or caring for other relatives and to transition to retirement. While part time work suits many, others would prefer to work more hours. Recognising and responding constructively to these differing needs is important in attracting and retaining employees.

It is beneficial and cost-effective for employers to draw on the existing skills of part time staff, as well as full time staff. For the employer, flexible work arrangements can help retain skilled workers (albeit at a lower level) and reduces the cost of recruitment. Further, utilising existing skills harnesses previous investments in education and training.

Employers can help staff achieve work life balance by implementing flexible work arrangements which encompass: flexitime; quality party time work; career, study and community participation breaks; compressed working hours; rostered days off; job sharing; time off in lieu; purchased leave; grandparents leave; term time; working from home; paternity leave, employee choice rostering; and flexible annual leave (SafeWork SA, 2011).

Around half the female workforce in South Australia is employed part time, and around 90% of the nursing workforce is female – so while this isn't a woman's issue it does have a particular salience for the nursing workforce. Successfully addressing the challenges and balancing the workforce and workplace needs will help improve womens' workforce participation rates, which in turn will lessen the impact of expected labour and skills shortages as retirement of the baby boomer generation looms.

2 INVESTIGATING FLEXIBLE WORKING ARRANGEMENTS

SafeWork SA and the Australian Nursing and Midwifery Federation (SA Branch) commissioned this project as part of the Work Life Balance Strategy. This work investigates strategies and cutting edge initiatives to implement and support flexible working arrangements in South Australian hospitals providing acute hospital care.

The research design includes:

- A literature review to identify issues specific to nurse and midwife recruitment, retention and productivity in the acute care sector, with reference to work health and safety issues associated with workload pressures and work patterns. The review is available in Appendix A.
- An online survey seeking the perspectives of nurses and midwives working in the acute hospital sector with questions developed from the literature review and in consultation with SafeWork SA's Employer Reference Group[3].
- Interviews with Directors of Nursing from a selection of public and private acute hospitals in metropolitan and regional settings to determine the fit between hospital policies about flexible work arrangements and the perspectives and experiences of nurses and midwives as captured through the survey.

3 NURSES AND MIDWIVES IN SA HOSPITALS

According to the 2011 Census of Population and Housing (Australian Bureau of Statistics, 2011), in Australia there are three times the number of nurses and midwives (n=239,288) than medical practitioners (n=70,226). Per capita, South Australia had the highest rates of all States and Territories of nurses and midwives, and medical practitioners.

More than half of the nursing/midwifery workforce are employed by hospitals. For example, in 2011 n=169,824 nurses and midwives worked in an inpatient hospital setting and worked an average of 33.1 hours per week (Australian Institite of Health and Welfare (AIHW), 2012).

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[3] This includes representatives from the Australian Nursing and Midwifery Federation (SA Branch), SA Health, Business SA and private hospitals.

A total of 1,365 nurses and midwives from public and private hospitals in metropolitan and rural South Australia completed the online survey about flexible work arrangements in the South Australian acute care hospital sector. This section provides the perspectives and experiences of these nurses and midwives. Details about the survey methodology are available in Appendix B.

Consistent with the overall gender representation in the profession, 90% of the 1,365 survey participants were female (Australian Institite of Health and Welfare (AIHW), 2012). Both males and females had an average age of 46 years[4] (ranging from 21 to 74 years of age), with no significant age difference between the genders. Baby Boomers (aged 48+ years)[5] made up half the group, with about a third from Generation X (aged 33-47 years) and the smallest cohort from Generation Y (aged 18-32 years).

Staff had worked as a nurse or midwife on average for 20 years, with a wide range of experience (from 0 to 50 years). Accordingly, qualifications as a registered or enrolled nurse or a midwife were gained from 1965 through 2013. In terms of their occupation, more than three quarters of respondents were registered nurses (n=1052) followed by enrolled nurse/advanced skills enrolled nurses (n=158; 11.6%), registered midwives (n=101; 7.4%) with a small number from another nursing or midwifery classification (n=54; 4.0%).

Three-quarters of staff were born in Australia (n=17 identified as being of Aboriginal or Torres Strait Islander background). Of the 337 people born overseas, the majority were born in the United Kingdom (see Figure 2 for a breakdown of birth country other than Australia). Consistent with this demography, 93% of all staff spoke English as their first language.

FIGURE 2: COUNTY OF BIRTH, OTHER THAN AUSTRALIA
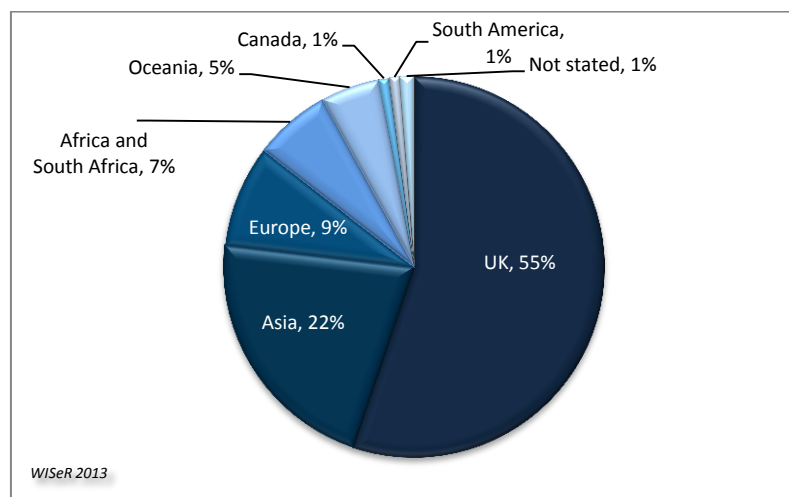
Note, n=337, Oceania includes New Zealand and Papua New Guinea.

Nurses and midwives were drawn from across the acute hospital sector, but most commonly worked in medical, surgical and 'other' surgical units (see Figure 3). Responses were gained from a broad spectrum of nursing/midwifery classifications (see Figure 4) with Level 1 – registered nurse or midwife being the most frequent (37.5% of respondents) and Level 2 – clinical nurse or midwife, the next most common (16.3%).

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[4] The average age of all employed nurses in Australia is 43.7 years (AIHW, 2012).
[5] There appears to be a greater representation of older nurses in the current sample compared to what occurs in the broader profession. For example, in 2011 33% of all nurses and midwives in Australia were aged 50 or older (AIHW, 2012).

FIGURE 3: WARDS/AREAS WHERE STAFF PRIMARILY WORK

Ward/area	%
Gynaecology	0.4%
Primary care	0.7%
Day services	1.0%
Recovery	1.2%
Rehabilitation	1.5%
Geriatric/aged care	1.5%
Other non-acute care	1.7%
Outpatient/Radiology	2.0%
Oncology	2.1%
Paediatrics	3.2%
Cardiology	3.2%
Mental health	6.1%
Obstetrics	6.7%
Peri-operative	7.6%
Emergency	7.7%
Critical Care	7.9%
Management/admin/education	8.9%
Surgical	10.8%
Other speciality units	12.6%
Medical	13.3%

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FIGURE 4: CLASSIFICATION/CATEGORY OF CURRENT MAIN JOB

Classification	%
Level 3 - occupational health nurse	0.1%
Level 4 - advanced education/ skill development	0.1%
Level 4 - advanced service coordinator	0.1%
Level 4 - advanced clinical practice consultant	0.1%
Level 4 - advanced management facilitator	0.4%
Level 4 - nurse practitioner	1.1%
Graduate nurse	1.6%
Level 5 - nursing or midwifery director	2.3%
Level 3 - educational/skill development	2.7%
Advanced skills enrolled nurse	3.1%
Level 3 - management facilitator	3.7%
Level 3 - clinical practice consultant	4.4%
Level 2 - associate clinical service coordinator	7.2%
Enrolled nurse	8.4%
Level 3 - clinical services coordinator	8.4%
Level 2 - clinical nurse or midwife	16.3%
Level 1 - registered nurse or midwife	37.5%
Other	2.5%

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3.1 WORK PATTERNS

Nurses and midwives were primarily employed on a permanent part time (50.4%; working an average of 28.8 hours per week) or permanent full time (40.5%; working an average of 40.4 hours per week) basis, working an overall average of 33 hours in a week (Table 1 provides a breakdown of hours worked by employment type). While permanent full time staff worked the most (an average of 40.4 hours per week) the workload for other employment contracts was similar and quite high.

Of note, respondents from private hospitals were more likely to be employed on a permanent part time basis (62.7%) compared to those working in public hospitals

(48.8%). Hospital staff in a management role were twice as likely to be employed as permanent full time than staff without any management responsibilities.

TABLE 1: SUMMARY OF HOURS WORKED PER WEEK BY EMPLOYMENT CONTRACT

Employment contracts	Number of staff	Average hours worked in week prior to survey	Range of hours worked in week prior to survey
Permanent full time	553	40.4	0 - 100
Permanent part time	688	28.8	0 - 100
Fixed term contract	47	34.2	0 - 70
Casual contract[6] and other	77	34.2	0 - 60
ALL	1365	33.3	0 - 100

Fifty-four percent of nurses and midwives worked over a 24-hour roster with permanent part time staff most likely to do so (31.0%), followed by permanent full time (17.6%), casual contract and other (3.4%), and fixed term contract staff (2.1%). This finding was consistent for both public and private hospital staff.

Departmental or unit/ward based rostering[7] was the predominant type of rostering used for both public and private hospitals surveyed but self-rostering[8] was also fairly common for private hospital respondents in particular (see Figure 5). For those staff indicating they work over a 24-hour roster, the most common responses for 'other' rostering systems (n=32) tended to be a combination of unit/ward and self-rostering (n=19) where staff would submit their requests for shifts/hours and then the nurse/midwifery manager or similar would finalise the roster. However, staff indicated variability as to how often the requests were granted and some indicated the roster had to be changed at times if the "skill mix wasn't great". Four staff were part of a casual pool where they indicated their availability.

Thirty-nine nurses and midwives *not* working over a 24-hour roster indicated using a different rostering system to those listed. The most common methods provided were working set hours or day (n=10), not having fixed hours or working in an agency or casual pool (n=10) while seven indicated a combination of unit/ward and self-rostering.

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6 About 5% of participants were on casual contracts. This compares to about 25% Australia-wide where more than one in four Australian workers are in casual employment. Voltz further noted that "casualisation is an increasingly problematic trend in the workplace. Casual jobs attract an hourly rate of pay but offer very few other rights and benefits, such as the right to notice, the right to severance pay and most forms of paid leave. Casualisation in the workplace has been further fuelled by the introduction of the Federal Government's industrial relations laws by way of lifting award restrictions and broadening employer power. This reform as a means for flexibility has encouraged instances of increasing casualisation in individual workplaces, thus reinforcing the increasing uncertainty and instability within the labour market" (Voltz, 2007, pp2203-2204).

[7] This system is a centralised scheduling approach conducted by a single manager.

[8] This involves a negotiation among nurses and midwives.

FIGURE 5: TYPES OF ROSTERING SYSTEMS USED BY HOSPITAL FUNDING
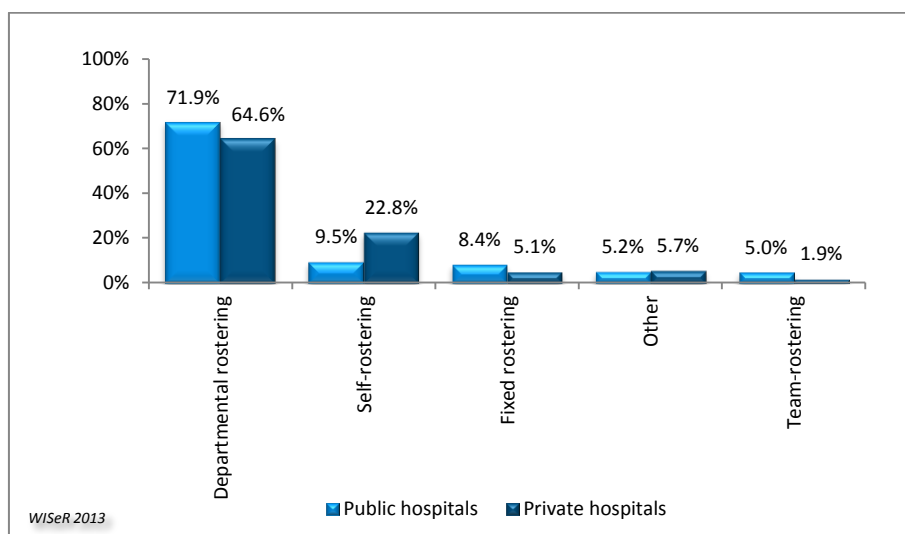
As for the actual shifts worked, earlies (between 7am and 3pm) were most widespread and split shifts[9] the least (see Figure 6). However, day shifts (between 9am and 3pm) were most numerous in terms of having '5 or more' shifts in a week.

FIGURE 6: SHIFTS WORKED IN THE WEEK PRIOR TO SURVEY COMPLETION
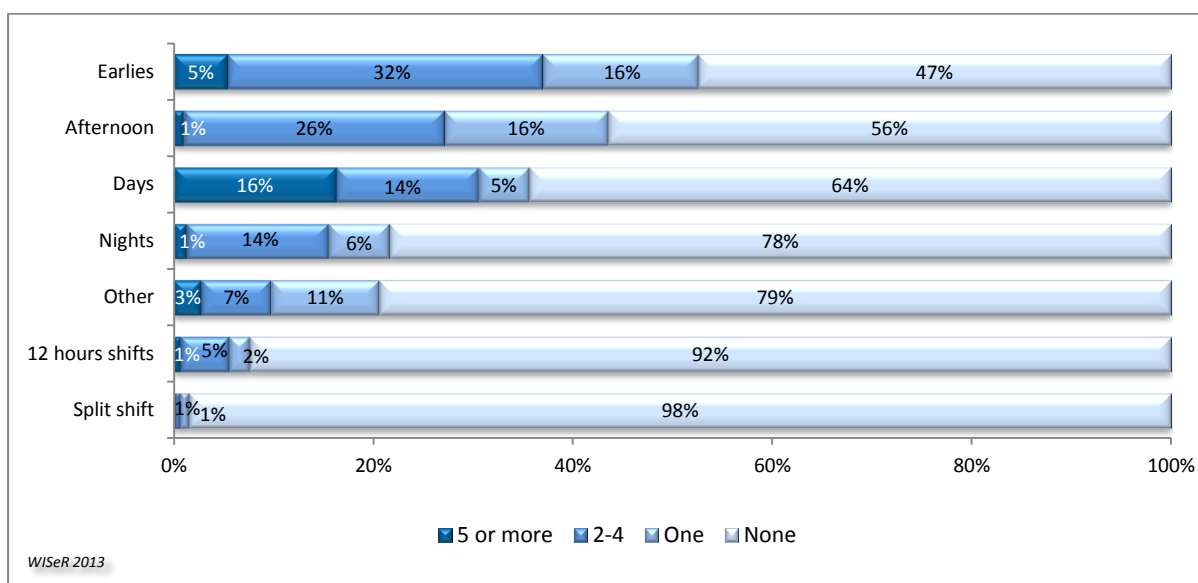
Around a third of nurses and midwives did not usually work weekends[10] at all, and about a quarter each worked either two or three weekends a month (see Figure 7). Compared to public hospital staff, nurses and midwives from private hospitals were twice as likely to work all four weekends of a month (6% and 12% of the staff cohort, respectively); more than half of management did not work any weekends in a month compared to a quarter of other staff; and younger workers (less than 45 years old) were more likely to work on weekends than older workers.

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[9] Please note that technically a 'split-shift' is not a recognised employment condition in South Australia. Responses to this may have indicated an emergency situation.
[10] The survey question did not ascertain whether nurses and midwives *elected* to work on weekends. It is observed that penalty rates apply on weekends and thus may make working weekends a positive scenario for some staff.

FIGURE 7: NUMBER OF WEEKENDS USUALLY WORKED IN A MONTH

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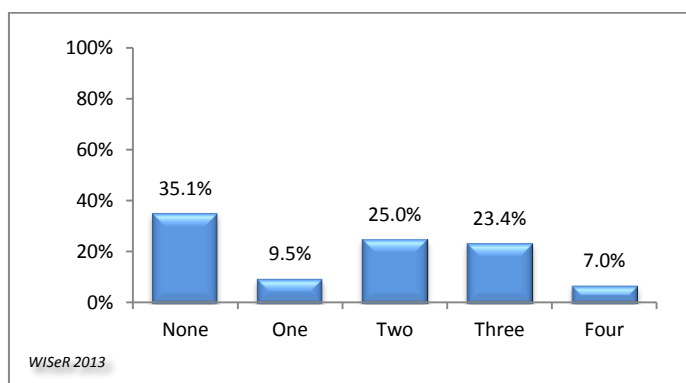
3.2 HEALTH AND SAFETY ISSUES OF WORKLOAD PRESSURES

As shown in Figure 8, there were many sources of work-related stress for nurses and midwives. *High workload*, *high self-expectations*, *negative communication* and the pressure of *meeting patients' needs* caused the greatest amount of work-related stress for nurses and midwives with a third or more of staff reporting these were experienced to a great extent. More than a quarter of nurses and midwives also reported experiencing a *lack of management support*, *colleague's inexperience* and *lack of resources and equipment* to a great extent.

In contrast, *lack of job security*, *amount of pay*, *lack of social support* and *ambiguity about authority* were experienced very little or not at all (around 50% of respondents reported in this way).

Despite the extent of work-related stress experienced, this rarely translated into leave taken. Most common was taking one day off because of stress, illness or injury (see Figure 9).

Staff from public hospitals (3.0)[11] were significantly more likely to feel stressed by *negative communication* compared to private hospital staff (2.8) while managers (2.4) were significantly less likely than other staff (2.6) to report stress due to a *lack of teamwork or social support at work*. Younger workers felt significantly more stressed than older workers by *high self-expectations* (3.3 and 3.2, respectively), *negative communication* (3.0 compared to 2.9) and *amount of pay* (2.7 compared to 2.5). Overall, no one particular group of nurses or midwives tended to take more/less leave due to work-related stress, illness or injury.

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[11] Note the rating scale used for contributors to work-related stress was: 1=Not at all, 2=Very little, 3=Somewhat and 4=Great extent. Individuals responding 'unsure or not applicable' were excluded when calculating the average to compare group differences.

FIGURE 8: CONTRIBUTION OF PARTICULAR ELEMENTS TO WORK RELATED STRESS
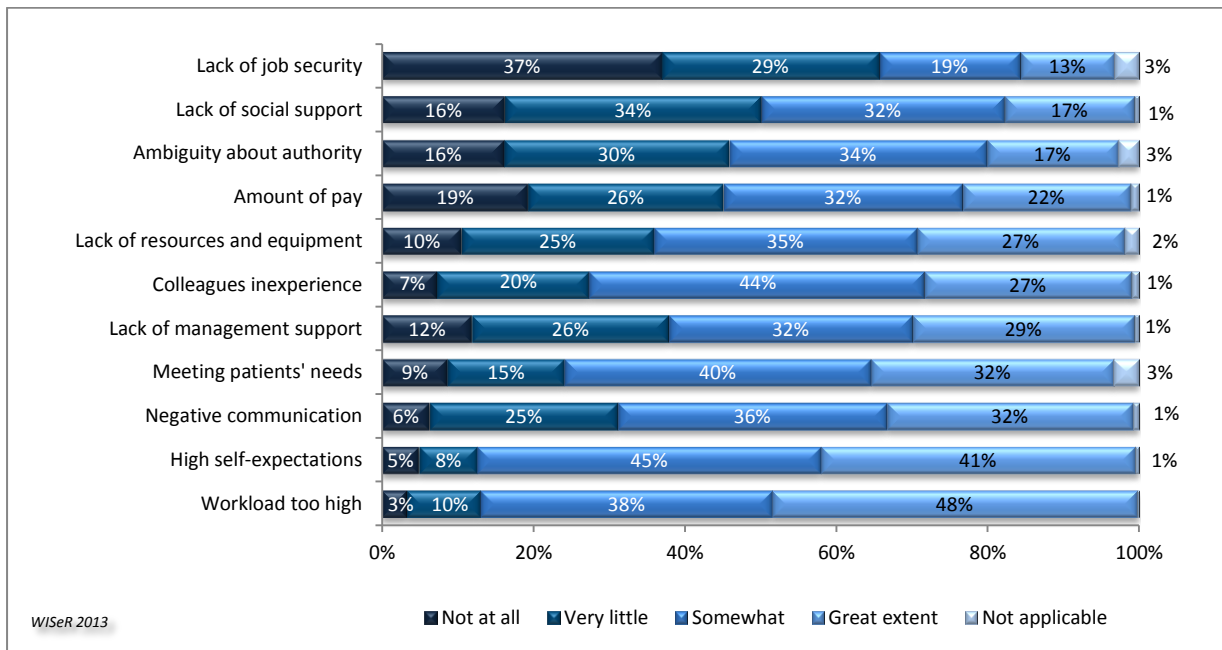
FIGURE 9: NATURE OF LEAVE TAKEN DUE TO STRESS, ILLNESS OR INJURY
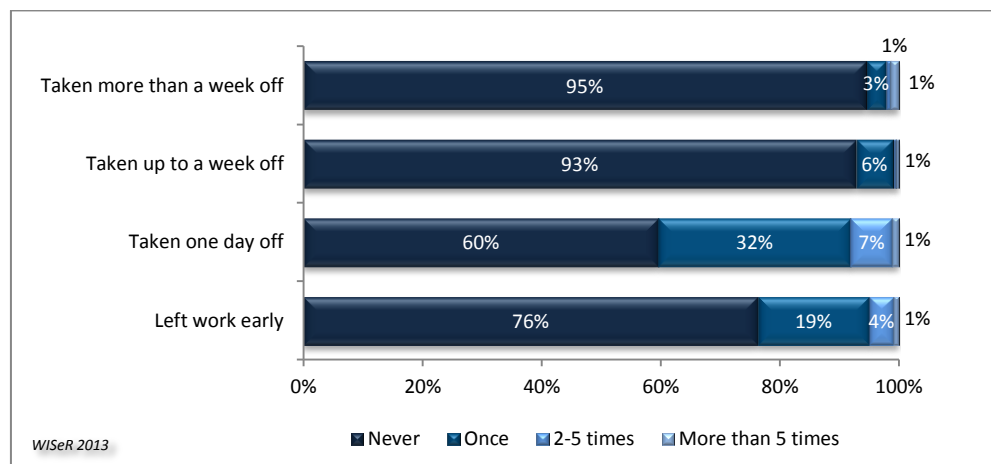
3.2.1 GENERAL ATTITUDES ABOUT WORK

Overall, nurses and midwives were positive about their work (see Figure 10):

- 93.9% agreed[12] *they are trusted and can work autonomously*;

- 88.9% agreed they *have good working relationships with people they work closely with*;

- 82.7% agreed they *communicate well with their nurse or midwifery manager/supervisor*;

- 70.5% agreed they *are satisfied in their job*[13];

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[12] Agreement includes the positive responses 'agree' and 'somewhat agree'.
[13] 16.8% disagreed to some extent, 12.1% neither agreed nor disagreed and 0.5% reported unsure or not applicable. Of the 89 respondents who indicated they are *not* satisfied in their job, 7.6% were older nurses and midwives compared to 4.9% of younger nurses and midwives. Very similar proportions of managers/other staff and public/private hospitals were represented in the 'disagree' group.

- 69.2% agreed *their work is valued by colleagues*;

- 65.0% agreed *they work in a supportive environment*[14];

- 58.1% agreed *their manager recognises their accomplishments*; and

- 51.4% agreed *there is opportunity for career progression*[15].

While this is a generally positive response, there remain a small proportion who did not feel adequately supported, satisfied or valued. It is also of note that one quarter of nurses and midwives did not feel that their manager recognised their accomplishments.

Less than 10% of nurses and midwives considered their work to be *too difficult* but more than three-quarters of respondents (76.9%) agreed (at least to some extent) that they *experience many interruptions in their daily work routine*, 72.1% indicated they *perform many non-nursing or midwifery tasks* and 58.2% reported their *workload is too heavy*. Half of the nurses and midwives (50.1%) agreed they have *adequate patient care supplies and equipment* – although one-third did not feel this was the case.

FIGURE 10: ATTITUDES ABOUT WORK
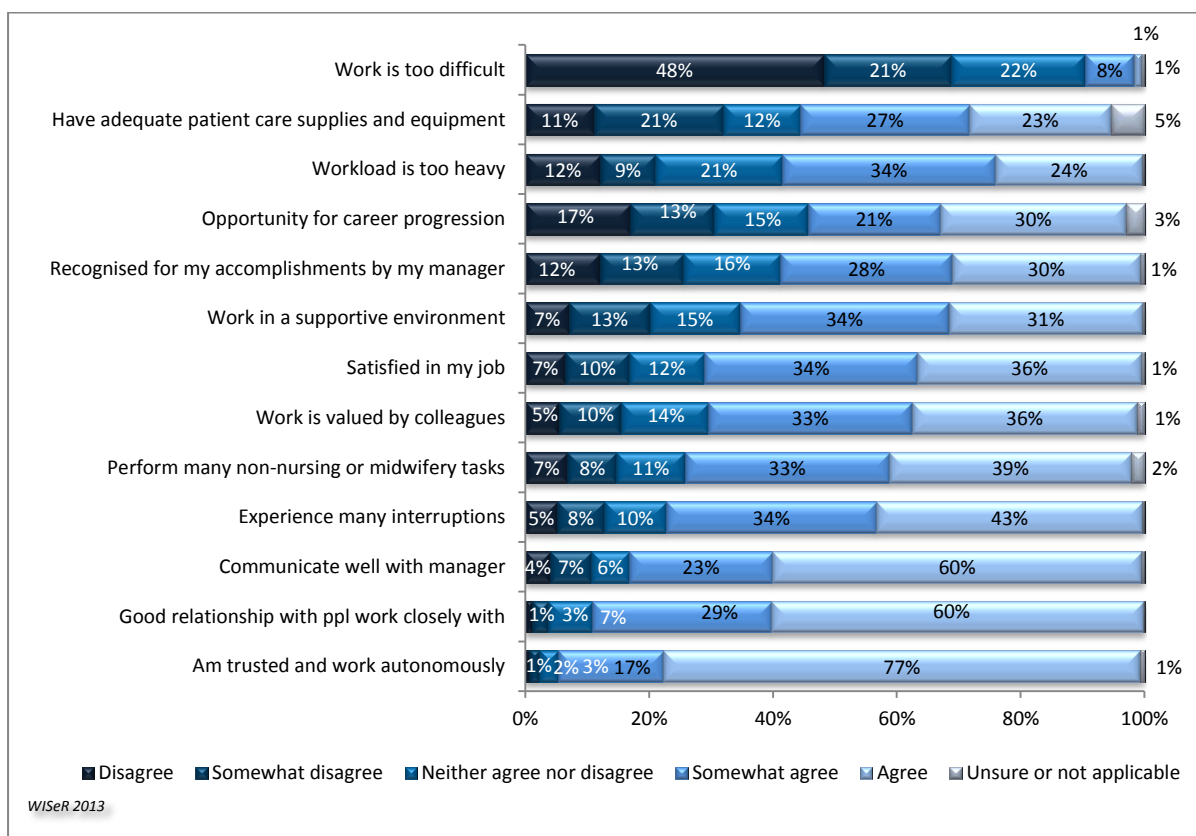
Note, rounding errors may occur.

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[14] 20.1% disagreed to some extent, 14.5% neither agreed nor disagreed and 0.4% reported unsure or not applicable. Of the 97 respondents who indicated they do *not* work in a supportive environment, 8.6% were older nurses and midwives compared to 4.7% of younger nurses and midwives and 6.8% worked in public hospitals compared to 9.5% in private hospitals. Very similar proportions of managers/other staff were represented in the 'disagree' group.

[15] 30.5% disagreed to some extent, 15.2% neither agreed nor disagreed and 3.0% reported unsure or not applicable. Of the 232 respondents who indicated there is *not* opportunity for career progression, they tended to be older staff (18.7% compared to 14.3% of younger staff), in non-management positions (18.5% compared to 13.7% of managers) and from private hospitals (20.3% compared to 16.6% of public hospital staff).

Differences in work attitudes between managers and other staff are shown in Figure 11. Highly significant differences were found regarding views that *my workload is too heavy* and *I have the opportunity for career progression*. In both instances, managers were more likely to agree with these statements. Managers were also more likely to agree that they *have adequate patient care supplies and equipment*. This can indicate a disconnect between the experiences of those working 'on the floor' and those with management responsibilities on these items.

There were no statistical differences between the attitudes to work of staff from public or private hospitals. In terms of age-related differences, younger workers were significantly more likely to report that *my work is too difficult for me* (average response=2.0) than older workers (average response=1.9).

FIGURE 11: ATTITUDES ABOUT WORK BY ORGANISATIONAL ROLE
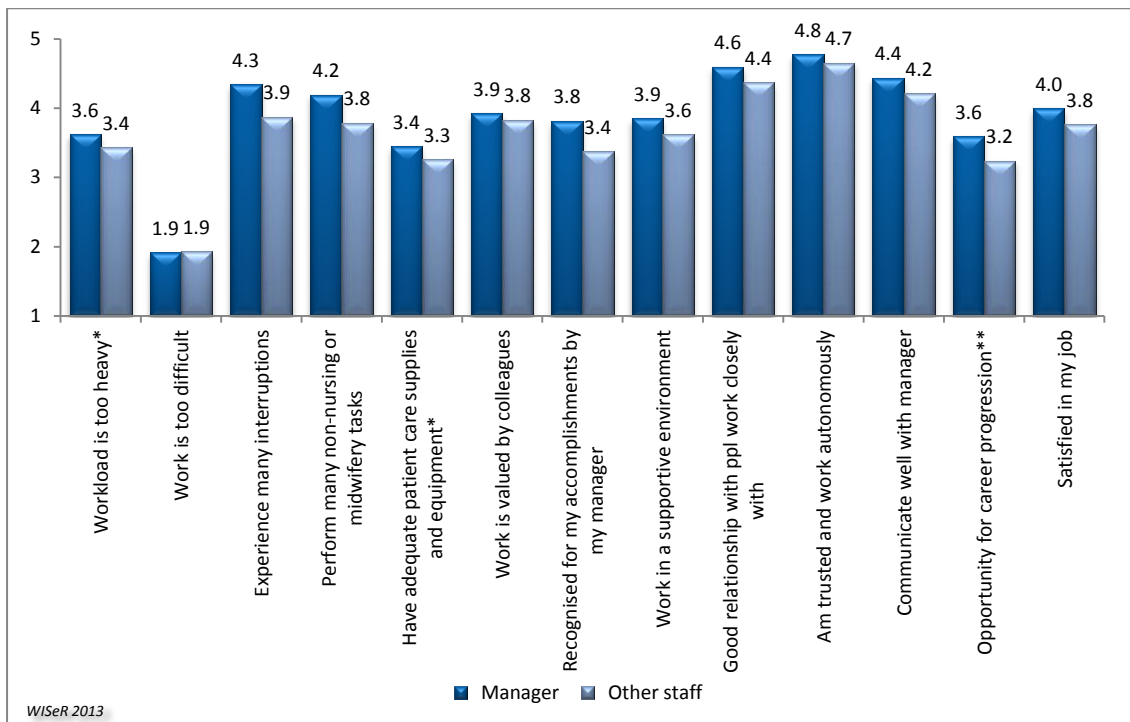
Note the rating scale used for workplace culture was: 1=Disagree, 2=Somewhat disagree, 3=Neither agree nor disagree, 4=Somewhat agree, and 5=Agree. Individuals rating 6=Unsure or not applicable were excluded when calculating the average to compare group differences.
***denotes a highly significant difference and *a significant difference.*

3.3 ATTITUDES AND EXPERIENCES OF FLEXIBLE WORK ARRANGEMENTS

3.3.1 'STAFF' PERSPECTIVE

Almost half (47.6%) of nurses and midwives had asked their manager to access flexible work arrangements (FWA)[16]. Requests were more commonly made by private hospital staff (60.1% of those making a request) compared to public hospital staff. Parenting responsibilities were reported by one third (35.2% of 650 requesting FWA) as the main reason for the request with another caring role reported by 5.2% as the reason for seeking FWA (see Figure 12). Almost sixteen percent indicated they either preferred to work fewer hours (8.2%) or increase their leisure time (7.7%) while more than ten percent requested FWA due to personal illness, injury or disability (6.8%) or work-related stress (4.2%). Fifty-eight people cited 'other' reasons for requesting FWA, the more common of which included: staff balancing a combination of work-life elements such as caring for children *and* relatives or to

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[16] In this instance FWA refers to a decrease in work hours.

manage personal illness *and* volunteer work (n=11); accommodating system limitations such as to reduce overtime or "avoid accruing time off in lieu which are not allowed to take" (n=7); and facilitation of working another part time job elsewhere (n=4).

On the whole, the most common reasons for requesting FWA were similar for nurses and midwives working in both public and private hospitals and for managers compared to other staff. However, managers were more likely to report *caring for older or disabled relatives* as a reason for requesting FWA, reflecting the older age of nurses and midwives in management positions.

FIGURE 12: REASONS FOR REQUESTING A FLEXIBLE WORK ARRANGEMENT
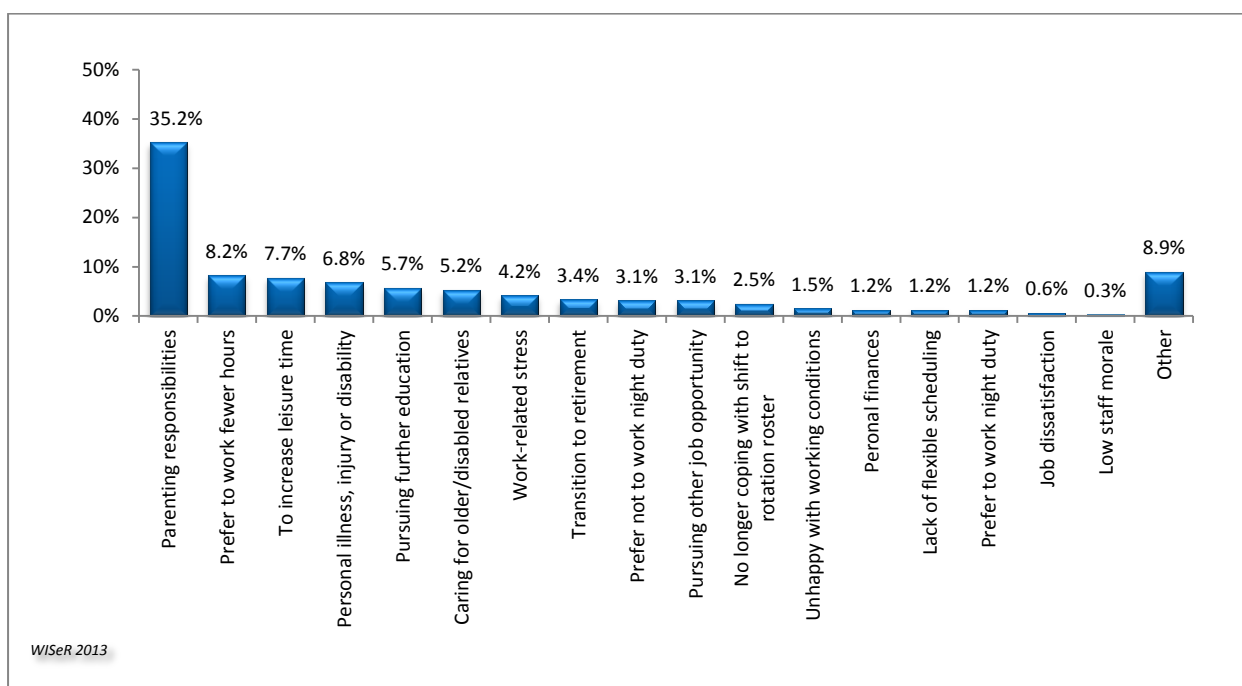
Note, respondents were asked to select the one option that best applies. Results are from 650 participants who reported requesting FWA.

Nurses and midwives indicated slightly less than a quarter (22.0%) of FWA requests were refused. The principal reason reported by nurses and midwives for refusal was *inflexible management*, which was reported by 23.8% of the 143 who were refused (see Figure 13). However, there was also recognition of the role *patient care requirements and workload constraints (15.4%)* played in decisions, in addition to *setting a precedent that others would want to follow* (14.0%) and *hospital policy limitations* (11.9%). 'Other' reasons provided for a refused request referred to contract specifications or they were simply "told [they] have to be available to work" (n=6 of 14 reporting 'other' reasons).

There were no significant trends in terms of the proportion of, or reason for, request refusals between types of hospital (public or private), management position compared to other staff or age of worker (older or younger).

Approximately two-thirds of nurses and midwives who requested FWA previously would make a request again in the future. Previous request refusal does not appear to have influenced the willingness to request in the future; 20.9% of those who have experienced a request refusal indicated willingness to request FWA again compared with 23.9% of those with a request refusal *not* willing to request again in the future.
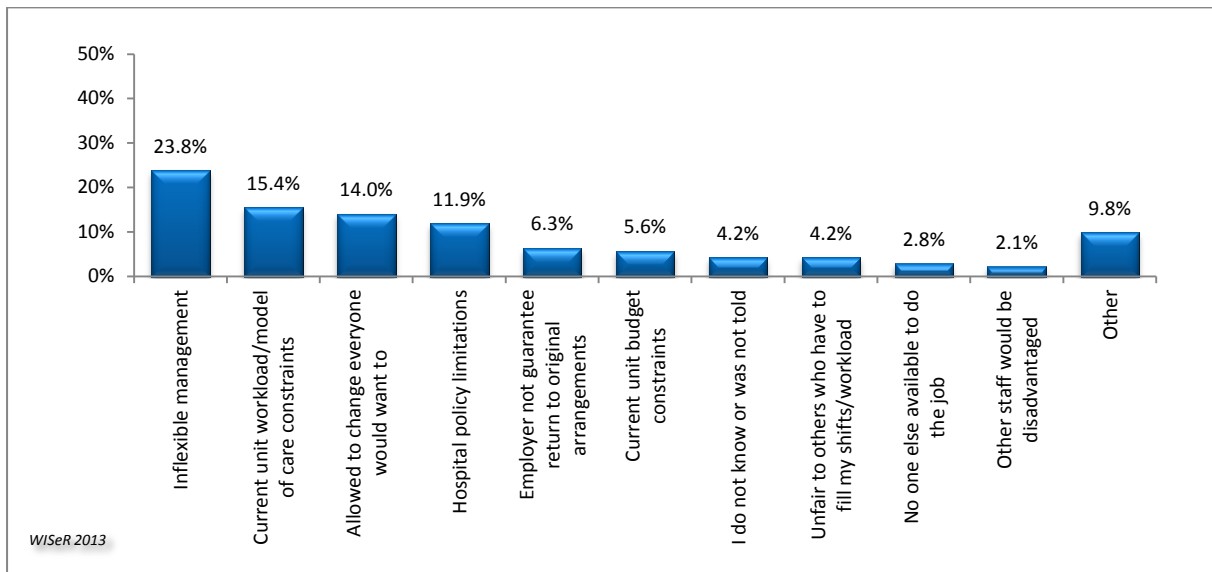
Note, respondents were asked to select the one option that best applies. Results are from 143 participants who reported requesting FWA.

One third (33.8%) of the 715 nurses and midwives who had not made a FWA request were *satisfied with current arrangements* (see Figure 14). In keeping with this, more than 10% indicated that the *roster system provides adequate flexibility*[17]. Around 5% of staff reported they would not ask for FWA because reduced hours *would not fit the model of care* provided by their unit or because they were aware *previous requests by others had been refused* (4.5%). Sixty-five people indicated specific 'other' reasons for not making a request, the most common was due to working in a casual role where flexible hours are already built-in (n=10).

FIGURE 14: REASONS WHY STAFF HAVE NEVER ASKED FOR FLEXIBLE WORK ARRANGEMENTS
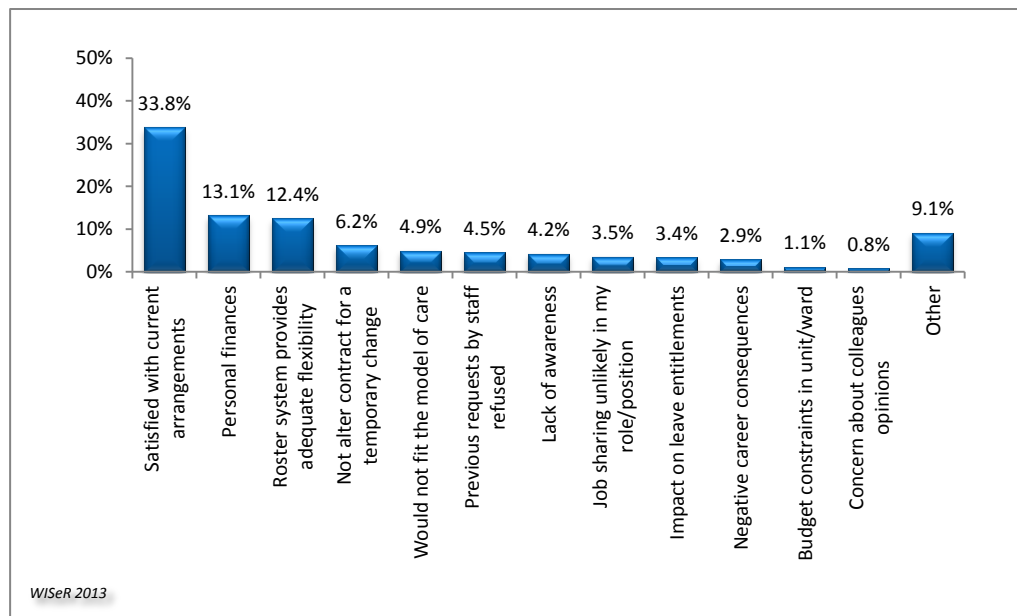
Note, respondents were asked to select the one option that best applies. Results are from 715 participants who reported not having requested an FWA

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[17] The main reasons for having never asked for FWA were similar for all groups: public and private hospital staff;; management staff and other staff; and younger and older nurses and midwives.

3.3.2 MANAGEMENT PERSPECTIVE

Around a third of respondents (n=431) indicated they manage staff in their current role. Fifty-eight percent of these 'managers' had been asked by staff for FWA and reported only a small proportion (4.0%) of the most recent requests were refused (see Table 2).

TABLE 2: OUTCOME OF FLEXIBLE WORK ARRANGEMENT REQUESTS TO MANAGERS BY HOSPITAL TYPE

Type of hospital	Manage staff (N)		Staff ever made a FWA request (N)		Most recent FWA request refused (N)	
	N	%	N	%^	N	%*
Public Hospital	384	89.1	223	58.1	7	3.1
Private Hospital	47	10.9	27	57.4	3	11.1
TOTAL	431	100.0	250	58.0	10	4.0

^denominator is number of respondents managing staff (n=431)
*denominator is number of staff requested FWA (n=650)

The most common broader-level barriers to implementing flexible work practices reported by nurses and midwives who managed staff were dealing with *numerous requests* (49.7%; also see Figure 15), *the need to treat all staff equally* (48.5%) and that *by granting some staff reduced overall hours, the full time staff get all of the unpopular shifts* (46.2%). Interestingly, budgetary issues (reported by 38.5%), difficulties in supervision (25.8%) and no agreement on new models of care (18.3%) could be overcome by policy development and implementation.

Seventy 'managers' reported not experiencing any barriers and this group showed relatively equal representation of public and private hospital staff and both 'young' and 'older' workers.

FIGURE 15: BARRIERS TO IMPLEMENTING FLEXIBLE WORK PRACTICES ACCORDING TO MANAGERS
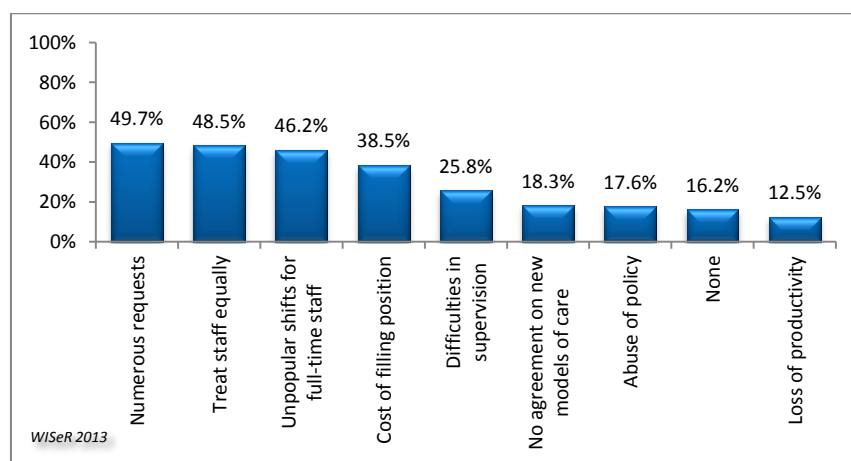
Note, respondents could select all options that apply.

3.3.3 IMPACT OF INCREASING STAFF FLEXIBILITY

More than three-quarters of all responding nurses and midwives (77.7%) agreed *models of care need to change* if staff flexibility was to increase (see Figure 16). Around one-quarter believed increased staff flexibility would impact on their freedom to *decide how I do my work* (23.0% agreed to some extent) and that *more satisfied staff lead to improved patient care* (22.5% agreed to some extent).

There was little variation in responses by hospital type (public or private). However, there was a highly significant difference in responses between managers and other staff -

managers (3.4)[18] were more likely than other staff (average response=3.2) to agree that increasing staff flexibility would lead to *increased responsibility for full time staff*. The only other significant group difference was that younger workers (3.5) were significantly more likely to agree that increasing staff flexibility leads to *more opportunities for me to do interesting work* compared to older workers (3.2).

FIGURE 16: IMPACTS OF INCREASING STAFF FLEXIBILITY
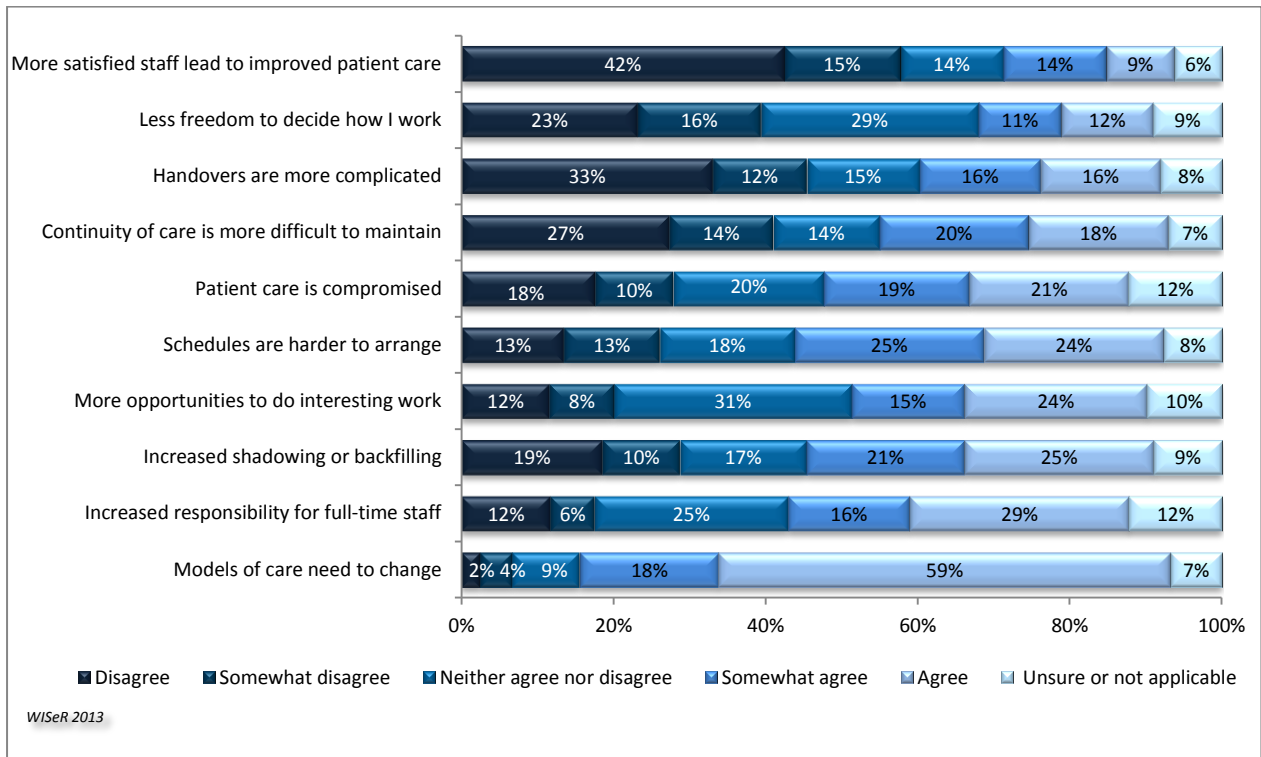
3.3.4 CULTURE OF WORKPLACE

Nurses and midwives indicated a sense of equality in their workplace in terms of support and opportunities for part time and full time staff. Three quarters (81.7%) agreed[19] that *nursing/midwifery staff who work part time have the same protections as the full time workforce*. Around two-thirds (69.2%) agreed that *nurses/midwives who work part time are encouraged to participate in training programs and apply for promotion* and that *part time nurses/midwives are treated no differently to those who are full time*[20] (63.2%; see Figure 17).

At the other end of the spectrum, around a third of staff disagreed[21] that they were *able to job share or work part time if I want (33.2%)* and nearly half indicated nurses/midwives cannot *move between full time and part time work as they require* (44.3%). While around one third of nurses and midwives did not feel they *work predictable hours* (31.9%).

More than half the respondents (58.6%) agreed that they were *aware of the concept of quality part time work*. However, less than a third reported that their *employer promotes*

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[18] Note the rating scale used for staff flexibility was: 1=Disagree, 2=Somewhat disagree, 3=Neither agree nor disagree, 4=Somewhat agree, and 5=Agree. Individuals responding 'unsure or not applicable' were excluded when calculating the average to compare group differences.
[19] Agreement includes the positive responses 'agree' and 'somewhat agree'.
[20] 24.8% disagreed to some extent, 10.1% neither agreed nor disagreed and 1.9% reported unsure or not applicable. Of the 133 respondents who believe part time staff *are* treated differently to full time staff, 10.9% are not in management positions compared to 7.2% in management positions. Very similar proportions of younger/older staff and public/private hospital staff were represented in the 'disagree' group.
[21] Disagreement includes the responses 'disagree' and 'somewhat disagree'.

the concept of quality part time work. The latter statement also generated the highest proportion of 'unsure or not applicable' responses (14.4%)[22].

Similar proportions of staff (approximately 60%) agreed to some extent that they *have enough flexibility in work hours to take care of personal needs*, their *employer recognises that staff have a life outside work*, they were *happy with existing arrangements supporting work life balance*, and that *preferred shift patterns are usually accommodated*.

In terms of trends for different groups of respondents, private nurses and midwives (with a rating of 3.2) felt they had significantly greater ability to *move between full and part time work* than public hospital staff (2.9)[23]. Private staff (3.7) were also significantly more likely than public hospital staff to agree they were *happy with existing arrangements supporting work life balance*.

The most numerous response differences were observed between those who manage staff and those who don't (see Figure 18). 'Managers' were significantly more likely to agree that:

- *nurses/midwives can move between full time and part time work as they require;*

- *in my workplace, I am happy with existing arrangements supporting work life balance; and*

- *my employer promotes the concept of 'quality part time work'.*

In contrast, managers were significantly less likely to agree that they are *able to job share/work part time if I want*.

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[22] It is not known what the awareness and promotion perceptions are of quality part time work in other sectors.
[23] Note the rating scale used for workplace culture was: 1=Disagree, 2=Somewhat disagree, 3=Neither agree nor disagree, 4=Somewhat agree, and 5=Agree. Individuals responding 'unsure or not applicable' were excluded when calculating the average to compare group differences.

Figure 17: Workplace culture

	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Unsure or not applicable
Promotion of quality part-time work	18%	12%	23%	13%	18%	14%
Can move between full and part time work	27%	18%	10%	19%	23%	5%
Preferred shift accommodated	12%	11%	11%	28%	32%	6%
Happy with work life balance	13%	18%	12%	24%	33%	1%
Recognises life outside work	13%	15%	12%	23%	37%	1%
Enough flexibility for personal needs	13%	16%	9%	23%	38%	1%
Able to job share	26%	7%	8%	13%	39%	7%
Aware of quality part-time work	12%	7%	13%	17%	42%	9%
Work predictable hours	22%	10%	7%	16%	44%	1%
Part-time treated the same as full-time	10%	15%	10%	17%	46%	2%
Part-time encouraged to participate in CPD and promotion	8%	10%	10%	17%	52%	3%
Part-time staff have same protections as full-time	4%	6%	5%	13%	68%	3%

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FIGURE 18: WORKPLACE CULTURE BY ORGANISATIONAL ROLE
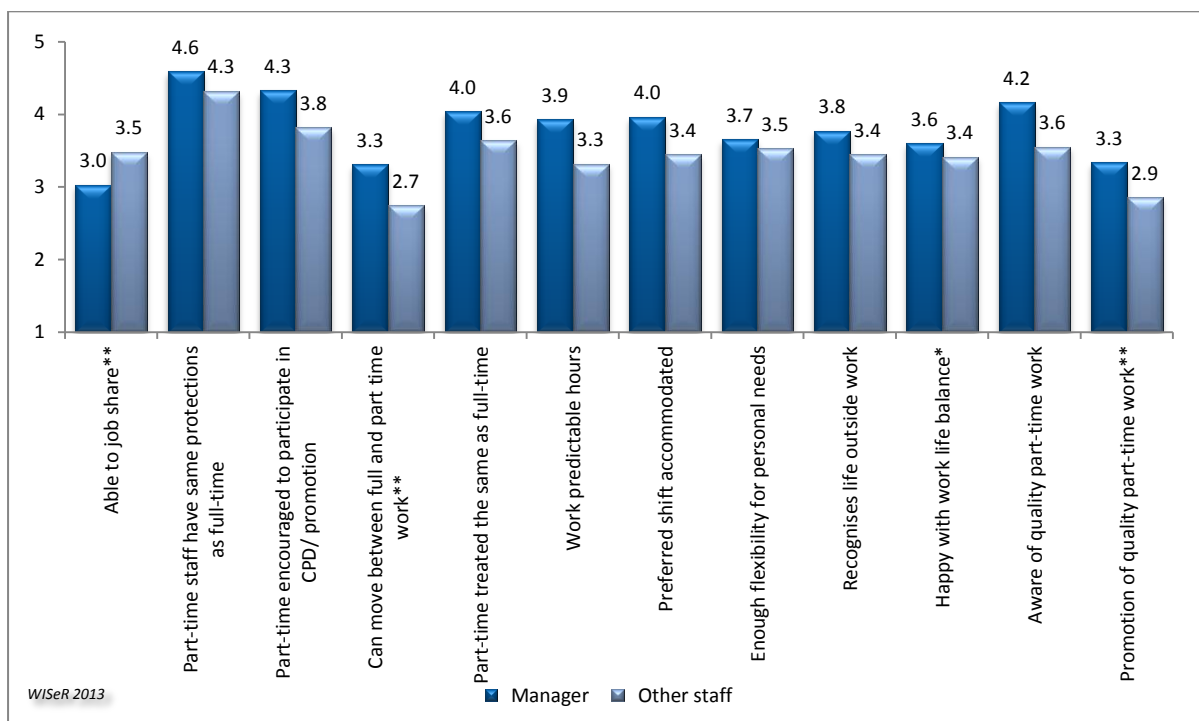
	Manager	Other staff
Able to job share**	3.0	3.5
Part-time staff have same protections as full-time	4.6	4.3
Part-time encouraged to participate in CPD/ promotion	4.3	3.8
Can move between full and part time work**	3.3	2.7
Part-time treated the same as full-time	4.0	3.6
Work predictable hours	3.9	3.3
Preferred shift accommodated	4.0	3.4
Enough flexibility for personal needs	3.7	3.5
Recognises life outside work	3.8	3.4
Happy with work life balance*	3.6	3.4
Aware of quality part-time work	4.2	3.6
Promotion of quality part-time work**	3.3	2.9

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Note the rating scale used for workplace culture was: 1=Disagree, 2=Somewhat disagree, 3=Neither agree nor disagree, 4=Somewhat agree, and 5=Agree. Individuals rating 6=Unsure or not applicable were excluded when calculating the average to compare group differences.
**denotes a highly significant difference and *a significant difference.

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3.4 CAREER PREFERENCES

Just over half of the respondents indicated that they were *not* intending to leave the nursing/midwifery profession within 10 years (55.1%; see Figure 19). However, this response in large part could be accounted for by the fact that those not leaving were significantly younger (average age of 42.4 years) than those planning to leave in the next 5 to 10 years (average age of 50.5 years) and those planning to leave in the next 5 years (average age of 52.3 years). In keeping with these characteristics the main reason provided for intending to leave the profession within 10 years was *retirement* (see Figure 20). Around a third of staff also indicated that the *physicality of nursing work*, *work-related stress* and job dissatisfaction were also reasons why they intended to leave within 10 years. In addition*, lack of flexible work conditions* and *low staff morale* were reported by nearly a quarter of these respondents.

Seventy-three respondents reported 'other' reasons for intending to leave the profession within 10 years. The more common specific responses to this category included governance issues such as "unqualified management", "poor autocratic leadership" and "meaningless hospital hierarchy" (n=11), too many non-nursing duties (especially paperwork; n=6) and safety concerns such as aggression and violence towards staff including bullying (n=5)[24].

For the almost 16% of nurses and midwives planning on leaving the profession within 5 years, retirement remained the most reported reason but they were approximately twice as likely to report *job dissatisfaction*, *low staff morale* and 'other' reasons than those planning on leaving between 5 and 10 years (see Figure 21).

FIGURE 19: CAREER INTENSIONS

Yes, within 5 years, 15.8%

Yes, in the next 5 to 10 years, 29.1%

Not within 10 years, 55.1%

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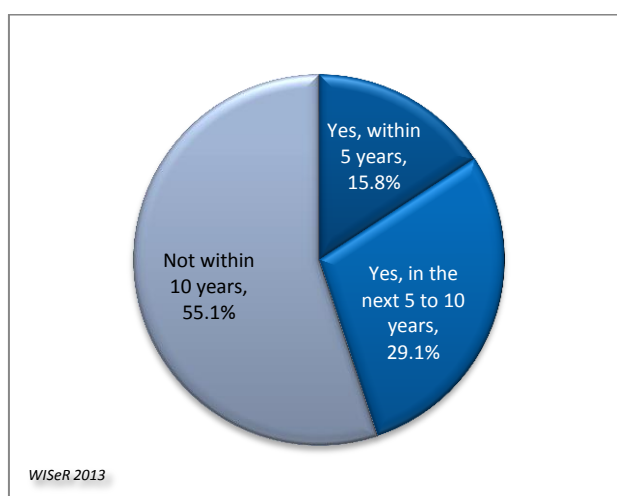
[24] An Australian study investigating workplace aggression among nurses found 63.5% of nurses registered with the Nursing Board of Tasmania had experienced some form of aggression in the four working weeks prior to completing the survey. Patients/clients or their visitors were the main perpetrators of verbal/physical abuse followed by medical and nursing colleagues. Abuse influenced nurses' distress, their desire to stay in nursing, their productivity and the potential to make errors (Farrell, Bobrowski, & Bobrowski, 2006).

Note, respondents could select all options that apply.

FIGURE 21: REASONS FOR CONSIDERING LEAVING THE NURSING/MIDWIFERY PROFESSION BY TIMEFRAME
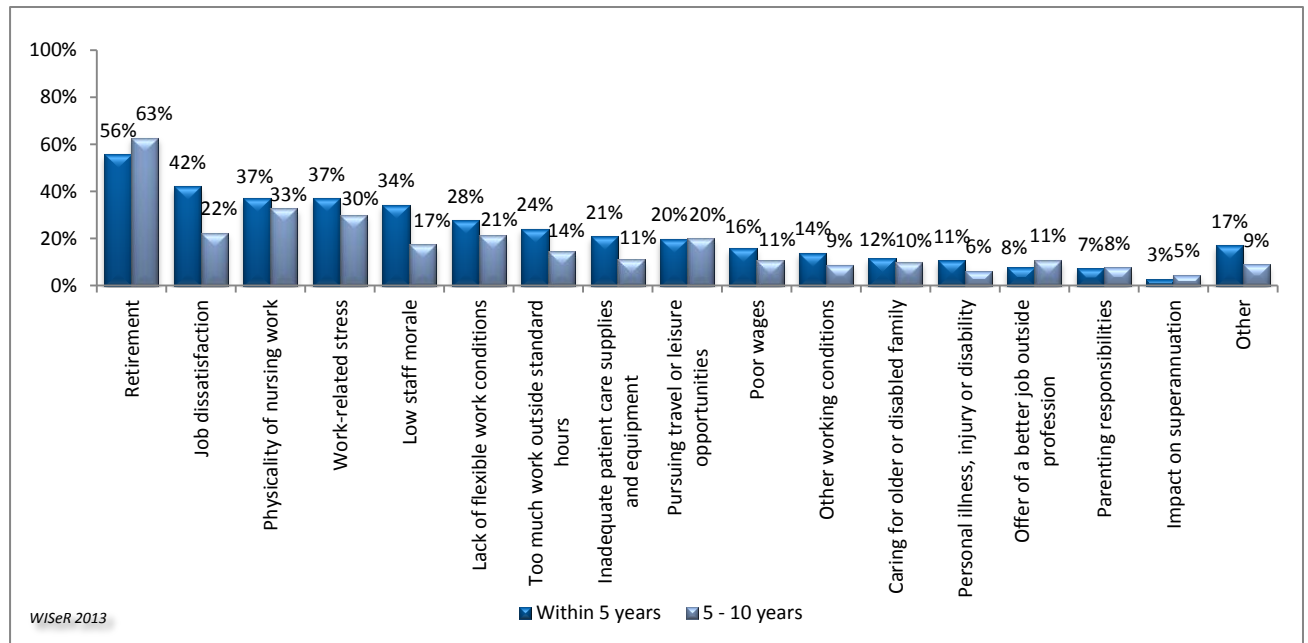
Note, respondents could select all options that apply.

4 HOSPITAL POLICY AND PROCESSES

Interviews were conducted with senior hospital staff to provide an organisational policy perspective on flexible work arrangements. Details about the interview methodology are available in Appendix B.

Interviewees had been in a Director of Nursing position for an average of 7.1 years (ranging from 18 months to 16 years). Just under half had worked at the same hospital for a longer period and progressed through the ranks. The majority of interviewees were female. Table 3 provides a breakdown of where interviewees were conducted, predominantly from publicly funded, larger hospitals.

TABLE 3: NATURE OF HOSPITALS WHERE INTERVIEWEES WORKED

Funding	Location	Number of beds				TOTAL
		0-50	51-100	101-200	201+	
Public						
	Metropolitan				3	**3**
	Regional	1	1	1		**3**
Private						
	Metropolitan				2	**2**
	Regional*					
TOTAL						**8**

*There are not a lot of private regional hospitals; where they do exist they tend to be co-located with a public hospital and staffed by publicly funded nurses and midwives.

4.1 LABOUR SHORTAGE ISSUES

Staff turnover ranged from around 2% (a private metropolitan hospital) to 11% (a public metropolitan hospital) with several noting turnover had slowed in the last 12 months, likely in part to the national and global economic conditions. A private metropolitan hospital highlighted that they would not want turnover to fall below their current rate of 5% as they believe this is a healthy rate for an organisation as "new blood is good for promoting innovation". A public metropolitan hospital also made the distinction between turnover and vacancy rate; their turnover was around 11% but the hospital has had no staff vacancies for the last five years. Another public metropolitan hospital observed increased turnover in medical wards compared to other areas because they tended to be busier and the work was more demanding.

Regional hospitals also reported a reasonably stable workforce with minimal turnover although none nominated an actual figure with one hospital expressing that they did not measure staff turnover as it was not a key performance indicator (KPI). An additional contributing factor to staff retention for these hospitals is their relative physical isolation and employees having other reasons for being in that location. In most cases, it is simply not practical for staff to travel to another hospital to work. The availability of free car parking and staff feeling 'comfortable' was also mentioned by one regional hospital.

STRATEGIES AND RESOURCES

Publicly and privately funded hospitals from regional and metropolitan areas recognised that being 'family friendly' and providing good flexible work arrangements (e.g. part time work, job sharing, compressed hours)[25] were important strategies to minimising staff turnover. Moreover, these arrangements were important not only to working mothers but all staff whether they are caring for older parents or grandchildren or simply trying to achieve a better lifestyle.

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[25] Please note that there is a separate section to follow devoted to Flexible Work Arrangements

Valuing staff was another factor mentioned by a public and private metropolitan hospital where the workforce is considered as "the most valuable resource". Having operational senior management who engage with staff regularly and offering staff opportunities for development were also identified as strategies by one private metropolitan hospital. A public metropolitan hospital agreed that having frequent feedback opportunities were useful for nipping any issues in the bud and thereby retaining staff. Four hospitals from both metropolitan and regional areas indicated recruitment or "a need to be conscious of forward planning" as another strategy.

RECRUITMENT

Related to the topic of staff retention is staff recruitment and whilst this was not included as a specific question, at least half of the interviewees initiated a discussion about this, some in response to the issue of minimising staff turnover.

Across metropolitan hospitals in particular, overseas recruitment was raised as an issue. Overseas recruitment was fairly common 5 or 6 years ago when demand for nurses/midwives was greater than the supply. However, several hospitals encountered issues with this method of recruitment. Not only is the recruitment process lengthy (for example, 1-2 years), but a private metropolitan hospital found that when a staff member did start with the organisation, their work arrangements were not flexible as they had to fulfil Temporary Work (Skilled) 457 visa requirements[26]. Two public metropolitan hospitals also found that overseas recruitment led to cultural issues, such as nurses/midwives not speaking English at work with other nurses/midwives of the same nationality and nurses/midwives from eastern cultures tended to be submissive to other medical staff and not challenge decisions. For one public metropolitan hospital, these types of issues led to the implementation of a 'cultural competence' program for all staff.

Consequently, there is currently very little overseas recruitment in most of the hospitals interviewed and if so, it is targeted recruitment for very skilled staff. Alternatively, many hospitals have a strong graduate model. A public metropolitan hospital realised that when they held vacancies in specialised areas and it was difficult to find nurses/midwives with those skills, they had to re-evaluate their expectations of staff and increase their tolerance of a low knowledge base. They also responded by offering more programs to up-skill junior staff. The Director of Nursing at this hospital described the key to this process as providing support and knowing the skills or knowledge that you want your staff to have.

For regional hospitals there was acknowledgement of the need to be self-reliant in terms of staff and that they cannot "tap into agency staff" in times of high workload or in unforseen situations. One regional hospital indicated that they had not used agency staff for the last 8 or 9 years.

A public metropolitan hospital also referred to funding as a potential barrier to recruitment and retention in terms of funding uncertainty (i.e. only being able to offer short-term contracts) and lack of funds to improve facilities, therefore making it more difficult to compete with other hospitals that have more modern theatres and so on.

4.2 STAFFING AND WORKLOAD

SKILL MIX

For all hospitals interviewed, staffing and skill mix is largely determined by the Nursing/Midwifery (South Australian Public Sector) Enterprise Bargaining Agreement (EBA) 2010[27]. This states a skill mix for general inpatient units as 70% registered nurses (RNs)/registered midwives (RMs) to 30% enrolled nurses (ENs)/assistants in nursing or

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[26] For more information about this go to http://www.workingin-australia.com/visa/information/457
[27] This agreement was effective from 9 December 2010 to 30 June 2013 and is currently under review/being negotiated.

midwifery[28]. There is some flexibility in this ratio and a focus on staffing to demand (i.e. the skill mix may be adjusted should any role, service requirement or change in service volume occur; Government of South Australia, 2010). At least one of the private hospitals also appeared to be working towards this particular skill mix ratio (the other did not go into detail).

Regardless of geographical location or whether they are publicly or privately funded, many hospitals find that it is a daily management issue to provide safe staffing levels and achieve the mandated staffing model set out in the EBA. Several hospitals often staff above this skill mix (e.g. 78% RNs to 22% ENs) but financial pressures often require it to be brought back down. One regional hospital believes the key to managing workloads rests with RNs, especially in speciality areas.

Another regional hospital actively engages with students and graduates to achieve appropriate skill mix[29]. They have recently focused their attention on ENs through a cadet program in an attempt to improve EN utilisation. This hospital has a "grow your own" staff approach (especially for midwives) so that you can actively manage staff education to reflect community need. A public metropolitan hospital shared similar views and noted that younger generations like clinical education so they are particularly encouraged to obtain post graduate qualifications and are offered free modules to complete. These views tie in with the general support for providing staff development opportunities to improve recruitment and retention (described in an earlier section).

However, one public metropolitan hospital commented on the flip side of supporting and providing education to staff - ENs tend to train to become RNs so it can actually be difficult to find enough ENs to fill positions. The EBA brought in the 'Advanced Skills EN'[30] role but according to this Director of Nursing it has not been enough to maintain nurses in an EN position and it is highly variable as to what 'advanced skills' means across wards.

STAFFING MODELS

Nursing/midwifery hours per patient day (NHPPD) [31] are used as the general staffing method by most hospitals. This provides them with staffing which reflects patients' nursing and midwifery care requirements. Hospitals then tend to adjust the workload to reflect changes in the acuity of patients and additional clinical care requirements such as patients requiring a ratio of 1:1 clinical care (patient acuity is typically reviewed by a nurse/midwifery manager). Four hospitals – both metropolitan and regional - named Excelcare[32] as being the main mechanism for implementing this method of staffing resource calculation. The majority of these hospitals drew attention to the known disadvantages of Excelcare (also discussed in the EBA, see page 8) such as it is a subjective system and the quality of the data used to predict staffing need is dependent on the quality of the data that goes into the system with some nurses/midwives overestimating the length of time tasks take and some underestimating. The system requires regular auditing if it is to be of any use.

At least two hospitals (one regional and one private metropolitan) used manual (i.e. not computerised) workforce planning systems. Included in one of these was a 'forward planning' document which factored in staff maternity leave, annual leave and so forth.

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[28] For more details please refer to p.11 of the agreement:
http://www.nursingsa.com/pdf/Nursing/Nursing_Midwifery_Enterprise_Agreement_2010.pdf.
[29] Please note the EBA (2010) states "graduate nurses/midwives are to be included in the RN/M ratio but are not, unless otherwise agreed between the parties, to be rostered as the only registered nurse/midwife in a health unit site or patient care area in the first 6 months of employment" (p.11).
[30] For more information about this go to http://www.nursingsa.com/pdf/Office/ASEN_FINAL_TOOLKIT.pdf.
[31] This staffing method classifies each hospital ward into one of seven categories using characteristics such as patient complexity, intervention levels, the presence of high dependency beds, the emergency/elective patient mix and patient turnover. Once classified, NHPPD are allocated for each ward (Twigg, Duffield, Bremner, Rapley, & Finn, 2011).
[32] This is a clinical and administrative support software that projects the patient numbers and RN hours required in a given shift.

In terms of developing a specific roster, two metropolitan hospitals (one public and one private) named ProAct[33] as the tool they used to achieve this. Essentially all hospitals use a request-driven roster system but management has final discretion over the roster. Several hospitals stipulate how many requests can be made in a fortnight (e.g. private metro = 3 plus 'special circumstances').

STRATEGIES TO MINIMISE ILL-EFFECTS OF HIGH WORKLOADS

All hospitals had multiple strategies or resources for minimising staff health, safety and welfare issues related to high workloads. These ranged from very basic, practical measures such as having good availability of resources and equipment (a public metropolitan hospital) to more successful evidence-based approaches such as the use of the TeamSTEPPS[34] program to improve teamwork, communication and safety, particularly at times of high workload (a regional hospital).

Six hospitals provided a range of workforce development, training or education programs to assist their nurses and midwives cope with their jobs, particularly at times of high workload and stress. Training most commonly involved work safe environments and other mandatory occupational health and safety training; training in de-escalation techniques (metropolitan public hospital); managing stress, death and dying (metropolitan private hospital), strategies for dealing with pressure (another metropolitan private hospital) and a guest speaker sharing ways to manage 'busyness' (metropolitan public hospital); building resilience (regional hospital); and bullying (metropolitan private hospital).

Five hospitals promoted use of the Employee Assistance Program (EAP)[35] available through their organisation and had evidence that the program was being used. The two metropolitan private hospitals also had an onsite chaplain who always enjoyed discussions with staff, regardless of the specific content. Two metropolitan hospitals encouraged involvement in staff health programs, one participated in the Global Corporate Challenge[36] (metropolitan private) and the other offered onsite exercise facilities (metropolitan public hospital). The latter hospital also introduced the innovative practice of doing Tai Chi five minutes prior to the start of a shift to reduce muscle strain. This came out of its 'cultural competence' program (also refer to the section on recruitment). One metropolitan public hospital mentioned that an organisational psychologist is available to work with 'stressed wards' if the problem is of a larger scale.

Other more individual approaches taken by hospitals included: celebration of International nurses/midwives day or other relevant specific days of the year (a metropolitan public and private hospital); encourage staff to receive a free flu vaccination (a regional hospital); and provide a multidisciplinary peer support system (a regional hospital).

Some logistical mechanisms employed to alleviate workload pressures included moving staff between wards and offering shorter shifts (a metropolitan private hospital) and enforcing meal breaks (a metropolitan public and a regional hospital).

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[33] ProAct is the Nursing and Midwifery Rostering System that provides the source data for the calculation of nursing and midwifery actual direct care hours (EBA, 2010). This is a scheduling software that can accommodate any shift length or start time, record staff requests for shifts, monitor casual staff and much more (for more information go to http://www.polyoptimum.com/solutions/3.html).
[34] For more information about this program please go to:
http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/safety+and+quality/clinical+handover/teamstepps.
[35] This is a work-based intervention program designed to enhance the general psychological wellbeing of employees (for more information go to http://www.eapaa.org.au/).
[36] This program encourages staff to walk more and staff join as teams and wear a pedometer (for more information go to https://www.gettheworldmoving.com/).

MANDATORY STAFF RATIOS

Mandatory staff ratios were legislated in Victoria in 2001 and have since received a lot of attention in Australia so opinion was gained from the interviewees regarding whether ratios would work in their hospital (the example of the Victorian public hospital ratio of 5 RNs to 20 patients was provided). One regional hospital did not respond to this question but all other hospitals essentially did not support their implementation, primarily because an acuity-based system is needed which involves applying clinical judgement.

One private hospital Director of Nursing indicated a ratio of one nurse to five or six patients was the norm and that the 1:4 ratio of the public sector was not financially sustainable[37].

Apart from providing a "normal expectation of staffing levels" (a metropolitan public hospital) there were few advantages attributed to ratios. Among the drawbacks were: they are complicated (a regional hospital); they lead to bad patient outcomes and are dependent on staff skill mix at an individual level and the skill level of an EN, for example, can vary (a regional hospital); they are inefficient and not a good use of resources (a metropolitan private hospital); and offer little intuitive flexibility if patient acuity is above or below a 'norm' (a metropolitan public hospital).

4.3 JOB SATISFACTION

Four hospitals (three regional and one public metropolitan) stated they don't monitor staff job satisfaction formally. The public metropolitan hospital went on to describe that monitoring staff turnover, use of personal carers leave, uptake of professional development and complaints made by patients or staff is a good proxy for any job satisfaction survey or evaluation. The regional hospitals also reflected using a more individual monitoring process. One regional hospital explained their decision not to conduct formal surveys or similar as not wanting to ask about things that they cannot deliver.

The remaining hospitals all used staff satisfaction surveys periodically. The two public metropolitan hospitals were aware of and had used the survey offered by the Department of Health but found that the results were not available in a timely fashion. The two private metropolitan hospitals described conducting staff satisfaction surveys every couple of years; one hospital uses the survey through Best Practice Australia[38] and it captures staff opinions of managers and looks at the culture of the organisation (e.g. to what extent is there a culture of blame).

All hospitals provide staff with multiple opportunities or avenues for providing feedback. The most common are regular ward meetings (e.g. fortnightly), open forums for the whole hospital (e.g. monthly or every 6 weeks), anonymous feedback sheets and exit surveys. All Directors of Nursing understood the importance of being accessible to nursing and midwifery staff and conduct regular rounds of the hospital, either as part of or additional to the aforementioned processes. One public metropolitan hospital has frequency of meetings with staff as a key performance indicator and emphasises at staff inductions her "open door policy".

The majority of hospitals interviewed indicated they had fairly flat management structures (i.e. not hierarchical) where there are a number of managers appropriate to speak with when the 'standard' feedback systems are not effective. Beyond that, mediation through Human Resources or use of Employee Assistance Program officers were common strategies. One public metropolitan hospital was very supportive of *all*

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[37] However, it is unknown whether this comment refers to a situation where 'all things are equal', where the staffing skill mix is the same in the private and public sectors. Sometimes private hospitals have a higher proportion of registered nurses overall than the public system operating in general surgical and medical wards.

[38] For more information about this organisation please go to http://www.bpanz.com/.

staff and indicated that where resolution could not be found, they would assist staff to find work elsewhere. Another public metropolitan hospital explained that mediation through Human Resources usually only occurred when a Clinical Services Coordinator (CSC) was trying to performance manage a staff member. A private metropolitan hospital acknowledged that some staff issues were dependent on the "openness of a manager" and if there were ongoing issues with staff then that particular ward area would be assessed in terms of its culture.

The hospitals agreed that their organisations were trying to be responsive to staff needs, albeit not necessarily in a particularly structured way. Two regional hospitals indicated this was achieved by having an open workplace and focusing on patient-centred care and what it means to provide good care. Another regional hospital endorsed senior management attending workshops on topics such as building positive culture and change management. A public metropolitan hospital touched on the importance of being able to offer more than temporary contracts to recruit and retain valuable staff.

4.4 FLEXIBLE WORK ARRANGEMENTS

Two metropolitan hospitals (one public and one private) drew attention to the mutual dimension of flexible work arrangements; these arrangements must be mutually agreeable for employee and employer, they must meet the needs of staff and patients. Other salient interpretations of what flexible work arrangements mean included that it allows work to "fit in with their other life" and if they are happier at work they take less sick leave (a private metropolitan hospital) and that it is important to give people work life balance regardless of why (a public metropolitan hospital). All hospitals mentioned being aware of/providing a range of flexible work arrangements. The most common responses were: part time work, compressed hours, shorter shifts, time off in lieu (TOIL), job sharing, purchased leave and access to leave at short notice.

Part time work was by far the most common flexible work arrangement that is in place with between 45% (a public metropolitan hospital) and 80% (some regional hospitals) of staff across the eight hospitals employed on a part time basis[39]. Some hospitals were unable to provide an exact figure but indicated the majority of staff were part time. Some hospitals did not observe any trends as to who requests part time work (one regional hospital and one public metropolitan hospital) and others found more distinct groupings such as mothers returning from maternity leave or with family commitments (two metropolitan hospitals, one public and one private and a regional hospital), Generation Y not wanting to work full time for lifestyle reasons (two private and one public metropolitan hospitals), and those seeking the health benefits of having a '3-day weekend' (a regional hospital). Two public metropolitan hospitals indicated that having substantial proportions of part time nurses/midwives is not necessarily a good model of care because issues can arise in terms of continuity of patient care as well as it placing greater responsibility and shift limitations on full time workers. For example, part time workers don't tend to worry about administrative aspects such as audits (a public metropolitan hospital).

Compressed hours were predominantly an option for management positions (i.e. Level 3 nurses/midwives upwards). For example, many CSCs work compressed hours. However, one public metropolitan hospital indicated that compressed hours were not available to any nursing or midwifery staff. Another public metropolitan hospital said that they only have one nurse working compressed hours because many wards can't fit the Monday to Friday 'office hours' model. A regional hospital provided a more explicit example of this stating their mental health nurse manager has one Friday off a fortnight but for the infection control manager there are fewer staff able to fulfil her accountability duties and therefore she needs to be more available.

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[39] These proportions are comparable to those reported by Victorian nurses in *Value added: the wisdom of older nurses at work*, p.8 (http://www.health.vic.gov.au/__data/assets/pdf_file/0019/507070/web-bookmarked-version-value-added.pdf)

Similarly, job sharing was another arrangement that tended to be offered to nursing/midwifery staff in more senior or management positions although one private metropolitan hospital implied a broader application of job sharing to all nursing staff. Several hospitals commented that they had utilised job sharing in the past but currently did not have any staff with this arrangement. The effectiveness of job sharing was very much determined by the characteristics of the two people job sharing. A private metropolitan hospital nominated three key staff attributes that lead to successful job share experiences: having two people of similar mind set who want to make it work, they communicate well and are willing to do some out of hours work (usually involving short phone calls to clarify issues). Consequently, the same Director of Nursing found that when one of the two job share staff leave or change to another work arrangement it is very difficult to then replicate the same job share success in that position. Two public metropolitan hospitals and a private metropolitan hospital also suggested that how the job share arrangement is split and how primary responsibility of tasks is managed are critical to a successful, effective arrangement. This private metropolitan hospital continued on to describe an "exceptional model of patient care" where two managers job share one position and both work as a clinical nurse in the same hospital for the remainder of their time. This allows them to keep in touch with clinical nursing demands/what it's like at the bedside.

In theory, all hospitals agreed that flexible work arrangements are available to all nursing and midwifery staff (note the limitations discussed above) but that "it is not a given, it must be applied for and negotiated" (a regional hospital). There was a general willingness by the majority of hospitals to, at the very least, look at all flexible work arrangements being proposed by staff but that pragmatically, all arrangements are contextual and dependent on work demands. A public metropolitan hospital captured this sentiment well by saying "if staff are flexible for us, we will be flexible for them" (i.e. there is a give and take attitude). Examples of how this may work apply more so to rostering.

ROSTERING

The hospitals interviewed chiefly used request driven rosters but rosters were derived from patient demand with management having final approval. However, all hospitals allowed several shift requests per fortnight (around 2 or 3) in addition to requests for special circumstances (e.g. wedding). Most Directors of Nursing agreed that it was in everyone's best interest to try and accommodate shift requests. One private metropolitan hospital always offers annual leave or leave without pay to a staff member if they cannot grant all of their shift requests. Similarly, in periods of reduced patient demand, one public metropolitan hospital always asks if anyone wants to take leave without pay or leave without pay with on call which provides a financial gain for the possibility of being called back to work.

The majority of hospitals did not allow staff to have set shifts due to the issues this generates around needing to fill all shifts in a 24 hour period and fairness of shift allocation to full time staff. The only exception to this tended to be for night duty as this is one of the most unpopular shifts. However, a public metropolitan hospital who offers permanent night duty has found that this can make maintaining that staff member's training difficult. In contrast, one private metropolitan hospital is comfortable with offering set shifts and also offers a large range of shorter shifts, primarily to accommodate working mothers. The 'standard' alternative to not being able to offer set shifts is to employ that staff member as part of the casual pool where they can accept or decline any shift offered.

CHANGES IN UPTAKE OF WORK ARRANGEMENTS

Two hospitals noted a change in staff working arrangements from full time to part time contracts (a public metropolitan) or a steady increase in part time staff (a regional hospital). Two hospitals felt that compressed hours were more common; one public metropolitan hospital said that there as has been an increase in these requests compared

to 12 months ago and another public hospital felt compressed hours, in addition to purchased leave, were more common in the last 5 years. A regional hospital observed that female staff are back to contracts faster due to flexible work arrangements like accommodating a staff member's childcare days in their roster.

PROCESSES INVOLVED WITH REQUESTING FLEXIBLE WORK ARRANGEMENTS

At six of the eight hospitals the Director of Nursing (DoN) has final approval of any flexible work arrangement requests. A staff member's direct manager supports or recommends the request to the DON and the DON considers issues such as whether the request will allow a staff member to maintain their skill level as well as provide continuity of services to patients, for example (a public metropolitan hospital). In one regional hospital, approval is given by the direct manager and in a public metropolitan hospital the next line up from the immediate manager approves requests.

IMPLICATIONS OF PRACTISING FLEXIBLE WORK ARRANGEMENTS

Two hospitals considered that they had always operated as though flexible work arrangements were in place and that simply "what was informal is now formal" (a public metropolitan and a regional hospital). The same public metropolitan hospital believed flexible work arrangements had generally resulted in an improvement to staffing since nurses/midwives didn't get as fatigued. Other benefits of flexible work arrangements included that staff can work in their preferred area (a regional hospital) and graduate nurses/midwives (who can only work 0.84 FTE) can pick up extra shifts (a public metropolitan hospital). Hospitals did caution about the impact of flexible work arrangements regarding: filling night duty (a public metropolitan hospital); that it is difficult to achieve a precise fit for staff and hospital needs (a regional hospital); that communication needs to be very good (a regional hospital); there is greater need to have clear accountability for set tasks and to be mindful of the impact arrangements have on others (a regional hospital).

Two hospitals in particular made reference to the enterprise bargaining agreement (EBA) being counter-productive. One private metropolitan hospital said "Unions may have taken the EBA too far, it's too prescriptive and can make flexible work arrangements difficult. This Director of Nursing continued on to provide the example that the EBA stipulates that a meal break is required after 5 hours of work; most staff do not want to be having lunch at 11am. A regional hospital described the profession as being "industrially constipated" and that it would be helpful if there were less industrial obligations that bind us.

A public metropolitan hospital argued for the need to increase the visibility of flexible work arrangements within their organisation because they felt it was not always clear that they provide flexible work arrangements when they do. Additionally, a private metropolitan hospital called for the education of staff about what is considered a reasonable flexible work arrangement request as well as recognition that the employer does the best they can to accommodate the needs of their staff.

ORGANISATIONAL VIEW OF FLEXIBLE WORK ARRANGEMENTS

Organisational views on flexible work arrangements for nurses and midwifes were generally supportive and ranged from very supportive – "all mangers are on board" because the evidence is out as to the benefits of flexible work arrangements for staff and patients (a private metropolitan hospital) to almost indifferent with management not being remotely aware of what goes on with a "nursing is nursing's business" attitude and that they are satisfied as long as staff are delivering safe care (a public metropolitan hospital). A regional hospital indicated that they are supportive but feel they don't need to promote flexible work arrangements in an ongoing sense (i.e. after the enterprise bargaining agreement first came out in 2010) and one public metropolitan hospital

observed that whilst supportive, sometimes people need to be given "permission" to be innovative.

4.5 AGEING WORKERS

Overwhelmingly, the key challenge older nurses/midwives (i.e. upwards of 45 years of age) experience is the physicality of their profession. According to a private metropolitan hospital, shoulder injuries in older staff members have replaced back injuries (due to improvements in manual handling techniques and equipment). A regional hospital commented that some older nurses/midwives (i.e. those over 60 years of age) are slower and more tired but also have less insight into how they feel and are reluctant to drop hours, unlike younger generations.

A private metropolitan hospital also noted that older nurses/midwives struggle to understand the work ethic of Generation Y staff; there is a sense that younger staff are more reluctant to chip in and do extra work or shifts to help colleagues. Another private metropolitan hospital observed Generation Y staff want career advancement faster and a public metropolitan hospital found that often Generation Y staff will not simply do tasks as requested but *expect* a more consultative approach to their work. The Director of Nursing at one public metropolitan hospital had noticed greater loyalty from her older staff.

A regional hospital made the contribution that shift work becomes more demanding as you get older with less fixed sleep patterns and poor nutrition/diet. Another regional hospital observed that older nurses/midwives struggle on busy occasions and have mentioned feeling "overwhelmed" at the implementation of new electronic systems such as the Enterprise Patient Administration System (EPAS).

SUPPORTING AGEING NURSES AND MIDWIVES

The majority of hospitals indicated that no formal policies were in place to address issues specifically faced by older nurses/midwives. A regional hospital made the point that older workers are the beneficiaries of work safety improvements generally with the availability of manual handling resources such as ceiling hoists to all staff. Three hospitals (one regional and two private metropolitan) indicated that they try to give older nurses and midwives lighter loads and shorter shifts and are more considerate in their rostering (e.g. won't roster them on a late shift followed by an early). One of the same private metropolitan hospitals also mentioned they monitor unused sick and annual leave as well as long service leave and staff are encouraged to take this leave otherwise they know staff will get fatigued.

A public metropolitan hospital drew attention to the Department of Health's 'transition to retirement policy' to support older nurses/midwives phase out of work however this has not been a particularly popular option. Consistent with this view point is a private metropolitan hospital's observation that many older workers further reduce their part time hours in order to keep working (the oldest nurse at that particular hospital is 70 years old).

One public metropolitan hospital strongly supports increased research about the "mature worker", emphasising the need for succession planning otherwise a lot of corporate knowledge will be lost. The Director of Nursing at this hospital felt a good model was one employed in Canada where older nurses/midwives have one day a week to train and mentor younger nurses/midwives. This gives the older nurse/midwife a break from the physicality of nursing but they are still involved in patient care. Further, she endorsed exploration of different models and liked the notion of nurses/midwives being able to "traverse the patient's journey" from inpatient to outpatient and beyond. Another public metropolitan hospital also discussed the need for succession planning within the part time context.

4.6 INDUSTRY BEST PRACTICE

Not all interviewees understood what industry best practice meant in terms of implementing flexible work arrangements with one regional hospital unable to respond to this question. Others responded but struggled to articulate specific elements instead saying "if you're a good manager then you should be able to make it work" (a regional hospital). A private metropolitan hospital extended this idea by stating "good managers who share the organisation's values" are central. A more detailed response along these lines suggested the education of managers so that they are "all on the same page" and know what the organisation's vision is – ultimately safe care for patients and staff. This regional hospital believed that such a vision starts at the top, and organisational leaders must "believe, behave, build".

More specific elements believed to constitute best practice include having a very clear understanding of roles and responsibilities and what you need to deliver. For example, if a CSC works compressed hours then she needs to know how she will keep on top of fall rates (a public metropolitan hospital). Another public metropolitan hospital stressed the importance of trust and adjusting expectations of staff work output to be commensurate with the amount of time staff actually work. Good communication and negotiation with staff, fairness in decisions and knowing staff were all factors nominated by a private metropolitan hospital.

5 DISCUSSION

5.1 NURSING AND MIDWIFERY SHORTAGES

Just under half of survey respondents indicated they were intending to leave the nursing/midwifery profession within 10 years. However, this response in large part can be accounted for by the fact that those not intending to leave were significantly younger (average age of 42.4 years) than those with intentions to leave in the next 5 to 10 years (50.5 years) and the next 5 years (52.3 years). In keeping with these characteristics the main reason provided for intending to leave the profession within 10 years was retirement. Around a third of staff also indicated that the physicality of nursing work and work-related stress were also reasons they intended to leave within 10 years. Notably, lack of flexible work conditions and low staff morale were reported by nearly a quarter of these respondents.

Regardless of the specific reasons for leaving the nursing/midwifery profession, these figures support likely nursing shortages projected by Health Workforce Australia (2012, p.iii): "Australia is likely to experience limitations in the delivery of high quality health services as a consequence of workforce shortages – highly significant in the case of nurses (109,000 or 27%)".

Turnover rates described by Directors of Nursing were generally lower than indicated in the literature (20%) and are more in keeping with those reported for a 'typical' business (4%) although this may be a result of the current global economic conditions. Turnover did not seem to vary by location or staff position but there was general acknowledgement from Directors of Nursing of higher turnover in medical or surgical wards where the workloads tend to be greater.

The physicality of nursing was mentioned in the interviews as a particular issue for older nurses and midwives along with carrying out activities more slowly, feeling more fatigued, having less insight into how they feel and a reluctance to drop hours, unlike younger generations. The principal methods employed to overcome these issues by hospital management were to assign lighter workloads and shorter shifts (i.e. considerate rostering). These approaches have been identified previously in the literature.

5.2 Retention of nursing and midwifery staff

The literature suggests job satisfaction and staff retention are negatively impacted by overwhelming workload, unclear career progression, inflexible working hours, low salary, limited autonomy, poor communication and job dissatisfaction. These did not appear to be major factors for the nurses and midwives responding to our survey, most of whom reported being reasonably satisfied with their workplace. More than three quarters felt they: *are trusted and can work autonomously*, *have good working relationships with people they work closely with* and *communicate well with their nurse or midwifery manager/supervisor*. More than half indicated that: *they are satisfied in their job*, *their work is valued by colleagues*, *they work in a supportive environment*, *their manager recognises their accomplishments* and *there is opportunity for career progression*.

Other factors were of more concern - more than seventy percent of respondents agreed that they *experience many interruptions in their daily work routine* and that they *perform many non-nursing or midwifery tasks.* At least half of the nurses and midwives reported that their *workload is too heavy* and they do not have *adequate patient care supplies and equipment*. These factors can result in the perception that patients are not receiving a high quality of care.

Consistent with the literature, not being able to provide a high quality of care to patients was a source of stress for nurses and midwives. *High workload*, *high self-expectations*, *negative communication* and pressure to *meet patients' needs* caused the greatest amount of work-related stress for respondents with more than a third of staff reporting these were experienced to a great extent. In contrast, *lack of job security*, *amount of pay*, *lack of social support* and *ambiguity about authority* were experienced very little or not at all. However, younger workers felt significantly more stressed than older workers by the *amount of pay* which is in keeping with evidence that younger nurses/midwives place higher value on remuneration.

5.3 Flexible work arrangements

All senior management interviewed recognised that being 'family friendly' and providing good flexible work arrangements were important strategies to minimise staff turnover. Almost half of survey respondents had asked their manager for flexible work arrangements (FWA)[40]. Requests were more commonly made by private hospital staff compared to public hospital staff and parenting responsibilities were reported by one third as the main reason for the request - other caring roles were reported by an additional 5.2% as the reason for seeking FWA. Almost sixteen percent indicated they either preferred to work fewer hours or increase their leisure time. The variability in responses for why FWA are requested is consistent with the experiences of Directors of Nursing where nurses and midwives of all ages and backgrounds are interested in working reduced hours, including Generation Y staff that are making a lifestyle choice, rather than trading off for other responsibilities.

Common responses from nurses and midwives about why a FWA had *not* been requested included they were *satisfied with current arrangements* or that they are working in a casual role where flexible hours are already built in. Interviews supported these findings by suggesting that a high proportion of nursing and midwifery staff (reported as between 45-80%) are already in part time positions and when certain requests cannot be accommodated (e.g. working less than 2 days a week or wanting set shifts), Directors of Nursing recommend working as part of the casual pool.

There appears to be some disparity between how FWA are received by managers and other staff members. Just under a quarter of the nurses and midwives who had ever made a FWA request reported it was refused. This compares to only 4% of requests

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[40] In this instance FWA refers to a decrease in work hours.

reportedly refused by managers (noting that managers based their response on the *most recent* FWA request, whereas staff were reporting about any previous request). Some of this difference may be accounted for by a distinction between 'formal' and 'informal' request. For example, a nurse or midwife may (informally) ask their line management for a FWA with the discussion leading to the perception that the request would be denied and a formal application not being made.

Nurses and midwives reported the principal reason for refusal was *inflexible management* but there was also recognition of the role *patient care requirements and workload constraints* played in decisions, in addition to *setting a precedent that others would want to follow* and *hospital policy limitations*. Top reasons managers used to refuse a request were *not having the authority to approve* it and *current unit workload constraints*. Interviews revealed that Directors of Nursing had ultimate authority when it came to approving FWA but that immediate nursing managers would recommend whether they felt the request was appropriate.

Regardless of why a request was refused, approximately two-thirds of nurses and midwives who requested FWA previously indicated they would make a request again. That is, previous request refusal does not appear to have influenced the willingness to request in the future.

Fairness of requests and possible impacts on workloads were key issues reported by managers in both the survey and interviews regarding barriers to implementing FWA. Around half of all managers found dealing with *numerous requests* and *the need to treat all staff equally* problematic and they felt that *by granting some staff reduced overall hours, the full time staff get all of the unpopular shifts.* Directors of Nursing focused on the balance needed between providing safe care and accommodating staff needs and as such stated that FWA are not to be assumed but that all reasonable options will be explored.

Rostering provides an example of this type of scrutiny whereby staff can submit a certain number of shift requests but that final decisions rest with the nursing or midwifery manager based on patient dependency and staff skill mix. From the survey results, departmental or unit/ward rostering[41] was the predominant type of rostering used for both public and private hospitals but self-rostering[42] was also fairly common for private hospital respondents in particular. Some nurses and midwives also articulated 'other' rostering systems such as the combination of departmental and self-rostering approaches described by Directors of Nursing.

Concerns have been expressed in the literature that increased FWA or more part time staff can create a sense of staff being 'transient'. This notion was upheld by several Directors of Nursing who felt that high proportions of part time staff could impact continuity of care for patients as well as place greater responsibility and shift limitations on full time workers.

There was some disagreement shown in the survey results around certain aspects of FWA options; around a quarter of staff disagreed that they were *able to job share or work part time if they want* and that they *can move between full time and part time work as they require.* Moreover, one third of nurses and midwives disagreed to some extent that they *work predictable hours*. However, these results are balanced by approximately 60% of survey respondents agreeing to some extent that they *have enough flexibility in work hours to take care of personal needs*, their *employer recognises that staff have a life outside work*, they were *happy with existing arrangements supporting work life balance*, and that *preferred shift patterns are usually accommodated.*

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[41] This system is a centralised scheduling approach conducted by a single manager.
[42] This involves a negotiation among nurses and midwives.

Despite concerns from management about the fairness of FWA (although 'fairness' seemed to be geared towards full time staff, not part time staff), nurses and midwives indicated a sense of equality in their workplace in terms of support and opportunities for part time and full time staff. For example, two thirds of survey respondents agreed that *nursing/midwifery staff who work part time have the same protections as the full time workforce*; half agreed that *nurses/midwives who work part time are encouraged to participate in training programs and apply for promotion*; and almost half agreed that *part time nurses/midwives are treated no differently to those who are full time*.

Affirmation of these statements suggest that quality part time work is being practiced in acute care hospitals and more than half the respondents agreed to some extent that they were *aware of the concept of quality part time work*. However, less than a third agreed to some extent that their *employer promotes the concept of quality part time work*. This discrepancy was also highlighted by Directors of Nursing who felt that they most certainly do apply the concept of quality part time work/FWA but that this is not always apparent to staff.

In terms of staff flexibility in the workplace, more than three-quarters of survey respondents agreed that *models of care need to change* if staff flexibility is to increase. Interestingly, younger workers were significantly more likely to agree that increasing staff flexibility leads to *more opportunities for me to do interesting work* compared to older workers. Directors of Nursing identified career progression and choice of tasks as particularly important to Generation Y staff.

5.4 Industry best practice

Interviewees were not always able to articulate what is best practice when it comes to implementing flexible work arrangements. However several focused on the central role of management such as good management who shares the organisation's values and organisational leaders who have a vision and "believe, behave, build". Other key elements included: having a very clear understanding of roles and responsibilities and what you need to deliver; the importance of trust; and adjusting expectations of staff work output to be commensurate with the amount of time staff actually work.

Appendix A. LITERATURE REVIEW

NATURE AND EFFECT OF NURSING AND MIDWIFERY SHORTAGES

Australia, like other Organisation for Economic Co-operation and Development (OECD) countries is "experiencing turbulent nursing labour markets characterised by extreme staff shortages and high levels of turnover" (Currie & Carr Hill, 2012, p.1180). Turnover may be temporary (e.g. maternity leave) or permanent (e.g. retirement), and it may be organisational (intention to change employer/workplace) or professional (intention to change profession/leave nursing altogether).

Internationally recognised factors related to nurse and midwife shortages and high turnover include: work and the nature of the work environment (such as unit size and safety concerns, leadership style, other managerial and organisational factors and workplace stress and location); personal reasons (such as home and family, age and generation related, values and ethics and personal career opportunities and professional development); and economic reasons such as level of remuneration (ibid).

Generally speaking, turnover rates for *hospital* nursing and midwifery staff are reported to sit at an average of around 20% per year across Australia, Canada, and the United States (e.g. Hayhurst, Saylor, & Stuenkel, 2005; O'Brien-Pallas, Tomblin Murphy, Shamian, Li, & Hayes, 2010; Queensland Health, 1999). This is significantly higher than the 'usual' turnover rate of about 4% for a 'typical' business (Holland, Allen, & Cooper, 2012). It is acknowledged that turnover rates vary dramatically between different types of nursing and midwifery units with turnover rates greatest for critical or intensive care units followed by surgical, paediatric and medical units (O'Brien-Pallas, et al., 2010). The location of a site also impacts turnover, with a high of 92% nurse turnover reported at Tennant Creek Hospital (a remote hospital in Northern Territory, Australia) in 2006-07(Garnett et al., 2008).

Recent health workforce reports have highlighted key concerns regarding trends in the Australian nursing and midwifery workforce. The Australian Institute of Health and Welfare (AIHW) examined demographic and employment characteristics of nurses and midwives who were registered in Australia in 2011, identifying a 1.3% decrease in supply of full-time equivalent nurses and midwives per 100,000 population between 2007 and 2011 (AIHW, 2012). Health Workforce Australia conducted a workforce planning analysis of supply and demand trends for doctors, nurses and midwives, noting the "likely continuation of health workforce shortages out to 2025 for doctors and nurses, with the magnitude of shortage likely to be highly significant for nurses and less so for doctors, with the midwifery workforce more likely to be in balance" (Health Workforce Australia, 2012, p.1).

There are a number of industry drivers influencing these trends, with the ageing of the health care workforce at the forefront. WISeR has identified the health care industry as among those with the highest proportion of workers aged 55 and over in South Australia (Barnett, Spoehr, & Parnis, 2008). The "Nursing Pulse Check" study (Kronos, 2012) confirmed that retirement of ageing workers was the main reason for nurses exiting the industry, although stress factors within the industry also play a key role in workforce attrition. Many nurses and midwives report that overwhelming workload, unclear career progression, inflexible working hours and low salary contribute to stress, dissatisfaction, burnout and injury in the workplace. Other implications of job stress and dissatisfaction include increased absenteeism and tardiness as well as poorer patient care (Curtis, Ball, & Kirkham, 2006; Drouin & Potter, 2005; Kendall Sengin, 2003). For midwives in the United Kingdom who left the profession in 2000 due to dissatisfaction, nearly two-thirds reported lack of management support as a key factor in their decision to leave (Curtis, et al., 2006).

Similarly, Buchan and Aiken (2008) in their international assessment of nursing shortages attribute the main causes of shortages to: inadequate workforce planning and allocation mechanisms; resource-constrained undersupply of new staff; poor recruitment, retention and 'return' policies; and ineffective use of available nursing resources through inappropriate skill mix and utilisation, poor incentive structures and inadequate career support. They also make the important distinction that the shortage of nurses is not necessarily a shortage of individuals with nursing qualifications but rather a shortage of nurses willing to work in the present conditions (Buchan & Aiken, 2008). Skill mix is a particular issue for midwives and according to the Australian College of Midwives, "midwives are leaving the profession due largely to stress and frustration caused by the dominance of medicalised systems of maternity care in Australia" (Australian College of Midwives, 2005, p.2).

Added to broader stresses on the system - including the rapidly ageing population, increased demand for quality health services, changing burden of disease patterns, particularly rising rates of chronic disease, and broader labour market issues - there is a clear need for a workforce reform agenda emphasising recruitment, retention and productivity in the nursing and midwifery sector (Kronos, 2012).

NURSE AND MIDWIFE RECRUITMENT, RETENTION AND PRODUCTIVITY

Nursing and midwifery are physically and mentally demanding professions but these attributes tend to be offset by the inherent reward of helping others, or more specifically, by being able to comfort patients, make a difference, educate patients and advocate on their behalf (Craft Morgan & Lynn, 2009). Thus, one of the greatest challenges for these professions in the 21st century is how to maintain and increase such patient-centred rewards as workload demands continually increase. Moreover, the recruitment and retention of nurses and midwives, particularly in acute care hospital settings, is complicated by the very nature of patient care being ongoing and required around-the-clock. This aspect of care generates the need for shift work and adds scheduling to the mix of nurse and midwife-specific employment and retention issues and stressors (Drouin & Potter, 2005).

Parker and her colleagues summarised the nearly universal characteristics of current nursing practice environments as having increasing differentiation, increasing patient acuity, an ageing population of patients and staff, staff shortages and larger numbers of non-graduate nurses of various levels of education (Parker, Giles, & Higgins, 2009). These workplace features are linked to staffing issues such as workload and skill mix.

WORKLOAD, STAFFING AND SKILL MIX

Nurses in hospital settings tend to report heavier workloads and more stress compared to nurses in other settings (e.g. Hayhurst, et al., 2005). There are several reasons why workloads have increased and become more intense and complex in acute care hospital settings. Two main reasons include expanding technology and a decrease in the average length of stay of inpatients in hospitals (Hogan, Moxham, & Dwyer, 2007). Recuperation from illness is now expected to take place at home or in other tertiary facilities therefore nurses and midwives in acute hospitals treat patients with more serious conditions, more often.

Based on the *National Review of Nursing Education* in Australia conducted in 2001 and other international research, O'Brien-Pallas and her colleagues concluded that an "excessive and unrelenting workload has been identified as the major cause of stress and dissatisfaction in the nursing workforce in Australia and overseas" (O'Brien-Pallas, et al., 2004, p.299). This is because it interferes with a nurse's ability to provide a high quality of patient care. Heavy workloads can also lead to unsafe work environments and errors or near-misses in patient care (Berry & Curry, 2012; Stanton, 2004). Particularly for more experienced, older nurses, high workload can result in increased musculoskeletal

problems. More broadly, there is a strong positive relationship between sick leave and overtime (O'Brien-Pallas, et al., 2004).

Focusing on the Australian nursing experience, Wickett and colleagues raise the cost-cutting measure of substituting registered nurses (RNs) for unskilled workers as causing increased workloads and dissatisfaction. RNs are subsequently required to play more of a supervisory role and are less involved in providing direct patient care (Wickett, McCutcheon, & Long, 2003). Emerging from focus groups of Australian nurses, Buchanan and Considine found that increased patient turnover and acuity without adjusting staffing levels was a great source of stress for RNs (Buchanan & Considine, 2002, cited by; Chang, Hancock, Johnson, Daly, & Jackson, 2005). Aiken and colleagues also argued that understaffing leads to greater nursing turnover because they are unable to provide the quality and quantity of care that they wish (Aiken, Clarke, & Sloane, 2002). Results from the United Kingdom's "Why do Midwives Leave" study support this; Curtis and her colleagues found that more than a third of midwives who had left the profession in 2000 felt that "they had not usually been able to provide the type of care they had wished", just under a third felt "women had not received an appropriate standard of care" and more than a quarter felt they had "ceased to be able to develop meaningful relationships with their clients" (Curtis, et al., 2006, p.28).

ALLOCATING RESOURCES

According to Spetz and colleagues (Spetz, Donaldson, Aydin, & Brown, 2008), nurse staffing is measured in one of two basic ways: nursing hours per patient day (NHPPD) or the nurse to patient ratio (a 'top-down' approach). Duffield and colleagues contribute a further method of using patient dependency or patient acuity systems (Duffield et al., 2009). NHPPD is the most commonly used indicator of activity and includes clinical (direct) and non-clinical (indirect) hours worked by all nursing staff over a 24 hour period (Queensland Health, 2008). However, NHPPD assumes the level of patient acuity remains the same (which is almost never the case), therefore staffing and skill mix are often adjusted according to immediate patient acuity demands at the local ward level (a 'bottom-up' approach).

Regarding nurse to patient ratios, to date these have rarely been formalised in legislation. Internationally, ratios were introduced in California in 1999 with specific ratios applied to each speciality area, for example one RN was to be available for every five patients on medical and surgical wards. In Australia, minimum nurse to patient ratios were first introduced in Victorian public sector hospitals in 2001 and set at one RN for every four patients (plus one in charge on medical or surgical wards). This ratio was reconceived as five RNs for every 20 patients in 2004 believing this model increases the flexibility through which RNs could be deployed across a ward (Gerdtz & Nelson, 2007). James Buchan summarised the strengths and weaknesses of ratios well (see Table 4 for specific attributes); essentially their simplicity and transparency are counterbalanced by their relative inflexibility and potential inefficiency if they are wrongly calibrated (Buchan, 2005). Although specific ratios had not been enforced by law in the United Kingdom in 2010, NHS hospital wards averaged a ratio of 8 patients per RN during day time and 11 at night (Royal College of Nursing, 2010).

TABLE 4: ATTRIBUTES OF MINIMUM STAFFING RATIOS

Pros	Cons
Can halt or reverse reductions in nurse staffing	Defining 'minimum' – does it become average or maximum?
Can encourage workforce stability	Measuring minimum – is it calibrated adequately in relation to workload? (i.e. what is considered a safe staffing level)
'Simple' to implement and understand	How can compliance be assured? And what are the penalties for non-compliance?
Provides a standard approach; reduces need for complex local systems	What is the cost of compliance – will other staffing be reduced?
If mandatory, it can ensure compliance from all employers	Inflexible? Can one size really fit all?

(Source: Reproduced from Buchan, 2005)

Patient safety and staff workload are inextricably linked with skill mix. Skill mix is defined as the proportion of RNs to total clinical nursing staff. It is argued that a lesser qualified skill mix may result in increased nurse turnover and unproductive time (Duffield, et al., 2009). The Royal College of Nursing in the United Kingdom observed that overall, there has been little change in the average number of nursing staff in the last 5 years but the skill mix has shifted over this time and become more dilute (Royal College of Nursing, 2010). Higher nurse staffing and richer skill mix (especially of RNs) are associated with improved patient outcomes (e.g. Kane, Shamliyan, Mueller, Duval, & Wilt, 2007).

WORK ENVIRONMENT

Other factors of note to have an impact on nursing retention include unsafe work environments (often characterised by bullying and harassment by staff and patients), lack of recognition for work done, lack of autonomy, lack of support from managers and colleagues, lack of rewards, lack of leadership roles for nurses, and limited control over practice and scheduling (O'Brien-Pallas, et al., 2004).

In particular, physical aspects of working in a hospital that contribute to nurse/midwife stress include exposure to infectious diseases, needlestick injuries, exposure to work-related violence or threats, sleep deprivation and dealing with difficult or seriously ill patients (Department of Health and Human Services, 2008). According to Duffield and colleagues, "successful retention strategies will require an understanding of workload and factors in the work environment which impact on patient and staff outcomes" (Duffield et al., 2007, p.21).

JOB SATISFACTION

Job satisfaction is a strong and consistent predictor of retention but it is a complex concept combining both work and individual determinants and has been found to differ across generations (Currie & Carr Hill, 2012; McNeese-Smith & Crook, 2003; Wilson, Squires, Widger, Cranley, & Tourangeau, 2008). For example, Wilson and colleagues found that Canadian RNs working in a hospital setting who were from the Baby Boomer generation experienced greater overall job satisfaction than their Generation X and Y colleagues, in particular regarding pay, benefits and scheduling. Compared to Generation X, these Baby Boomer nurses were significantly more satisfied with professional opportunities, praise and recognition, and control and responsibility (Wilson, et al., 2008). Similarly, McNeese-Smith and Cook found that younger nurses in US hospitals placed higher value on remuneration and task variety. In general, the American nurses of all ages rated good supervisory relations (i.e. a supervisor who is fair and with whom one can get along) as their most important value (McNeese-Smith & Crook, 2003).

In 2003, Kathi Kendall Sengin conducted a review of the literature, summarising commonly cited attributes that influence RN job satisfaction in acute care hospitals in the

US (these are presented in Table 5). Their inclusion was based on the frequency and consistency of their appearance in the literature (Kendall Sengin, 2003).

Attribute	Description
Autonomy	This refers to the ability to exercise nursing judgment for patient care. The presence of autonomy has strong links with job satisfaction.
Interpersonal communication/ collaboration	This incorporates relationships with co-workers and supervisors, how well staff work together. Good communication and a sense of 'team work' are associated with increased job satisfaction.
Professional practice	This refers to professionalism and dedication to occupational standards as well as employing evidence-based practice models. It has been reported as important to job satisfaction.
Administrative/ management practices	This refers to the structure of the organisation, (e.g. centralisation/decentralisation of authority & clarity/fairness of policies and procedures). Decentralisation and participatory management styles are linked to increased satisfaction.
Status recognition	This refers to how nursing is valued within the organisation and how individual nurses perceive the value of their role. Recognition for good work performance is associated with satisfaction.
Job/ task requirements	This refers to activities accomplished as a regular part of the job. Job satisfaction is lower when tasks are repetitive and routinised.
Opportunity for advancement	This refers to professional opportunities, promotions, and the presence of a 'clinical ladder'. The perception of these opportunities is associated with increased job satisfaction.
Working conditions/ physical environment	This includes staffing, workload, type of shift worked, supplies and equipment available, and work scheduling and flexibility. Lack of flexibility, for example, has been associated with lower job satisfaction.
Pay	This includes actual dollar remuneration as well as fringe benefits received for work. Adequate pay may not enhance job satisfaction but pay perceived as inadequate will certainly produce job dissatisfaction.
Fairness or distributive justice	This can be described as perceived fairness of the processes through which decisions are made and includes the relationship between job performance and subsequent rewards and punishment. Perceptions of fairness are linked to job satisfaction.

(Source: Summarised fromKendall Sengin, 2003)

SUPPORTING THE NURSING AND MIDWIFERY WORKFORCE

A supportive work environment enables nurses to provide quality patient care, enhance their own self-esteem, increase job satisfaction, and provide cost savings to their employers. Such an environment promotes retention of skilled, caring, knowledgeable, and experienced nurses who provide better patient care with fewer complications, and reduces the economic and social costs of healthcare for both providers and consumers (Hayhurst, et al., 2005, p.283).

A survey exploring the relationships between environmental uncertainty, nurse characteristics and perceptions of work climate with professional burnout was administered to full time RNs in an American acute care hospital. Results indicated that a supportive workplace can protect against burnout and social networks are particularly

important during times of change and uncertainty in the work environment (Garrett & McDaniel, 2001).

Despite the commonality of factors contributing to job satisfaction across countries and nursing roles (as described above), there remains no *single* factor or reason responsible for high nurse and midwife turnover. Indeed, reasons for turnover are likely to fluctuate over time depending on the health professional's stage of life/career and the general labour market environment. Therefore, as acknowledged by Currie and Carr Hill, strategies identified to address shortages and turnover need to be numerous, multifaceted and flexible (Currie & Carr Hill, 2012).

Based on a review of the literature, Chang and colleagues proposed several strategies to support nurses with their role stress and high workloads. These included: use of stress education and management strategies, team building strategies, balancing priorities, enhancing social and peer support, flexibility in work hours, protocols to deal with violence and retention and attraction of nursing staff strategies (Chang, et al., 2005). Some of these strategies are discussed in more detail below.

Hogan and her colleagues provide a summary of the numerous state and federal government reports commissioned to identify issues around the recruitment and retention of nurses in Australia. Some of these reports include the: *South Australian Nursing and Midwifery Recruitment and Retention Strategic Directions Plan* (Department of Human Services, 2002); *Australian Capital Territory Health Workforce Plan 2005-2010* (Australian Capital Territory (ACT) Health, 2005); *Queensland Health Action Plan (Queensland Government, 2005)*; *NSW Recruitment and Retention of Nurses Progress Report* (New South Wales (NSW) Health, 2002, cited by Hogan et al., 2007); *Nursing Labourforce Northern Territory Report* (Northern Territory Government, 2002, cited by Hogan et al., 2007); and *Tasmania Recruitment and Retention Report* (Tasmanian Department of Health and Human Services, 2001, cited by Hogan et al., 2007). The overarching recommendations from these reports were to (Hogan, et al., 2007):

- Develop strong leadership

- Change existing health care organisational culture

- Provide staff with recognition and rewards

- Value employees

- Decrease existing workloads

- Improve change management strategies

- Provide an increase in education to employees

- Take into consideration employee lifestyle choices when considering full time or part time employment.

These themes were still acknowledged more recently in SA Health's *Delivering the Future* report as ways to create workplaces where people want to work. They nominated five areas of focus: safety, flexibility, work design, technology and culture (SA Health, 2008).

FLEXIBLE WORK ARRANGEMENTS

According to Chang and colleagues, the lack of a 'family friendly' workplace is one of the major personal issues identified in Australia as influencing nursing retention. Having flexibility in work hours may improve a nurse's ability to cope with the demands of family roles and participating in a 7 day per week/24 hour coverage roster (Chang, et al., 2005). Flexible scheduling is an important element of flexible work hours and in achieving work life balance (e.g. Nelson & Tarpey, 2011). Drouin and Potter describe flexible scheduling as "any system that allows nurses to have control over the hours they work" (Drouin &

Potter, 2005, p.72) and they propose this as a strategy that is likely to minimise job stress and benefit patients, nurses and the organisation.

In 2000, the British Royal College of Nursing conducted a survey investigating nurses' wellbeing and their working lives. The survey was sent to 6,000 full members (excluding students) and more than 4,000 members responded. The study found that 60% of nurses work shifts, and that shift working is more common for nurses in the first ten years of their career. Shift work was also more prevalent for nurses working in hospitals compared to the community. In addition, internal rotation was found to be the most widespread pattern of shift working in National Health Service (NHS) hospitals, even though it was the least popular. Slightly less than half of the nurses surveyed reported that they do not work the shift pattern they would like but 80% agreed that they were generally able to get the off-duty they wanted (Royal College of Nursing, 2002).

Another British study, conducted by Brooks and Swailes, looked at flexible working (including shift patterns) and commitment to nursing. A postal survey was completed by nearly 3,000 nurses employed in a range of settings, including hospitals and hospices. The results showed that those on permanent night shifts reported lower levels of commitment to nursing. More generally, the study showed that the strongest predictor of commitment to nursing was positive perceptions of career development opportunities. Thus, Brooks and Swailes concluded that the impact of unfavourable shifts can be minimised by human resource managers providing a strong sense of career development (Brooks & Swailes, 2002).

The promotion of flexible work arrangements is specifically mentioned in the *Queensland Health Action Plan* (Queensland Government, 2005) and the *South Australian Nursing and Midwifery Recruitment and Retention Strategic Directions Plan* (Department of Human Services, 2002) as a means to improve the health professional work environment and assist in recruitment and retention. Compiled by the Western Australia Department of Health for their health industry, the *Achieving work life balance* document (Department of Health, 2006) nominates flexible working hours as the first of ten essential work life balance retention and attraction strategies (all ten are summarised in Table 6). Other strategies of particular relevance here include part time work.

TABLE 6: TEN MOST ESSENTIAL 'WORK LIFE BALANCE' RETENTION AND ATTRACTION STRATEGIES

Strategy	Description
Flexible working hours	Providing more flexible and consultative rostering arrangements and working hours to all employees, including shift work.
Part time work	Providing more part time jobs with less hours or fewer shifts, or job sharing arrangements to all employees.
Reasonable working hours	Reducing excessively long working hours and double shifts.
Access to childcare	Improving access to childcare with onsite childcare facilities and giving shift workers, who need access to childcare facilities, regular fixed shifts.
Flexible leave arrangements	Providing greater flexibility in leave arrangements to suit employees' personal circumstances, including leave for school holidays through purchased leave arrangements and extended leave without pay to provide full-time care to family members.
Leave in single days	Allowing employees to request and take leave in single days and accrue hours as time off in lieu of payment.
Job mobility	Providing increased mobility for employees to transfer between wards, hospitals, work areas and health services to find more suitable working arrangements that will assist them to better balance their current work and family/personal responsibilities.
Safety and wellbeing	Improving safety, wellbeing and respect for all employees in the workplace.
Telephone access	Ensuring all employees are able to receive urgent telephone calls or messages from family members at work and have access to a telephone to remain contactable with their family during working hours.
Casual work	Introducing pools of permanent flexible part time or casual employees, similar to NurseWest[43], in other occupations to cover leave and other absences.

(Source: Reproduced from the Achieving work life balance document, Department of Health, 2006).

AGE MANAGEMENT AND GENERATION SPECIFIC STRATEGIES

There are a range of benefits associated with retaining older workers across various industries, including capitalising on accrued experience and wisdom and transferring skills and knowledge to those following on, as well as recognising older workers' propensity for greater reliability, lower absenteeism, higher retention rates and more responsible attitude to workplace safety (Barnett, et al., 2008). WISeR outlined four components of good practice in age management[44] to support the retention of older workers, including an emphasis on *prevention*, a *holistic* focus on the *whole life course*, and *compensatory provision* for older workers (ibid). Central to the notion of effective age management is work-life-balance, which in turn is intrinsically linked to flexibility of work conditions and worker autonomy in the organisation of work (ibid).

O'Brien-Pallas and colleagues provide reflections on the Canadian nurse experience and acknowledge that many existing retention strategies are aimed at the needs of more junior staff members (e.g. scholarships, additional education, childcare facilities) and are less relevant and appealing to older nurses. At the same time, the composition of a senior nurse's workload is different to that of junior colleagues and usually entails providing direct patient care, managing the activities of the unit and mentoring junior or relief staff (O'Brien-Pallas, et al., 2004).

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[43] For more information about NurseWest, go to http://www.nursing.health.wa.gov.au/nursewest/about_us.cfm

[44] Age management is a term that refers to good practice in the employment of older workers and involves "...establishing employment conditions for older and ageing workers that provides an environment in which each individual can achieve their full potential without being disadvantaged by their age" (Taylor, 2006). According to Quintin (Quintin, 2001, cited by Taylor, 2006), it is particularly important that people are not worn out by their jobs and are not forced to quit early due to working conditions. Barnett et al. (2008) explore issues around age management and ageing workforces.

Reconfiguring the work effort of older nurses (e.g. 50 years of age and older) could reduce stress, maintain interest in the work and increase career longevity thereby extending the benefits and experience older staff bring to the role. Some mechanisms that could help achieve this include: rotation through clinical areas where the workload is known to be lighter; offer extended breaks to cope with physical demands; offer financial incentives to compensate for increased responsibility; permit flexible self-rostering in order to achieve a balance between work and family commitments; and provide job sharing as an option, giving staff the autonomy to decide on how they split the position (O'Brien-Pallas, et al., 2004). Cohen's paper on healthcare management (primarily set in the US) also raises the importance of providing salary structures and benefit programs that reward experience, and hold value for an ageing workforce (Cohen, 2006).

In their discussion of factors contributing to, and remedies for, high turnover in nursing, Currie and Carr Hill reported on several flexible work patterns designed for older nurses. One pattern, employed by several hospitals in Belgium, reduces workload but does not negatively affect pay. For example, a full 40 hour per week salary is paid but those nurses and midwives aged 45-54 years old only need to work 36 hours and those 55 years and older only need to work 32 hours per week. This has been an effective but expensive strategy. For more than a decade nurses and midwives in the UK have had access to a flexible retirement initiative where those nearing retirement age could transition into part time work (or new roles at a lower salary) without reducing their original pension benefits. Coupled with such initiatives are incentives for retired nurses to return to the workforce; a key element to this is the 'keep-in-touch' scheme developed by the National Health Service Trusts where staff/ex-staff are kept informed about policies and work options (Currie & Carr Hill, 2012).

In a study aiming to identify factors that may influence nurse retirement, Cyr found that in a sample of more than 1,500 older nurses employed in US hospitals, financial independence was the most common factor prompting early retirement (Cyr, 2005). This was followed by poor health, work intensity, spouse's poor health and spouse's early retirement. In order to retain older workers, creative scheduling was supported by most older nurses, including working part time or doing per diem work (three quarters would consider these options), and seasonal employment (e.g. half indicated an interest in working in the winter and having summers off; ibid).

As a way "to prevent a drain of experience from the workforce", Chang and colleagues (Chang, et al., 2005, p.62) suggest that nurses be encouraged to pursue further study. Although, Wray and her colleagues observed that despite continuing and professional development (CPD) being important to the retention of nurses and midwives of all ages, nurses and midwives aged 50 years and over reported less involvement in CPD activities than their younger counterparts (Wray, Aspland, Gibson, Stimpson, & Watson, 2009). These results were from an UK-wide postal survey of nurses and midwives working in National Health Service Trusts and Primary Care Trusts. The survey was designed to capture the employment experiences of nurses and midwives with a particular focus on age, ill-health and disability.

THE ROLE OF QUALITY PART TIME WORK

Equally important to supporting retention among older nurses and midwives is recognising the role played by quality part time work[45] in achieving work-life balance *across different stages of the life cycle*. Key transition points across the life cycle might include study and family commitments, care-giving responsibilities, moving into retirement and acquiring sickness or disability. In this context WISeR (Barnett & Hordacre, 2011) have noted:

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45 Quality Part Time Work (QPTW) refers to flexible, safe and voluntary work practices that provide appropriate rights, entitlements and security to those employees who, with their employer's agreement choose to work part time. A fuller description of what quality part time work entails is provided by Barnett and Hordacre (2011).

Quality part time work provides a critical mechanism for smoothly managing major transitions across the life cycle. It can mean the difference between working and not working, and for successfully balancing work and other key life responsibilities. This illustrates the importance from a policy perspective, of locating part time work within a life course framework as well as within labour market policy.

A pamphlet on quality part time work from Industrial Relations Victoria highlights the important distinction that *quality* part time work for nursing jobs is about people working part time being seen as part of the regular workforce. They also support implementing quality part time work as a means to reduce staff stress and unplanned absenteeism (Industrial Relations Victoria, 2005).

Two key international pieces of work with direct relevance to investigating flexibility in working for Australian nurses and midwives include the *Wisdom at Work: the Importance of the Older and Experienced Nurses in the Workplace* white paper commissioned by the Robert Wood Johnson Foundation (2006) in the United States of America (The Lewin Group, 2009), and the *Improving Working Lives Initiative* launched in 2000 by the NHS in the United Kingdom (Mercer, Buchan, & Chubb, 2010). According to these initiatives, strategies critical to supporting the nursing and midwifery workforce include sustained and consistent leadership, based on effective communication, transparency and a culture that intrinsically values and supports staff. Examples of effective flexible working strategies include phased retirement options, flexible scheduling (e.g. team-based self-rostering), nursing pools, transfers from bedside to clinical mentoring roles for older nurses, and IT-based workforce management databases.

In Australia, the Victorian Department of Health has commenced the *Value Added: Mature worker intervention projects 2011*, with funding provided to eight health services to design and develop intervention projects using the Business, Work and Ageing Mature Worker Retention model. Of particular interest is the Peninsula Health led project to investigate strategies that "promote work-life balance choices through flexible and supportive welfare... to maximise 1) retention of older nurses/midwives and 2) recognition of their commitment to the organisation" (Victorian Department of Health, 2011). These initiatives will form the starting point for reviewing key activity in developing flexible work arrangements and quality part time work approaches to support the Australian nursing and midwifery workforce.

POTENTIAL ISSUES, BARRIERS, AND ENABLERS INVOLVED IN EMBEDDING FLEXIBLE WORK AND QUALITY PART TIME WORK ARRANGEMENTS

Job stress and workplace tension are inherent in healthcare. The key is how they are managed. (Magee Gullatte & Jirasakhiran, 2005, p.598).

Leadership and management style and supervisory relationships are all themes frequently raised as enablers of, or indeed barriers to, nurse and midwife recruitment and retention, job satisfaction and successful implementation of flexible work arrangements and quality part time work (e.g. McNeese-Smith & Crook, 2003; Parker, et al., 2009). As such, these topics are addressed in more detail in the sections that follow.

Other issues related to implementing flexible work arrangements were presented by Harris and colleagues (Harris, Bennett, Davey, & Ross, 2010). To address a lack of knowledge around older nurses' experience of family friendly policies and flexible working, Harris and colleagues conducted a qualitative study of mid-life nurses (aged 45 years and older) working in various settings in the United Kingdom, including an acute teaching hospital. They investigated the factors that influence commitment and participation in the workforce. The following four themes emerged from their interviews and the biographical information they collected: the nature of nursing poses a challenge to the implementation of flexible working; there are differences in perceptions of the availability of flexible working; ward managers have a crucial role in the implementation

of flexible working policies; and the implementation of flexible working may be creating an inflexible workforce.

LEADERSHIP AND MANAGEMENT

According to an American Human Resources expert, Susan Heathfield, employees leave managers and supervisors more than they leave organisations (Heathfield, 2013). Thus a critical recruitment and retention strategy for nurses and midwives is to have "skilled nurse managers who are actively involved with their staff" (McNeese-Smith & Crook, 2003, p.266). Effective leadership was also nominated as a retention strategy in the Tasmanian Recruitment and Retention Report (Tasmanian Department of Health and Human Services, 2001). In addition, the Queensland Health Action Plan recommended employing and nurturing leaders "who demonstrate honesty, professional integrity and collaborative approaches to management" (Queensland Government, 2005, p.14)

The findings from Parker and colleagues' mixed-method study looking at the challenges confronting Australian clinicians in acute care also suggest a need for management styles that focus on staff empowerment, participation and team building (Parker, et al., 2009). Participatory management or shared decision making has been found to be an effective retention strategy increasing nurse job satisfaction (Hall Ellenbecker, Samia, Cushman, & Porell, 2007). Contingent on realising these ideas, of course, is an organisation having effective recruitment and retention strategies for managers as turnover rates for nursing managers can be comparable to those of other nursing staff (Cohen, 2006).

More than a decade ago NSW Health (2002) recognised nurse unit managers (NUMs) as being crucial to the future of nursing practice. By incorporating strategic human resource management in their role, problems are solved at the source, there is increased speed in decision making and better change management is achieved. However, to fulfil their multifaceted role, adequate resources, support and education are required by the organisation (Anthony et al., 2005). Thus ultimately, the quality of retention and recruitment strategies and the effective implementation of policies to support flexible work arrangements and quality part time work are dependent on the overarching organisational culture.

FLEXIBLE WORK ARRANGEMENTS

Exploring flexibility in work arrangements - what this means, how it works, and what the implications are – is attracting increasing interest in the context of recruitment, retention and productivity in pressured workforces. Part time work is an increasingly attractive option for many workers, particularly older workers, striving to balance family and caring roles, and to manage mental and physical workloads across the life course. However, the shift toward part time work has required significant attitudinal adjustment from employers and managers, in terms of recognising the value and benefits of this mode of work compared with full time work (Mercer, et al., 2010).

There are important considerations regarding part time work arrangements, noting that these can variously serve the interests of employees and employers, depending on prevailing labour conditions. From the perspective of employees, there is the potential for increased flexibility and work-life-family balance, which may be offset by reduced income. From the perspective of employers and managers, support for flexible work arrangements can afford enhanced recruitment and retention, higher workforce morale and being seen as an employer of choice, potentially offset by increased administrative burden and difficulty balancing organisational commitments. This is particularly pronounced in the nursing and midwifery context, where concerns have been expressed that flexible contracting may interfere with 24 hour commitments at the ward level. It has been noted that part time staff work fewer additional hours, making it difficult to balance fluctuations in staff requirements and periodic staff shortages (ibid).

Concerns have also been expressed that increased flexible work arrangements or more part time staff can create a sense of staff being 'transient' which can reduce the

perception of cohesiveness of ward staff which may impact on job satisfaction (Adams & Bond, 2000). Similarly, flexible work policies may generate an inflexible workforce according to Harris and colleagues where "older nurses are required to compensate for the flexible working patterns of their colleagues" (Harris, et al., 2010, p.421). However, this may simply highlight the need to better market and tailor flexible or part time work options for older nurses so their uptake is comparable to that of their younger colleagues.

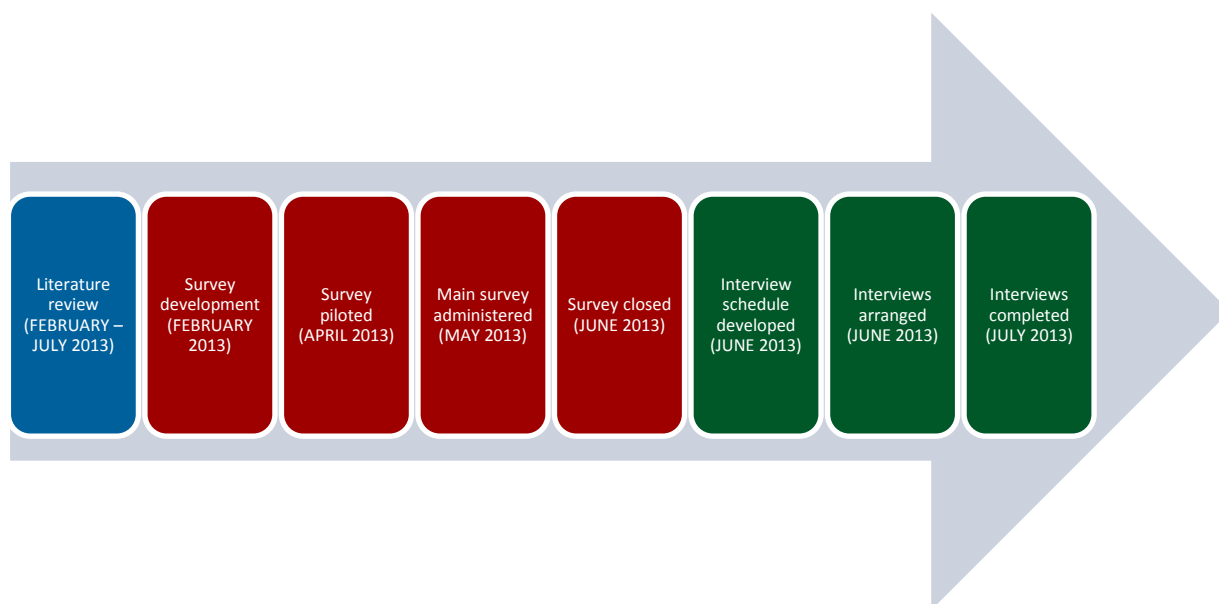## IMPLEMENTING QUALITY PART TIME WORK

WISeR (Barnett & Hordacre, 2011) has identified a number of factors central to the implementation of quality part time work, namely:

- Part time work is part of a broader workplace culture that values its employees, and values work-life balance

- Part time work is part of a broader suite of flexible work and leave options

- Part time work includes predictable hours and worker-sensitive scheduling and rostering and is available in hours that don't conflict with family and personal life

- Senior management demonstrates leadership and commitment to quality part time levels, at all levels in the organisation, and consistent responses to requests for part time work

- Backfill/shadowing is provided to support quality part time work at all levels

- Processes are in place to ensure all managers are informed of their responsibilities and all employees are informed of their entitlements regarding quality part time work

- Training and guidelines are provided for a) negotiating and b) managing quality part time work

- Quality part time work is part of a whole of organisation approach.

Appendix B. PROJECT METHODOLOGY

A quantitative online survey of nurses and midwives working in acute hospital settings in South Australia was followed by qualitative interviews with senior hospital management. Figure 22 illustrates the project's overall sequencing and milestones.

FIGURE 22: PROJECT TIMELINE

| Literature review (FEBRUARY – JULY 2013) | Survey development (FEBRUARY 2013) | Survey piloted (APRIL 2013) | Main survey administered (MAY 2013) | Survey closed (JUNE 2013) | Interview schedule developed (JUNE 2013) | Interviews arranged (JUNE 2013) | Interviews completed (JULY 2013) |

SURVEY DEVELOPMENT

The Australian Nursing and Midwifery Federation (ANMF SA Branch) sent a pilot survey to 20 members identified as working in an acute care setting. Six commenced the online survey and four of these completed it and provided feedback about survey content and processes. No major issues were identified with the interpretability of the survey or survey length thus no changes were made to the survey for the main rollout. Responses from the pilot survey were not included in the main analysis.

SURVEY ADMINISTRATION

More than 12,000 midwifery and nursing professionals worked in South Australian acute hospitals (excluding psychiatric) in 2011 (ABS 2011 Census of Population and Housing).

The primary method of survey distribution was through the ANMF (SA Branch) and managed by WISeR. Members identified by the ANMF as working in the acute care sector (n=8,869)[46] were sent an email comprising endorsement for the survey from their CEO/Secretary (Elizabeth Dabars) and information compiled by WISeR about the survey (including a link to the online survey which used the Survey Monkey web platform).

Nurses and midwives were given approximately 2 weeks to complete the survey with a reminder email sent after one week and another sent a day before survey closure. Reminder emails from the ANMF were very effective with a notable increase (e.g. 20%) in responses soon after the reminder was sent.

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[46] It is unknown how regularly the ANMF update their membership information/databases but anecdotal evidence suggests they have not been updated recently. Thus, 8 869 is unlikely to reflect the actual number of nurses and midwives currently working in acute care hospital settings in South Australia.

In order to capture a broader cross-section of nurse and midwife experiences and views, SA Health and three other hospitals expressed interest in distributing the online survey to staff (for a summary of all distribution sources see Table 7). Safework SA liaised directly with these other groups to distribute the survey using the materials produced by WISeR.[47] Due to the possibility of the same staff member receiving more than one email about the survey from different sources (e.g. from the ANMF and the hospital where employed), recipients of the email were asked to respond to the survey once only.

TABLE 7: SURVEY DISTRIBUTION AND COMPLETION

Organisation who distributed survey	Email sent to (N)	N who started survey	N who completed survey	Completion rate
ANMF (SA Branch)	8 869	1 373	1 095	79.8%
SA Health	unknown	332	227	68.4%
St Andrews Hospital	unknown	33	28	84.8%
Repatriation Hospital	unknown	13	11	84.6%
Memorial Hospital	unknown	8	4	50.0%
TOTAL		1759	1365	77.6%

DATA ANALYSIS

Data were imported from the online survey medium, Survey Monkey, to the statistical software package SPSS (version 19) where further variables were computed and various analyses carried out. Little data cleaning was required due to the online survey method prohibiting missing data or invalid responses.

This report presents the analysis of 1,365 eligible participants. Staff who did not fit the criteria as eligible nurses and midwives (n=5), those who did not work in an acute care hospital setting (n=142), and respondents who failed to complete the main elements of the survey (n=247) were excluded from analysis.

Analyses typically involved descriptive statistics and some parametric tests (e.g. independent t-tests and analysis of variance), where appropriate, to identify differences between groups. For example, group differences that reached *statistical significance*[48] are presented within the text. The three main groups that were tested for differences in responses were:

- Public hospital (n=1207) compared to private hospital (n=158) staff;

- Managers of staff (n=431) compared to other staff (n=934); and

- Older workers (45+ years; n=833) compared to younger workers (less than 45 years; n=532).

Analysis by distribution source (see Appendix C for more information), nursing classification and ward/area of work was not appropriate due to the small sample size in each group.

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[47] Specific details about the distribution of surveys to other organisations/hospitals are unknown. However, it appears internal processes delayed the dissemination of the survey and the survey was not administered to all relevant nurses and midwives.

[48] Statistical significance indicates whether data points or 'observations' reflect a pattern or have occurred by chance. The probability ("p") values or limits of what is considered statistically significant are conventionally set at "p<.05" ('significant') or "p<.01" ('highly significant'). The former means there is only a 5% chance of this result being a coincidence and the latter meaning only a 1% chance of the result being a coincidence.

Due to the selected survey distribution method, the majority of participants were ANMF (SA Branch) members (n=1247) but overall, 102 participants reported non-membership[49]. There was not a great deal of difference between member and non-member responses although Appendix D provides a summary of where differences did occur.

Non-parametric tests such as the chi-square test for independence were also applied when two categorical measures were involved. This test determines if two categorical measures are related, for example, are females more likely than males to be nurses.

INTERVIEW METHOD

Interviews were sought with senior hospital or human resource (HR) staff who would be able to respond to questions about flexible work arrangements from an organisational perspective. For all eight interviews conducted[50] this staff member was the Director of Nursing although some had other related roles (e.g. operations manager, director of patient services or directorates).

Interviewees were sourced by either SafeWork SA providing contact details through their Employee Reference Group members or a WISeR researcher cold-calling hospitals. Efforts were made to be inclusive of all types of acute hospitals (i.e. covering public and private funding sectors and metropolitan and regional locations). Four interviews were completed in person and four (mostly regional) were conducted over the telephone.

Interviews were designed to take approximately 40 to 45 minutes and most were completed in about 40 minutes. A couple of interviews needed to be completed in 30 minutes due to time constraints of the interviewee and the longest duration of an interview was an hour. All participants were sent the interview schedule two days prior to the interview for consideration.

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[49] Please note that responding to the question about union membership was optional therefore the total responses do not equal 1,365.

[50] The target number of interviews was 10 – just under 10% of the acute hospitals in South Australia (at June 2008 South Australia had 78 public acute hospitals and 31 private hospitals (Department of Health and Ageing, 2009). Interviews did not proceed at two regional hospitals because (1) the participant was ill and could not reschedule within the timeframe of the project; and (2) the position was being held by several acting Directors of Nursing who had not been in the position for very long and it was concluded that the same depth of information would not be available.

Appendix C. SUMMARY OF RESPONDENT CHARACTERISTICS BY DISTRIBUTION SOURCE

The survey was originally designed to be administered through the ANMF SA branch only. However, SA Health and three other hospitals expressed interest in participating in order to capture responses from non-ANMF (SA Branch) staff (see Appendix B for more details about Survey administration). As previously identified, the distribution method and uptake from SA Health and the other hospitals was extremely variable. We also note that respondent numbers from hospital specific dissemination was extremely low. In consultation with SafeWork SA, the decision was made to include all responses for analysis in the main dataset. However, we draw attention to some variation in respondents from each source and suggest some caution when drawing conclusions from the data.

In summary, SA Health data were most similar to ANMF data. Some of the more marked differences observed include:

- Classification/experience of nurses appeared quite limited, particularly for Memorial and Repatriation Hospital staff.

  o Staff from Memorial and Repatriation Hospitals (n=15) only included Level 2 or 3 nurses and midwives. The other sources had wider representation across the different nursing/midwifery classifications. The ANMF had representation of all classifications listed.

- Reasons for requesting flexible work arrangements were different across some sources.

  o Memorial and Repatriation Hospital staff were the only ones not to report parenting responsibilities as a reason for requesting flexible work arrangements. In contrast, this was the top reason provided by staff at each of the other sources (47.1% reported this reason at St Andrews; 40.2% reported this reason at SA Health and 34.3% reported this at the ANMF).

- No flexible work arrangement requests were refused by St Andrews, Repatriation or Memorial Hospitals.

  o This compares to around a quarter of requests being refused both through the SA Health and ANMF sources.

Appendix D.Summary of differential responses by ANMF (SA Branch) membership

Generally, ANMF (SA Branch) members replied to survey questions in a similar fashion to non-members. There were three main areas where some differences emerged -

- Health and safety issues of workload pressures – while average levels for both members and non-members were in the 'very little' to 'somewhat' range, members reported higher level of work related stress associated with the pressure to *meet patients' needs*, having a *workload that is too high*, *colleagues' inexperience*, *amount of pay*, *ambiguity about authority*, *lack of resources or equipment to support care delivery* and *lack of support from management* and that their *workload is too heavy*.
- Attitudes and experiences of flexible work arrangements - non-members were more likely to report a preference *not to work night duty* as the reason for requesting FWA
- Workplace culture - members were significantly less likely to indicate their *employer promotes the concept of 'quality part time work'* compared to non-members or that their *preferred shift patterns are usually accommodated* (with average responses varying between 'somewhat agree' and 'neither agree nor disagree'.

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