REGISTERED NURSE UNDERSTANDING OF ORGANISATIONAL COMMITMENT AND ITS LINK TO RETENTION: A GROUNDED THEORY STUDY

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This thesis is submitted in fulfilment of the requirements for the degree of Doctor of Philosophy.

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19th September 2012
DECLARATION

I hereby certify that this thesis does not, to the best of my knowledge and belief:

I. Incorporate without acknowledgment any material previously submitted for a degree or diploma in any institution of higher education;

II. Contain any material previously published or written by another person except where due reference is made in the text; or

III. Is the result of original research and has not been submitted for a higher degree to any other University or Institution.

Signature: ____________________________

Date: 19th September 2012
I would like to acknowledge and thank a number of individuals who have played particularly important roles by contributing to and supporting me during this research.

Foremost I wish to thank my principal supervisor, Professor Lorna Moxham, for her commitment and unfailing support and guidance throughout the course of my candidature. I also wish to thank and acknowledge the contribution of my co-supervisor Professor Trudy Dwyer.

This research could not have been accomplished without the generosity of the Registered Nurse participants. Though they must remain anonymous I acknowledge their major contribution and thank them sincerely for their willingness to share their time and their stories.

Finally and most importantly I thank my husband Colin and children Adam and Simon, who made many sacrifices to help me pursue this dream. Thank you for your enduring patience and love. You all supported and encouraged me and I am eternally grateful.
ABSTRACT

Destabilisation of the nursing workforce due to poor retention creates inconsistencies and disruptions to the delivery of health care services. It can also have a negative impact on patient care and safety. If registered nurses remain in their jobs then hospitals and the health care system will realise significant savings in costs associated with replacing registered nurses. The impact of the nursing shortage is that health care facilities will continue to have difficulty replacing registered nurses once they have left. Focusing on nurse retention rather than on recruitment, may be a useful strategy to address the nursing shortage.

Organisational commitment as a construct in workforce research has been related both negatively to turnover intentions and positively related to retention amongst employees. This construct was applied to this research which used a Grounded Theory methodology to examine how registered nurses understand organisational commitment and its link to retention. The registered nurse participant group came from acute care hospitals in Australia. The findings of this research are posited privileging the voices of the participants. Results add to the existing body of knowledge and are able to be explained and supported by existing literature within the field.

The purposive sample group contributed to this study by participating in semi-structured in-depth interviews in which they described and discussed their commitment and their experiences related to workplace commitment and its link to retention. The main finding of this study was that the registered nurse participants understood organisational commitment to be at the ‘local’ level. That is, being committed to their work unit, to their nursing practice within the work unit and to the patients within the work unit. The strength of the participants’ organisational commitment, and hence their
retention, was influenced positively or negatively by the management behaviours of their Nurse Managers. These findings formed the substantive theory of how registered nurses understand organisational commitment and its link to retention.
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CHAPTER ONE

RESEARCH OVERVIEW

INTRODUCTION

This thesis is the result of a Grounded Theory study conducted to examine how Registered Nurses understand organisational commitment and its link to retention. This research is a timely investigation into the possible use of the construct of organisational commitment with its link to retention, to increase Registered Nurse retention in acute care hospitals in Australia.

The media is replete with reports on the nursing shortage in Australia and the impact this may have on health care for the public. It has also attracted research into the causes and possible solutions for the problem. The Australian Federal, State and Territories governments have also undertaken investigations and provided reports which offered strategies to provide possible solutions to the nursing workforce shortage. Outcomes of research, together with Australian Government studies and reports, suggest that the nursing shortage requires initiatives which include: an increase in new recruits to the profession, retaining the Registered Nurses who are currently employed in nursing, and attracting Registered Nurses who have left the profession back into nursing employment. These strategies are often the most vocal in the literature on the nursing workforce shortage. This Grounded Theory research compliments these strategies, however it offers an alternative which extends this knowledge to focus on the retention of Registered Nurses currently employed in acute care hospitals in Australia.

The nursing workforce forms the largest body of employees in health care (Australia Health Practitioner Regulation Agency ([AHPRA] 2011), therefore, the
nursing shortage significantly impacts the quality of health care that can be provided (Ledgister 2003). Retention of nurses is of significant importance to health care organisations as it decrease costs, associated with turnover and recruitment, improves the quality of patient care that can be provided and keeps Registered Nurses with their organisations thus stabilising that organisation’s nursing workforce (Jones & Gates 2007). At a time when there is an increased demand for Registered Nurses, Australia is experiencing a nursing workforce shortage (National Health Workforce Taskforce 2009).

The management culture, policies and practices within the health care system are key influences for nurse workforce participation and job satisfaction (Duffield, Kearin, Johnston & Leonard 2006). If the employers and managers within the health care system do not meet the workplace expectations of contemporary nurses then this will become a causative factor that will impact the organisation’s ability to retain nurses. The growth in the number of private hospitals, the improvement in health care outcomes for Australians, an increase in the acuity and complexity of patient care requirements and an increase in the number of day only surgery cases have all contributed to the nursing shortage (Doiron, Hall & Jones 2008). An accelerated patient throughput and acute understaffing has increased the workload and responsibility of the Registered Nurse, leading to job dissatisfaction and nurses leaving the profession (Duffield et al. 2006). The Australian nursing shortage has also been exacerbated by a rapidly aging nursing workforce, with the largest nursing cohort in Australia aged between 50 and 54 years (APHRA 2011). These statistics combined with an aging general population will lead to an increase in health service utilisation. The Baby Boomer demographics in Australia demonstrate that there is a larger proportion of the population approaching their senior years than in the past. The number of people 65 years to 84 years is expected to more than double, and the number of people 85 years and over more than
quadruple by 2050 (World Health Organisation [WHO] 2011). This large cohort of elderly population will have expanding health care needs at a time when there will be proportionately fewer younger people to not only provide but also fund the health care requirements of this section of the community (Leurer, Donnelly & Domm 2007). Poor nurse retention rates also lead to a loss of acquired knowledge, expertise and experience resulting in both financial and quality of care costs for health care organisations (Twigg, Duffield, Thompson & Rapley 2010). These costs include those associated with recruiting, training and professional development and productivity losses. Effective retention of Australia’s nurses could mitigate this impact by sustaining the nursing workforce.

The predicted loss of years of nursing experience due to nurse retirement together with the current nursing shortage could have a devastating impact on the quality of health care that Australia can provide for its citizens (Schofield 2007). Retaining the nursing workforce is not only a challenge but a priority for today’s health care managers and nurse leaders. A consolidated approach which includes identifying those human resource management practices which foster and support attachment to the organisation is a positive approach to address the problem (Hogan, Moxham & Dwyer 2007). As health care organisations battle to gain the most from their existing nurse employees in an environment characterised by nurse and nurse skills shortages, the role of human resource management in fostering employee attachment and commitment is paramount (Nehmeh 2009). Therefore, identifying how Registered Nurses understand organisational commitment and its link to retention is an important step in providing information that may be used to create a health care environment that encourages nurse employees to want to stay.

This chapter will outline the research question and discuss the purpose, aims and
rationale and significance of this Grounded Theory study. The definition of key terms and a description of the organisation of this thesis are also provided.

**RESEARCH PURPOSE AND AIDS**

The aim of this research was to discover how Registered Nurses (RN) understand, organisational commitment and its link to retention. This Grounded Theory offers an explanation as to why RN organisational commitment and hence retention continues to be the problematic by developing a substantive theory that explains RN understanding of organisational commitment and its link to retention.

Destabilisation of the nursing workforce by poor nurse retention leads to high nurse turnover. This is characterised by inconsistencies and disruptions to the delivery of health care services and potentially negatively impacts on patient care and safety (Ledgister 2003). If nurses can be retained in their jobs then hospitals and the health care system will realise significant savings on costs that are associated with replacing nursing staff (Jones & Gates 2007). The current nursing shortage means that health care facilities will continue to have difficulty replacing nurses once they have left (National Health Workforce Taskforce 2009). Examining organisational commitment as a construct in workforce research identified that organisational commitment is negatively related to turnover intentions and positively related to retention amongst employees (Meyer & Allen 1997). Therefore, this research aimed at examining RN understanding of organisational commitment and its link to retention is well placed to provide health care managers with information with regard to what positively or negatively affects nurse retention. Health care managers may be able to use the substantive theory developed by this Grounded Theory research to inform the development of organisation wide strategies to support nurse retention objectives.
RESEARCH QUESTION

How do Registered Nurses understand organisational commitment and its link to retention?

RATIONALE AND SIGNIFICANCE OF THE STUDY

There are few occupations that have attracted as much media and government interest, with regard to supply and demand as nursing. The Australian Federal, State and Territories governments have, over numerous years commissioned a number of reports into the labour market for nurses (Forster 2005; Australian Health Workforce Advisory Committee [AHWAC] 2004; NSW Health 2004; Department of Health and Human Services, Tasmania 2001; NSW Health Department 1998). Some of these reports were undertaken more than a decade ago, yet the retention of nurses remains a significant problem in Australia today (Holland, Allen & Cooper 2012). To illustrate the magnitude of the problem, the New South Wales (NSW) State Government released figures indicating that 6,700 nurses had resigned from the NSW health system from July 2007 to June 2008. The figures indicated that some of these nurses were promoted into other position within NSW Health, some completed their training and moved to new positions in other healthcare facilities and a portion decided to take some time out from nursing (Skinner 2008).

The current severe shortage of nurses working in Australia can be attributed to both the decreasing enrolments in nursing education and poor retention rates within the nursing workforce (Cormack 2011; Doiron, Hall & Jones 2008). As alluded to, the aging of the nursing workforce will also create critical shortages in the future as a greater proportion of nurses reach retirement age (Hogan, Moxham & Dwyer 2007). The Australia Health Practitioner Regulation Agency (APHRA 2011) reported that the
The largest nursing cohort in Australia is aged between 50 to 54 years.

The growth in the number of privately owned and operated hospitals over the past twenty years may have also contributed to the shortage of nurses in the public sector, as nurse resources shifted to this rapidly growing area of private health care (Doiron, Hall & Jones 2008). The total number of private hospitals in 1991-92 was 391, expanding to 502 in 1998-99 (Australian Bureau of Statistics [ABS] 2001) and increasing to 561 in 2008-09 (Australian Institute of Health and Welfare [AIHW] 2008), and reaching a total of 573 in 2009-10 (AIHW 2010).

A further impact on requirements for future nursing workforce numbers is the increase in longevity for Australians. The required nursing numbers and hospital inpatient beds numbers will need to increase to accommodate a population with improved mortality rates and increasing life expectancy rates (New South Wales [NSW] Government 2010). The Australian population is projected to grow from around 22 million people currently to 39.5 million people in 2050. The aging of the Australian population will see the number of people 65 years to 84 years, more than double and the number of people 85 years and over more than quadruple within this period (World Health Organisation [WHO] 2011). Most of the gains in life expectancy among older Australians occurred during the latter three decades of the twentieth century when mortality from cardiovascular disease fell rapidly (NSW Health 2010). The World Health Organisation ranks Australian life expectancy among the highest in the world in 2009, with females at this time expected to live to 84 years and males to live to 80 years (WHO 2011). This large group of what will be older citizens will have expanding and more complex health care needs at a time when there will be proportionately fewer younger people to provide and fund the required health care of this section of the population (Leurer, Donnelly & Domm 2007).
Another significant challenge that will impact on the required numbers of nurses for the future will be the expected increase in the number of severely ill patients (WHO 2011). This situation coupled with shortened lengths of hospital stay and an increase in the acuity and complexity of hospital inpatients’ nursing care requirements, together with an increase in day surgery admissions and day only surgery will see a need for hospitals to increase their nursing workforce numbers (Duffield, Diers, Aisbett & Roche 2009).

The most valuable and yet volatile asset for any health care organisation is a stable workforce of competent, dedicated employees (Malyon, Zhao & Guthridge 2010; Doiron, Hall & Jones 2008; McCabe & Garavan 2008; Hogan, Moxham & Dwyer 2007; Dockel, Basson & Coetzee 2006 ). The depth of knowledge of an organisation’s employees gives the organisation its strength, but personnel can also contribute to its weakest link (Kreisman 2002). When a competent nurse employee resigns it is increasingly difficult to replace them with someone of comparable competence, even with an effective succession planning process and wide marketing (Dockel, Basson & Coetzee 2006). Competition is fierce within and amongst organisations which are often forced to hire persons with less experience (Wright & Kehoe 2007). If this process of experienced nursing staff loss is repeated often enough then, according to Kreisman (2002), the competence and capacity of the organisation’s nursing workforce will gradually diminish along with the ability to meet health care consumer expectations.

Nursing forms the largest body of employees in the health care system, so a shortage of nurses jeopardises many aspects of health care delivery (Ledgister 2003). Australia Health Practitioner Regulation Agency (APHRA) (2011), which is Australia’s single national agency for health practitioner registration, reported that of the 530,115 health practitioners registered in Australia, the nursing and midwifery profession
formed the largest group with 290,072 registered nurses, 1,789 registered midwives and 40,324 nurses registered as both registered nurses and midwives. Australia’s rapidly maturing nursing workforce is fast approaching retirement age (Leurer, Donnelly & Domm 2007). This translates to a looming and dramatic loss of acquired knowledge and expertise. The projection of nursing retirement numbers indicate that Australia can expect to need to replace an average of fourteen percent of the nursing workforce every five years from 2006 to 2026 due to older nurses leaving the workforce alone (Schofield 2007). For the nurses who remain in the workforce, working with greater numbers of less experienced nurses could lead to a loss of job satisfaction due, in part, to concerns for the clinical safety of the patient (Atencio, Cohen & Gorenberg 2003). A registered nursing workforce with less experienced staff and without the required number of nurses available to accurately assess a patient’s condition and intervene appropriately, may lead to negative patient outcomes such as shock and cardiac arrest and failure to rescue (Leurer, Donnelly & Domm 2007). This situation could have a devastating impact on the quality of health care that is able to be provided.

As indicated, this decrease in both available nursing hours and experienced nurses can lead to negative patient outcomes as RNs provide a 24 hour, seven day per week surveillance system for patients. This surveillance enables early detection and prompt intervention if a patient’s condition begins to deteriorate (Twigg et al. 2010). Because of this, nurses are in the best position to initiate actions and minimise adverse events and negative outcomes for their patients such as sepsis, urinary tract infections, skin pressure ulcers and pulmonary embolism (Twigg et al. 2010). The effectiveness of nurse surveillance is directly influenced by the number and skill mix of nurses available to assess patients on an ongoing basis. Risk factors for hospital acquired pneumonia such as prolonged patient immobility leading to inadequate ventilation of parts of the lungs and inadequate pulmonary hygienic techniques have been directly associated with
the hours and skill of nursing care (Twigg et al. 2010). The number of RNs and staffing levels in hospitals can also have a direct impact on mistakes made together with error prevention, and these can be attributed to unsafe staffing and education and unsafe work (Ritter 2011).

The association between patient to nurse ratios, patient mortality, failure to rescue (patient deaths following complications) and factors related to nurse retention was established by a seminal study undertaken by Aitken, Clarke, Sloane, Sochalski and Silber (2002). The study was a cross-sectional analysis of linked data from 101,184 staff nurses surveyed, 232,342 general, orthopaedic and vascular surgery patients discharged from hospital between April 1998 and November 1999, and administrative data from 168 non-federal adult general hospitals in Pennsylvania in the United States of America. The study found that each additional patient per nurse over the five patients to one nurse ratio (5:1) was associated with a seven percent increase in the likelihood of dying within 30 days of admission and a seven percent increase in the odds of failure to rescue (Aitken et al. 2002). The study also found that each additional patient per nurse over the five patients to one nurse ratio (5:1) was associated with a twenty three percent increase in the odds of nurse burnout and a fifteen percent increase in the odds of nurse job dissatisfaction (Aitken et al. 2002).

Raffety, Clarke, Coles, Ball, James, McKee and Aiken (2007) also undertook research to examine the effects of hospital wide nurse staffing levels (patient-to-nurse ratios) on patient mortality, failure to rescue (mortality risk for patients with complicated stays) and nurse job dissatisfaction, burnout and nurse-rated quality of care. Cross-sectional analysis was used which combined nurse survey data with discharge abstracts utilising nurses (n=3984) and general, orthopaedic and vascular surgery patients (n=118752) in 30 English acute trusts (Raffety et al. 2007). Findings
demonstrated that patients and nurses in the quartile of hospitals with the most favourable staffing levels (the lowest patient-to-nurse ratios) had consistently better outcomes than those in hospitals with less favourable staffing. Patients in the hospitals with the highest patient to nurse ratios, had twenty six percent higher mortality (ninety five percent CI: twelve to forty nine percent). The research also found that nurses in those hospitals were approximately twice as likely to be dissatisfied with their jobs, to show high burnout levels and to report low or deteriorating quality of care on their wards and hospitals (Raffety et al. 2007).

Further research by Hinno, Partanen and Vehvilainen-Julkunen (2012) was undertaken to investigate the relationship between nurse staffing and adverse patient outcomes to optimise the management of professional nursing resources and patient care. This research utilised nurses employed in hospitals in Finland (n=535) and the Netherlands (n=334). The nurse-to-patient ratio was on average 8.74:1; however, there were fewer RNs and significantly more licensed practical nurses among the Dutch hospital staff than the Finnish staff. The research found a significant association between nurse staffing and adverse patient outcomes, with Finnish nurses having higher patient-to-nurse ratios and higher rates of adverse patient outcomes. Frequencies of patient falls were directly attributed to the patient-to-nurse ratio in both countries. These findings demonstrate the potential effects of reductions in nursing staff on the occurrence of adverse patient outcomes in hospital settings (Hinno, Partanen & Vehvilainen-Julkunen 2012).

A further consequence of the nursing shortage for health care organisations is the high cost in actual dollars. The rate of nurse turnover in North America in 2000 was twenty one point three percent, with the turnover costs up to two times a nurse’s salary (Atencio, Cohen & Gorenberg 2003). A discussion paper to illuminate numerous
employee-retention related issues of particular significance to organisations was undertaken by Kreisman (2002). The discussion paper utilised the concept of ‘insight’ to demonstrate how this can be used as a process to enhance understanding between employees and managers to enable a closer relationship to develop to improve employee motivation, commitment and retention. A breakdown of costs associated with nurse turnover was divided into various components which were included in the overall calculation (Kreisman 2002). This breakdown consisted of: the loss of productivity; cost of overtime or temporary workers; loss of efficiency, including institutional knowledge; lowered morale of co-workers; recruiting costs; screening of applicants; interviewing time and how many people are required to interview each applicant; hiring costs such as background checks; relocation expenditures and temporary housing; time spent in orientation; training and assimilation into work teams and lower productivity during learning periods (Kreisman 2002). A further discussion paper by American authors Jones and Gates (2007) called for the construction of a business case for nurse retention, using benefit-cost and cost effectiveness analysis, relevant to nurse turnover and retention. A foundation for including the costs and benefits of nurse turnover and retention in estimating the economic value of nursing was also provided (Jones & Gates 2007). The identified costs related to nurse turnover included those identified by Kreisman (2002) together with the additional components of potential patient errors and compromised care, poor work environment and culture, dissatisfaction and distrust and additional nurse turnover (Jones & Gates 2007). Alternatively, benefits associated with nurse retention were identified as:

- reduction in advertisement and recruitment costs;
- fewer vacancies and reduction in vacancy costs;
- fewer new hires and reduction in hiring costs;
fewer orientees and reduced orientation and training costs;

- maintained or increased productivity;

- fewer terminations and reduction in termination costs;

- decreased patient errors and increased quality of care;

- improved work environment and culture, increased satisfaction, trust and accountability;

- preservation of organisational knowledge;

- easier nurse recruitment.

(Jones & Gates 2007, p.5).

Building and sustaining a stable nursing workforce is a priority as well as a challenge for health care organisations (Hogan, Moxham & Dwyer 2007; Wagner 2007). The factors discussed here that confront the nursing workforce, nursing care and health care outcomes now and in the future will only be exacerbated by the continuation of the nursing shortage. These issues provide the background as to why this Grounded Theory research, which utilised the construct of organisation commitment and its link to retention to provide a substantive theory of how RNs understand organisational commitment and its link to retention, is significant. As the purposive participant group for the research was RNs working in acute care hospitals in Australia, this substantive theory provides new information which can contribute to improvements in the retention of the nursing workforce.

The following page provides definitions for key terms used throughout this thesis.
**DEFINITION OF KEY TERMS**

**Acute Care Hospitals:** hospitals that provide acute inpatient care.

**Australia Health Practitioner Health Registration Agency:** Australia’s single national agency for health practitioner registration.

**Bachelor of Nursing Degree:** an undergraduate degree awarded on satisfactory completion of a course of study at an accredited educational institution. The recipient of this degree is eligible to be granted national registration by the Australia Health Practitioner Regulation Agency as a registered nurse.

**Human Resource Management:** purposeful practices that are introduced into an organisation to affect organisational outcomes by shaping employee behaviours and attitudes.

**Job satisfaction:** the degree to which individuals like their jobs.

**Leadership:** a behaviour enacted that sets the tone of the organisation, defining its values and norms and one which creates and maintains a persona of what the organisation is like.

**Nurse Management:** this position acts as an agent for the organisation. The incumbent enacts leadership behaviour and provides management of the designated area via adherence to the goals, mission, policies and practices of the organisation and the nursing
codes, ethics and competencies set out by the Nursing and Midwifery Board of Australia. Employee supervision, multi-disciplinary consultation and the application of the organisation’s Human Resource Management practices also encompasses this role.

**Nurse Managers:**

The title for this position may vary according to the size and management structure within the individual acute care hospital.

**Nursing and Midwifery Board of Australia:**

registers nursing and midwifery practitioners and students; develops standards, codes and guidelines for the nursing and midwifery profession; handles notifications, complaints, investigations and disciplinary hearings; assesses overseas trained practitioners who wish to practise in Australia and approves accreditation standards and accredited courses of study.

**Organisational commitment:**

a psychological bond between the employee and the organisation, which is conceptualised as the degree to which individuals identify with and are involved in the organisation and wish to remain with the organisation.

**Registered Nurse (RN):**

a person who has completed a course of training as a nurse in an institution that is recognised by the
Nursing and Midwifery Board of Australia (Australian Health Practitioner Regulation Agency) as entitling the person to be registered by this Board as a nurse. The person will hold a degree, diploma, certificate or other qualification to the effect that the person has successfully completed the course of training as a nurse.

**Retention:** the extent to which employees remain employed within an organisation.

**Turnover:** the act of leaving a current job; departing the organisation all together.

**Turnover intention:** is a behavioural intention to leave the organisation at which the person is employed.
KEY TO TRANSCRIPT RESPONSE EXCERPTS

Quoted sections from participant data (interview transcripts) are included in this thesis. Please note that for ease of reading, where there is no effect on the meaning of the statement, I have excluded from the quotes:

1) Verbal utterances such as “mmm” and “err”;
2) Use of ‘fill in’ words such as “like” and “right” and “OK”; and
3) Repeated words due to stuttering.

The following font and symbols have been used when including participant data in the thesis:

1) *Italics*: Used to indicate all excerpts from interview transcripts;
2) . . . Section of the original quote has been left out;
3) - - - Long pauses (several seconds) by participants.

The page that follows provides a diagrammatic depiction of the information contained in each chapter to demonstrate the overall organisation of this thesis.
ORGANISATION OF THIS THESIS

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- Research purpose and aims
- Research question
- Rationale and significance of the study
- Definition of key terms
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- The nursing workforce shortage
- Nurse retention
- Organisational commitment and its link to retention

CHAPTER THREE
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BACKGROUND

INTRODUCTION

This chapter provides an explanation of the contribution of the literature in this Grounded Theory research and an overview of Australia’s health care system to establish a background for this study. This overview explains how the health care system is funded and functions, and provides details of the number of hospitals in Australia, their location and a description of the services provided. The number and distribution of hospital beds is also discussed, together with the Australian nursing workforce’s demographics and employment characteristics. A discussion of the reasons for the Australian nursing workforce’s shortage is undertaken. A brief overview of the importance of nurse retention in enabling health care organisations to maintain an appropriate supply of nurses to meet the health needs of their patients also provides a contextualised background, and sets the scene for this research. A brief discussion of the construct of organisational commitment, and its link to retention, establishes the vital importance of this construct in the occupational context of organisational research.

THE CONTRIBUTION OF LITERATURE IN GROUNDED THEORY RESEARCH

The literature within a Grounded Theory research is more selective than exhaustive, and more a part of the data collection and analysis when compared to the traditional literature review. It is not a precursor to the activities of data collection and analysis but an integral part of those activities (Glaser 1992). The literature provided the foundation for the scope of this research, limiting it to discovering what RNs understand of organisational commitment and its link to retention. The literature also
assisted in defining the key components of the nursing shortage and the significance of
this research. It provided an overview of the Australian health care system and the
Australian nursing workforce, nurse retention as well as the construct of organisational
commitment and its link to retention as used in organisational research.

Following the completion of data collection and analysis, the literature was
further reviewed to provide both data validation and refinement. Classic Grounded
theorist Glaser (1992) advocates delaying the review of the literature until after the data
collection is complete. He stresses that research should not be inadvertently affected by
a review of the literature. Hence, the literature is not given a privileged position in this
research.

Rather, the literature in this research is an important source of scoping and data
but not more so than the other data sources. The literature and the data collected
complement each other. In this way the theory, which has emerged from the voices of
the participants, is consistent and adds to the body of knowledge.

The literature provides a final check on the emergent theory and completes the
process of validation and relevancy. In this manner, the literature in this research
conforms to the intent of what Glaser (1992) prescribed for the use of literature in a
Classic Grounded Theory research.

The following sections provide an overview of the Australian health care
system, the Australian nursing workforce and the nursing workforce shortage.

**OVERVIEW OF THE AUSTRALIAN HEALTH SYSTEM**

The Australian health care environment is complex, involving multiple funding
sources and a mix of public and private sector health care providers. The major part of
the national health care funding system is Medicare, allowing universal access to health
care which is often free of charge at the point of care (Australian Government 2009). Funding agreements between the Commonwealth government and state and territory governments contain aspects within the agreements which must be complied with to avoid financial penalties for non-compliance (Johnstone 2007). Therefore it is necessary to firstly understand these complexities to establish that the nursing shortage has indeed influenced both the funding and the functioning of the health care system.

The Australian health care system is funded and administered by different levels of National, State, Territory and Local government and is also supported by private health insurance arrangements. The Australian (Federal) Government administers the Australian national public health insurance scheme, Medicare. This is a universal, tax-financed public health insurance that was established in Australia in 1984 (Australian Bureau of Statistics [ABS] 2008). In 1977 the Australian Government introduced a Medicare levy of one point five percent of an individual’s taxable income to enable the government to meet the additional costs of the national health care system (ABS 2008). Currently individuals and families who do not purchase an appropriate level of private hospital health insurance may pay a Medicare levy surcharge of an additional one percent to one point five percent calculated according to their level of annual taxable income (Australian Government 2012). Medicare consists of the care components of medical services, prescription pharmaceuticals and hospital treatment as an inpatient. The objective of Medicare is to make health care accessible and affordable to all Australians (Australian Bureau of Statistics 2008). Medicare offers Australians subsidized access to their doctor of choice for out-of-hospital care, free public hospital care and subsidized pharmaceuticals. Approximately sixty eight percent of the total health expenditure comes from public sources with the Australian (Federal) Government financing forty six percent and the Australian States and Territories twenty two percent of the expenditure and private sources funding the remaining twenty two

30
percent (Leeder 2011).

Private health insurance is a voluntary option to all Australians for private funding of their hospital and health treatment. This insurance supplements the Medicare system. Private health insurance can cover costs associated with private hospital theatre and accommodation charges to patients, either in a public or private hospital. Private insurance also covers a portion of medical fees for services provided to private patients such as the allied health services of dental care and the provision of prescription spectacles (ABS 2008).

Fiscal and functional responsibilities for health care in Australia are divided between the Australian Government, the six Australian States, the two Territories and between public and private providers (Leeder 2011). The Australian Government is primarily responsible for health service funding, health products, services and workforce and national health policy leadership (ABS 2008). The Australian Government Department of Health and Aging engages in national health policy-making, funds health care, is concerned with population health and research and monitoring of population health and the health system activities (Leeder 2011). The Australian (Federal) Government contributes funds to the States and Territories to run public hospitals through the Australian Health Care Agreements which document the portion of funding contributed individually by the Federal Government and State Governments (ABS 2008). Australia’s public hospital system provides the majority of acute care services and provides access free of charge for public patients. The Australian State and Territory Governments have primary responsibility for the delivery and management of their public health services which include public hospitals, community health and public dental care (ABS 2008). Local government municipal or shire councils are responsible for environmental health services and public health programmes but have no role in
clinical services (Leeder 2011). The structure of the Australian health care system and its flow of funds is provided in

**Figure 1.**

![The Structure of the Australian Health Care System and its Flow of Funds](image-url)

**Figure 1:** The structure of the Australian health care system and its flow of funds. (Australian Institute of Health and Welfare 2008, p.2).
HOSPITALS IN AUSTRALIA

BEDS, LOCATION AND SERVICES

In Australia both public and private hospitals provide hospital services. Acute care hospitals provide active short term treatment for a severe injury or episode of illness, urgent medical condition or recovery from surgery. The Australian Institute of Health and Welfare ([AIHW] 2011), which reports on the characteristics and activity of Australian hospitals, showed that there were 1,326 hospitals in Australia. An overview of the number and types of hospitals is provided in Figure 2. An overview of available hospital beds in Australia is provided in Figure 3.

1,326 Hospitals in Australia: Overview

- 736 Public Acute Hospitals
- 17 Public Psychiatric Hospitals
- 293 Private Day Only Hospitals
- 280 Private Hospitals

Figure 2: Overview of hospitals in Australia.
(Adapted from statistics presented by The Australian Institute of Health and Welfare 2011, p.4).
Hospital Beds in Australia: 
Overview

<table>
<thead>
<tr>
<th>Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Hospital Beds</td>
<td>54,812</td>
</tr>
<tr>
<td>Public Psychiatric Hospital Beds</td>
<td>2,088</td>
</tr>
<tr>
<td>Private Day Only Hospital Beds</td>
<td>2,260</td>
</tr>
<tr>
<td>Private Hospital Beds</td>
<td>25,778</td>
</tr>
</tbody>
</table>

**Figure 3: Overview of hospital beds in Australia.**
(Adapted from statistics presented by The Australian Institute of Health and Welfare 2011, p.5).

The Australian Institute of Health and Welfare Report (AIHW) (2011) Australian Hospitals at a Glance, showed that Australian public hospitals are very diverse in size and types of services provided for admitted and non-admitted patients. Australian hospitals are located in major cities and regional and remote areas. Principal referral hospitals in major cities average 411 beds, large regional hospitals average 143 beds and hospitals in remote areas average 21 beds (AIHW 2011). Australian hospitals provide out-patient clinics and emergency treatment for non-admitted patients and emergency and planned elective care for in-patients. Principal referral hospitals are predominately located in major cities and offer a range of speciality services such as cardiac and neurosurgery and the management of burns. Hospitals located in regional Australia offer psychiatric, medical, surgical and obstetric and accident and emergency services (AIHW 2011).

The Australian health system is currently being reformed as a result of the
Federal Government signing a national health reforms package in August 2011 (Roxon 2011). This reform package allows for the Australian (Federal) Government to invest an extra $19.8 billion in public hospitals through 2019-20 rising to a total extra $175 billion in 2029-30. This reform means that the Federal and State and Territories Government will share future funding growth for hospitals in equal partnership. The Australian (Federal) Government will permanently pay forty five percent of growth in hospital services in 2014-15, increasing to fifty percent in 2017-18 (Roxon 2011).

**THE AUSTRALIAN NURSING WORKFORCE**

**DEMOGRAPHICS AND EMPLOYMENT CHARACTERISTICS**

A registered nurse is defined as a nurse or midwife who is on the register maintained by the Australia Health Practitioner Regulation Agency. Nurses in Australia commenced national registration with the Australia Health Practitioner Regulation Agency (AHPRA) in 2011. Prior to this, registration was legislated at state and territory levels. The minimum educational requirement for a registered nurse or midwife is a 3-year degree from a higher education institution or equivalent from a recognised hospital-based program. For ongoing maintenance of their registration a nurse must have practised for a specified minimum period in the five years prior to registration renewal (AHPRA 2011; AIHW 2009).

National demographic data on nursing and midwifery was released by AHPRA and National Boards in their annual report in November 2011. The report found:

- the nursing profession had both the youngest and oldest practitioners with the typical nurse being female and the largest cohort aged between 50 and 54 years. This accounted for 18 percent or 51,998 of the profession;
the largest number of nurses practised in the Australian state of New South Wales;

midwifery was the most female dominated profession with ninety nine point six seven percent or 1,783 of all midwives being women;

the largest group of midwives was aged 40-44 years and practised in the Australian state of Victoria;

as of June 2011 there were 332,185 nurses and midwives registered to practice in Australia;

the breakdown of nurses showed that 1,789 nurses held midwifery registration only and 290,072 held nursing registration only with 40,324 holding dual nursing and midwifery registration;

there were 59,901 enrolled nurses and 228,114 registered nurses;

eighty three percent or 274,228 of the total number of registered nurses and dual midwifery registrants were female;

there were 61,416 students of nursing and 2,483 students of midwifery from April 2011.

(AHPRA 2011, p.2).

The AIHW (2009) Nursing and Midwifery Labour Force Survey collected information on the employment characteristics of nurses who were registered or enrolled in Australia during the 2009 survey. The difference between a RN and an enrolled nurse is that the enrolled nurse attains a Diploma of Enrolled Nursing from a recognised educational institution and is required to work under the supervision and direction of the Registered Nurse (Commonwealth Department of Education, Science and Training 2011). The survey data was collected by Australian State and Territory health authorities, with the questionnaire administered by the registration boards in each
jurisdiction in conjunction with the registration renewal process. This data was collected prior to the introduction of national nurse registration which commenced in 2011. This data is the latest available on Australian nurse employment characteristics:

- between 2005 and 2009, the number of nurses actually employed in nursing increased by thirteen point three percent, from 244,360 to 276,751;
- the average weekly hours worked by employed nurses and midwives increased slightly from 33.0 hours in 2005 to 33.3 hours in 2009. Over the same period, the proportion of nurses working part time (less than 35 hours per week) declined slightly from forty nine point eight percent to forty seven point seven percent;
- overall, nursing supply increased by six point two percent between 2005 and 2009, from 1,040 full-time equivalent nurses per 100,000 head of population to 1,105 full-time equivalent nurses, based on a 38-hour week. This was mainly a result of both a thirteen point three percent increase in the number of employed nurses, and a point nine percent increase in the average hours they worked over this period;
- nursing supply across regions ranged from 997 full-time equivalent nurses per 100,000 head of population in major Australian cities to 1,240 in very remote areas of Australia;
- between 2005 and 2009, the proportion of employed nurses aged 50 years and over increased from thirty five point eight percent to thirty six point three percent. The average age of nurses decreased from 45.1 years in 2005 to 44.3 years in 2009.

(AIHW 2009, p.7).
Most Australian nurses work in acute care hospitals, while others work in places such as residential aged care facilities, mental health units and in community health centres. In terms of skill levels and areas of responsibility, the nursing workforce is not homogeneous, but varies widely according to the type of care being provided, and between work settings from operating theatres to community care (Australian Institute of Health and Welfare 2009).

The profile of nurses by employment sector changed little between 2005 and 2009, with around two-thirds of nurses employed in the public sector with sixty five point nine percent in 2005 and sixty seven point three percent in 2009. In 2009 nurses employed in the public sector worked an average of two point one hours per week more than nurses employed in the private sector, with 34.0 and 31.9 hours respectively (AIHW 2009).

The nursing profession has a duty of care, bound by legislation, morals and ethics to treat patients competently and in a caring and professional manner (AHPRA 2011). Legislation under Section 12 of the Health Practitioner Regulation National Law (2009) enacted by participating jurisdictions, was approved by the Australian Health Workforce Ministerial Council in July 2010 and forms the national nurse registration standards in relation to:

- criminal history registration standard;
- English language requirements registration standards;
- professional indemnity insurance arrangements registration standard;
- recency of practice registration standard;
- registration standard for endorsement of nurse practitioners in accordance with section 95 of the National Law.
Furthermore in accordance with Section 14 of the National Law for endorsement in relation to scheduled medicines for registered nurses (rural and isolated practice):

- class of Health Practitioner – any person registered as a registered nurse under the National Law whose registration has been endorsed by the Board in accordance with Section 94 of the National Law;
- type of use – endorsed as qualified to obtain, supply and administer a class of scheduled medicines (as prescribed below);
- class of scheduled medicines – Schedule 2, 3, 4 and 8 medicines for nursing practice in a rural and isolated area.

(AHWMC 2010, p.1).

Australian nurses must also practise within Federal Government Legislation such as the Freedom of Information Act 1992 which is a statutory avenue through which an individual can access their personal medical and health records held by a public authority. The Mental Health Acts contain provisions for initiating involuntary assessment, authorizing involuntary treatment and an independent review of involuntary treatment and patient rights. The Workplace Health and Safety Legislation, applies to all hospitals and health care agencies to ensure freedom from the risk of disease or injury created by workplaces and workplace operations or specific high-risk plants (Queensland Government 2011).

The Nursing and Midwifery Board of Australia (NMBA) (2010) has established codes and guidelines to provide guidance to the nursing profession, clarifying their views and expectations on a range of issues. Australian nurses are expected to practise within these parameters; penalties or deregistration may apply if a nurse is found guilty.
of practising outside these codes and guidelines. The NMBA (2010) provides codes for nursing ethics which outline the nursing profession’s commitment to respect, promote, protect and uphold the fundamental rights of people who are both the recipients and providers of nursing and health care. The NMBA (2010) has also established a code of conduct which sets the minimum standards for practice a professional person is expected to uphold, both within and outside of professional domains, in order to ensure the ‘good standing’ of the nursing profession. The NMBA (2010) have also identified a decision making framework and guidelines for registration standards. The NMBA has established principles for the assessment of national competency standards, professional boundaries and professional practice guidelines which provide a framework for legally and professionally accountable and responsible nursing practice in all clinical, management, education and research domains (NMBA 2010). Australian nurses must also adhere to Health Law which encompasses medical negligence, children and consent, confidentiality, privacy and access to health records (White, McDonald & Willmott 2010).

The section that follows will discuss the reasons for and impact of the nursing workforce shortage.

**The Nursing Workforce Shortage**

There are a number of reasons why the inability to retain nurses continues to be a major problem for health care organisations in Australia. The Australian nursing workforce is aging, with the largest cohort of nurses registered with the Australia Health Practitioner Regulation Agency (2011) being aged 50-54 years, and the largest group of midwives aged 40-44 years. Consequently, over the next decade more than one third of the Australian nursing workforce is likely to retire (Twigg et al. 2010). High attrition rates in the profession, for example, in the Australian State of Victoria 4,500-5,500
nurses leave each year (Victorian Government 2010). Up to forty percent leave in the first two years of employment with Queensland Health, the Australian State of Queensland’s public health services employer (Forster 2005). Increasing attrition rates are purported to be related to organisational factors such as negative organisational climate (Hayes, O’Brien-Pallas, Duffield, Shamian, Buchan, Laschinger & North 2011), poor communication, training and staff development initiatives and management styles (Day, Minichello & Madison 2006). Nursing is often described as a rewarding career but not an easy job (International Council of Nurses 2005). The International Council of Nurses (ICN) (2005) describes nursing work as physically demanding, requiring constant mental vigilance and producing high levels of emotional stress, coupled with occupational injury and shift work which plays havoc with the nurse’s family and personal life. The ICN (2005) believe nurses in the profession are there because primarily they care for people. Whilst nurses provide care, they also need to be cared for in an employment context. The ICN (2005) recognises this employee need and has identified that government and health care organisations need to care for people as well - the people they are committed to providing health services for and the people who actually provide that service (ICN 2005).

There is a lack of strong clinical leadership to drive Australian nursing workforce planning, which has resulted in a lack of growth in nursing position numbers. This has led to significant challenges for health care services in securing adequate nursing resources, for both hours of care requirements and skill mix requirements for safe and effective patient care (Forster 2005). This situation leads to rising workloads which are a major driver of nursing turnover (Twigg et al. 2010).

Contemporary nursing practice is much more complex than in the past, with consumers who are increasingly more informed and who have higher levels of health
literacy which leads to greater expectations regarding the provision of health care (Duffield & O’Brien-Pallas 2003). Against this backdrop is an increasing shortage of skilled and qualified nursing staff to provide the care required, creating a nurse skill-mix adjustment, such as more enrolled nurses and less experienced registered nurses. This situation results in more hours being required to deliver the prescribed nursing care (Duffield & O’Brien-Pallas 2003).

Restructuring of health care organisations in Australia may also have an impact on the nursing shortage (Duffield et al. 2006). Health care reforms have seen a shift toward an organisational structure that involves managing a network of inpatient, outpatient, community and support services at the hospital level (Duffield et al. 2006). In the Australian State of Queensland these services have been formed into divisional structures. For example the Division of Families, which encompasses all services related to women’s health, child and adolescent health, child safety units, school-based youth health and mobile women’s health services (Queensland Health 2010). Under the Australian (Federal) Government health reforms package, New South Wales was the first state to restructure into the Local Health Networks (LHN) in January 2012 (NSW Ministry of Health 2011). These networks are designed to involve local planning and the delivery of clinical hospital and community services. LHN replace existing area health services and comprise a single hospital or group of hospitals and other health services that are geographically or functionally linked. Each of these networks are governed by a chief executive and governing council of nine to thirteen people, including clinicians, community representatives and health care managers (NSW Ministry of Health 2011).
Restructuring of health services in the past has led to a situation whereby nursing executives are responsible for the quality of the services provided, but have only a limited control over human and financial resources to provide the service (Duffield et al. 2006). A literature review of health care reforms in Australia, which led to changes in hospital structures, undertaken by Duffield, Kearin, Johnston and Leonard (2006) concluded that restructuring impacted nursing management roles and functions. This review found that nurse executives have a diminished influence on nursing in institutional priorities and operational decisions and weakened ties between clinical staff and administrators (Duffield et al. 2006). This situation may lead to unintended voluntary resignations because of an increased dissatisfaction with the changes in processes, and the remaining nurses may experience low morale and motivation prompted by reactions of insecurity, distrust and anger which can result in poorer patient outcomes (Duffield et al. 2006). Therefore, restructuring of health services may exacerbate the loss of nurses from the health care system.

The nursing shortage also affects the economics of hospitals in Australia in a variety of ways (Johnstone 2007). Reduced numbers of RNs translates into closure of hospital beds and increased wait times in emergency departments. The follow-on effect of the RN shortage is an increase in ambulance by-pass rates, delays in elective and emergency surgery and an inability to admit into intensive care and medical and surgical units due to a lack of available vacant beds. This creates a situation whereby the hospital’s health care funding entitlements are reduced (Johnstone 2007). Funding for hospitals in Australia is provided via an ‘Activity Based Funding’ arrangement with the Australian (Federal) Government. Funds are provided based on the activity the hospitals undertake through the mix of cases that a hospital treats (Eagar 2010). These mix of cases, are known as ‘casemix classifications’ which are used to count activity that is based on the number and types of patients treated in diagnosis-related groups.
(DRG) (Eagar 2010). DRGs are clinical and resource homogeneous categories that are a means of grouping types of patients treated. These are then used for payment, determined primarily on the performance or output of the health care organisation (Eagar 2010). Health care activities funded under activity-based funding are:

- acute inpatient admissions such as surgery, medical admissions, maternity and paediatrics;
- emergency department services;
- sub-acute care both inpatient and outpatient such as rehabilitation and palliative care;
- outpatient services;
- hospital-auspiced community health services such as home nursing and post acute care.

(Eagar 2010, p.3).

In most hospital models, activity is counted by ‘episode of care’ which refers to the whole time a patient is in hospital from admission to discharge. The financial incentive is to minimise the cost of each episode of care which inevitably rewards the shortest length of stay in a hospital (Eagar 2010). Public and private hospitals are funded from a range of different sources, reflecting the types of patients they treat and the services they provide. The Federal Government mainly fund emergency departments and outpatient services and admitted patients services are commonly funded by private (non-government) sources as well as Federal Government sources (AIHW 2009). The sources of funding for public hospitals is shown in Figure 4 and the funding sources for private hospitals is shown in Figure 5.
**FUNDING SOURCES FOR PUBLIC HOSPITALS 2008–09**

- Department of Veterans’ Affairs
- Australian Health Care Agreements and other Australian government
- Rebates of health insurance premiums
- State/territory government
- Health insurance funds
- Individuals
- Other

![Pie chart showing funding sources for public hospitals 2008-09](image)

**Figure 4:** Funding sources for public hospitals 2008-09. (Australian Institute of Health and Welfare 2010, p.5).

**FUNDING SOURCES FOR PRIVATE HOSPITALS 2008–09**

- Department of Veterans’ Affairs
- Australian Health Care Agreements and other Australian government
- Rebates of health insurance premiums
- State/territory government
- Non-government

![Pie chart showing funding sources for private hospitals 2008-09](image)

**Figure 5:** Funding sources for private hospitals 2008-09. (Australian Institute of Health and Welfare 2010, p.5).
Funding to public hospitals for elective surgery is provided under the Australian Health Care Agreements between the Australian (Federal) Government and Australian States and Territories. These agreements define payment for surgery that meets the clinically recommended waiting times within the allocated category (Australian Government 2009). Patients requiring elective surgery in public hospitals are assigned to one of three ‘urgency categories’ based on their health condition and circumstances (Australian Government 2009).

1) category one is a patient with a health condition that has the potential to deteriorate quickly to the point that it may become an emergency. Category one is defined as ‘urgent’ and recommended waiting time is no longer than 30 days;

2) category two is allocated to a patient if their health condition is causing some pain, dysfunction or disability but is unlikely to deteriorate quickly or become an emergency. Category two is defined as ‘non-urgent’ and recommended waiting time is no longer than 90 days;

3) category three is allocated to a patient whose health condition is causing them minimal or no pain, dysfunction or disability and is unlikely to deteriorate quickly and does not have the potential to become an emergency. Category three is defined as ‘non-urgent’ and the recommended waiting time is no longer than 12 months.


Therefore, the closure of hospital beds due to the shortage of RNs increases elective surgery waiting times. Funding for elective surgery is directly related to the Australian (Federal) Government’s prescribed activity expectations and any downturn in these activities. For example an increase in elective surgery waiting times, reduces funding to
the individual health care organisation, which in turn impacts on the overall economic performance of that hospital (Johnstone 2007).

It is expected that RN retirement in Australia will make up an increasingly larger component of nurse turnover than job mobility and job termination as the largest cohort of nurses practising in Australia are aged 50 to 54 years (AHPRA 2011). Leurer, Donnelly and Domm (2007) undertook research to investigate the perceptions of nurses (n=16) in western Canada regarding issues affecting their profession and retention strategies they would recommend to policy makers. The findings of this study showed that nurses’ believed that the numbers of long term nurses due to retire will result in a great loss of nursing capital; that is the acquired knowledge, skills and abilities of the retiring RNs (Leurer, Donnelly & Domm 2007). Experienced and highly qualified nurses also leave health care organisations to pursue other careers due to both a perceived lack of recognition for their role and feeling overworked (Australian Health Workforce Advisory Committee Report [AHWAC] 2004), whilst recent university nurse graduates leave due to a mismatch of their expectations of nursing work and the reality of the nursing workplace (Lavoic-Tremblay, Leclerc, Marchionni & Drevniok 2010). It is perceived that alternative career options for nurses may offer them more flexibility and better working conditions; however, the AHWAC report (2004) found that there will be a continued syphoning of nurses from the health workforce.

The ‘net’ supply of nurses in any one year is determined by the sum of training rate of new entrants, net migration, net wastage from the occupation and retirement (AIHW 2009). Kronos Incorporated (Kronos Worldwide 2008), a health workforce specialist company and supplier of employee scheduling and labour analytics software for government organisations, together with the Australian Health Workforce Institute (AHWI) (2008) who provide information and statistics on Australia’s health system and
workforce, undertook a collaborative three month meta-research project into the
Australian nursing workforce. The objective of this project was to assess data on the
state of the Australian nursing workforce. The aim of the project was to assess if there
was enough valid information to propose solutions for a sustainable nursing workforce
(Kronos Worldwide 2008). Key findings articulated in the report, that the author titled
“Research confirms Australian nurses on the endangered species list”, indicated that
forty nine percent of nurses worked part time and the average age of nurses had risen
from 40 years in 1986 to 45 years in 2007. In addition, one in point five of the total
number of nurses, work 45 hours or more per week, whilst one in point three
undergraduate nurses are not completing their degree (Kronos Worldwide 2008). The
Kronos Incorporated and AHWI (2008) project further identified registered nurses that
are 55 years and over increased from eleven percent to twenty percent between 1999
and 2005, with fourteen percent retiring every five years and only seventy percent of
qualified nurses actually working as nurses. The authors concluded this trend will
ensure the Australian nursing workforce is unsustainable (Kronos Worldwide 2008).
The researchers believe that the use of the term ‘nursing shortage’ to describe the
current situation with the nursing workforce is a gross oversimplification and that the
actual picture is much more dire than what has been depicted. The Kronos Worldwide
(2008) report showed that the nursing workforce indicators across Australia are falling
behind the increased need for nurses due to the growth and ageing of the population.
The Kronos Worldwide (2008) report indicated that the solution is not simply a matter
of replacing the numbers, but one of sustainability in domestic training, adopting best
practice workforce management practices and managing the migration and attrition of
the 90,000 nurses expected to retire between now and 2020. The oldest in the Baby
Boomer cohort, those nurses born between 1946 and 1964, turn 60 in 2007 indicating
that there will be significant numbers retiring over the next ten to fifteen years (Kronos
From 2006 to 2026 the total population is expected to grow by twenty four percent and the population aged 65 years or more will grow by seventy nine percent. The growth in the aged population has been projected to result in an increased demand for hospital bed days of approximately 40 percent from 2005 to 2025 (Schofield 2007). The population aged less than 30 years is only projected to grow by eight percent, and this is the age group of the majority of nursing students (Schofield 2007). Approximately 8,000 students commence nursing degrees each year; some 4,800 of those could be expected to complete within four years. If the same proportion of the population under 30 years chose to become a registered nurse as their career, by 2025 there would be expected to be approximately 5,1000 completions per annum (Schofield 2007). These graduate nurses would fill approximately 20,000 to 25,000 places vacated by retiring nurses. Despite these seemingly large numbers, they would not adequately provide for the increased demand of a more aged population or the attrition from nursing that occurs prior to the age of 45 years (Schofield 2007). Australia is facing a period of rapid retirement from the nursing workforce, resulting in the loss of approximately 90,000 nurses over the next 20 years (Schofield 2007). The aging population coupled with the population growth will result in an increase in demand for nursing care. This requirement is unlikely to be met by the current proportion of students completing their Bachelor of Nursing Degree (Schofield 2007). These statistics paint a daunting picture that serves to demonstrate how increasing RN organisational commitment with its positive link to retention may be a significant step toward increasing nurse retention.

The section that follows will discuss nurse retention in relation to the value of the construct of organisational commitment with its positive link to retention.
**Nurse Retention**

The retention of nurses in health care organisations enables the organisation to maintain an appropriate supply of nurses to meet the health needs of the patients (Magda, Hala & Naglaa 2011; Hogan, Moxham & Dwyer 2007; Duffield & O’Brien-Pallas 2003). Retention can be described as initiatives taken by management to keep employees from leaving the organisation (Dockel, Basson & Coetzee 2006). These initiatives can take the form of rewards for employees for performing their jobs effectively, ensuring harmonious working relations between managers and employees and maintaining a safe, healthy work environment (Dockel, Basson & Coetzee 2006).

The ability of organisations to retain their employees is dependent on how committed the employees feel toward their employer (Sturgess & Guest 2001). The globalisation of labour markets has significantly impacted on worker mobility, with the greatest impact on professionals, such as nurses, who engage in knowledge work. This enhanced mobility affects organisations as they struggle to maintain their share of the world’s professional talent. Hence, retention is paramount for employers of professional employees such as nurses (Hooks, Edgar, Inkson, Carr, Edwards, Jackson, Thorn & Allfree 2007).

A contemporary organisation’s key to employee retention may be to enhance employee organisational commitment. The link between organisational commitment and various effectiveness indicators such as low turnover and low absenteeism has been established through previous studies (Baek-Kyoo 2010; Ponnu & Chuah 2010; Suliman & Al-Junaibi 2010; Dockel, Bassen & Coetzee 2006; Mowday, Porter & Steers 1982; Meyer & Allen 1991). These studies propose that employee commitment to the organisation has a positive influence on job performance and a negative influence on intention to leave or employee turnover. It is argued then, that it would be beneficial for
health care organisations to consider the determinants of organisational commitment, ensuring that these are addressed in their human resource management (HRM) strategies, as committed employees can lead to improved employee retention rates (Dale & Fox 2008; Luna-Arocas & Camps 2008; Chew, Girardi & Entrekin 2005).

Hence the importance of this research to the management of acute care hospitals, as it has identified RN participants understanding of organisational commitment and its link to retention via a substantive Grounded Theory. This substantive theory may provide information required by health care managers to develop a nurse retention program to enable them to retain and, thus stabilise their nursing workforce.

The relationship between organisational commitment and retention as identified in organisational research will now be discussed.

**Organisational Commitment and its Link to Retention**

Organisational commitment has attracted considerable interest in an attempt to understand and clarify the employee’s intensity and stability in relation to their dedication to the organisation (Chew & Chan 2008; Bashir & Ramay 2008; Dockel, Basson & Coetzee 2006). The relationships, identified in organisational commitment research, between commitment and job performance and job satisfaction and employee turnover intentions demonstrate the vital importance of this construct in an occupational context (Caykoylu, Egri, Havlovic & Bradley 2011; Zettler, Friedrich & Hilbig 2011; Nehmeh 2009; Chew & Chan 2008; Meyer & Allen 1991). Research has also identified attitudinal, behavioural and motivational perspectives to the study of commitment (Dockel, Basson & Coetzee 2006). Organisational commitment can be described as a psychological bond that binds the employee to the organisation. This psychological bond has three distinguishable themes which Meyer and Allan (1991, p.60) label as:
- affective commitment
- continuance commitment and
- normative commitment.

These three distinguishable components of organisational commitment reflect a difference between a preference to stay with the organisation arising out of a sense of emotional attachment - known as affective commitment - compared to one rooted in a sense of economic necessity or the perceived cost of leaving - which is known as continuance commitment; or one of moral obligation known as normative commitment (Dockel, Basson & Coetzee 2006). Within this research the construct of organisational commitment was used as a single entity rather than in its three components, as an employee can display aspects of all three components of organisational commitment simultaneously (Nehmeh 2009).

Employees with a high level of organisational commitment are less inclined to leave, therefore, a HRM focus on commitment ensures that employees are managed in a way that positively impacts their commitment to the organisation (Nehmeh 2009). Fair HRM practices such as procedural justice, good communications, increased participation in decision making and supportive management all contribute to increased organisational commitment (Nehmeh 2009). Meyer and Allen (1991, p.61) state that organisational commitment “is a psychological state that characterises the employee’s relationship with the organisation and has implications for the decision to continue membership in the organisation”. Its relevance to this research is evident as the focus is on discovering RNs’ understanding of organisational commitment and its link to retention.
CONCLUSION

This chapter provided an explanation of how literature contributes to this Grounded Theory research from a methodological perspective. Following, an overview of the Australian health care system describing how it is funded and administrated by different levels of state and territories governments was provided. A detailed explanation of the role of the national public health insurance scheme, Medicare and private insurances in providing funding health care in Australia was discussed, with

Figure 1 utilised to depict the structure and flow of funds within the health care system. The number of both public and private hospitals and the available beds were demonstrated in Figure 2 and Figure 3. A discussion of the Australian hospitals, details their locations, average size and types of services was provided. Information about the current reform of the Australian health care system was also provided.

The Australian nursing workforce was discussed, encompassing a definition of a registered nurse and their educational requirements. How they are registered to practice was also outlined. The demographics and employment characteristics of the workforce was also provided together with a brief discussion of legislative requirements and the codes of conduct and ethics, and guidelines for practice that govern Australian nurses.

The reasons for the Australian nursing workforce shortage was discussed with regard to how the net supply of nurses is determined: aging, attrition, organisational factors, the increasing complexity of contemporary nursing practice, restructuring within health care organisations and the effects on hospital funding created by the shortage of nurses. The funding of both public and private hospitals was identified in Figure 4 and Figure 5 accompanied by a discussion of the ‘Activity Based’ funding arrangements for hospitals, which is related to the Australian (Federal) Government prescribed activity expectations. This discussion supports the premise that the nursing
shortage impacts on the funding of hospitals.

A discussion was also provided on the importance of the retention of nurses to enable health care organisations to meet the health needs of their patients. The construct of organisational commitment and its link to retention provided an explanation in relation to its importance in retaining staff, as employees with high levels of organisational commitment are less inclined to leave the organisations in which they are employed.

Chapter Three which follows describes the research design. The discussion includes the role of the researcher and research paradigm and provides an explanation and understanding of Grounded Theory methodology. The research methods are also identified along with ethical considerations. Information on the participant group, which includes the recruitment process and a description of the data analysis process using the constant comparative method and a description of the rigour of the data analysis, will also be provided.
CHAPTER THREE

RESEARCH DESIGN

INTRODUCTION

This chapter covers the research design and methods used in this Classical Grounded Theory study. A discussion of the role of the researcher and the research paradigm for this study begins this chapter. This is followed by an in-depth discussion of the Grounded Theory methodology that this study used. A discussion of the research methods in relation to ethical considerations, the recruitment of participants and inclusion criteria are discussed next. The in-depth semi-structured interviewing process is then explored, together with a presentation of the participant’s demographic data. The process of sampling and collecting data, together with the questions used to guide the collection of data are then provided and discussed. A detailed presentation and discussion of the coding process for this Classical Grounded Theory study is provided. The remainder of this chapter discusses memos and diagrams, theoretical sensitivity and the final analysis with the literature, together with theoretical saturation and how rigour was maintained throughout this study.

THE ROLE OF THE RESEARCHER

In a qualitative study the researcher is the primary instrument for data gathering and analysis as well as an integral part of the research process (Wilson Scott & Howell 2008). This Classical Grounded Theory study used in-depth semi-structured interviews to explore the research question “How do RNs understand organisational commitment and its link to retention?” This interviewing technique enabled the researcher to tunnel beneath the surface of ordinary conversation by asking the participant to describe and
reflect upon their experiences in ways that seldom occur in everyday life. The broad introductory question was followed by the researcher probing deeper into the experiences described by the participant. The researcher used questions to clarify her understanding of the participant’s main concerns. The participant was active in the conversation, whilst the researcher actively listened, encouraging the participant to expand on and clarify issues identified within the discussion (Brown et al. 2002). These interviews produced the data set used in this Classical Grounded Theory study.

The qualitative research approach used a process of inquiry into the social and human phenomena under study. This study was based on building a complex, holistic picture of ‘what was going on’, with the researcher playing a critical role within the process of enquiry (Gardner 2010). The role of the researcher was to produce memos, undertake initial coding, focused coding and theoretical and constant comparative analysis (Glaser 1992). The researcher’s purpose in this Grounded Theory study was to explain a given social situation by identifying the core and subsidiary processes operating within it (Brown et al. 2002).

Qualitative research has an interpretive character, aimed at discovering the meaning events have for the participants who experience these events (Abrams & Curran 2009). The interpretation of the meaning of these events for the participants was undertaken by the researcher (Glaser & Strauss 1967). Qualitative research has an emergent design, with the researcher focusing on this, as well as the outcomes or products of the research (Gardner 2010). The researcher in this study paid attention to the idiosyncratic nature of data together with the persuasive information given by individuals (Hoepfl 1997) to identify the uniqueness of each case.

In Classical Grounded Theory it is the role of the researcher to demonstrate theoretical sensitivity to subtleties of the data (Brown et al. 2002). The researcher
accomplished this, by steeping themselves within the literature after completing the data analysis, in combination with professional and personal experience of working as a nurse and manager within acute care hospitals. Theoretical sensitivity was further enhanced when the researcher both questioned the data in a way that enabled her to identify who, when, where and why, and analysed the multiple meanings and assumptions of a single word, phrase or sentence (Gardner 2010). The researcher also analysed the multiple meanings and assumptions of words, phrases or sentences to promote nonstandard ways of looking at the data (Brown et al. 2002). The approach undertaken provided a dense theoretical conceptualisation of the research findings.

The following section will discuss the ontology of critical realism which is the philosophy that underpins this Classic Grounded Theory research.

**RESEARCH PARADIGM**

This research was informed by the ontology of critical realism. Critical realism is associated with the work of Roy Bhaskar (1997), who developed a general philosophy of science, which he described as transcendental realism. Bhasker (1997) also developed a special philosophy of the human sciences, that he termed critical naturalism. These two terms form the umbrella term of ‘critical realism’ (Bhaskar 1997). Transcendental realism attempts to establish that, in order for scientific investigation to take place, the object of that investigation must have real, manipulable internal mechanisms that are able to be actualised to produce particular outcomes (Bhaskar 1997). Critical naturalism argues that the transcendental realist model of science is equally applicable to both the physical and the human worlds (Bhaskar 1997).

Critical realism in social science identifies the agent-agent and agent-structure relations as the objects for study, as critical realism determines that society is nothing but the sum of these interactions (Connelly 2000). Agents in the past have organized
and constructed social, economic, cultural and political structures (Bhaskar 1997) with present generations born into a largely pre-given social world. Critical realism argues that reality is social relationships, whether enacted at a person level (social roles, positional categories or membership of a social strata) or enacted at a collective level (a family, an organization or a social class), comprise the categories of social science (Bhaskar 1997). Utilising critical realism in this study, assumes that social reality is constituted by agent-structure and agent-agent relationships. Therefore, health care managers need to know the causal mechanisms within specific situational contexts (Connelly 2000). This enables these mechanisms to become the focus, so that health care managers can target these for consolidation, blocking or facilitation, resulting in desired outcomes (Connelly 2000). The facilitation of these desired outcomes enables managers within health care organisations to constitute the production, maintenance and transformation of health care (Connelly 2000). The agents within this study are RNs, and the agent-structure and agent-agent relationships are those relationships that the participants have with other RNs as well as those in nursing management positions within an acute care hospital. The focus of such an approach within this study is to understand how the RNs working in acute care hospitals construct their ‘reality’ in relation to their understanding of organisational commitment and its link to retention.

Realism has a variety of viewpoints within philosophy, but all share the core belief that the world and the universe exist without any human awareness of this existence as being necessary (Connelly 2000). A distinctive feature of realist philosophy is that ontology, the theory of being, is seen as distinct from epistemology, which is the theory of knowledge; therefore, scientific theorising is based on the assumption that a mind-independent reality exists (Wikgren 2005). Realism insists that being has precedence over any possible knowledge of being (Connelly 2000). Critical realism is, therefore, a specific form of realist philosophical theory about the world,
human agency and the interaction between the two (Radescu 2006). Critical realism philosophy assumes that reality is composed of the biological, the psychological, the social and the cultural level. These levels and what occurs at these levels cannot be reduced to another level (Sobh & Perry 2006). Critical realists recognise the reality of the natural world together with the events and discourses of the social world (Wikgren 2005).

Within a critical realist examination, the objects of enquiry are the deep structures, mechanisms and events and effects hidden in social phenomena (Radescu 2006). The researcher begins in the ‘actual’ level of reality, with observed connections between the phenomena under study and tries to explain why such connections occur, providing an ongoing process of explanation (Radescu 2006). Critical realist theories are both exploratory and explanatory, identifying mechanisms that lead to events so that the phenomena under analysis can be explained but not predicted. Critical realism also acknowledges an external, objective reality, as well as acknowledging that concepts are human, perception-based constructions (Sobh & Perry 2006). It views having a deep understanding of why patterns exist as a prerequisite to effective action. As such, its future in guiding work to address intransigent real-world problems, as in this study, is a particularly fruitful area for its utilisation (Bhaskar 1997). Therefore, appropriate for this research, which seeks to explore and explain how RNs understand organisational commitment and its link to retention, to utilise a Classical Grounded Theory approach. Critical realism provides the concepts and structures and causal mechanisms that form the outline of theory construction, while the grounded theory method provides the research strategy to transform them into a theory (Radescu 2006). Although the Classic Grounded Theory approach dismisses the applicability of any specific philosophical position, including symbolic interactionism, the language used by Glaser
in his research writings is generally cited as those of a critical realist (Glaser 1998).

Critical realist philosophy acknowledges the possibility of social theory based on the existence of real social structures and systems that are emergent entities, which operate independently of our conception of them (Wikgren 2005). These structures and systems are dependent on human activity to endure or change, but do not pre-determine what this activity will be (Wikgren 2005). Events can be seen, but social mechanisms are not readily observable. Thus critical realists argue for a shift from prediction to explanation and the use of abstraction and reliance on interpretative forms of investigation (Raduescu 2006). This is what this study did, using exploration to explain RNs’ understanding of organisational commitment and its link to retention. The aim of science is to identify and describe hidden, not readily observable structures and objects that have causal powers to produce effects (Raduescu 2006). In this study, a critical realist approach is demonstrated by the provision of rich descriptions and explanations of RNs’ understanding of organisational commitment and its link to retention. The RNs’ understandings are, of course, informed by social mechanisms which are not readily observable. These social structures and systems affect the participants’ experiences, which in turn influence their commitment to the organisation and the organisation’s ability to retain their services.

Individuals are social beings who develop character attitudes, beliefs and behavioural intentions by means of interactions with others. Critical realism is a useful worldview increasingly used by social scientists in management research (Sobh & Perry 2006), as critical realism can provide managers with a powerful tool for analysis and a coherent and ethically based approach to identify issues (Connelly 2000). The discussions presented in Chapters one and two of this thesis highlighted the fact that health care organisations have difficulty retaining their RN employees. Given the
significance of this fact to this study, it was important to understand what it is that impacts on the decision of nursing staff to stay with or leave their organisation. Therefore, how RNs’ understand organisational commitment and its link to retention is of importance, as one must first know what the RNs are committed to and whether they link retention to their organisational commitment. If RNs do link organisational commitment to retention, then what negatively or positively influences that commitment must be known to enable these areas to be targeted to improve RN retention rates.

Founding this research on critical realism philosophy facilitated cognisance of participants’ worldviews, being and knowledge. Given that participants’ voices are privileged throughout this thesis the results may provide health care managers with an understanding of what it is that influences RN organisational commitment and hence retention in a positive or a negative way.

The Classic Grounded Theory methodology utilised in this research will now be discussed.

**Grounded Theory**

Grounded Theory methodology was developed by Barney Glaser and Anselm Strauss in the early 1960s. The joint research approach of Glaser and Strauss was the constant comparative method of grounded theory, which was at the forefront of what was to be called a qualitative revolution (Hallberg 2006). The publication of their book, ‘The discovery of grounded theory; strategies for qualitative research’ by Glaser & Strauss, in 1967, outlined a set of systematic procedures that were clearly documented to enable researchers to follow. Their book countered the prevailing opinion that quantitative research was the only approach to scientific inquiry (Hallberg 2006).

Grounded Theory’s emphasis is that individuals are a unique living whole. Therefore, the Grounded Theory researcher focuses on the world as it is
experienced by these unique individuals (Aldiabat & Le Navence 2011). Grounded Theory offers the researcher a well established set of guidelines to be used as flexible tools for building conceptual frameworks that specify the relationships among categories (Aldiabat & Le Navence 2011). Given this philosophical stance, Grounded Theory and critical realism are comfortable companions.

Glaser and Strauss were American sociologists who focused their research on symbolic interactions. These interactions include, that meaning is constructed and changed via interactions between people who act on the basis of the meaning they ascribe to a situation (Glaser & Strauss 1967). Glaser and Strauss met when they were hired to help and guide nursing students in their research at the University of California (Charmaz 2000). The study they initially worked on together examined the awareness concepts in dying patients culminating in the publication of two books - titled ‘Awareness of Dying’ published in 1965 and ‘Time for Dying’ published in 1968 (Charmaz 2000). The Grounded Theory method used by Glaser and Strauss at that time was influenced by their research traditions. Strauss’s research tradition was the identification of social processes and the exploration of complex social life. Whereas Glaser used the strict and close line-by-line reading of interview text, rigorous identification of codes, and the systematic division into categories and the determination of properties of categories that arose from these (Charmaz 2000). Glaser believed that Grounded Theory should be evaluated in terms of its fit, work, relevance and modifiability (1992). This meant emerging categories must fit and explain the collected data rather than preconceived concepts being forced upon the data (Glaser 1992).

This Classical Grounded Theory study used Glaser’s research traditions whereby the researcher uses disciplined restraint, by reflecting on and questioning interpretations and results (Hall & Callery 2001). In Classic Grounded Theory the researcher enters
into the study of a phenomenon with no preconceived ideas of what the data should be and remains true to the data that are found. There is no, predetermined hypotheses to guide specific data collection with which to ‘test’ the hypothesis. A further distinction of Glaser’s approach is the need to stay long enough in the setting to allow the researcher to identify the major concern of the participants (core category) or process that depicts their answer to the problem. Glaser’s Grounded Theory also insists that the substantive theory must respect and reveal the perspective of the participants not the researcher (Glaser 1992). The researcher achieved this through a continuous interplay between analysis and data collection. Grounded Theory explains the phenomenon that is being studied in an analytical manner and changes when conditions are changing (Glaser 1992). Glaser (1992) believes that qualitative research should be judged on the criterion of trustworthiness and whether the data reflect empirically accurate descriptions and understandings of the selected phenomenon being studied. This will be discussed further later in this chapter.

Classical Grounded Theory was considered the best approach to use in this study as it produces a clear, accurate understanding of ‘what is’. It also places emphasis on minimising preconceptions as it answers the questions regarding ‘what is happening in the data and what is really going on’ (Glaser 1978, p.73), requiring that a theory be as true to the data as possible. In Classic Grounded Theory, throughout the data analysis process, everything must ‘earn’ its way into a theory through constant comparison of data rather than being imported from other sources (Glaser 1992).

Qualitative researchers study phenomena and processes in their natural setting, with the intention of making sense of the situation in terms of the meanings people bring to them (Aldiabat & Le Navence 2011). Qualitative research explores the world of individual people’s experiences and their socially constructed realities. The research
question generally directs which research method is most appropriate in each specific case, which implies that the research question must be formulated before the research method is chosen (Hallberg 2006). The researcher in this study is an RN, midwife and mental health nurse and is employed in the role of Nurse Manager in an acute care hospital in Australia. The researcher’s work-life is impacted almost daily by the nursing workforce shortages, hence an active interest in this topic. During the undertaking of the researcher’s Master of Business Administration degree, the study of organisational commitment and its positive link to staff retention was encountered. This ignited the researcher’s interest in utilising the construct of organisational commitment to conduct research to discover some solution to the nursing workforce shortage. The researcher’s personal experience of many years of working as an RN in the acute care hospital environment allowed her to relate to and understand the meanings and subtlety within the data collected for this Grounded Theory study. This enhanced theoretical sensitivity, as the researcher already possessed insight, experience and expertise within the health care setting. The researcher’s theoretical sensitivity also enabled her to engage with the participants through a lens of understanding and lived experience, which enabled her to recognise important data and assisted in formulating a conceptually dense theory.

Following an extensive examination of the literature by the candidate and finding no theory to explain how Australian nurses understand organisational commitment and its link to retention, the candidate then formulated the research question. This Grounded Theory study was then undertaken to discover how RNs understand organisational commitment and its link to retention. The Grounded Theory generated from this study is of importance as it provides new knowledge of what RNs are committed to and whether they link retention to their organisational commitment. If
RNs do link organisational commitment to retention, then what negatively or positively influences that commitment must be known, to enable these areas to be targeted to improve RN retention rates.

The use of phenomenon research can produce meaningful results and a deep understanding of the case being studied (Hallberg 2006). The research task within this study is to understand, comprehend and explain why research participants and social processes are the way they are. Therefore, the research question for this study of “How do RNs understand organisational commitment and its link to retention?” is best answered by a qualitative approach. Therefore, the Grounded Theory approach fits well in this instance.

This research deliberately used the Glaserian classical version of Grounded Theory as its ontological roots lie in critical realism as does this research. Glaser’s approach to research is guided by informants and their socially constructed realities in order to provide detailed descriptions of the cultural scene (Bryant 2002). Grounded Theory applies a systematic, concurrent data collection and analysis process throughout the inquiry that allows salient features of the phenomenon being studied to emerge from the data (Sharrock 2006). The researcher is an integral part of the research process, viewed as the instrument through which data collection and analysis are conducted (Brown et al. 2002). The identification and specification of the research issue to be addressed is entirely dependent upon the perceptions of the participants and the systematised analysis adopted by the researcher (Aldiabat & Le Navence 2011). Glaser also prefers an analytical method that is more general in its frame of reference, relying primarily upon the constant comparison of different incidents, perceptions, relationships and issues, with the aim of identifying inconsistencies, contradictions and gaps in the data and emerging consensus on key concepts and relationships (Douglas 2003). Glaser
maintains that in Grounded Theory the meanings people bring to the phenomena under study are not known until they emerge through a systemised analysis of the data (Douglas 2003).

Grounded Theory is a non-mathematical process of interpretation carried out for the purpose of discovering concepts and relationships within raw data and then organising these into a theoretical explanatory scheme (Aldiabat & Le Navence 2011). Grounded Theories are drawn from the data and offer insight, enhance understanding and provide a meaningful guide to action (Byrant 2002). Grounded Theory methodology is predicted on eight assumptions:

1) the need to get out in the field to discover what is really going on;
2) the relevance of theory, grounded in data, to the development of a discipline and as a basis for social action;
3) the complexity and variability of phenomena and of human action;
4) the belief that persons are actors who take an active role in responding to problematic situations;
5) the realisation that persons act on the basis of meaning;
6) the understanding that meaning is defined and redefined through interaction;
7) sensitivity to the evolving and unfolding nature of events;
8) an awareness of the interrelationships among conditions (structure), action (process) and consequences.


As previously suggested, Grounded Theory and critical realism fit well together given their similar philosophical underpinnings.
Grounded Theory researchers should start with an open mind (Tan 2010). Researchers should ignore the use of prior theories and concepts because Grounded Theory aims to generate theory from data rather than by verifying theory (Tan 2010). When the Grounded Theory is nearly complete this is the time for the researcher to search the literature, with the results of the search being woven into the theory as more data for the emerging concepts (Elliott & Lazenbatt 2005). Given the parameters of a PhD candidature, some literature was reviewed to ensure this research was contributing to new knowledge and that this study had not already been undertaken. In keeping true to Classical Grounded Theory methodology extensive literature analysis occurred after data analysis was completed. Therefore, Grounded Theory is not ‘atheoretical’, as an understanding of related theory and empirical work serves to enhance theoretical sensitivity and enables the researcher to generate a substantive theory (Elliott & Lazenbatt 2005). Grounded Theory should be understood as a package of research methods which include data collection, coding and analysing, through memoing, theoretical sampling and sorting to writing and the use of the constant comparative method (Figure 6). These are not separate procedural steps in the research process but a continuous cycle of data collection, analysis and sampling (Elliott & Lazenbatt 2005).

The goal of Grounded Theory is to develop a substantive theory from data that is collected in natural settings, and for the researcher to seek an understanding of the problem as experienced by a group of participants (Ng & Hase 2008). For this study, the aim was to examine ‘RN’s understanding of organisational commitment and its link to retention’. The research established what RNs are committed to and whether they acknowledge that this commitment is linked to retention. Further, it uncovered, for this participant group, what is it in the work environment that impacts their commitment and hence retention. Participants posited this in both positive and negative influences. Grounded Theory then is an appropriate methodology with which to examine
complexities in business management due to its ability to generate a comprehensive account of organisational action (Elliott & Lazenbatt 2005). Hospitals, it can be argued are ‘health care businesses that need to be managed’ and Grounded Theory facilitated an insight into the contextual explanations rather than descriptions of what was occurring for the RN participant group (Elliott & Lazenbatt 2005). Grounded Theory provides a theoretical lens for both the researcher and practitioners to improve workplace practices (Ng & Hase 2008). This research sought to understand RNs’ organisational commitment and its link to retention by gaining knowledge of what organisational commitment means for the RN participant group and what influences this commitment in the workplace.

As it applies to this study, Grounded Theory required the researcher to interview enough RNs so as to generate a clear picture which illuminated patterns, concepts, properties and dimensions of the given phenomena (Elliott & Lazenbatt 2005). It was essential to obtain an appropriate number of participants to generate sufficient data to reach ‘theoretical saturation’. This required the expansion of the participant sample size to 16 participants to reach the point in data collection whereby no new data was revealed (Thomson & Smith 2004). This final stage of the analysis process is known as theoretical saturation (Gardner 2010).
**The Grounded Theory Method**

Figure 6: Grounded Theory model of data analysis.

(Gasson 2003, p.81).
RESEARCH METHODS

ETHICAL CONSIDERATIONS

This research was guided by the ethical principles on research with human participants set out by the National Health and Medical Research Council (NHMRC) in accordance with the Australian Code for the Responsible Conduct of Research on Human Participants (2007). Approval was granted from the CQUniversity Australia, Human Research Ethics Committee and the research was assigned Project number H10/04-057 (Appendix A).

The focus of this research was to explain RNs’ understanding of organisational commitment and its link to retention. The first step in undertaking this research was to safeguard the participants from any physical, psychological or social harm as a result of the study. Recruitment was undertaken by the publishing of a brief article in Australian Nursing Journals and on nursing association websites. Potential participants were requested to contact the researcher if interested in participating in the research. This empowered potential participants to initiate contact with the researcher and ensured free and voluntary participation. Willingness to become involved in the research was, therefore, totally at the discretion of the potential participant and completely voluntary. Participants were informed that they could withdraw at any time without prejudice. Those participants willing to participate in this research signed the consent form (Appendix B) and completed a small demographic form (Appendix C) to allow for a general description of the participant sample.

The principles of beneficence and non-maleficence (NHMRC 2007) were upheld by ensuring the risk of harm, discomfort and distress was minimal. The risks associated with participants being involved with this research were considered quite low, and one mainly of inconvenience. RNs did give up their time for the period of the
interview; however, these were conducted at a time that was suitable for the participant so as to mitigate inconvenience as much as possible. Given the research was not of an emotional nature, nor did it ask questions about complex care or patient outcomes, negative sequel as a result of participation did not occur. The possible benefits of this research, for example, the increased retention of RNs in acute care hospitals in Australia to stabilise their nursing workforce, far outweighs the risks of any inconvenience experienced by the RN participants.

The principle of respect (NHMRC 2007) was upheld by allowing participants to participate in the research voluntarily, thus allowing them the right to self-determination. Potential identifiable coding was required during data collection so that the researcher could return to that same participant in the event that clarification was required. In order to protect the participant’s identity, participant information was assigned a code. It was this unidentifiable data that was utilised in this research. This was an important part of respecting each participant’s willingness to give freely of their time and knowledge.

The principle of justice (NHMRC 2007) was maintained by the provision of neutral and unbiased treatment of all participants throughout the data collection process. The researcher displayed respect for all the participants’ views and ensured a non-judgemental approach was maintained throughout the interview process. The participants were assured the maintenance of confidentiality and the acquisition of informed voluntary consent together with the removal of all participant personal identifiers. This was carried out by the researcher, as guaranteed, at the beginning of the research. The principal researcher and the researcher’s supervisors were the only personnel with authority to access participant information as per ethical approval. The data was stored predominately as digital audio recordings and password protected.
computer files, and all data was coded to prevent misuse and to ensure the confidentiality of the participants.

**RECRUITMENT OF PARTICIPANTS**

The participant group for this study was a purposeful sample of Registered Nurses who were currently employed in a full time, part time or casual position, in a clinical capacity (providing direct patient care) in an acute care hospital in Australia. The use of a purposeful sample was to ensure that the participant sample was representative of the intended target population (Elliott & Lazenbatt 2005) and those best suited to answer the question under examination (Brown et al. 2002). To provide information that informed potential participants about the study was achieved via advertisements (*Appendix D*) which were placed in Australian nursing journals and nursing association websites; for example, Australian Nursing Journal, the Nursepoint website and the Queensland Nurse a journal for members of the Queensland Nurses Union. The RNs who desired to participate in the research independently contacted the researcher via electronic mail. Contact information for the researcher was available in the advertisements.

Grounded Theory research requires that the researcher interview an adequate number of participants so that a clear picture of the patterns, concepts, categories, properties and dimensions of the phenomena under study emerge (Thomson 2011). An appropriate participant sample size is answered when theoretical saturation is achieved. This required that the researcher continue to expand the number of study participants until data collection provides no new data, which means theoretical saturation has been reached (Thomson 2011). The recruitment process for this research was of eight months duration with the researcher continually expanding the participant group until theoretical saturation was achieved. The final number of the participant group was 16.
After potential participants initiated contact the researcher sent a recruitment package to each respondent that contained a consent form, a demographic form and information sheet giving an overview of the research (Appendix E). The demographic form identified the Australian state or territory and the town or city in which the participant was working to enable the researcher to build a demographic profile of participants. A consent form which explicitly stated that participation in the research was voluntary and the participant’s right to withdraw from the study at any time without consequences was provided. Potential participants were also invited to ask questions or voice any concerns prior to consenting to participate in the research. Those participants willing to participate signed the consent form which ensured their free and voluntary participation. Willingness to become involved in the research was, therefore, totally at the discretion of the participant and completely voluntary in line with research involving human participants ethics requirements.

The comprehensive recruitment package included a description of the benefits and risks associated with the research; gave information on the consent process, participant confidentiality and dissemination of the findings. Participants were informed of the concerns and complaints process and an explanation was provided regarding how participants could obtain further information about the research together with contact details for the researcher and their supervisors. The use of this recruitment package ensured that the recruitment process adhered to the approval obtained from the Human Research Ethics Committee (HREC). Once the RN decided to participate in the research they completed the consent and demographic forms and returned these to the researcher via electronic mail. A time suitable to the participant was then arranged for the interview to be undertaken.
**INCLUSION CRITERIA**

The RN participants were required to meet the inclusion criteria of working in a clinical capacity (providing direct patient care) and be currently employed in an acute care hospital in Australia, be it on a full time, part time or casual basis. The acute care hospital was defined as those hospitals that provide hospital based acute inpatient care for patients receiving active but short term treatment for a severe injury or episode of illness, an urgent medical condition or during recovery from surgery. The potential participant group who initially contacted the researcher consisted of 22 RNs. Two of these potential participants were excluded as they did not meet the inclusion criteria, and four decided not to participate after receiving and reading the research package. The final participant group required to reach saturation consisted of 16 RN participants who met the inclusion criteria outlined above and voluntarily consented to participate in this research after receiving and reading the research package.

**IN-DEPTH SEMI-STRUCTURED INTERVIEWS**

Sources for data collection in Grounded Theory research can be based on a variety of investigative methods such as direct observation, individual interviews, focus groups and questionnaires (Bryant 2002). Due to the tyranny of distance across Australia and budgetary constraints the researcher elected to investigate the RN understanding of organisational commitment and its link to retention via individual in-depth, semi-structured interviews using the mode of telecommunication to collect data. This decision was justified as data provided by the Australian Government (2011) shows that Australia is the planet's sixth largest country after Russia, Canada, China, the United States of America and Brazil. At 7, 692, 024 km, it accounts for five percent of the world’s land area of 149, 450, 000 km (Australian Government 2011). The size of Australia compared to Europe, Japan, the British Isles and the United States of America
is demonstrated in **Figure 7**:  

**SIZE OF THE AUSTRALIAN CONTINENT COMPARED TO EUROPE, JAPAN, THE BRITISH ISLES AND THE UNITED STATES OF AMERICA**

![Maps comparing Australia to Europe, Japan, the British Isles, and the United States](#)

*Figure 7: Size of the Australian continent compared to Europe, Japan, the British Isles and the United States of America. (Australian Government 2011, p.1).*

Interviews were undertaken at a time and place that was most convenient for the participant. Generally the place of choice for the interview was either their personal residence or workplace. The participants provided their personal or work telephone numbers, and were available for interview at the agreed time which provides support for
the claim of voluntary research participation. The average length of each interview was 60 minutes.

Interviews commenced with clarification of the purpose of the study followed by the interviewer asking the research question of “how do you understand organisational commitment and its link to retention?” The interviewer presented themselves as non-threatening, understanding and non-judgemental with regard to the participant’s conversation (Louw, Todd & Jimakorn 2008). The participants were encouraged to discuss their experiences in the workplace in relation to organisational commitment and retention. The aim was to explore what each individual RN understood about the concept of organisational commitment and its link to retention using the participant’s experiences in the workplace. The engagement in conversation was of sufficient length to enable the interviewer to become familiar with the interviewee thus reducing the possibility of misinformation or distortions of information provided (DiCicco-Bloom & Crabtree 2006). The use of open ended questions and making use of the words ‘why’ and ‘how’ enabled participants to expand on the topic using their own words (Louw, Todd & Jimakorn 2008).

The interview proceeded in a conversational manner with questions flowing from previous responses so that when a remark was made the participants were then asked how they felt about the situation they had described previously. Active listening skills were used by the interviewer to reflect upon what the speaker was saying with clarification sought from the participant regarding the interviewer’s understanding of what was being said (DiCicco-Bloom & Crabtree 2006). The interviewer maintained an open mind during the interview to enable the participant to openly share their opinions. The participants were encouraged to speak freely and open up at their own pace so they would feel comfortable during the process of the interview. Changes in the
participant’s tone of voice or language were cues for the interviewer to seek further clarification on what was being discussed and the participants’ emotions in relation to what was being disclosed (National Institutes of Health 1999). The interview method described here provided a discovery orientated approach to explore the participants’ feelings and their perspectives on their understanding of organisational commitment and its link to retention. Each interview was audio-taped for accuracy and transcribed verbatim to prevent misinterpretation of the content or influence from the resultant expectations of the researcher. These transcribed interviews formed the basis for data analysis.

**PARTICIPANT DEMOGRAPHIC DATA**

Demographic data for this research was collected via a questionnaire which asked the participants to identify the Australian State or Territory, together with the town or city in which they were employed. This questionnaire was completed by the research participant and returned to the researcher via electronic mail together with the consent form. The participant gender was confirmed at interview. The collated demographics are:

- there were sixteen registered nurse participants;
- the participants were employed in four Australian states and no territories. These states were Queensland, Tasmania, Victoria and New South Wales. The geographical distribution and total number of participants from each state is demonstrated in **Figure 8**.
PARTICIPANT GEOGRAPHICAL ORIGINS AND TOTAL NUMBERS OF PARTICIPANTS FROM EACH STATE

![Map of Australia showing participant geographical origins and total numbers of participants from each state.](Image)

Figure 8: Participant geographical origins and total numbers of participants from each state.
(Adapted using map of Australia provided by Australian Government 2011, p.5).

- the acute care hospitals in which the registered nurses were employed spanned the metropolitan, regional and remote areas of Australia;

- the majority of participants were female which is consistent with the ratio of females to males working in nursing in Australia. The Australian nursing workforce in 2008 was composed of 272,741 nurses with only nine point four percent of the workforce of male gender (Australian Government 2008).

**SAMPLING**

Theoretical sampling procedures in Grounded Theory, dictates that the researcher chooses participants who have experienced or are experiencing the phenomenon under study (Glaser & Strauss 1967). This enables the researcher to
recruit ‘experts’ in the phenomenon enabling the researcher to provide the best available data for the study (Glaser & Strauss 1967). The process of selecting participants is an evolving one, based on the arising patterns, categories and dimensions emerging from the data. The researcher, in this study, sought participants who were able to provide a deeper understanding of the patterns, categories and dimensions that were emerging in the data (Glaser & Strauss 1967).

The population from which the sample was drawn in this study consisted of Registered Nurses working in a clinical capacity (providing direct patient care) and being currently employed in a full time, part time or casual position in an acute care hospital in Australia. An initial purposive sample of five Registered Nurses who met the criteria for selection and inclusion was recruited for this study. The sampling plan together with the justification for this decision was linked to the specific aims of the study (Chapter one) and the research question (Chapter one).

Following on from the initial sample, theoretical sampling was used so the researcher could explore more deeply the emerging categories, allowing the data to guide the sampling process. Theoretical sampling guided the questions used to collect data as well as the source of data to enable the theory to be developed fully. The theoretical sampling process involved expanding the sample group to include those RNs working in different types of acute clinical areas; in hospitals in different states and territories of Australia and different hospital locations, for example rural, remote and city. This broader theoretical sampling was utilised to gain sensitivity to the differences between the groups sampled and also to establish a definite set of conditions when a category will exist. The researcher took an active role in theoretical sampling by pursuing leads and similarities found in the data samples and broadening the scope of the emerging theory by developing the properties of the conceptual categories via this
This theoretical sampling process enabled the researcher to recruit participants who were ‘experts’ in the phenomenon under study who could support the development of the emerging theory to discover how these participants understood organisational commitment and its link to retention.

COLLECTING THE DATA

As previously explained in this chapter, Registered Nurses who had individually consented to participate in the research were contacted in order to schedule an interview at a time suitable to them. Data collection consisted of an in-depth semi-structured interview which was audio-taped. Due to the size of the Australian continent, as demonstrated in Figure 8 (earlier in this chapter) the interviews were conducted via a teleconference which lasted an average of 60 minutes.

The research question was initially expressed “As an RN how do you understand organisational commitment and its link to retention?” The participant was thereafter encouraged to discuss their experiences in the workplace in relation to their understanding of organisational commitment and its link to retention. The interview was structured so as to yield in-depth information about the perceptions of the RNs regarding organisational commitment and its link to retention that was grounded in the RNs’ day to day experiences within the acute care hospital setting. The researcher used active listening techniques to deepen the interviewer’s understanding of the speaker’s preoccupations and interests by creating empathy and making the speaker feel listened to (Louw, Todd & Jimakorn 2008). The phrasing and intention of the interviewer’s prompts to the speaker served to facilitate the kind of reflection, insights and connections that helped make active listening successful. Strategies used by the interviewer were intended to create opportunities for open responses from the
interviewee through the interviewer showing interest in the topics being discussed and asking questions that encouraged the speaker to reveal more (Louw, Todd & Jimakorn 2008). For example, the interviewer asked “Tell me how do you deal with this”; “Why do you think this?”; “It sounds as if you…” and “I am not sure I understand – do you mean that you...?” This technique encouraged the participant to talk about their experiences of the topic and what was of most concern for them. Broad, open ended questions were asked which enabled probing by the researcher in the wake of the interviewee’s answers to elicit a fuller, more detailed response based on the participant’s expertise (DiCicco-Bloom & Crabtree 2006). Direct questions that may have reflected preconceived concepts of the researcher were avoided (National Institutes of Health 1999). This recognised interviewing technique (Louw, Todd & Jimakorn 2008; DiCicco-Bloom & Crabtree 2006; National Institutes of Health 1999) obtained information regarding the RN’s perceptions, personal experiences, hopes and fears related to commitment, retention and the workplace in acute care hospitals currently and in the future.

Between data collection and analysis the researcher undertook memoing to record hunches, describe emergent categories and theoretical constructs. The interviews were firstly transcribed verbatim. The researcher then read all of the transcripts immediately following transcription, which is consistent with the Grounded Theory method whereby data collection and analysis occur simultaneously. This enabled the researcher to generate an understanding of the topic under discussion and then informed the researcher what questions should be asked next to begin to build a theoretical framework. This open coding process enabled the creation of preliminary clusters of similar and related codes that were considered as emerging categories (Ng & Hase 2008).
Overriding data patterns and themes pertaining to the lived experience of each participant were identified, and these codes were then compared with the initial codes and RN quotes, to ensure that the abstracted group of categories captured the range of experiences contained in the raw data. The findings in the Results chapter follow the general structure of how the researcher organised categories into an overall understanding of the phenomenon of ‘how RNs understand organisational commitment and its link to retention’.

**QUESTIONS USED TO COLLECT THE DATA**

The initial data collection was designed to generate as many categories as possible related to the phenomena under study; therefore, interviews were guided by the broad research question of “How do RNs understand organisational commitment and its link to retention?” Sixteen interviews were undertaken with RN participants from four Australian states. The context of the first four interviews was very broad but as the interviews progressed, although still guided by the research question, the focus of the interviews became increasingly specific. The subsequent interviews were guided by the initial data analysis which determined where to go and what to look for next in the data collection. Interview questions to achieve this outcome were:

- Can you tell me what it is that you are committed to?
- Are you committed to your organisation, if not can you tell me what you are committed to?
- Can you describe for me what it is that your organisation does for you that encourage you to stay with the organisation?
- Tell me about some of your experiences in the workplace and if any of these have made you consider leaving the organisation, and if so can you tell me why?
Can you tell me what you believe nursing management should be doing to retain you?

As the analysis and data collection continually informed one another, provisional categories and properties and the main concerns of the participants emerging from the data was used during subsequent interviews, relating data to ideas, then ideas to other ideas. Examples of questions asked during this phase to verify and clarify information were:

- What is your intention then, to continue working for the organisation and if so can you explain why?
- Can you tell me what it is that you believe nurses want from the organisation?
- You have described some bad experiences, so can you explain to me why you stay with the organisation?
- Do you believe that the way you are managed by nursing management influences whether you stay or leave the organisation?
- Can you tell me what nursing management does that influences your retention?

This style and format of questioning and clarifying continued throughout the data collection phase until the data became saturated and no new information emerged in the interviews.

**DATA ANALYSIS**

Grounded Theory is a constant comparative methodology that combines data analysis with data collection (Glaser & Strauss 1967). Grounded Theory is a systematic, inductive approach to developing theory to help understand complex social processes. To develop a theory of how RNs understand organisational commitment and its link to retention, the researcher sought to understand the problem situation.
experienced by the group of participants and how they dealt with this problem (Glaser 1992). The insights that Grounded Theory revealed were the contextual explanations rather than descriptions of what was going on (Ng & Hase 2008). This Grounded Theory study focused on:

1) identifying concepts and sub-concepts in open coding;
2) linking sub-concepts to concepts in open coding;
3) integrating and refining the theory in selective coding;
4) bringing process to the dynamic and evolving actions and interactions via the analysis in coding for process and sampling events;
5) incidents based on the concept of making comparisons in theoretical sampling which continued until all categories were saturated in theoretical saturation.

(Raduescu 2006, p.8).

Coding consisted of open coding, selective coding and theoretical coding (Devadas, Silong & Ismail 2011). The researcher then developed and applied codes that closely reflected the interviews. This is the central task of data analysis which develops a theory to explain participant’s main concerns. Open coding is the first step of data analysis which identifies and names, categorises and describes the phenomena under study. Selective coding is then undertaken following the identification of the core category and continues with coding for this category and those related to it (Glaser 1978). Finally, theoretical coding is undertaken to conceptualise the way in which substantive codes relate to each other, to enable the researcher to weave the categories
that have been identified during open and selective coding into a theoretical framework (Glaser 1992).

**CONSTANT COMPARATIVE ANALYSIS**

The primary principle of Grounded Theory generation is that data is analysed using the constant comparative method (Glaser 1992). This research method is used to study human phenomena where the researcher assumes that fundamental social processes will explain something of human behaviour and experience (Thorne 2000). Within this study this was how the RN participants understood organisational commitment and its link to retention. The constant comparative method of data analysis was achieved by the researcher when new data was compared with previously collected data, facilitating the concurrent and interactive collection of data and analysis (Adolph, Hall & Kruchten 2004). Glaser and Strauss state there are four stages involved in the constant comparative method of data analysis:

1) comparing incidents applicable to each category;

2) integrating categories and their properties;

3) delimiting the theory;

4) writing the theory.

(Glaser & Strauss 1967, p.5).

In this Grounded Theory study the researcher utilised this method of data analysis by collecting data, coding data and analysing the data simultaneously. During each phase of the data analysis the researcher constantly compared new data, concepts, ideas and propositions. For example, comparing two different accounts of participants who had similar experiences, the researcher posed the analytical questions of “Why is this different from that?” and “How are these two experiences related?” (Glaser 1992).
This process then continued with the comparison of each new interview until all the interviews were compared to each other. Each step of this process added to the integrity, accuracy and authenticity of the research presented in this thesis.

CODING

Grounded Theory coding can be likened to a kind of content analysis, to find and conceptualise the core issues from within the huge repository of data (Moghaddam 2006). Within this Grounded Theory study, data collection and data analysis occurred concurrently. Throughout the analysis of the interviews the researcher became conscious that interviewees were using words and phrases that highlighted their understanding of organisational commitment and its link to retention. The researcher noted this, highlighted and underlined the phrases in the transcript, grouped them together as ‘chunks of data’, then used short memos to describe what was happening in the data. When this issue was mentioned again in further interview transcripts, with the participants using either the same phrase or similar words and phrases, the researcher again noted that this had occurred. In Grounded Theory data analysis this process is described as ‘coding’ and the short description of these phrases is known as a code (Moghaddam 2006). Coding is the process of breaking down data into distinct units of meaning for analysis and the aim in this study was to identify as many tentative categories and their properties as possible (Glaser & Strauss 1967).

The data in this study was reviewed many times through the researcher looking and relooking for emerging codes. This was accomplished by micro-analysis of the data, word by word, sentence by sentence, whilst continuing to code the meanings found in words or groups of words. This conceptualisation of data through coding is the foundation of Grounded Theory development (Glaser 1992). The mandate for coding is for the researcher to remain open to what is actually happening in the data, to listen and
observe and in this manner discover the main concern of the participants in the field and how they resolve this concern. As prescribed by Glaser (1992), the researcher entered this study without preconceived ideas with regard to what the study would find, but waited to see what would emerge conceptually from undertaking the constant comparative analysis. This Grounded Theory study produced a set of grounded concepts organised around a core category and integrated into a theory. This generated theory explained how RNs understand organisational commitment and its link to retention. The tasks for each of the coding phases within this study are described in Figure 9. The researcher used multiple diagrams during the data analysis phase to visualise what was occurring in the data.

The following section utilises a diagram to depict the coding process used in the analysis of data.
**THE CODING PROCESS FOR DATA ANALYSIS IN THIS STUDY**

**DATA GROUPING**
- **Interviews** transcribed verbatim
- **Phrases** are grouped together as ‘data chunks’

**OPEN CODING**
- ‘Chunks data’ was coded with a conceptual label
- **Repeated** this process for all the interviews
- **Identified** concepts were compared to existing concepts and to other incidents
- **Main** categories were identified together with the properties of these categories
- **Coding** continued until each category was saturated
- **Categories** were formed into a hierarchy and core category was identified

**SELECTIVE CODING**
- **Selective** coding was undertaken to confirm the core category and those related to it
- **Data** not related to the core category was ignored
- **Substantive** codes directly related to the core category were developed

**EMERGING THEORY**
- **Wrote** the theoretical statement
- A diagram was drawn to illustrate the emerging theory

**SORTING**
- **Memos** were again sorted in order to develop the outline of the theory
- The aim was to find a place in the theory for all the concepts and properties that related to the core category

**THEORETICAL CODING**
- **Theoretical** codes were conceptualised to see the way in which substantive codes related to each other
- The theoretical codes emerged from the theoretical memos written from the process of sorting memos
- The researcher remained sensitive to a broad range of potential codes

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*Figure 9: Coding process used to analyse data in this study.*
OPEN CODING

Open coding is the first step in the data analysis process in Grounded Theory (Urquhart 2001). The aim of this part of the data analysis was to identify, name, categorise and describe the phenomena under study (Borgatti 2010). Each incident in the data may be represented by as little as a word or by a sentence or a paragraph, and as these patterns were noted they were coded with a conceptual label (Glaser 1998). Open coding is the part of the data analysis that deals with the labelling and categorising of phenomena as indicated by the data (Glaser 1998). The product of this labelling and categorising process were concepts, which are the basic building blocks in Grounded Theory construction (Pandit 1996).

In this study, as each interview was completed, it was transcribed verbatim. Each transcript was then read carefully, the phrases ‘chunked’ and any key words were highlighted. Following on from this, phrases of each interview were taken and each piece of ‘chunked data’ was coded with a code name or label. This procedure, as described by Spiggle (1994), is associated with primary concept development, which consists of the identification of a ‘chunk’ or ‘unit’ of data as belonging to, representing, or an example of a more general phenomena. The open coding process began after the first interview was transcribed and continued through consecutive interview transcripts until no new categories were identified and saturation of categories was achieved (Ng & Hase 2008). An example of the process undertaken by the researcher to label initial concepts appears in Table 1. Transcript exerts describing participant’s experiences of ‘being managed’ were bolded and underlined and the ‘chunked data’ were subsequently coded under the initial concept of “managers”.

89
<table>
<thead>
<tr>
<th>Concept Label</th>
<th>Interview Transcript</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managers: Participant’s perceptions of the their experiences of being managed</td>
<td>I used to go home crying every day. I felt like we were just being undervalued, not respected, absolutely no support. You know, I see the function of the leader as to support the staff, I mean everybody left because they were undervalued, bullied, harassed and you know, just didn’t enjoy being at work because the atmosphere was shocking. It’s a sad story, it’s really sad because, you know, basically everybody wants to go to work and do the job and be happy, and be trusted and valued. I’d like some action on the things that just keep happening rather than just sweeping things under the carpet. . . . not supportive, I would never go to them with a problem . . . they make nurses feel insecure and isolated.</td>
</tr>
</tbody>
</table>

Table 1: Example of excerpts of transcripts of participant’s perceptions of ‘being managed’: coded under the concept name “Managers”.

The researcher then continued to examine the interview transcripts line by line, to discover and name concepts or ideas that determined what was going on. Significant ideas or incidents were given a name that represented what was important about what had happened or what had been said that was important. This process focused on and was guided by the answer to the questions, “What is going on here?” and “What is being referenced here?” (Borgatti 2010) enabling the researcher to identify and label discrete concepts present in the data.
The second reading of the transcripts involved coding line by line and paragraph by paragraph. Concepts were viewed as an abstract illustration of an event, action or interaction that the researcher identified as being of significance in the data (Moghaddam 2006). The indicator for a concept was achieved by comparing words, a phrase or sentence or series of sentences with previous indicators that were coded in the same way (Larossa 2005). The concept identified by the researcher was the name associated with the indicator, which was perhaps stated another way by a subsequent interviewee. This process was consistent with the concept-indicator model which Glaser (1998) espoused to be used in the constant comparison of indicators to identify similarities and variations in data. An example of the concept-indicator process utilised in this study to identify the concept of ‘commitment’ is shown in Figure 10. As coding continued in the manner previously described, a number of initial concepts were identified and labelled by the researcher as “managers”; “workload”; “clinical unit”; “patients”; “nursing” and “commitment”.

**Concept Indicator Model**

![Concept Indicator Model Diagram](image-url)

**Figure 10: Concept Indicator Model.**

(adapted from Glaser & Strauss 1967, p.106).
The researcher then proceeded to create a list, which included all the relevant ‘chunked data’ associated with all the created concepts. The chunked data was then rechecked for relevance to the associated concept, and if relevance was confirmed, they remained on the list. Those that were not relevant were moved to an appropriate concept list or placed on a newly created list if they did not fit well under existing concepts. Glaser (1992) suggests that the researcher at this stage should compare all codes by asking key questions of the data:

- what is this data a study of?
- what category or property does the incident indicate?
- what is the basic process that ‘processes the main problem that makes life viable in the action scene’?

(Glaser 1992, p.51).

An example of the identified preliminary concepts is shown in Figure 11.

**Preliminary Identified Concepts**

![Diagram of Preliminary Identified Concepts](image)

*Figure 11: Preliminary identified concepts.*
As the concepts were identified, each incident in the data was compared to existing concepts as well as other incidents in a process of constant comparison (Glaser & Strauss 1967). This process enabled the researcher to build up layers of conceptualisation and as the theoretical framework was built up, some concepts emerged as the main categories and other concepts emerged as the properties of these categories. By the continuation of the constant comparison method by the researcher, properties of a category were gradually identified until new incidents yielded no further properties.

Categories were identified by comparing many incidents, with the researcher sometimes finding it necessary to change the names of categories to ensure a better fit to the incident described by the participant. The focus remained one of explaining the participant’s behaviour in relation to the ways in which they processed their main concern. It was through this process of constantly questioning that the identification of categories was achieved and the coding process began moving beyond description to begin conceptualisation (Glaser 1992).

Data analysis in this study progressed with the researcher continuing to compare and contrast data across interviews and review the codes and concepts in light of these comparisons. The researcher’s aim was to have concepts, phenomena and categories at the completion of this process. Once the concepts were identified they were then grouped to form categories. Glaser and Strauss (1967) believed that a category stands by itself as a conceptual element of the theory, with Glaser (1992, p.38) defining a category as a type of concept that is usually used for a higher level of abstraction. Once a category was developed it was necessary to analyse its specific properties. Glaser and Strauss (1967, p.36) defined a ‘property’ as “a conceptual aspect or element of a category” that assist with uncovering relationships between categories and sub-
categories. Table 2 provides an example of the end product of this process.

<table>
<thead>
<tr>
<th>Concept label as attached to interview transcript</th>
<th>Categories</th>
<th>Major Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNs experience of being managed by nursing</td>
<td>Nurse managers</td>
<td>Nurse Manager management behaviours</td>
</tr>
<tr>
<td>Positive and negative experiences of being managed</td>
<td>RN expectations of management behaviour</td>
<td></td>
</tr>
<tr>
<td>Commitment to ward/unit - patients - nursing</td>
<td>How RNs are managed positively or negatively influences RN commitment</td>
<td></td>
</tr>
<tr>
<td>Influences RN intention to stay or leave the hospital</td>
<td>How RNs are managed positively or negatively influences RN retention</td>
<td></td>
</tr>
</tbody>
</table>

Table 2: Illustration of transformation from concepts to different levels of categories.

The researcher continued this process, analysing the observations made during the constant comparison of data and compared them to the concepts that were derived from the interviews. Hard copies of the interview transcripts were used to assist in this process, with codes written along the transcript margins. In this manner 11 preliminary categories were identified. These preliminary categories are displayed in Figure 12.
In Figure 12, preliminary categories in relation to the impact on participant organisational commitment is presented. As the researcher worked through the process of open coding different ways of relating these categories to each other was considered. The researcher eventually linked bad managers, line managers and nursing executives to how the participants were managed by Nurse Managers. Therefore, all these categories were gathered together to form the core category of ‘Nurse Managers’. The researcher then concluded that the categories of education, retention and understaffing were all related to how the participants were managed by Nurse Managers. In relation to education, it became clear to the researcher that the participants were concerned about the trustworthiness and credibility of what the Nurse Manager was telling them in relation to education opportunities, not education as a singular entity. Continuing the open coding process the researcher reviewed the preliminary category of ‘retention’ and concluded that it was also related to how the participants were managed by Nurse Managers. Further review of the transcripts and memos led the researcher to link the
management behaviour of communication by the Nurse Manager to the previously named category of ‘retention’. The participants’ discussions pertaining to the poor communication skills of the Nurse Manager led them to believe that their concerns were not being heard and this impacted their retention within the organisation.

Continuing this process the researcher again related the preliminary category of “understaffing” to whether the Nurse Manager was supportive of the nursing staff in the case of understaffing and whether the Nurse Manager undertook adequate performance management of staff who were not performing at an acceptable level. Therefore, the researcher concluded that the categories of education, retention and understaffing could be gathered together under the core category of Nurse Manager, and that management behaviours was in fact a subcategory of the core category of Nurse Managers. This converging of categories into a single core category is shown in Figure 13 and the converging of categories into a single sub category is shown in Figure 14.

**Converging of Preliminary Categories to a single Core Category**

![Figure 13: Converging of preliminary categories into the single core category of “Nurse Manager”.](image-url)
Converging of Preliminary Categories to a single Subcategory

Figure 14: Converging of preliminary categories into the single subcategory of “manager behaviours”.

Further review of preliminary categories and memos enabled the researcher to address the categories of ‘patients’, ‘nursing’ and ‘work area’. The researcher concluded that these categories were related to the participants’ perceptions of their organisational commitment. The participants continually discussed their commitment in relation to the patients, their nursing and the area in which they worked. This supported the researcher’s conclusion that this was how the participants’ understood their organisational commitment. This relationship is demonstrated in Figure 15.
As the open coding process continued the researcher sought to name the main concerns of the participants in relation to their understanding of organisational commitment and its link to retention. The researcher established that the main concerns of the participants were directly related to how they were managed by Nurse Managers. This conclusion is represented in Figure 16. The researcher then concluded that Nurse Managers was indeed the core category, as this explained how all the participants processed their concerns related to their organisational commitment and retention. This core category was related to the other categories and their properties, and the researcher considered this as central to the emerging theory. This core category was frequently identified in the data from the participant interviews and the researcher then worked to saturate this identified core category and related categories via selective coding.
Nurse Manager behaviours influence RN Organisational Commitment and Retention

Figure 16: Nurse Manager’s behaviours influence RN organisational commitment and retention.

**SELECTIVE CODING**

Once the core category of Nurse Managers had been identified, the researcher began to selectively code for this category and those that were related to it (Glaser 1978). Data that did not relate to the core category were then set aside. This enabled the researcher to deal with more data at a faster pace. The researcher identified the main data that related to the core category as the management behaviours of the Nurse Manager, as these behaviours clearly influenced the participants’ organisational commitment and retention. The management behaviours were assigned as subcategories of the core category by the researcher. The researcher then proceeded to label these management behaviours as enabling behaviours and inhibiting behaviours. Continuing through the selective coding process organisational commitment and retention were also identified as subcategories of the core category.

The participants also continued to express their understanding of organisational
commitment related to the clinical unit in which they worked, their nursing in this
clinical unit and the patients in the clinical unit. The researcher then concluded that the
participants’ level of organisational commitment impacted on their retention. These
were labelled as categories and then coded as subcategories of the core category as the
researcher established that Nurse Managers and their behaviours clearly impacted on
the participants’ organisational commitment and hence their retention. Thus the
participants’ commitment and their retention at their hospital were influenced either
positively or negatively by the management behaviours of their Nurse Manager. These
subcategories are identified and diagrammed in **Figure 17**.

**Identifying subcategories of the core category of Nurse Managers**

![Diagram of subcategories related to the core category](image)

**Figure 17: Subcategories related to the core category.**

The researcher then proceeded to selectively code the data to enable the actual
management behaviours that positively or negatively influenced the participants’
organisational commitment and retention to be identified and coded. The data from all
the interviews was rescanned to identify exactly what it was about the behaviour of the
Nurse Managers that was the main concern of the participants. The researcher
constantly asked the questions “What is the main problem contained in the action scene?” and “What is this action indicative of in relation to the type of management behaviour?” (Glaser 1992). These specific behaviours were identified via the impact they had on the participant or the emphasis the participant placed on the importance of the particular behaviour. The importance or impact of the behaviour was in relation to the participants’ understanding of the influence this behaviour exerted with regard to their organisational commitment and retention. Some of the identified management behaviours were: poor communication, supportive and lack of professional respect. These management behaviours were coded and relabelled and then assigned under the subcategories of enabling behaviours or inhibiting behaviours. These are demonstrated in Figure 18 and Figure 19.

Nurse Manager Enabling Behaviours

![Communicative](Communicative)

![Supportive](Supportive)

![Trustworthiness](Trustworthiness)

![Credibility](Credibility)

![Enthusiastic](Enthusiastic)

Figure 18: Identified Nurse Manager enabling behaviours.
Figure 19: Identification of Nurse Manager inhibiting behaviours.

The management behaviours that the researcher identified were coded as the properties of the subcategories of enabling and inhibiting behaviours and related to the core category of Nurse Managers.

THEORETICAL CODING

Within the theoretical coding phase Glaser (1978, pp.74-76) named three specific coding procedures:

1) looking for causes, contexts, contingencies, consequences, covariances and conditions around a focal category;

2) building process into the analysis: that is stages, staging, phases, phasing;

3) paying attention to people’s ‘strategies, tactics, manoeuvrings, ploys, dominating and positioning’.

According to Glaser (1978, p.72) theoretical codes “conceptualise how the substantive codes may relate to each other as hypotheses to be integrated into the theory. They, like
the substantive codes are emergent weaving the fractured story back together again”. Theoretical coding generated meaning and scope to the theory that was emerging and involved conceptualising the relationship between categories (Larossa 2005).

Theoretical coding relates the concepts of a theory to each other in a clear and distinct way (Glaser 1978). The researcher in this study dedicated a significant amount of time to fitting and refitting the codes and undertaking different ways of relating concepts to each other. The sorting of memos was important at this stage to enable the researcher to develop categories that covered all the concepts related to the core category. Diagrams were utilised to map this process to find a way of presenting the substantive theory so that it covered the whole data set and communicated the process in a clear way. The theory required that the researcher be able to relate the core category of Nurse Managers to the subcategories of organisational commitment, retention, enabling behaviours and inhibiting behaviours in a clear and understandable way.

At the completion of theoretical coding the researcher concluded that the theory of how the participants understood organisational commitment and its link to retention, was that their organisational commitment was localised to their work unit and, simultaneously, to the patients and their nursing within their work unit. The participants’ organisational commitment was influenced positively by the enabling behaviours of their Nurse Manager or negatively by the inhibiting behaviours of their Nurse Manager. This understanding of organisational commitment was related to retention in that if the participants’ organisational commitment was enabled by the management behaviours of their Nurse Manager then they would be retained at their hospital. But if the participants’ organisational commitment was inhibited by the management behaviours of their Nurse Manager then they would not be retained at their
MEMOS AND DIAGRAMS

Memoing was a key analytic tool for this study. Theoretical memoing is the core stage of Grounded Theory methodology, enabling the researcher to theorise by the writing up of ideas about substantive codes and their theoretically coded relationships (Glaser 1998). The researcher in this study began writing memos from the beginning of data collection to summarise key ideas and potential questions for follow up, together with recording emerging issues that required further exploration.

The researcher continued writing memos throughout the open coding phase of data analysis to conceptualise incidents. These memos were used to both refine and keep track of ideas that developed when comparing incidents to incidents and then concepts to concepts in the evolving theory. The researcher again used these memos and wrote further memos to develop ideas about naming concepts and relating them to each other. During this phase the researcher also used the ‘concept indicator model’ by Glaser (1978) which is based on the constant comparison of indicators. This enabled the researcher to diagram and compare indicator to indicator, generating a conceptual code initially, and then indicators were again compared to the newly emerged concept providing further definition. A diagrammed example of this process is provided in this chapter in Figure 10 (earlier in this chapter). The continued diagramming using the ‘concept indicator model’ enabled the researcher to identify similarities, differences, and consistency of meaning, which resulted in the construction of a concept or category and its dimensions (Glaser 1978).

Following on from initial open coding, when sufficient relationships amongst codes had emerged, the researcher continued to use diagrams to depict relationships
among code categories to visually depict the relationships in the coded data. These diagrams were created on paper and, as they were tentative in nature, they were used to further the development of the categories and subcategories of this study. A number of these diagrams appear in this chapter as examples in the description of data analysis phase within this study. Memoing and diagramming continued throughout the selective and theoretical coding phases of data analysis. This provided an accumulation of written ideas and diagrams which the researcher was able to develop into a bank of ideas about concepts and categories and how they related to each other. This rich source of theoretical information was later used to assist the researcher to write the substantive theory for this study.

**THEORETICAL SENSITIVITY**

The ability of the researcher to generate concepts from data and to relate them according to normal models of theory in general, is the essence of theoretical sensitivity (Glaser & Strauss 1967). Generating a theory from data means that most hypotheses and concepts not only come from the data, but are systematically worked out in relation to the data, during the course of the study (Glaser 1992). Therefore, the ability of the researcher to conceptualise and formulate theory by constant comparison of data increasingly develops during the course of the study. The end result is that the researcher is able to demonstrate theoretical sensitivity to the subtleties within the data collected to undertake the study (Brown et al. 2002).

The first step for the researcher in this study, who is a nurse and manager with many years’ experience of working in hospitals, was to consciously enter the research setting with as few predetermined ideas as possible. The researcher maintained an analytic distance, learned to tolerate confusion and regression whilst remaining open, trusting that the data processing would lead to a conceptual emergence. The researcher
also learned to develop theoretical insight into the phenomena under study and combined this with the ability to make something of these insights. The researcher’s ability to conceptualise and organise, to make abstract connections as well as visualise what was happening in the data were also enhanced during the data collection and analysis phase of this study. Through the process of collecting and analysing more data the researcher’s theoretical sensitivity increased, enhancing the focus of subsequent interviews. By using the constant comparison of data from the interviews the researcher found that ideas would either fade out as irrelevant or earn their way into the theory.

The researcher utilised open questions to promote the participants’ thoughts about their experiences; more specific questions were then asked in relation to certain events, behaviours or experiences. Examples of more specific questions asked at interview included the participants’ relationship with their Nurse Manager; their experiences of being managed by their Nurse Manager; and whether they believed the management behaviours of their Nurse Manager influenced their organisational commitment and retention. These questions, participants’ answers and the resultant discussions in relation to these questions were helpful in assisting the researcher to saturate concepts, identify categories and their properties, and confirm the core category.

**Finalising the Analysis with the Literature**

In Classical Grounded Theory, searching and reading the literature is performed in different stages (Glaser 1998):

1) the first stage is the planning stage when the literature is searched in an attempt to identify gaps in knowledge;

2) the second stage is when the researcher searches the literature to access
theories in other similar areas of study to highlight other aspects of the theory formulated in their study;

3) the third stage is when the researcher shows how their work fits into the area of existing knowledge by using the literature to weave their findings into the body of existing knowledge found in the literature.

(Giske & Artinian 2007, p.78).

In this study, the first reading of the literature occurred during the planning phase. At this stage the researcher completed an initial search of the literature to identify gaps in knowledge. The researcher was aware that organisational commitment had been studied in the broad sense. The literature search yielded no studies specific to RNs in Australia and their understanding of organisational commitment and its link to retention. Therefore, this study would contribute to new knowledge in the area of organisational commitment and its link to retention in relation to RNs working in acute care hospitals in Australia.

During data collection, coding and writing memos, literature related to Grounded Theory methodology was read to improve openness to this study (Glaser 1998). When the substantive theory of how RNs understood organisational commitment and its link to retention was developed enough to stand alone, the researcher then reviewed existing literature related to studies of organisational commitment and its link to retention. This enabled the researcher to compare and contrast the findings of this study with the knowledge base within the field of organisational commitment and its link to retention.

To enable this study to contribute to the field of research associated with organisational commitment and its link to retention, the researcher needed to demonstrate how this study fitted into this area through weaving the findings of this
study into the body of already existing knowledge. Integration of the findings of this study with the existing literature helped identify theoretical grounding that could further explain what had been discovered in this study. Hence, the literature was reviewed in relation to organisational commitment and its link to retention, including what factors influenced the employee’s organisational commitment and retention in other studies. The researcher found multiple studies on organisational commitment with links to retention in the workplace. These studies were considered to be important as organisational commitment was the foundation of this study.

Bringing the literature into the writing meant allowing for the extension, validation and refining of knowledge that already existed in this field of study. The drawback of comparing the findings of this study with the existing body of knowledge was that Registered Nurses working in Australian acute care hospitals had not previously been studied.

THEORETICAL SATURATION

The constant comparative method was used to validate the developing theory against newly collected data and to facilitate recognition of the point when data saturation was reached. Theoretical saturation relates to staying in the field, collecting data until the researcher recognises the point in analysis in which further data collection is not going to add to the developing theory (Glaser 1998). In the present study, after 16 in-depth semi-structured interviews were conducted, it became apparent to the researcher that there were no further variations emerging from the field. Prior to declaring theoretical saturation had been reached, all conclusions reached from the data were thoroughly interrogated by the researcher.

During the final stages in the constant comparison analysing process, a central phenomenon of Nurse Managers, the core category, was identified. This followed
continual questioning of the data by asking “What is actually happening in the data?” and “What is the basic social structural process that processes the problem which is of the main concern for the participants, to make life viable in the action scene?” (Glaser & Strauss 1967). The constant comparison between emergent theory and new data continued until the researcher reached the point of diminishing returns from any new analysis. The researcher then concluded that theoretical saturation had been reached. The point at which theoretical saturation was achieved was that when diminishing returns were obtained from new data analysis or refinement of coding categories (Glaser & Strauss 1967). The researcher noted that this had occurred when the theoretical constructs fitted with existing data and the comparison of theoretical constructs with new data yielded no significant new insights. When the theoretical saturation was obtained the emerging theory that is the core category was considered grounded in the data.

**Rigour in Data Analysis**

Rigour refers to the correct use of the research method, and is an important aspect of the quality of research processes and outcomes (Glaser & Strauss 1967). Grounded Theory methodology has a checking system in-built into the research process which is an integral part of the constant comparative analysis and theoretical sampling (Trochim 2006). Additional member verification and validation is not required due to this inbuilt verification and validation which is embedded in the constant comparative method (Glaser 1992). The value of Grounded Theory methods is that they provide an integrated research approach to data collection, analysis and checking the quality of research findings (Elliott & Lazenbatt 2005).

Glaser (1992) believes that qualitative research should be judged on the criterion of trustworthiness, which is whether the data reflect empirically accurate descriptions
and understandings of the selected phenomenon being studied. Glaser and Strauss (1967, p.261) proffer that Grounded sociological theories need to ensure that the four interrelated criteria are met to achieve rigour and credibility in a Classical Grounded Theory study:

1) fit;
2) understanding;
3) generality;
4) control.

These will be examined in turn in relation to how the researcher met these criteria within this study.

The first criterion of ‘fit’ dictates that the discovered theory fit the substantive area to which it will be applied (Glaser & Strauss 1967). ‘Fit’ denotes that codes, categories and relationships ‘fit’ the data rather than the data fitting the codes, categories and relationships (Glaser 1978). During initial analysis in this study, many categories and relationships were derived. It was only through ongoing data collection and reflection by the researcher that ‘fit’ between the data and emerging categories occurred. This study gathered data through in-depth semi-structured interviews with RN participants working in acute care hospitals. The researcher ensured that the developed concepts and models were well established and conceptually adequate to fully describe how the participants understood organisational commitment and its link to retention. This process is fully described in the coding section in this chapter.

The second criterion of ‘understanding’ relates to whether the findings resemble the realities of the area under study and are understandable to the people in the substantive area (Glaser & Strauss 1967). A Grounded Theory study should explain
what happened and predict what will happen, as well as interpret what is happening in an area of inquiry (Glaser 1978). Understanding means readiness for use of the discovered theory and the creation of a perception that it can improve the participant’s situation (Glaser 1992). ‘Understanding’ was achieved in this study through the constant comparative process of data analysis. During this process the researcher identified the emergence of ‘management behaviours’ and ‘the experience of being managed’ as the main concerns of participants. Following further analysis of data the researcher was able to link management behaviours to the Nurse Manager and to the RNs’ understanding of organisational commitment and its link to retention. This data analysis process is discussed in detail in the coding section of this chapter.

‘Generality’, the third criterion, means the theory should not be too abstract to lose its sensitising effect, yet abstract enough to allow its applicability to a multi-conditional and continually evolving situation (Glaser & Strauss 1967). Generality of the Grounded Theory in this study also indicates that it can be applied to the total picture of the organisational situation. The theory generated in this study is reliant on a multidimensional approach, as it firstly depicts the very specific way in which the participants understand organisational commitment and its link to retention. Secondly the main concern of the participants in relation to their organisational commitment and retention is the core category of ‘Nurse Managers’ together with the subcategories of the Nurse Managers’ ‘enabling and inhibiting management behaviours’. These management behaviours directly impact the participants’ organisational commitment and retention via the negative influence of the Nurse Manager’s inhibiting management behaviours and the positive influence of the Nurse Manager’s enabling management behaviours. These inhibiting and enabling behaviours are subcategories of the core category and the specific identified management behaviours are the properties of these subcategories. Therefore, the substantive theory explains how the participants
understand organisational commitment and its link to retention by explaining what it is within the work environment that influences the participants’ commitment and retention within the organisation. This substantive theory is depicted in Figure 22 in Chapter five.

The fourth criterion for rigour in this study is ‘control’. This refers to the ability of the discovered theory to enable the participants in the substantive situation to predict changes and their consequences (Glaser & Strauss 1967). The substantive theory within this study does indeed meet this criterion as the participants already understand their commitment and retention in relation to the influence the Nurse Manager’s management behaviours exert on the degree to which they are committed and hence, their intention to stay with or leave their hospital. This substantive theory also identifies impediments to and support for organisational commitment and retention via the clarification of which management behaviours inhibit, and which behaviours enable, the participants’ commitment and retention. The substantive theory is described in detail in the section titled theoretical coding in this chapter.

The Grounded Theory that emerged in this study meets rigour and credibility in terms of ‘fit’, ‘understanding’, ‘generality’ and ‘control’. These criteria served as the guideposts to achieve and strengthen the findings within this study. The rigour and credibility of the research findings were achieved through strictly structured data collection and analysis methods under the Grounded Theory approach. For instance theoretical sampling for selecting interview participants; employing in-depth semi-structured interviews; coding of data to generate concepts and categories; constantly comparing generated concepts and categories and enriching findings and data against related literature. This process is fully explained in this chapter.
CONCLUSION

Within this chapter, the role of the researcher in this Grounded Theory study was defined and discussed. The research paradigm of critical realism was also discussed. The fit of the research paradigm, within this Grounded Theory study of how RNs understand organisational commitment and its link to retention, was demonstrated. A discussion of Grounded Theory methodology provided an historical background, the research traditions of this methodology and a description of the research method used within this qualitative study.

The research methods used in this study were then identified and discussed in relation to ethical considerations, the recruitment of research participants and the inclusion criteria to select the participants. A description of the in-depth semi-structured interviews that were used to collect the data was also provided. The demographic data for the participant group was presented, followed by a description of the sampling procedures that recruited this purposive sample, from which the data was collected. Data collection was discussed, providing a description of how this was achieved during the interview process together with the questions asked at interview.

The process of data analysis was discussed in detail, providing a description of the constant comparative analysis and coding method utilised. Together with the provision of examples of diagrams and tables this discussion enabled the researcher to visualise the data analysis process. During the open coding phase the core category was identified and the selective coding phase identified the subcategories of the core category. During the final analysis phase of theoretical coding the researcher was able to conceptualise how the substantive codes related to each other to form the substantive theory of how RNs understood organisational commitment and its link to retention.

The remainder of this chapter focused upon the memos and diagramming used
in this study and the theoretical sensitivity of the researcher. How the analysis was finalised with the literature to allow for the extension, validation and refining of knowledge that already existed in the field of study was presented. A discussion of the way in which the researcher reached theoretical saturation to substantiate the correct use of the research method, follow. Finally, rigour in the data analysis for this study is discussed in relation to the criterion for rigour in a Classical Grounded Theory study.

Chapter Four that follows presents the results of this study via discussion supported by the presentation of interview excerpts of the privileged voices of the participants. The discussion covers the central category of Nurse Managers and the seven subcategories and their properties.
CHAPTER FOUR

RESULTS

INTRODUCTION

This chapter presents the results of this study via discussion which is supported by participant’s voices. The central category of Nurse Managers and the subcategories of enabling and inhibiting behaviours of the Nurse Manager are discussed in relation to how these behaviours influence the participants’ organisational commitment. This is achieved via discussion of the properties of the enabling and inhibiting Nurse Manager behaviours which identifies specific characteristics that either enable or inhibit the participants’ organisational commitment. The subcategories of organisational commitment and retention are then discussed in relation to how the participants understand organisational commitment and its link to retention. The positive and negative influences that the enabling and inhibiting behaviours of Nurse Managers have on the participants’ organisational commitment and retention, is then discussed in relation to an acute care hospital’s ability to retain RNs in their organisation.

CENTRAL CATEGORY

Chapter Three described the emergence of the central or core category of Nurse Managers which formed the centre of the Grounded Theory paradigm model that provides structure for reporting the findings of this study. The term ‘Nurse Managers’ as used in this study is defined as: ‘a nurse in a management position who enacts leadership behaviour and provides management of a designated area via adherence to the goals, mission, policies and practices of the organisation and the nursing codes, ethics and competencies set out by the Nursing and Midwifery Board of Australia’. The
Nurse Managers were the mechanism through which the participants expressed their understanding of the central concern in this study. The central category emerged as a result of data analysis which used a systematic and rigorous constant comparative method. This method, together with theoretical sampling and the analytic schemes of Grounded Theory, yielded this core theoretical category which pulled together the other subcategories to explain how RNs understand organisational commitment and its link to retention. This section presents the results that emerged from the data collected from participants via the in-depth semi-structured interview process.

The central category of Nurse Managers was informed by seven subcategories and their properties. The first and second subcategories comprised the management behaviours which the researcher labelled as enabling and inhibiting behaviours. The properties of the subcategory of enabling behaviours are the specific management behaviours of trustworthiness, credibility, supportive, communicative and enthusiastic. The properties of the subcategory of inhibiting behaviours are the management behaviours of being invisible, reactionary, lack of professional respect and lack of performance management. The third subcategory is organisational commitment which defined the participant’s very specific understanding of their organisational commitment. The fourth, fifth and sixth subcategories were identified as work unit, patients and nursing. These three subcategories formed the specific way in which the participants understood their organisational commitment. This understanding was defined as simultaneous commitment to their work unit, the patients and their nursing which was encapsulated within the area in which they were employed. The seventh subcategory was retention, which the participants understood as linked to their organisational commitment; both these subcategories were influenced by the positive
and negative management behaviours of the central category of Nurse Managers. The relationship between the central category and the subcategories is portrayed in Figure 20.

![Diagram of How the Central Category relates to the Subcategories]

**Figure 20: How the central category relates to the subcategories.**

A detailed exploration of the central category and subcategories is now undertaken using the voices of the participants.

**Nurse Managers**

The participants in this study understood that there were a number of elements that continually impacted their level of organisational commitment and whether they would stay at the hospital at which they were employed. These elements encompassed the enabling and inhibiting management behaviours of Nurse Managers. The specific management behaviours of the Nurse Managers were either enabling factors which influenced the participants’ organisational commitment and hence their retention at the hospital or factors that inhibited the participants’ organisational commitment and hence
their desire to leave their organisation. These specific enabling and inhibiting management behaviours are depicted in Figure 21. The findings in relation to the Nurse Managers and the effect their management behaviours have on the participants will now be presented.

**ENABLING AND INHIBITING BEHAVIOURS ENACTED BY THE NURSE MANAGER**

Management Behaviours

![Diagram](image)

**ENABLING BEHAVIOURS**
- Trustworthiness
- Credibility
- Supportive
- Communicative
- Enthusiastic

**INHIBITING BEHAVIOURS**
- Being Invisible
- Reactionary
- Lack of Professional Respect
- Lack of Performance Management

*Figure 21: Identification of the Nurse Manager’s enabling and inhibiting management behaviours.*

The main concern of the participants directly related to their experiences of being managed by their Nurse Managers. The participants understood their organisational commitment and its link to retention through the lens of their experiences with regard to the enabling or inhibiting management behaviours of the Nurse Manager. The behaviour of Nurse Managers as experienced by participants during the process of being managed was consistently and significantly cited by all participants as impacting
their level of organisational commitment and, hence, their retention at their particular hospital. The participants used terms such as “having good and bad days” and “being resilient” during discussions related to the impact of their Nurse Manager’s behaviour and the participants’ response to particular situations. The enabling and inhibiting management behaviours of the Nurse Manager continually impacted the participants’ experience of being managed in a positive or negative way.

According to Participant 11 the lack of good communication with their Nurse Manager impacts their experience of being managed in a negative way:

...that would make a huge difference, I know it’s a very basic need for communication but because it is so lacking and the other problems that we have that stems from that on every point really, on every front on the ward.

The perspective of Participant 13 with regard to their negative experience of being managed by their Nurse Manager is that they are not respected and lack ability:

And, you know, the manager hasn’t earned that respect because they’ve never done anything about putting some limits and boundaries on staff... Well, you know, it’s because they don’t know how to motivate people. They don’t know how to lead people.

Participant 7 believes the way she is managed is not only negative but also does not focus on good patient care:

I think management have lost sight that it’s really all about patients and people.

Participants 2 and 12 describe the enabling behaviour of their Nurse Managers:

I’m supported in the way that I know that if I have an issue I could go to my manager and, you know they will support me.

My immediate nurse manager is wonderful. The um, nurse manager who runs our unit, at a unit level is extremely supportive.
Participant 5 described the difference between enabling and inhibiting behaviours of Nurse Managers and the impact of these behaviours on the staff:

... that the tension between the management and the staff sometimes occurs ... it depends, if the management is really good with the staff and works with them . . . then it is very good. I was working with a nurse manager who almost bulldozed their way through the staff, making too many changes too quickly . . . this led to a number of resignations . . . created a lot of unhappiness and people left.

From the perspective of Participant 16 inhibiting nurse management behaviour caused stress, unhappiness and resignations:

. . . but it also it causes stress to people and it makes people unhappy so they don’t want to stay. We shouldn’t have to have that, like . . . I think it’s the whole mentality that needs to change to get people to actually stay and to want to stay. The staff were leaving because they were miserable and basically ah, the registered nurses um, value was being devalued: that’s how we all felt, it’s been really traumatic.

The identified enabling and inhibiting behaviours will now be discussed using the voices of the participants who participated in this study.

**Enabling Behaviours**

The participants who experienced enabling behaviours from their Nurse Manager understood that they would stay with their organisation as they enjoyed the enabling management behaviours of the Nurse Manager and, hence, going to work. The experiences of the participants in relation to the enabling management behaviours of the Nurse Manager and the impact on the participants’ organisational commitment and intention to stay with the organisation will now be presented.
Trustworthiness

The participants in this research placed great emphasis on the need to have trust in their Nurse Manager and for the Nurse Manager to reciprocate this by demonstrating trust in the professional ability of the RN.

Participant 2 demonstrated the enabling ability of trustworthiness when they described their experience with their Nurse Manager in a previous position. Trust in this Nurse Manager, which was reciprocated, enabled their job satisfaction and enhanced teamwork and provided recognition for their work performance:

_The management had great understanding of what we did on a day-to-day, minute-to-minute basis, it was an acute area with kids, paediatric oncology . . . so a particularly stressful area but still my job satisfaction was far higher despite the area being far more stressful. Just knowing that any of our needs would be heard and addressed even if the outcomes weren't necessarily what we would have wanted but we knew we were supported we had somebody to go to, we trusted them. There was far more teamwork, there was clinical supervision, there were debriefings, just recognition also of the work that you did because often it would have negative outcomes because of the area we worked in but still knowing that you were doing a good job._

Participant 10 also describes how trust in their Nurse Manager and her trust in them, creates a positive trusting work environment:

_... people know they can approach her and she is supportive of the nursing staff. So you know that the ward works well because you can depend on each other and you trust each other’s professionalism and you trust each other. You support each other in the good times and the bad times._

A number of participants described instances where the Nurse Manager broke the participant’s trust and then the Nurse Manager tried to cover their mistake
despite the negative implications for the participant involved. The participants in these situations describe their emotional responses to these situations as being stressed, devastated, angry and feeling completely unsupported and let down by their Nurse Manager. The consequence for some of these participants was not only the loss of their position or role, or possible personal financial cost, but also the devastating realisation that if they stayed in their position they may never be able to trust their Nurse Manager again.

Participant 9 described how they were placed into a nursing position in an ‘acting’ capacity and then removed from this position due to a failure of procedure on the part of nurse management:

. . . so I declined the other job. I came over here and did this role and after three weeks they ripped me out of it quite unceremoniously, just rang me and said that there hadn't been an 'expression of interest', they just can't put someone in the role, and took me out of it. 'Cause they asked me, and I'm really angry that they let me knock the other job back and then treated me this way.

Participant 13 described how they were given incorrect information from their Nurse Manager and then, because the manager denied its occurrence, the participant was told they had to pay back their training fees to the hospital:

. . . because she’s told me don’t apply for the jobs. Then she denied this . . . So it was later on when I realised, “Oh, crap, I’m going to have to pay the hospital back $15,000 because I don’t have a job now.” If you didn’t stay for 12 months then you’d have to refund the cost of the course. We went through the whole situation and I had witnesses to say, “Actually you did tell her not to apply for the job,” So it becomes a fault of the organisation itself. And I didn’t have to pay back the money but I had to go to the Union (- - -) it was awful, very stressful.
Participant 8 also related their experience of being managed by Nurse Managers within their work unit and the influence this had on her perception of being trusted:

*Our service is just so full of people cross-checking on people, at a management level, and there is just so many layers of management now that it’s just amazing. I just think we’re bogged down with management here, it’s just dreadful. Dreadful. You know, you can’t move without someone double checking you on anything.*

Participant 11 comments about how her Nurse Manager demonstrated this limited trust in their management ability:

*We have major problems with my manager and her management strategies and skills even her personal skills . . . anything that she can do could not help me if I needed assistance with concerns in the workplace.*

Participant 13 discussed the resultant behaviour of nurses when they have no trust in the ability of their Nurse Manager to address the nurse’s concerns:

*These people have been around the block and they've seen it all happen before you know, so whilst they feel a bit like, well you know they're the Manager and that's how it's going to be and it's come from above, this is how it is. You still have to coerce people to do stuff. You know to make sure that they are, although they don't have a lot of say in it, but they do in a way. I don't know, it's kind of hard to explain, but I think some of the Managers are a bit young and they've had a few problems with staff in that way and you know once again, I think it's got that way that, a lot of people don't bother to talk about their problems, they just move on. 'Cause you feel like, well even if I talk to someone who's really going to listen and what are they going to change.*

Participant 7 discussed their own and colleague’s lack of trust in their Nurse Manager:
I don’t think anyone on our ward would go to her with a problem. Well actually I don’t know where they would go, they’d probably go to the union first I think.

This comment is of great concern as the participant did not nominate any other person in nursing management to go to with a problem. This demonstrates a lack of trust in the nursing administration as a whole within this participant’s hospital.

Participant 12 also explained why they had no trust in their Nurse Manager:

*I personally feel that she just doesn’t have any interest. She’s quite obstructive.*

Participant 2 commented on the lack of trust in nursing management. They described what they believed were policies that nurse managers made up to suit themselves, which compromised both the employee and the hospital:

*After having our babies we wanted to return to work part-time and were told by the Nurse Manager that we had to work full time or not at all. Then two years ago they were so desperate for staff and they had a change of leadership who just started offering 1 day, 2 days, whatever people wanted and I thought “Isn’t that funny.” You know, when it’s, the stone turns and they really need staff, they’re willing to change the rules, which really aren’t rules anyway. They’re just made up as they go along. So a lot of people . . . moved on to the other hospitals. Some went to private areas where they were offered part time work.*

Participant 14 described how their Nurse Manager did not honour their promise of permanent work:

*Math job at the unit finished because the organisation decided that they didn’t want to keep me and that was done in a really bad way as well. I got my job there and I was there for five months and was offered to stay on part-time permanently and so half-way through the contract I said “Can I please see my contract and what am I, when do I*
actually - - - is it permanent as agreed or whatever?” and they turnaround and they go, “Well, actually, we’re only going to keep you until the end of the month”. When everyone found out that I was leaving they were all going, “Why are you leaving? Like, you’re such a good nurse, we shouldn’t be letting you go” and that was coming from ANUMs and everyone, and I felt, “Oh that’s, that’s interesting.” I was like, oh, and then seeing as we’d agreed, as far as I was concerned we’d agreed on an ongoing contract and to be turned around and be told, “No, you’re actually here till the end of the month,” . . . these guys actually wanted me on the floor, wanted me working there, but the NUM didn’t want to keep me - - - and no explanation, nothing.

The participants also expressed a lack of trust in the ability of some of their Nurse Managers leading to the expression by some participants of an almost wistful need for “just somebody to go to whom they could trust”. An example of this is provided by Participant 9:

But just knowing that any of our needs would be heard and addressed even if the outcomes weren’t necessarily what we would have wanted but if only we knew we were supported, we had somebody to go to, we trusted them.

Participant 8 also commented on the lack of trust in their Nurse Manager’s clinical ability and the Nurse Manager’s lack of professional respect for them:

. . . to have their own input into what we do even though they haven’t been involved with patient management for 20-odd years. Now I find that annoying.

Participant 5 also voiced their frustration at the lack of trust shown by the Nurse Manager in relation to the nurses:

. . . their attitude or questioning your judgement as to why you might need more staff, that sort of thing you know, lack of trust I think.
Credibility

The participants also discussed the importance of credibility in relation to their Nurse Manager as this enabled the manager to negotiate successfully with upper management on behalf of the nurses and the work unit. The credibility of the participants’ Nurse Manager also elicited feelings of pride and enabled positive role modelling to occur.

Participant 3 spoke with pride when describing her Nurse Manager:

*Oh I have great leadership here. My Nurse Manager is a great leader, very supportive. . . always tries to do their best often with short staffing and enormous amounts of admissions. She actually listens when you do have a problem with things . . . I feel trusted and well looked after and am valued and developed.*

Participant 10 describes her perception of her Nurse Manager’s credibility:

*She’s not scared to get in and help, be seen to be a part of the team rather than the boss of the team.*

The participants discussed a number of situations that occurred in their work unit where they perceived the Nurse Manager as lacking credibility and the impact this had on the individual and the work unit.

Participant 3 described the situation of a constant stream of nurses acting in the Nurse Manager position:

*I’ve actually had a change of manager, three, no more than that, probably four times, I think, in the last, say, I don’t know, 6 years. And we have gone through a stage that is continuing of people who are acting in roles. Whether that be from, you know, acting manager of the department to the program manager within the nursing unit, a medical section of the hospital, which has, I think, been somewhat unsettling. That does make*
things a little bit unsteady, because the person enacting the position is, you know in some instances, not all, they've been less committed to the role. These acting positions have, oh, it’s varied - - - we have had you know, 6 months, a year to nearly 2 years. Then likewise it’s been difficult for that person not to own the job, but likewise, you know, if your boss is, is a little bit less anchored in the role then you get a feel of that.

Another example regarding perceived lack of credibility came from Participant 12 who describes the response of their Nurse Manager when questioned about employing more staff to fill existing vacancies and the impact this had on the participant’s work unit and perceptions of credibility:

I’ve changed shifts for people you know I’ve swapped my shift around to make up for shortage in staff. Yeah, I mean I could’ve left by now and I’m actually thinking this year I might, I might be going, I mean at the moment we’re short, whenever we’re short of staff it - - - I mean we’ve been short of four FTEs staff for the last four to five months and no one new has been employed, no permanent staff member has been employed. They have been advertised and that’s also one of the harsh realities that isn’t spoken about much but it, last I heard from our, my boss that they’ve advertised and they’ve interviewed 40 people and no one seems suitable. I mean out of 40 people!! Exactly, I mean and just that’s rubbish you know and when you hear that kind of stuff at a staff meeting that’s really disappointing, I mean how is it that not one of them could be suitable and I mean surely there must have been someone suitability amongst them that you could’ve bought them on board and trained them up - - - and the excuse was “oh but you know we really want someone, we really want to employ people who already know what they’re doing to help you guys out” and I mean I was just - - - and when you hear that kind of stuff, like I, I get really disappointed.

Participant 10 also described why they perceived their Nurse Manager as having
no credibility:

*The most basic thing would be for them to have even a close idea of what it means to have this unit, an understanding of what we do an understanding of the work that we do on a day-to-day basis that would help. For them to some take responsibility and not just shirk off their responsibilities.*

In contrast, Participant 5 who perceived their Nurse Manager as having credibility, spoke of them and their effect on the work unit in glowing terms:

*I can’t speak highly enough of, I guess, um, you know, how our service works and runs and the communication levels and so on, um, I think are very good.*

**Supportive**

The participants in this study continually commented on whether their Nurse Manager was supportive or not. ‘Supportive’ was used in a broad context by the participants when describing situations they had experienced. The term was used to describe whether the Nurse Manager ‘was supportive’ or ‘not supportive’ in particular situations. The frequency of use of the term ‘supportive’ added strength to the identification of this as an enabling management behaviour of great importance to the participants. The participants perceived that support from their Nurse Manager did not necessarily mean that the Nurse Manager agreed with everything the RN wanted, yet they still felt supported as they were listened to and their concerns were at least acknowledged. It became apparent that if the Nurse Manager ‘did not support’ the participant, they perceived the behaviour of the manager in a negative way; conversely, if the Nurse Manager ‘supported’ the participant they were perceived in a positive way.

Participant 4 provides insights regarding the impact the enabling behaviour of a supportive Nurse Manager has in their workplace:
Our boss is really nice and very understanding, and the team that work there we all work very closely together, we take care of one another and it’s a very cohesive thing, I want to actually, I want to go to work as well because we are such a good group that work together.

Participant 8 described how they felt supported by their immediate Nurse Manager but not by upper nurse management:

Um, our, my immediate management I feel very well supported. I’m in a partially an education role and I have clinical shifts as well and I feel very supported in education um, and in clinical by our immediate managers. But once you start to go up the chain, no, I don’t think so. I think it all gets down to the bottom line. Um, it’s all governed by money and just saving money rather than, there’s no vision.

Insights into how nursing staff did not feel supported by Nursing Executive are offered by Participant 8:

I think that the general staff feel that the Executive aren’t interested in the day to day running of the hospital unless something happens and it becomes a court case and then all of a sudden they’re interested, they want to know about accountability and if people haven’t been, done their documentation, I think they feel like they’re dropped.

Participant 7 described how the lack of information flow from their Nurse Manager left the staff owing money at tax time on their RAMIT (remote area allowance) and this made them feel unsupported:

Information might go from Executive to the NUMs, but then it doesn’t go any further to the workplace, to the people who needed the information. And a sample of that recently, because of our RAMIT package and salary sacrifice um, we're going to pay fringe benefits tax on our free air flights. Now people weren’t aware of that, the NUMs had been advised, but it didn’t get filtered back down into the workplace and
then after tax time this year, a whole lot of people received bills for up to I think about $1,800.

Participant 10 describes a situation whereby their NUM appeared to display a lack of concern and support for her nurses in relation to a situation of understaffing:

*I guess our NUMs are under a lot of stress and stuff but that night I was mentioning where we didn’t get any extra help and I only handed over one bed in the morning, um when the NUM came in the morning I was in one of the . . . with an . . . patient and she walked in and looked straight at one of the computers and counted up how many bed blocks and said have we got any extra help? I said oh we didn’t, I said one of the night, evening girls stayed until 2 o’clock in the morning but um you know she went and that was it. She said no not you, I mean for us today! And I said oh I don’t know and she said well have you asked, have you rung and said we are going to need extra help? And I said well to be honest with you I haven’t had the time and the doctor that I spent the night with was sitting there and he said oh that’s great you don’t care about us, you only care about the day staff. She never said anything, she never you know withdrew or anything and I felt fairly, pretty unsupported by her.*

Participant 11 described, what was for them a distressing situation, where they perceived a lack of support:

*I think the nurses on my ward are fantastic, I think it’s a really great little unit um but I think it performs as well as it does because of the commitment of the nurses um despite, um despite understaffing, under resourcing, times when you know we have situations happen on our ward where oh I just don’t think um, like just recently as an example um there was a complaint about a nurse by um, by another Queensland Health Member who was on the ward who saw an interaction with a patient that, and it was, they just saw a tiny little bit of it, totally out of context what they saw, they didn’t see the context*
of it and they put in a complaint and I, there was no support for that nurse. The ward was quite traumatised by it as was that nurse. Well it’s only for her commitment to the ward and to her work that um she’s okay, you know she’s back and working and back on track but really the lack of support for her, everybody on the ward felt like it could have been them and if they got into trouble the organisation wouldn’t be there for them. And we all, this was a long term girl that we had on the ward who we all actually really like even though she is a manipulative patient and um just an interaction was taken out of context and looked bad and all of us could have been in that situation where we, you know so it was a traumatic time and um not only did we all question our own, and then it affected how we performed later on, how do we deal with these kids? So that was a time when we felt very unsupported by the organisation, yeah very unfortunate, but the ward is still functioning well and um . . . No unfortunately that’s another thing, the NUM did not provide any support for the nurse or for her staff . . . she is a really nice woman but she’s not a very good manager. She’s not very organised and she’s not um, you know she’s got her own issues and that’s the cause of that, but no she did not support us.

Expectations in relation to how they believed they should be supported by their Nurse Manager are described by Participant 5:

The main thing is about being valued, being able to be autonomous sometimes with things, giving off your ideas, people listening to your ideas, not just for the sake of listening because you want to have a say, or whatever, I mean, but when you make valuable contributions - - - when you want to make a contribution and be part of the team . . . feeling supported, that sense of support is one of the big things”.

Further insights are provided by Participant 16:

I used to go home crying every day. Um, I felt like we were just being undervalued, um
not respected, absolutely no support. You know, I see the function of the leader as to support the staff, I mean everybody left because they were undervalued, bullied, harassed and you know, just didn’t enjoy being at work because the atmosphere was shocking, it’s a sad story, it’s really sad because, you know, basically everybody wants to go to work and do the job and be happy and be trusted and value and supported.

Expectations of the supportive Nurse Manager, is evident in the following statement by Participant 1:

*Just somebody who is interested in listening to us and is genuinely interested, instead of just saying the words their actions need to speak as well.*

Participant 3 described how they did not feel supported by their Nurse Manager in the day to day management of the unit:

*I don’t think that they’re too interested especially in the day-to-day nitty gritty stuff, they’re much more, big picture people, but they don’t have very much interest in the human resource side of the unit.*

The desire of participants to see their Nurse Manager show support is offered by Participant 12:

*And the nurses, they want to be, you know, thanked for a good job and to the best of their ability they, you know, people try to do a good job.*

When support is shown and is felt by participants, the following, as offered by Participant 9 occurs:

*My immediate Nurse Manager is wonderful. The Nurse Manager who runs our unit, at a unit level is extremely supportive.*

**Communicative**

The participants also acknowledged the importance of effective communication
on the part of the Nurse Manager. The majority of participants were dissatisfied with the communication style used by their Nurse Managers. They also acknowledged that this impacted on their perception of the management ability of their Nurse Manager. Some participants felt isolated by the poor communication within their work unit and others wanted feedback when issues were raised that they felt needed addressing. One participant’s example of poor communication was that they could not tell the researcher the management structure or the roles of the Nurse Managers within their department or, indeed, who they were. This participant had been working in the particular organisation for over four years. A number of participants wanted more consultation in the workplace and discussed situations where their Nurse Manager had introduced new procedures which the participants felt would not work in their current format.

Participant 6 described the communication in their work unit as diabolical and the domino effect it has on every aspect of their work:

Absolutely diabolical, which is very frustrating. I know it’s a very basic need for communication but because it is so lacking and the other problems that we have that stems from that on every point really, on every front.

The importance of effective communication is described by Participant 10:

I had continually tried to discuss issues and sought solutions, and you know I just got nowhere, just continually hit a brick wall . . . then I just stopped trying to address things as it was obvious that nothing was going to change . . . I just gave up and left.

And Participant 12 just wanted to be heard by their Nurse Manager:

If you feel heard, if you feel supported, so someone is actually listening to you. Like I said before you might not get the result that you want because of whatever reason, the hierarchy structure or Health policies or whatever but just know that you've been heard.
The management communication path at the hospital where Participant 14 worked demonstrates the importance of effective communication in the workplace. This participant described a situation where the communication was so lacking that they had no idea of the management structure of nursing or their roles and responsibilities in the management of the work unit were they were employed:

*The NUM was there for about three years and, and before he started there, there was another NUM so in the last five years or so there have been three different NUMs. There always seems to be a large turnover of staff as well which puts just a huge strain on everyone . . . To be honest I don’t know what their role is and I don’t know how they assist in managing or running our department. So I guess that is also perhaps a fault of line management or the fault of an individual not to take an interest in who’s who in the organisational hierarchy you know to find these things out. But I, to be honest I really don’t know if their role is a logistical one or if they have to manage people in any way, which people they’re managing, I mean I guess they’re managing the NUMs aren’t they from all the wards, I’d hope so. There’s a woman who works on our floor who’s oh I mean she, she works above the NUMs but I don’t know what her title is and I’ve had a lot to do with her but I really don’t know what she does.*

Good communication was seen as important. Participant 8 said it very simply:

* . . . for staying at work, the communication is paramount.*

Effective communication can either hinder or facilitate the change process. Participant 5 expressed frustration with the poor communication style of the Nurse Manager before implementing change:

*They implement it even without consulting with us. They don’t ask for our input, they don’t recognise that we are the expert in the area and ask for our input to actually implement it . . . We are not very often given that opportunity to voice what we want*
and it doesn’t go very far or well it doesn’t go anywhere; it doesn’t go very far or once it’s fed to another managerial position it's incorrect.

Frustration at the lack of feedback received from the Nurse Manager when concerns were raised was voiced by Participant 10:

*I’ve communicated to my Unit Manager about things and I don’t hear back from her, which is really, really frustrating and then suggestions that I’ve made and my boss said oh we’re already doing something about that and I haven’t heard about any, well how frustrating, you know.*

**Enthusiastic**

Participants understood that nurses would follow a leader with vision; one who inspired them. They believed that a manager who demonstrates enthusiastic behaviour will motivate and inspire the employees to achieve organisational goals. The participants in this study discussed how they wanted their Nurse Manager to be enthusiastic and energetic but only one participant actually acknowledged that their Nurse Managers exhibited these behaviours.

Participant 6 stated that:

*... the general feeling that I get is that everyone’s striving along the same path to achieve what’s good for the patient and undoubtedly that’s where, where, you know, we as nurses come from.*

Participant 3 described how they perceived the ability of their Nurse Manager with regard to their performance and that they needed to be enthusiastic and drive improvements in the ward forward. The participant then stated what they actually wanted with regard to ability in their Nurse Manager:

*... and really she’s not, she’s a really nice woman but she’s not a very good manager.*
She’s not very organised and she’s not, you know she’s got her own issues that’s the cause of problems but - - - often things don’t get done, forms don’t get sent you know and I think if you don’t have a good line manager, it makes life really difficult. Hmm and she’s like that and I think you need to have someone at the top of the ward who is, they have to be energetic, enthusiastic I think and passionate about making the ward the best it can be. She just doesn’t have that energy. Which is very unfortunate. Having said that everybody likes her but we all are very frustrated that because the ward could be so much better. Yeah. It’s very sad. I don’t know I just think a boss has to look after the workers. She’s just doing a job but she does the minimum job.

Participant 3 also made the comment about how they perceived the effect an enthusiastic Nurse Manager would have on the work unit:

Which I think, it’s like any organisation, if the person at the top is excited or wants to improve all the time, then everybody else does, you know.

The disabling behaviours of Nurse Managers will now be discussed.

**INHIBITING BEHAVIOURS**

The participants generally responded to inhibiting Nurse Manager behaviours with an expectation that the situation must eventually improve. They then refocused on their commitment to their work unit, the patients and their nursing to enable them to cope with what they perceived to be unfair treatment. The participants who experienced inhibiting behaviours of the Nurse Manager generally verbalised that if the situation did not improve they would resign from the organisation.

**Being Invisible**

Participants also expressed concerns with the lack of visibility of their Nurse Managers. The participants attribute this to the manager’s workload as well as what
they described as ‘an avoidance technique’ used by the manager to avoid addressing problems in the work unit. Managers in some hospitals were physically not present with their office located in an area distant to the work unit. Some of the participants describe how they have little face to face communication with their Nurse Managers and discussed how this lack of contact impacts in an emotional sense as a working relationship was not established with the Nurse Manager. This lack of Nurse Manager, visibility, influenced the participants’ perception of their Nurse Manager’s ability.

Comments by Participant 7 reflect this notion of being managed at a distance:

*I’ve had very little to do with my manager, like, you know, any management at that level and knowing that I can go to someone if I have a problem or something like that. So it’s a little bit more managing by distance, which can be satisfactory, but in retrospect, it’s, you know, it’s less comforting.*

The notion of distance and its impact on face to face contact with the Nurse Managers is reinforced by Participant 13 when they said:

*They’re located in a different location to where my daily work is done. It’s not sort of - you don’t have face-to-face communication with them. And that’s because they stay down in the office, they’re not getting out, they’re not circulating, so I think that the general staff feel that the nursing executive aren’t interested in the day to day running of the hospital unless something happens and it becomes a court case and then all of a sudden they're interested, they want to know about accountability and if people haven’t done their documentation, I think the staff feel like they’re dropped. So I think from the workers’ perspective, they don’t trust the nurse executive.*

The lack of contact with their Nurse Manager was interpreted by Participant 14 as:
. . . that closed shop-ness is more, well, what I’ve seen, what I’ve observed is more about basically, “Don’t come to me. If you don't come to me with a problem, then everything’s all right.” There should be an open door policy, “Come in. Come on, what’s the problem? Oh, gosh. That's, that’s really hard. Well, let’s see what we can do about it.

**Reactionary**

Participants also identified numerous incidents where the Nurse Manager had displayed reactionary management behaviour. The participants discussed their perceptions of this type of behaviour in relation to the perceived ability of the Nurse Manager together with the impact this type of behaviour had on the work unit and the participant. Participants expressed disappointment and dissatisfaction with this style of management and believed that it did not achieve anything positive, serving only to upset and distress employees who experienced this behaviour. The participants also expressed concern at the possible consequences if this behaviour became the norm and that consequence would be that nurses would leave.

Participant 8 described the situation of nursing management continually trying to meet the Department of Health’s directives creating a reactionary style of management:

‘Cause you know they, they, they’ve lost sight of what we’re all here for. You know the, and it’s all just the Department of Health and fudging numbers and you know, making sure everything looks good and proper and surgical cases get treated, it’s all very reactive rather than proactive...

Ongoing controlling and reactionary behaviour of their Nurse Manager was described by Participant 10:
My manager who tells me - - - “you must do everything through me and I’ll make the decision on that”. And she puts her hand up in front of your face, you know, and, “I won’t, we’ll stop talking about that right now”. You know, when you try to bring something up. “We’re not here to talk about that now!” and up goes the hand.

Participant 6 aligned this management style with an organisation that is very critical:

It’s, it’s a very critical organisational here. Ah often, very often people get reprimanded but very, very seldom do you get, “Thanks guys, you know, you’ve worked your butt off today and we’ve done a good job.” So you hardly ever get that. They only address it when, when there’s a problem.

Another participant displayed shock as they described their Nurse Manager’s reaction to the results of a survey which asked staff to identify problems and concerns with management. Participant 10 commented that:

The first thing that this person said was, “I don’t trust any of these surveys that you do because they’re not true. It's people making mischief” and I just looked at her and I thought, my God, people are filling out the surveys and she's not even taking it on board that this is how people truly feel. So yeah and she said that in front of people who have actually done the survey and were feeding back the results of it.

Concern and a lack of confidence in their Nurse Manager’s management style in addressing staff problems as they arise was expressed by Participant 8:

So there's a few people here that I think are emus with their head in the sand. Yes and where they see anything as being their fault, the unfortunate thing is, they're the people in power.

Participant 12 described experiences of reactionary management style from their
Nurse Manager and the significant psychological effect this had on the participant:

I’ve had some pretty horrific experiences where I haven’t received feedback when I should have. I was eight weeks into a trial for a 10 week rotation...I got pulled into a meeting with the clinical educator with the course coordinator of the course, the unit manager, and was instructed that I was doing quite a few things wrong and that I was told I had two weeks to fix it all, and I had no idea that that had happened. I thought I’d gone, was going reasonably well and then because I was, like, “Oh, I haven’t heard anything so there’s nothing wrong,” and then to be told by nursing management “you’ve actually got all these issues that you need to fix.” I actually had to work my shift after that meeting and I’d obviously been crying in the meeting and I had to work, and the next day I had to call in sick because I was just so stressed about everything that they’d said. Well, I was, I was quite disappointed and I was at the point of actually leaving and going back home because it upset me so much, why stay in, why stay here when they’ve got no commitment to me to provide feedback, to give me instruction about how things are going when I’ve been asking what’s going on, how do I do things? Well, if you’re going to treat your staff like idiots and you’re not going to help them, of course they’re not going to stay. So they just let it all build up and then it’s like, “Oh, we better do something about that now”.

Participant 1 described how their Nurse Manager continually employed a reactionary management style and how this impacted the work unit and the nurses employed in this unit:

Yeah, yeah very defensive. I can’t, it’s, it’s not a pleasant environment and not to have confidence in the ability of your workmates, undermining what you do, controlling everything, I mean that’s terrible, I mean questioning everything you do, it’s actually really insulting as well.
Lack of Professional Respect

The participants believed that professional respect for nurses in the contemporary health care workplace was less evident than in the past. The reasons the participants cited for this phenomenon was that managers looked at nursing as a cost cutting area and the ongoing staffing and skill mix problems associated with the nursing shortage meant that the nursing workforce in hospitals had become problematic for management.

An example of this is provided by Participant 7:

*In the past there were doctors and nurses and that was it and the nurses did everything in between . . . we were respected then. Managements main concern is money . . . nurses are the first in cost cutting measures . . . Now it’s the little things, it’s often the little things that make the gaps very obvious. If I ever want to get a morning tea organised for a hospital reason like an education group or something I’ll get the doctor to order it because we won’t get anything. Of course when there’s a nurses’ thing there’s nothing so this is how they cut costs.*

Participant 3 describes her perception of how she believes non nurse managers perceive nurses:

* . . . people in management don't understand our role and we've not given any status of any kind at all it's all just a big joke you're just the nurse. But its because they've never had to do it they really don't understand.*

Participant 8 believes the lack of funds for nursing demonstrates management’s lack of respect for nurses:

*It’s just, there’s just, the money thing, as money, more money goes into the pot that money gets swallowed up by people who aren’t actually looking after patients. Yet we*
have vacant positions and these are not being filled . . . their not even advertising! We are just flogged . . . the workload is exhausting . . . I am actually looking at jobs outside of nursing.

Participant 1 describes how Nurse Managers no longer support professional respect for the nurses when they should:

. . . you know they, they, they’ve lost sight of what we’re all here for. You know the, and it’s all just fudging numbers and you know, making sure everything looks good and proper on paper. I think it all gets down to the bottom line. Um, it’s all governed by money and just saving money rather than, there’s no vision.

The participants were particularly scathing with regard to any display of non-professional respect from their nurse management. They appeared to be more forgiving of non-Nurse Managers as they may not understand the nursing profession but other nurses and in particular nurse management they believed should never be disrespectful to other nurses. The participants believed that managers, both nursing and non-nursing, should display more respect for the contribution of nurse clinicians to the health care system. They also believed that they were working harder and longer hours due the staff shortages. The participants believed that as they were the largest group in health care, without them the industry and more importantly the patients would suffer. The general feeling of the participants was that if an individual hospital wants to keep us then they need to show us some respect or they would go to another hospital that will respect them.

The participants described a number of situations where they believed they were disrespected by their Nurse Managers. Participant 6 spoke of an incident with nursing management:

One international nurses’ day the Nurse Managers all came around, all the executive
came around and gave out chocolates to the nurses but they were out of date!! Yeah totally out of date, it was just that kind of thing. And the nurses felt somewhat insulted. So they really didn’t do anything positive at all.

Participant 7 described how they felt disrespected by their Nurse Managers:

But there are sometimes, sorry I feel like I’m, I’m not heard, I mean there are a lot of things that I’ve spoken up about and you know like I said sometimes it’s not acknowledged. I don’t feel like I’m given the, the opportunity to speak, this is, this is at staff meetings. Some of the decisions I’ve made at work where I’ve felt that they have been right ones, all the ANUMs that I’m working with, rather than bringing up why they think it’s, it’s not a good idea and, and talking about it professionally, I mean they can be quite rude about it. I guess what I’m saying is that there’s not that much professionalism.

Another participant described an incident whereby they felt that nurse management had shown a total disregard and disrespect for a group of nurses:

So we all turned up at 8:00 in the morning and we were ambushed by five management people who, without any notice at all, came and said, “Right, into the conference room we want to meet with you”. They proceeded to present us with an education session about bullying and harassment, and we all sat there absolutely gobsmacked because, you know, we were the ones that were being bullied and harassed, and basically it was a veiled threat against us, to do what the new manager wanted, you know, to not argue with the new manager basically. Participant 16.

Another participant, by contrast, described what they believed was professional respect from their Nurse Manager. Participant 12 stated:

She’s a very proactive DON. She’s not scared to get in and help, be seen to be a part of the team rather than the boss of the team. But she makes a kind of effort to be
seen. The departments and the various wards, just to have her presence known and people know they can approach her. She’s very - - - approachable.

**Lack of Performance Management**

The participants were generally dissatisfied with the performance appraisal system in the hospital. This dissatisfaction centred mainly on the inconsistent behaviour of Nurse Managers and the formal appraisal process, and the variability in the frequency with some employees having never been appraised. The other major issue for the participants was the inability or reluctance of their Nurse Manager to address poor performance issues in the work unit. Of great concern for a number of participants was the poor performance of the Nurse Manager themselves.

Insights into experiences with the Nurse Manager not performing with regard to addressing problems on the work unit were offered by Participant 5:

*Speaking personally, my previous line manager, I didn’t get sufficient guide and support from and that was – that has been difficult for me and I’ve felt that I’ve perhaps been more experienced and more knowledgeable than they were and when I had an issue, I wasn’t – I didn’t have – I wasn’t in a position of authority to be able to take it to the next level. Um, because the next level would be – well, it would be going through my immediate line manager and then for them to take it onwards and upwards to, you know, escalate the problem, but that wasn’t happening and I was feeling – look, I can’t say it was bullying, but the, the problem that I might have had would have been thrown back at me to be sort out, because clearly, there, there was no understanding or a lack of insight.*

Participant 10 described how they needed to take leave due to the poor performance of their Nurse Manager as they had become stressed in the work-place because their Nurse Manager was not addressing ongoing problems. This participant
then contrasted this experience with the more satisfactory performance of their new Nurse Manager and how this has changed their work environment for the better:

They do not get, it, you, it’s frustrating. In fact, in retrospect, my last, last year, not this year gone, but the year before I actually came close to taking, sort of, stress leave, because I wasn't able to come into work. And knowing that you're not going to be able to fulfil what you need to fulfil or indeed be - - - to the same problem that you were trying to struggle with 6 months ago that are piling up, 'cause you’re not getting the right support and the right people helping you out. So I took some leave suddenly when someone said, “Oh, you know, I’ve never seen you like this before. Darling, you need – when did you last have a holiday?” And so I got out of – I just got through last year and then you know, this year I’ve had a change of manager and that – things have been much more positive for me and for the patients. I really feel like I’m being heard.

The need for the Nurse Manager to improve their performance and take ownership of new initiatives so that they are actually successful is described by Participant 13:

One is that there has to be - - - whenever a new initiative is generated or a, you know there’s a challenge or we need to revamp something, rejigger it or there’s, there’s a working party who - or should I say a problem that needs to be addressed ...Then there has to be ownership of that problem. And not just by the nurses, not just by the doctors, it has to actually come from the manager. Unless that manager or indeed the executive own up and say, “Okay, I’m responsible to make sure that this happens.” then it’s not going to work. You can - - - and that's what, I think that's what - - - that's a big part of the problem. “We’ll work with you to change this”. Yes, it has to be driven by someone in authority someone has to have a name on that to be responsible for it, otherwise it ain’t going to happen.
Participant 3 describes how the Nurse Manager delays or avoids addressing staff issues as they arise, instead choosing to wait, sometimes for extended periods, to address areas of concern at the annual performance appraisal:

And through a PA and D, like you were doing this, it's not appropriate, but you don't tell someone that at 12 months when it's been supposedly going on the last nine months. You clear it up there and then and say something and that's where I find that occasionally things don't happen the way they should. How distressing would that be. Well very, because then it leads to a dysfunctional workplace where people start getting paranoid, well what's she saying about me and all this sort of thing, so they've got to sort of get past that.

The psychological effect created by the lack of timely performance management by their Nurse Manager is discussed by Participant 6:

Well, I think it’s the whole mentality that needs to change to get people to actually stay and to want to stay. Because unfortunately when it gets to the point that people don’t want to go to work in the morning because they don’t know what’s happening or who’s going to say something, and also it makes it harder because when you start nursing you do it for the love of the job. You do it because you want to help people, you do it to get in there and try and solve things and make people feel better. But if you’re being criticised and, or feel like you’re being spoken about behind your back it makes it harder to do that and suddenly it goes from you not doing nursing because you want to or you love it, you’re doing it because it’s a job. Instead of you having to go and seek feedback if you’d just got the feedback to start with you feel that we can go to work, and even if an issue arises then it will be addressed, addressed as soon as possible rather than however many weeks down the track.

Participant 2 identified how the Nurse Manager uses the annual performance
appraisal as a punitive tool:

No, and we're actually, because I've said it a few times to the District Director of Nursing that they're being used a punitive tools, now there's a whole lot of education going into the NUMs about PA and D. It was just, it was completely negative. Everything that was on it was, people say you do this and this and this, so got it all sorted, took it to the Union because nothing was actually happening in the work area and as a result of taking it to the Union, now the NUMs are receiving a whole lot of education. Because a lot of the NUMs don't have, they are put into positions and they really don't have the experience either. And I mean there's no Incident Form, there's nothing really, all they're doing is punishing you for people's gossip sort of thing.

The notion of performance appraisals in terms of the organisations commitment to the participant and to improve nurse retention was also raised by Participant 15 when she said:

Performance management is one thing that I wanted to mention earlier too, that in order to retain nurses and you know, have some evidence that the organisation is committed you know, we have the performance reviews and you know, the nurses often write down what they would like to do in terms of a staff development... personal development and overall career development. But often none of that gets met. No, there, just never a review about it, “Well how did we go?” yet it’s there in evaluation, you know? I know my last performance review was about two years ago, a little bit lacking in the organisation commitment side.

Organisational commitment will now be discussed in relation to the very specific way participants understand what they are committed to.
The participants in this study understood their organisational commitment in a very specific way. This was that they were committed to the ward on which they worked and simultaneously to the patients on the ward and their nursing on the ward. This ‘triad’ became clear when participants were initially asked about their understanding of organisational commitment, as they tended to firstly identify where they worked. For example participants would often begin with “I work in intensive care” or “I work in the emergency department” or they would refer to the type of role they have and proceed to discuss their understanding of commitment in relation to their role which encompassed their identification with their nursing and their patients.

This specific understanding of organisational commitment is consistent with the literature, which states, that it may be a multidimensional construct whereby an individual staff member may have multiple types of commitment operating simultaneously (McCabe & Garavan 2008). This understanding of organisational commitment will now be discussed, again using the voices of the participants.

**Work Unit, Nursing and Patients**

An example of this multiple type of organisational commitment is demonstrated by how Participant 4 responded when asked their understanding of organisational commitment:

*I'm committed to this unit, I'm committed to the staff in this unit and I'm committed to the patients that I see that's what I'm committed to.*

A further example of this multiple and simultaneous understanding of organisational commitment is provided by Participant 6:
I'm not committed to the organisation at all I'm committed to this unit . . . I'm committed to the staff in this unit and I'm committed to the patients that I see, that's what I'm committed to.

When asked about their understanding of organisational commitment Participant 2 also responded by referring to their work unit and their patients and their nursing:

My enjoyment with working with kids and families, wanting to improve the health outcomes for kids . . . Yeah improving the outcomes, improving the service for the kids and families . . . that is my commitment.

The participants also acknowledged the impact of camaraderie and teamwork and its interconnectedness with a positive nursing work unit. Participant 7 commented on the influence of team members in relation to the atmosphere within their work unit and related this to their nursing work:

It's a nice place to work on a general level but because we work and collaborate with so many other different departments and the specialists and the fellows and the registrars the great majority of those are just unbelievable and it's a pleasure to work with them.

Participant 10 also described their perception of their commitment:

I'm actually very happy in my role, I love it, I'm very excited about it. I am committed to my role and the area I work in.

And again when Participant 11 said:

Nurses I think are driven by the needs of the patient, 'cause that's probably why they were there in the first place.

Participant 2 described their commitment in terms of nursing colleagues, their patients and their working environment:
... the main thing that keeps me in my job and committed is my particular service - - - I think it is a really good one and that we have really good staff. You know, all are fairly dedicated and the patients are the other aspect that keeps me in that job as well, because of the job I do. I kind of feel like it’s worthwhile and that, you know, I get a lot of satisfaction out of what I do.

The following comment reflects other participants’ understanding of how organisational commitment is localised to the specific work unit, their nursing and the patients in the work area:

Everything in the day is a struggle but I’m here because of the kids (patients) and the satisfaction I get from them and also the way this unit is set up I also work with some fantastic staff . . . if it wasn’t for them I probably wouldn’t be here. Participant 9.

Participant 13 discussed their understanding of organisational commitment in terms of it needing to be reciprocated by the organisation:

Organisational commitment should be a two way street . . . I am committed to my unit and I work honestly, ethically and in the best evidenced based way I can - - - I do the best I can for my patients, I am punctual, tidy and document well so my employer doesn’t get into trouble as a result of my actions . . . my managers obligation to me is to treat me well, value me, recognise my contribution and provide a safe work environment.

The participants also felt strongly that their nursing care and care of their patients were important factors in their organisational commitment. Participant 4 summed this up by saying:

Being a great RN you know, and provide a great consumer service is what is important to me.
The working environment and relationships with colleagues within the workplace were also important to nurses, as was the care that the participants were able to provide for their patients. The participants also expressed the need, as nurses, to provide safe and quality nursing care to their patients.

There were many comments in relation to the nurse’s ability to achieve quality patient care, for example Participant 7 commented:

*Nurses can make a difference even under difficult circumstances . . . patients leave here feeling that they have been cared for properly.*

Participants also linked their professional identity as a nurse with their everyday practice:

*You do it because you care about the patients. Well I, you know, you just really care about people - - - that’s why you do it.* Participant 1.

Another participant summed up the fact that nurses’ professional identity is linked to the nursing work they do and hence nurses perceive their work unit from the perspective of being able to provide quality nursing care:

*I think nursing people are generally kind, caring people so they're really looking at things from a different perspective.* Participant 3.

Retention will now be discussed regarding its link to organisational retention.

**Retention**

The participants in this study understood that organisational commitment was indeed linked to retention. When asked about their understanding of organisational commitment and its link to retention, the participants discussed this in relation to the management behaviours of their Nurse Manager. The theoretical relationship between organisational commitment and retention is that it allows the participant a choice of
consequence in relation to their commitment or lack of commitment. The social process is for the participant to have the choice, to remain with the organisation if their commitment is enabled or leave the organisation if their commitment is inhibited by the behaviours of the Nurse Manager. This leads to the conceptual name of this theoretical relationship as the ‘link’ between organisational commitment and retention.

The participants understood their organisational commitment from the localised aspect of their work unit. They were simultaneously committed to their nursing and the patients in the work unit, and this commitment was linked to their retention. The participants understood this link to retention as being enabled or inhibited by the behaviour of the Nurse Manager. The link between organisational commitment and retention and management behaviours was understood by the following process. If the participants’ organisational commitment was enabled by the management behaviours of the Nurse Manager then the participants were more inclined to stay at the hospital. But if their organisational commitment was inhibited by the management behaviour of the Nurse Manager then they began to consider leaving the hospital. The following participants’ extracts demonstrate their understanding of this link between retention and management behaviours.

Participant 5 described what they required of their Nurse Manager to remain committed and be retained by the organisation:

*Nurse managers . . . they’ll be supportive of the employee, they’ll be able to provide them with the appropriate amount of services that is required both professionally and personally in terms of, you know, having the flexible work practices. But it’s also about the commitment of the employee to remain in that organisation if they feel that they are trusted and well looked after and they are being developed and valued.*

The manager’s obligation to the committed nurse employee was described by
Participant 11:

*I am committed and in return . . . my manager’s obligation to me is to treat me well . . . to value me, to recognise my contribution . . .*

Participant 13 discussed being listened to, acknowledged and being made to feel part of the team as management behaviours that encouraged them to stay:

*I think the main issues for nurses is around being valued, being able to be autonomous sometimes with things, giving off your ideas, . . . people listening to your ideas . . . I mean, but when you . . . want to make a contribution, as I said earlier on, be part of the team . . . And have good team work and interpersonal relationships . . . If I felt part of the nursing unit . . . the team, the organisation, then I’m more likely to stay.*

Participant 3 commented:

. . . to retain me my manager needs to be making efforts to have that open line of communication both ways . . . So that people feel that they’re being heard.

Participant 7 also commented in relation to retention and management behaviour:

. . . if nurses know they are supported they will stay . . . I know staff who have left because they were bullied and harassed and then unsupported by nurse management.

The following comment by Participant 6 reflects on a specific Nurse Manager management behaviour and its link to retention:

*Communication is awful here. This impacts everything we do. If this does not improve . . . if not I feel I will have to leave for my own sanity.*

The importance of effective communication at management level in relation to retaining nurses was noted by Participant 12:
Discussion in this chapter was undertaken utilising the voices of the participants. The central category of Nurse Manager and the subcategories of inhibiting and enabling behaviours together with their properties of specific management behaviours were discussed. The specific Nurse Manager behaviours were the ‘enabling’ behaviours of trustworthiness, credibility, supportive, communicative and enthusiastic and the ‘inhibiting’ behaviours were being invisible, reactionary, professional disrespect and performance non-management. These enabling and inhibiting behaviours of the Nurse Manager were discussed in relation to the influence they exerted on the participants’ organisational commitment and retention.

This was followed by a discussion of organisational commitment as it was understood by the participants. This understanding incorporated the participants’ work unit, their nursing and their patients. Retention was then discussed in relation to the participants’ understanding of its link with organisational commitment. This link was via the positive or negative influence that the enabling or inhibiting behaviours of Nurse Managers exerted on the participants’ level of organisational commitment. If the participants’ organisational commitment was enabled then they would stay at their hospital but if their organisational commitment was inhibited then they would leave their hospital.

Chapter Five that follows provides a discussion of the results and identifies the substantive theory for this study. The discussion incorporates the established knowledge within the literature in relation to the construct of organisational
commitment, the link to retention, the influence of management behaviours and the specific enabling and inhibiting behaviours of Nurse Managers.
CHAPTER FIVE

DISCUSSION

INTRODUCTION

This chapter provides a discussion of the substantive theory of this Grounded Theory study. The discussion of the substantive theory was incorporated with the existing body of knowledge within the field of the construct of organisational commitment used in management and organisational research. The specific understanding of organisational commitment discovered through this study is discussed in relation to findings in the existing body of knowledge. A discussion of the link to retention and the influence of management behaviours, together with the specific enabling and inhibiting management behaviours identified through this study are also provided, again incorporating links to the existing body of knowledge in the discussion.

THE SUBSTANTIVE THEORY:

REGISTERED NURSE UNDERSTANDING OF ORGANISATIONAL COMMITMENT AND ITS LINK TO RETENTION

In any substantive area of study, the participants will be driven to a particular pattern of behaviour, to resolve their main concern. In a Grounded Theory study the main concern, or core problem, describes the major issue experienced by participants regarding the area under study (Glaser 1992). The aim of this study was to develop a substantive theory of how RNs working in acute care hospitals in Australia understand organisational commitment and its link to retention. The conceptual name of the substantive theory that emerged from this study is ‘Registered Nurse understanding
of organisational commitment and its link to retention’. The substantive Grounded Theory that resulted from this study explained that the RN participants understood organisational commitment and its link to retention in a very specific way. The theory’s central category of Nurse Managers was the main concern expressed by the participants, and this main concern was directly related to the participants’ experience of being managed by their Nurse Managers. This central category was informed by seven subcategories which will now be explained.

The first and second subcategories are the enabling and inhibiting management behaviours of the central category, which are informed by their properties of specific management behaviours. The properties of the subcategory of enabling behaviour are consistent with trustworthiness, credibility, supportive, communicative and enthusiastic. The properties of the subcategory of inhibiting behaviours are consistent with being invisible, reactionary, lack of professional respect and lack of performance management. These specific behaviours were identified via the impact they had on the participant, or the emphasis the participant placed on the importance of the particular behaviour. The participants identified these behaviours in relation to their understanding of the influence this behaviour exerted with regard to their organisational commitment and retention. The third subcategory of organisational commitment was informed by the fourth, fifth and sixth subcategories of work unit, nursing and patients which defined the specific way in which the participants understood their organisational commitment. The participants understood their organisational commitment as simultaneous commitment to their work unit, their nursing within the work unit and their patients within the work unit. The seventh subcategory was retention which the participants understood as being directly influenced by the participant’s level of organisational commitment. This substantive theory of how RNs understand organisational commitment and its link to retention is presented in
The substantive theory generated from this Grounded Theory study is significant in that it contributes new knowledge about how the RN participants who were employed in acute care hospitals in Australia understand organisational commitment and its link to retention. This substantive theory as presented in Figure 2, demonstrates the very specific way in which the participants understand their organisational commitment. This substantive theory also demonstrates the importance of the enabling or inhibiting influence that is exerted by the Nurse Manager’s management behaviours on both the participants’ organisational commitment and their retention. These management behaviours play a pivotal role in how the participants understand organisational commitment and its link to retention. The Nurse Manager’s ability to enable or inhibit the participants’ organisational commitment which in turn affects the retention of the
participant at their hospital is a significant finding within this study. This substantive theory is of importance as it offers hospital managers an understanding of how the RNs in their organisational unit understand organisational commitment and whether they link this to retention. This knowledge then enables RN retention within hospital organisations to be addressed, possibly by Nurse Manager professional development programs.

No Australian or international studies were found in the existing body of knowledge that provided a substantive theory of how RNs working in acute care hospitals in Australia understood organisational commitment and its link to retention. Organisational commitment has, though, been studied in a broad sense (Manetje & Martins 2009; Nehmeh 2009; Chew & Chan 2008) but not specifically in relation to the understanding of this construct by RNs working in acute care hospitals in Australia. The existing knowledge gathered through previous studies of the construct of organisational commitment has established that there is a link between organisational commitment and retention (Yiing & Ahmad 2009; McCabe & Garavan 2008; Meyer & Allen 1997). These studies also establish that management behaviours do influence the employee’s level of organisational commitment and that it is the level of the employee’s commitment that predicts whether the employee will be retained at the organisation or not (Marmaya, Torsiman & Balakrishnan 2011; Weaver 2010). Other studies have identified that employees can indeed be committed to multiple facets within the organisation simultaneously (Manetje & Martins 2009; Nehmeh 2009; McCabe & Garavan 2008). This study concurs with previous studies, as mentioned above, as it too found that participants had multiple facets related to their understanding of commitment and its link to retention.

The emerging substantive theory will now be discussed in detail, as to the way it
relates to existing knowledge within the field of the construct of organisational commitment, and its relationship to retaining existing employees within organisations. First, the construct of organisational commitment will be defined and discussed in relation to the substantive theory from this study and the existing body of knowledge, followed by a discussion regarding its link to retention. Next, the influence of management behaviours with regard to the level of employee organisational commitment and the link to retention will be undertaken. This discussion will utilise the existing body of knowledge together with the findings of this Grounded Theory study.

**Organisational Commitment**

There is a bond that exists between an organisation and its staff, and neither exists in isolation of the other (Meyer & Allen 1997). The construct of organisational commitment is a psychological bond that ties the employee to the organisation. This bond develops slowly and consistently over the time the employee is employed within the organisation (Nehmeh 2009). Caykoylu, Egri, Havlovic and Bradley (2011) likened organisational commitment to the centre of a web which is comprised of employee attitudes and behaviours which can affect organisational outcomes in a positive or negative way. Organisational commitment is important for organisations, as highly committed employees who identify with an organisation’s goals and values have a stronger desire to belong to the organisation and display behaviours such as a willingness to go beyond the required duties (Caykoylu et al. 2011).

An organisation provides employees with financial and psychological support and opportunities to advance professionally, whilst the success of the organisation depends on the commitment and participation of its employees (Liou 2008). Employee commitment to the organisation improves the organisation’s performance and
efficiency. It also improves staff retention rates, which in turn reduces the running costs of the organisation (Meyer & Allen 1997). The purpose of gaining employee organisational commitment is to bind them to the attitudes, beliefs and values of the organisation (McCabe & Garavan 2008). Nehmeh (2009) believes that the more committed the employee is to the organisation the greater effort they will exert when performing their job, as committed employees wish to remain with the organisation, advancing the organisation’s goals. These employees are less likely to leave the organisation; employee retention is seen to be high when employees are committed to the organisation no matter how the employee perceives their commitment (Nehmeh 2009). Therefore, organisational commitment is a highly valuable construct to be fostered by organisations.

The aim of this study was to discover how RNs working in acute care hospitals in Australia understand organisational commitment and its link to retention. The importance of this knowledge is that managers within health care organisations must first know what it is that the RN employees are committed to, and whether this commitment is indeed linked to retention. This knowledge will allow managers to successfully target appropriate areas within their organisation to enhance employee commitment and, hence, the retention of RN employees.

The participants in this study clearly understood their organisational commitment to be localised to their immediate work unit, and simultaneously to their patients on the work unit and to their nursing on the work unit. For the participants in this study the work unit is what they know of the organisation, this is their ‘reality’. When asked about their commitment, this localised perception of the organisation is what participants referred to when discussing their understanding of organisational commitment. The simultaneous commitments of participants as found in this study, are
explained and supported by the discourse on organisational commitment which was also identified within the existing body of knowledge.

This discourse suggests that organisational commitment can be manifested as employees being committed to existing groups within the organisation (Manetje & Martins 2009) or simultaneously to other levels within the organisation such as their job, profession and boss (Nehmeh 2009). As organisational commitment is a multidimensional construct it is important for managers to understand and consider that multiple types of commitment may operate simultaneously in their staff (McCabe & Garavan 2008). Failure to consider these multiple types of commitment may lead managers to have an incomplete understanding of the role of commitment, as individual employees’ different types of commitment may be in conflict with each other within the workplace (Wagner 2007). The workplace target to which an employee is committed could be their job but not the organisation or to a supervisor, which in turn can impact commitment to the organisation (McCabe & Garavan 2008). The strength though is singular, therefore an employee can be committed to multiple targets but commitment strength has the same singular meaning regardless of the target (Wright & Kehoe 2007). An employee can also have multiple reasons for their particular commitment which can alter overtime and may be either conscious or unconscious. These rationales determine the employees’ reactions and responses to commitment (Wright & Kehoe 2007). Therefore, the participants’ understanding of their organisational commitment found in this study is consistent with existing knowledge. The participants in this study perceived their organisational commitment as being to a number of elements within the organisation simultaneously, but the strength of their organisational commitment was singular.

There are similarities with regard to the findings of this study and findings of
research undertaken by McCabe and Garavan (2008) in relation to how the participants understand their organisational commitment. McCabe and Garavan’s (2008) research which particularly focused on the role of training, development and career issues, highlighted factors influencing the commitment of nurses. Their qualitative research involved 40 semi-structured interviews with nursing staff from acute and community hospitals within the National Health Service in Ireland. The study found that a nurse’s commitment was focused primarily towards the nursing profession and their immediate work unit, and to a greater extent remained independent of the wider organization. The nurse’s immediate work unit was identified as encompassing their patients, colleagues and line management (McCabe & Garavan 2008). The nurse participants in the McCabe and Garavan (2008) study took great pride in belonging to the nursing profession; they expressed a high level of commitment and commented that they could not do their work without commitment. The nurses also believed that they shared a sense of ‘vocational commitment’, camaraderie and teamwork which helped them deliver quality patient care and, as committed nurses they were less likely to let their colleagues down by absenteeism or leaving the organisation (McCabe & Garavan 2008). McCabe and Garavan’s (2008) research identified the nurses’ commitment as being focused toward their immediate work unit, which also encompassed the patient as well as the ‘nursing profession’. The nurse’s focus of organisational commitment in McCabe and Garavan’s (2008) research and the RN participants’ understanding in this current study were similar, as organisational commitment was seen as independent of the wider organization, hence localised to their work unit.

‘Nursing’ was also identified as a component of the participants’ organisational commitment within this study. The participants presented this as being of great importance to them. The participants alternatively identified this as their job or their reason for being at work or wanting to make a difference. The participants also
understood their commitment to nursing simultaneously with their commitment to their ‘patients’. This commitment to their patients was expressed as *their main concern* or *because I care about the patients or that is why I’m here*. Existing literature explains reasons for the findings within this study. Magda, Hala and Naglaa (2011) explain that nursing as a profession has as the core of their mission, the caring for and the support of human beings during their experiences of health and illness. Nurses have a continual presence with their patients, providing an intimate and ongoing relationship with the patient. Nurses are concerned with emotions and feelings as well as science (Duffield et al. 2006), and are the section of the health care workforce who spend the most time with patients. Therefore, the understanding of commitment by the participants in this study is consistent with existing knowledge about how the nursing profession understands their core mission. Newton, Kelly, Kremser, Jolly and Billett (2009) also describe this core mission as the desire to help others, and that this is central to a nurse’s sense of engagement.

This mission of nursing, which is defined as caring for and supporting human beings, and the findings of research conducted by Takase, Maude and Manias (2005) also provides support for the findings in this study. The research undertaken by Takase, Maude and Manias (2005) utilised surveys to identify if the professional needs of the nurse participants were met in nursing practice. The participant group consisted of 346 Australian RNs from a metropolitan public hospital, one rural public hospital and post graduate nursing students in a diploma/certificate course at a university in the Australian state of Victoria (Takase, Maude & Manias 2005). The results of their research found that the RNs identified that the mission of nursing is to enable patients to achieve their maximum level of wellness through the provision of safe and quality nursing care (Takase, Maude & Manias 2005). Thus, the existing body of knowledge with regard to the mission of the nursing profession and the nurses’ understanding of
their role within health care organisations concurs with the findings within this study. The participants in this study understood their organisational commitment as simultaneous commitment to their work unit, their nursing and the patients within the work unit. The participant understanding of commitment in this study concurs with nurses’ understanding of the mission of the nursing profession as found in the literature.

Other qualitative research, undertaken by Furaker (2008), also provides information that supports the reasons why the participants in this study understood their organisational commitment in such a specific way. Furaker’s (2008) research utilised focus groups comprising nurses working in acute care hospitals in Sweden. The aim of the study was to gain the RNs’ opinions and reflections about their work tasks, competence and organisation in acute hospital care. The research found that the nurse’s professional identity is linked to their everyday practice as well as what it means to be and to act as a nurse (Furaker 2008). The research concluded that nurses have overall responsibility for nursing care and identified that the nursing profession is influenced by the culture and ward organisation within health care facilities (Furaker 2008). The RN participants in Furaker’s (2008) research perceived their job within the acute care hospital environment as that of the nurse and patient relationship. The participants defined this relationship as being centred on the physical, emotional, social and medical problems of their patients for whom they provide nursing care (Furaker 2008). Hence, the existing knowledge in the literature lends support to why the participants in this study understand their organisational commitment in the specific manner of simultaneous commitment to their work unit, their nursing and their patients.

**THE LINK TO RETENTION**

A lack of organisational commitment on the part of employees has been identified as a strong predictor of employee turnover (Mowday, Porter & Steers 1982).
According to Mowday, Porter and Steers (1982) strong organisational commitment is characterised by a strong desire to maintain organisational membership. Employees who are committed to their organisation are less likely to leave than employees who are not committed (Sikorska-Simmons 2005). The rhetoric of organisational commitment and its importance for organisations is the belief that if this is properly managed it can lead to beneficial consequences which include reduced employee turnover and reduced absenteeism (Suliman & Al-Junaibi 2010). Meyer and Allen (1991) propose that where organisations foster greater organisational commitment and an understanding of how employees develop organisational commitment they can reduce absenteeism and turnover of their employees, leading to improved employee retention.

Within this study the participant’s verbalised organisational commitment and its link to retention via the strength of their organisational commitment and the influence of the management behaviours of their Nurse Managers. The participants believed that where the Nurse Manager’s behaviour enabled their organisational commitment then their choice would be to remain with the organisation but if the Nurse Manager’s behaviour inhibited their organisational commitment then their choice may be to leave the organisation. The understanding of the participants in this study linked the strength of their organisational commitment and their ability to exercise their choice, as to whether they remained employed with the organisation. This understanding is consistent with the link between employee organisational commitment and employee retention within the existing body of knowledge established by the findings of numerous research projects.

One such project was undertaken by Baek-Kyoo (2010) to investigate the impact of perceived organisational learning culture and leader-member exchange (manager-employee) quality on organisational commitment and employee turnover. Staff (n=516)
were employed by a conglomerate located in Korea which represents diverse industries such as manufacturing, finance, construction and trading completed a workplace survey. The results of the study suggest that organisational learning and leader member exchange antecedents (how the employees were managed by their supervisors) impacted organisational commitment, which in turn contributed negatively to employees’ turnover intention (retention) (Baek-Kyoo 2010). The highest level of employee organisational commitment occurred when organisations had a higher learning culture and employees were supervised in a supportive management style. Turnover intentions were highest in the forty percent of employees who perceived lower levels of organisational commitment. The study concluded that there was a moderate and significant relationship between organisation commitment and turnover intention (Baek-Kyoo 2010).

A qualitative study of 600 oil company employees in the United Arab Emirates extends the evidence that organisational commitment is linked to retention (Suliman & Al-Junaibi 2010). This quantitative research used the organisational commitment questionnaires to measure withdrawal intention. The study found a significant negative relationship between organisation commitment and intention to quit. These finding suggest that employee organisational commitment is a major determinant of whether employees will be retained at or leave the organisation (Suliman & Al-Junaibi 2010).

The findings of qualitative research undertaken by Sikorska-Simmons (2005), supports the findings of this current study which established that the participants’ understanding of organisational commitment was linked to retention via the impact of management behaviours on the strength of organisational commitment of the participants. The research also supported this current study’s premise that the impact of the nursing shortage on a health care facility’s ability to provide the health care
required now and in the future will depend on the facility’s ability to foster organisational commitment in their RNs to retain them within their organisation.

Sikorska-Simmon’s (2005) research examined the role of organisational culture, job satisfaction and socio-demographic characteristics as predictors of organisational commitment. The aim of the research was to identify ways to increase employees’ organisational commitment and increase staff retention in assisted living facilities in the United States of America (Sikorska-Simmons 2005). Data was collected from 317 staff members in 61 facilities using self-administered questionnaires. The results were assessed using a nine item affective commitment scale. The dependent variable in the research was organisational commitment; the independent variables were job satisfaction, organisational culture and staff characteristics of age, gender, education, marital status, religiosity and organisational tenure, selected on the basis of a literature review (Sikorska-Simmons 2005). The findings of the research indicated that organisational culture, job satisfaction and education were independent predictors of organisational commitment. The study findings were deemed to have practical implications for managers who may want to improve staff organisational commitment and increase retention rates (Sikorska-Simmons 2005). The research found that management interventions should be centred on changes to organisational culture, whereby employees perceive they are valued and respected, plus increasing job satisfaction by fostering meaningful participation in resident care planning and decision making and building group support. These initiatives were identified as the most effective in producing higher levels of organisational commitment and reducing employee turnover (Sikorska-Simmons 2005). Sikorska-Simmons (2005) believes the projected nursing staff shortage and increasing need for services, related to the growing number of elderly people in the population, will impact the ability of assisted living facilities to provide the care required now and in the future. Sikorska-Simmons (2005)
believes this will greatly depend on the ability of facility managers to retain committed employees.

**THE INFLUENCE OF MANAGEMENT BEHAVIOURS**

As nursing numbers decrease due to the impact of the nursing shortage which was discussed in Chapter Two, it is clear that management styles must be adapted toward retention of nurses as a priority rather than merely subsisting from day to day (Duffield, Roche, Blay & Stasa 2010). Solving the labour shortage will only be accomplished if nurses who seek employment in the hospital sector stay there. Providing a work environment in which nurses are happy in their work and valued for their contribution to health care outcomes must be a management priority (Duffield et al. 2010).

This study has established that the participants’ understanding of organisational commitment is multi-faceted; the strength of commitment is influenced by the management behaviours of the Nurse Managers; their understanding of the link to retention is directly linked to their level of organisational commitment. The existing body of knowledge in the literature supports this finding and explains the need for management to focus on management behaviours that enable employee organisational commitment. Wright and Kehoe (2007) believe that competing employee commitments have implications for human resource management (HRM) practices that might impact on organisational commitment. Targets other than the organisation as a whole may be necessary to impact on employee commitment. For example, commitment to goals, to the job, the supervisor or workgroup can be as significant as commitment to the organisation as a whole (Wright & Kehoe 2007). Wright and Kehoe (2007) believe that management behaviours such as communication for role clarity, enabling autonomous employee practice, feedback on performance, supervisory consideration and team
support can also positively influence organisational commitment and job satisfaction. Management visibility, for example their presence on the ward, can have a major impact on employees by increasing their level of trust, motivation and organisational commitment (McCabe & Garavan 2008). It is the perception of employees with regard to employment relationships and management practices in use within the organisation, that influence the employees’ identification with, involvement in and emotional connection to the organisation (Gellatly, Hunter, Gurrie & Irving 2009).

Discourse in the literature related to the construct of organisational commitment and the link to retention supports the findings of this study. This study established that the management behaviours of the participants’ Nurse Managers either enabled or inhibited the participant’s organisational commitment. If the participants’ organisational commitment was enabled by the behaviour of the Nurse Managers then their ‘choice’ would be to remain at the hospital. But if their organisational commitment was inhibited by the behaviour of the Nurse Managers then their ‘choice’ may be to leave the hospital. This concept is supported by quotes from the participants in Chapter four on pp.152-154. Weaver (2010) believes that employees devote much of their adult life to work, therefore, the quality of an employees’ life is strongly influenced by the quality of their work life. An employee’s supervisor has considerable power over their daily life. A supervisor who is ineffective and inefficient can make work a very unpleasant experience, which may cause the employee to leave the organisation (Weaver 2010). HRM practices within an organisation are delivered or enacted by line managers, and it is how an employee perceives or experiences these practices that will influence the employee’s organisational commitment in a positive or negative way (Purcell & Hutchinson 2007). The line manager or supervisor’s role encompasses people, management activities, leadership behaviour and the application of HRM practices in order to motivate and reward employees, manage performance issues
and the needs of the worker (Weaver 2010). The way the line manager enacts these behaviours will be influenced by their personal leadership behaviour and that of senior management, which in turn establishes the organisational climate that is experienced by employees (Purcell & Hutchinson 2007).

This existing knowledge supports the findings of this study, which established that the participants understood organisational commitment and its link to retention through the lens of how they were managed by their Nurse Managers. The strength of the participant’s commitment, and their retention, was directly influenced by the enabling and inhibiting management behaviours of their Nurse Managers. There have been many research projects undertaken to establish the influence of management behaviours in the body of knowledge pertaining to employee organisational commitment.

One such project was a quantitative research undertaken by Parkes, Scully, West and Dawson (2007) to investigate the extent to which employee involvement predicts job performance, job satisfaction, wellbeing and organisational commitment in the National Health System in the United Kingdom. This research investigated the implementation and success of Human Resource Management (HRM) commitment strategies linked to employee involvement, which is closely linked to the notion that employee participation in decision making processes increases job satisfaction, gives employees a greater sense of fulfilment and control over their work, and contributes to overall organisational performance (Parkes et al. 2007). In the context of health care, employee involvement can improve patient care and assist in the management of change, aid employee motivation at work and increase organisational commitment (Parkes et al. 2007). The research described above consisted of interviews with senior managers and staff, utilising employee attitudes surveys and 20 in-depth case studies,
using interviews, focus groups and action research projects. Results identified that it is not just the existence of these commitment strategies that make a difference, but the successful link from strategy to policy to practice that is critical. The research concluded that it is how managers engage with and implement these HRM commitment strategies in their workplace that ensures that these practices are successful in improving employee motivation, organisational performance and increasing employee organisational commitment (Parkes et al. 2007). This is consistent with the findings in this study as the main concern of participants was the behaviour of individual Nurse Managers and the specific enabling or inhibiting management behaviours they enacted.

Further research on organisational commitment and retention also supported the findings of this study. Taplin (2007) undertook qualitative research via a case study approach. It was based on extensive interviews with workers and managers from seven organisations in the United States of America who had a high employee turnover rate (greater than 40 percent) and nine organisations who had low employee turnover rates (less than 13 percent). The aim of the study was to establish the importance of management style to organisational commitment and labour retention. The study involved detailed interviews with managers and small group interviews with employees (Taplin 2007). The study found that organisational commitment is more likely to be the product of direct managerial initiatives such as HRM systems built on commitment, rather than control, and that commitment approaches are often associated with lower turnover (Taplin 2007). The concept of commitment within HRM practices is that employees are valuable resources that need to be developed. HRM practices such as information dissemination, problem-solving groups, minimal status differentials, job flexibility and teamwork help create a supportive and considerate work environment which appears to be a crucial feature of organisations with low turnover rates (Taplin
This study, as in Taplin’s (2007) research, identified specific enabling and inhibiting behaviours enacted by the Nurse Manager that impacted the participant’s organisational commitment. The enabling behaviours were consistent with trustworthiness, credibility, supportive, communicative and enthusiastic. The inhibiting behaviours were consistent with being invisible, being reactionary, showing lack of professional respect and a lack of performance management. These behaviours will now be discussed in relation to existing knowledge regarding these behaviours and their impact on employee organisational commitment and, hence, retention.

**Enabling Behaviours**

**Trustworthiness**

Trustworthiness in a manager can be evident in the way an employee perceives the support from the organisation, and has confidence in their managers to make ethical decisions and display behaviours that are based on ethical principles (Aluntas & Baykal 2010). The participants in the current study placed great emphasis on the need to have trust in their Nurse Managers and for the Nurse Managers to reciprocate this by demonstrating trust in the participant’s professional ability. Trustworthiness was cited often as consistent with an enabling behaviour of the Nurse Manager which strengthened the participant’s organisational commitment.

The existing body of knowledge on organisational commitment supported the finding in this study by establishing that trust was crucial to all relationships within an organisation (Sabir, Sohail & Khan 2011; Aluntas & Baykal 2010). Research undertaken into organisational commitment and the relationship between organisational trust, focussing on, in particular the importance of trust between managers and their
employees, has demonstrated positive results for performance, organisational commitment, intention to leave, teamwork plus organisational citizenship behaviours (Tatlah, Ali & Saeed 2011; Sabir, Sohail & Khan 2011; Aluntas & Baykal 2010).

Trust is of particular importance in health care as the multidisciplinary approach used within health care requires good communication, collaboration, trust and teamwork. It is necessary that nurses have trust and confidence in their managers, the organisation and co-workers to enable them to provide health care services efficiently and effectively (Tatlah, Ali & Saeed 2011). This ensures patient and nurse satisfaction, improving nurse motivation and performance, increasing their commitment to the organisation and decreasing turnover rates (Sabir, Sohail & Khan 2011).

This study found that the participants wanted their Nurse Managers to trust them in their professional role as an RN, plus they wanted to have trust in their Nurse Manager. The participants believed that being able to trust their Nurse Managers along with the Nurse Managers trusting them, created a working environment of openness and acceptance in which the participants wanted to work. The literature supports the understanding of the participants in this study, in relation to the trustworthiness of their Nurse Managers and the ability of this enabling behaviour to enhance their organisational commitment. The literature portrayed the role of the Nurse Manager and their management style as needing to be democratic rather than authoritarian to gain the trust of the nurses (Smith 2012; Tatlah, Ali & Saeed 2011; Johansson, Andersson, Gustafsson & Sandahl 2010). This type of democratic management style requires the Nurse Manager to delegate authority rather than use their authority as a control mechanism. It also requires that the Nurse Manager trust in the ability of the nursing staff, thus allowing the RNs to take on responsibility for their own job performance (Johansson et al. 2010). The more trust there is toward another the less need there is to
control that person’s behaviour (Neves & Caetano 2006). This description is consistent with the behaviour of the Nurse Managers desired by the participants in this study.

Trustworthiness is a result of competence and character, the act of trust is belief in someone and having confidence in them (Johansson et al. 2010). Trust in an organisation is a crucial element as it is linked to employee performance and organisational commitment (Azaare & Gross 2011; Tatlah, Ali & Saeed 2011). This concurs with the understanding of participants in this study in relation to the importance of the trustworthiness of their Nurse Manager as an enabling factor to enhance their organisational commitment. The participants understood the trustworthiness of their Nurse Managers as being manifested as confidence in the manager’s truthfulness and ability, and that the Nurse Manager would always act in the best interest of the nurse employees. Previous research suggests that organisational commitment plays an intermediary role in the relationship between organisational trust and citizenship behaviours (Rezaiean, Givi & Nasrabadi 2010). Rezaiean, Givi and Nasrabadi (2010) believe that by exerting justice in organisational procedures levels of trust between employees and managers will increase. As a social construct, trust in a relationship influences each person’s behaviour toward the other. Trust is consistently related positively to organisational commitment (Sabir, Sohail & Khan 2011; Marmaya, Toriman & Balakrishnan 2011; Neves & Caetano 2006). Discourse in the existing literature, as demonstrated above, supports the findings of this study which established that the participants understood an important predictor of their trust level was the fairness with which they were treated by the organisation’s agent, which in this study, was the Nurse Manager. When the participants perceived support and interpersonal justice from their Nurse Managers it created participant trust in that particular Nurse Manager.
Therefore, the management behaviour of ‘trustworthiness’ is important, as existing knowledge presented here has established a positive relationship with organisational commitment which is negatively related to turnover. In the context of this study this knowledge supports the participants’ understanding of trustworthiness as an ‘enabling behaviour’ on the part of the Nurse Manager for the development and sustainability of the participants’ organisational commitment and, hence, retention.

Credibility

The participants in this study understood the importance of the Nurse Manager’s credibility, not only for them but also for the work unit at organisational level, as this enabled the Nurse Manager to negotiate successfully with upper management on behalf of the nurses and the work unit. The participants expressed their understanding of the credibility of their Nurse Manager via feelings of pride in their Nurse Manager and the positive role model this behaviour presented within their work unit. The participants understood this behaviour as enabling factors that enhanced their organisational commitment via the positive influence the behaviour had within the work unit. They also acknowledged the enabling effect of this behaviour when the Nurse Manager represented the work unit within the broader organisation.

The literature supports this understanding of the positive influence on perceptions of management credibility. Management credibility can be defined as the degree to which employees perceive that management is honest, competent and able to inspire (Jalilvand, Samiei, Zadeh, Khorrami & Ahmadi 2011). A study undertaken by Jalilvand et al. (2011) was the first known study that had investigated the connection between managerial credibility and organisational commitment. Their research examined the impact of credibility of managers on employees’ commitment via questionnaires distributed to employees (n=212) within a number of Iranian
organisations operating in the sport sector. Confirmatory factor analysis and a linear regression analysis were used to test the relationship between managerial credibility and affective organisational commitment (Jalilvand et al. 2011). The findings of this research revealed that manager credibility influences nurse employee’s affective organisational commitment. This suggests that managers who are consistently honest and accurate in their communications with employees; that is, that they possess credibility, are more likely to positively influence their employee’s affective organisational commitment (Jalilvand et al. 2011). The research contributes to evidence confirming the value of managerial credibility for organisational commitment (Jalilvand et al. 2011). Jalilvand et al.’s (2011) research supports the understanding of the participants in relation to the Nurse Manager behaviour of credibility as an enabling behaviour in relation to enhancing organisational commitment and, hence, retention within the context of this study.

**Supportive**

The RN participants in this study understood the leadership role of their Nurse Managers as providing support for the nursing staff. The participants continually referred to their need for their Nurse Managers to be ‘supportive’. The terms ‘support’, ‘supportive’ and ‘supported’ were used in a broad context by the participants when describing their experience of ‘being managed’ by their Nurse Managers. The terms were used to describe how the Nurse Manager ‘was either supportive’ or ‘not supportive’ in a particular situation. The participants’ frequency and consistency of use of the term ‘supportive’ in relation to the behaviour of the Nurse Manager and the importance they placed on this behaviour in relation to the participants’ understanding of organisational commitment and its link to retention, confirmed this as an enabling behaviour.
What is it that the participants are referring to by the term ‘supportive’? Schmalenberg and Kramer (2009) encountered the same problem when attempting to define the concept of ‘support’ to which nurses constantly refer. Therefore, they decided to undertake a study, which synthesized the results of seven research studies conducted in the United States of America from 2001 to 2007, to identify which behaviours of Nurse Managers, staff nurses perceived as supportive. The findings of their study identified ten universal role behaviours of Nurse Managers that are perceived as ‘supportive’ (Schmalenberg & Kramer 2009). These behaviours are: diplomacy, fair and honest in resolving conflicts between nurses, physicians and other departments; ensuring adequate numbers of competent staff to enable the job to be done; representing the position and interests of the unit and the staff to other departments and administration; accessibility, approachability and safe practice; living the values of the organisation regarding patient care; promoting staff cohesiveness and being a positive force in enabling staff to work together; fostering sound nurse decision making by asking for the ‘best practice’ evidence the nurse is using; making it possible for the nurse to attend continuing education, outside courses and/or degree completion programs; ensuring that equipment or supplies are provided and cites specific examples both positive and negative when providing feedback (Schmalenberg & Kramer 2009, P.65).

The participants in this study discussed various experiences of being managed by their Nurse Manager who was supportive or not supportive. The experiences of being managed as described by the participants and discussed in detail in Chapter Four, draws parallels with the identified ten universal role behaviours of Nurse Managers that were perceived as ‘supportive’ as described above. Quite a number of participants identified similar situations to the universal role behaviours where they were not managed in a supportive way by their Nurse Manager. In these circumstances, the
participants perceived that the role of their Nurse Manager should have been to support them in these situations.

Supportive behaviour by the Nurse Manager has been correlated positively with the construct of organisational commitment, and negatively with staff turnover in studies of leadership style and manager behaviour (Marmaya, Torsiman & Balakrishnan 2011; Taplin 2007). Therefore, supportive behaviour is an enabling management behaviour that supports and enhances organisational commitment and retention.

**Communicative**

The participants in the current study acknowledged the importance of effective communication behaviours on the part of their Nurse Managers. The majority of participants were dissatisfied with the communication style used by their Nurse Managers. They also identified that this impacted on their perception of the management ability of their Nurse Manager. Some participants felt isolated by the poor communication within their work unit whilst other participants said they had actually left hospitals where they perceived the communication practices were poor or dysfunctional. This is evidenced in the quotes from participants discussed in Chapter four on pp.133-135.

The reason the communicative behaviour of the Nurse Manager is so important to the participants in this study, and enhances their organisational commitment and hence retention is explained by the existing knowledge on organisational communication found in the literature. Tatlah, Ali and Saeed (2011) found that the quantity and quality of interactions between supervisors and employees determines the type of relationship that develops between the two. Informal communications involving a two way communication process such as informal meetings and conversations in the office, quickly build effective workplace relationships between managers and their
employees (Brunetto, Farr-Wharton & Shacklock 2011). Indirect communication strategies refer to management practices that empower employees via open communication channels. These enable employees to communicate their ideas and have these discussed which empowers employees by enabling them to contribute to the decision making process (Brunetto, Farr-Wharton & Shacklock 2011). Sabir, Sohail and Khan (2011) believe that a direct or command style of communication, utilising the manager’s hierarchical power will suppress the development of an effective manager employee relationship. The quality of communication flow is embedded in the manager employee relationship. A relationship whereby the employee can ask questions, make suggestions and interact with the manager in the workplace produces a quality communication style between the manager and the employee (Brunetto, Farr-Wharton & Shacklock 2011).

Participants in the current study understood communication to be a fundamental function of the management role and that good communication builds good employee and manager relations, which in turn improves the functioning of the workplace and employee performance. Research into leadership styles and management behaviours has linked good communication to organisational commitment and retention (Brunetto, Farr-Wharton & Shacklock 2011; Sabir, Sohail & Khan 2011; Tatlah, Ali & Saeed 2011). Therefore, a manager who embodies good communication in their management behaviour enhances organisational commitment and employee retention.

**Enthusiastic**

Participants in the current study described how nurses would follow a leader who had vision and who inspired them. The participants believed that a manager who demonstrated enthusiastic behaviour would not only motivate their employees but also inspire them to achieve the goals of the organisation. The participants in this study
discussed how they wanted their Nurse Manager to be enthusiastic and energetic; however, only one participant actually perceived their Nurse Manager as exhibiting these behaviours.

Literature related to organisational commitment discussed how the leadership ability of managers should enable them to motivate their followers to accomplish more than what the follower had planned to accomplish. This could be achieved by concentrating on the followers’ values and helping the follower to align these values to the values of the organisation (Marmaya, Torsiman & Balakrishnan 2011).

The participants in this study wanted their Nurse Managers to enact enthusiastic management behaviours to motivate both the participant and the Nurse Manager to higher levels of achievement. This they perceived would impact on their job satisfaction and commitment to the organisation. Givens (2008) describes a leader who has vision and passion as having the ability to inject enthusiasm and energy into getting things done. This in turn demonstrates to employees that the manager cares about them and wants them to succeed. Therefore, enthusiastic management behaviour is an enabling behaviour for organisational commitment and hence retention.

**INHIBITING BEHAVIOURS**

**Being Invisible**

Participants in this study expressed concern with the lack of visibility of some of their Nurse Managers. Managers in some of the participants’ hospitals were located in a different place to the work unit they manage. Some of the participants also described how they had little face to face communication with their Nurse Managers. They discussed how this lack of contact impacted on them in an emotional sense as they perceived that no working relationship has been established with their Nurse Manager. This lack of Nurse Manager visibility also influenced the participants’
organisational commitment in a negative way as the participants’ perception of the Nurse Manager’s ability was impacted negatively by their lack of interaction with their Nurse Manager.

Literature pertaining to organisational commitment explains negative perceptions of a Nurse Manager who was not visible. Duffield et al. (2010) believe that visibility and responsiveness of Nurse Managers contributes to nurse job satisfaction and empowerment; nurses are more respectful of managers who are approachable and visible within the work environment. An Australian study by Duffield et al. (2010) examined the impact of leadership characteristics of nursing unit managers, as perceived by registered nurses, in relation to staff satisfaction and retention. The study found that an immediate manager who is perceived to be a good leader and manager also enhanced nurse job satisfaction and retention. Five items that distinguished between wards with positive leadership scores and those with negative scores were: a Nurse Manager who is a good manager or leader; a Nurse Manager who consults with staff on daily problems and procedures; flexible or modified work schedules available; a senior nurse administrator who is highly visible and accessible to staff and praise and recognition for a job well done (Duffield et al. 2010, p.29).

Research undertaken by Kleinman (2004) in the United States of America supports the emerging sub-category of perceptions of inhibiting behaviour and the invisibility of the Nurse Managers. This correlational study assessed acute care staff nurses’ (n=79) perceptions of Nurse Manager leadership behaviours and self-rated perceptions of leadership behaviours of the Nurse Managers (n=10). This research found that staff nurses who have limited interactions with the Nurse Manager had less favourable perceptions of the manager’s leadership style. Visibility of, and contact with Nurse Managers were clearly identified critical needs (Kleinman 2004). The research
noted that these factors were of concern due to the critical relationship between effective leadership and nurse retention (Kleinman 2004).

The literature supports the perceptions of participants in this study with regard to leadership styles and management behaviour. As identified, the importance of manager visibility in the workplace has an established link to job satisfaction and employee retention. Research on organisational commitment has also established the link between job satisfaction and organisational commitment (Caykooylu et al. 2011; Zettler, Friedrich & Hilbig 2011; Nehmeh 2009; Chew & Chan 2008; Meyer & Allen 1991); therefore, a manager who displays ‘invisible’ management behaviour inhibits the employee’s organisational commitment which in turn impacts on their retention.

Reactivity

Participants in this current study discussed numerous experiences of being managed by Nurse Managers who had displayed reactionary management behaviour. The participants discussed their perceptions of this type of behaviour in relation to the perceived ability of their Nurse Manager together with the effect this type of behaviour had on the work unit and on them. The participants expressed disappointment and dissatisfaction with this style of management and believed that it did not achieve anything positive but only served to upset and distress employees who were the brunt of this behaviour. The participants also expressed concern at the possible consequences of this behaviour should it become the norm. They simply said nurses would leave.

Reactionary behaviour of management can be described as the manager immediately responding to issues before pausing to appraise them, then subsequently allowing one unpleasant encounter to influence the way they respond to subsequent problems (Azaare & Gross 2011). Emotions may play a role in this type of behaviour, leading to an immediate reaction to an incident and those employees involved in the
incident, rather than a thorough investigation into allegations (Azaare & Gross 2011).

Literature regarding leadership styles and management behaviours showed that management behaviours are linked to the degree to which an employee is committed to the organisation (Azaare & Gross 2011; Weaver 2010; Parkes et al. 2007). Though no previous research could be found with regard to this particular management behaviour the participants in this study were clear that if this behaviour became the norm then they would leave the organisation. Therefore, reactionary management behaviour is an inhibiting behaviour in relation to building employee organisational commitment and is linked to retention.

**Lack of Professional Respect**

The participants in this study believed that there was less professional respect for nurses in the contemporary health care workplace than in the past. The participants’ understanding of this phenomena was that health care managers looked at nursing as a cost cutting area. Plus the ongoing staffing and skill mix problems associated with the nursing shortage meant that the nursing workforce in hospitals had become problematic for management.

The participants were particularly scathing with regard to the lack of respect that they perceived could at times be displayed by their nurse management. The participants appeared to be more forgiving of non-Nurse Managers as they perceived that these managers may not fully understand the nursing profession whereas they felt nurse managers should never be disrespectful of other nurses. The participants believed that managers, both nursing and non-nursing, should display respect for the contribution nurses made to the health care team and system. Therefore, the participants understood that if the hospital wanted to keep them employed then management needed to show them some respect or they would leave and go to another hospital that would
demonstrate that respect. This is supported by quotes from the participants discussed in Chapter four on pp.141-144.

Respect is an essential component of professional nursing and a fundamental component of nursing care. Nursing education and the profession’s code of ethics and codes of conduct dictate that nurses are respectful of their patients and their colleagues (Nursing and Midwifery Board of Australia 2010). Respect is a central component of the professional nurses’ psyche and, therefore, it is of great importance to them that other staff and in particular Nurse Managers display respect in the workplace (Faulkner & Laschinger 2008).

Research undertaken by Faulkner and Laschinger (2008) may help to explain the perceptions of the participants in this study in relation to the importance they placed on professional respect for nurses. These North American researchers sought to examine the relationship between structural and psychological empowerment and the effect this had on hospital nurses’ (n=500) perceptions of respect. Their research hypothesized that registered nurses’ perceptions of structural and psychological empowerment were positively related to respect (Faulkner & Laschinger 2008). This North American research supported Kanter’s (1997) contention that effective collaborative relationships with managers, colleagues and subordinates, foster a feeling of respect in the worker. The study described above also found that nurses considered feedback from supportive managers and colleagues as manifestations of respect (Faulkner & Laschinger 2008). Nurses who felt they had some control over work practices and involvement in decision making also perceived greater degrees of respect. Nurses access to empowering structures to enable them to practice according to professional standards was seen as fundamental to nurses feeling respected in their workplace (Faulkner & Laschinger 2008). The research by Faulkner and Laschinger (2008) concluded that employees who
feel respected are more likely to be satisfied with their work, to have trust in the organisation and to be more committed to remain with the organisation. Their findings support the perceptions of participants in the current study who believed that if the managers at their hospitals did not afford them professional respect, they would leave the organisation.

Managers who are perceived as displaying a lack of professional respect do indeed inhibit organisational commitment. Therefore, Nurse Managers who display a lack of professional respect towards RNs will inhibit their organisational commitment which will impact the ability of the organisation to retain the RNs.

**Lack of Performance Management**

The participants in this study were generally dissatisfied with their Nurse Managers in relation to performance appraisal. The formal performance appraisals were not undertaken at the prescribed frequency and some participants had not had an appraisal undertaken for two years. Other concerns centred on the fact that specific staff development requirements identified during the appraisal process were not followed up by the Nurse Manager and subsequently did not occur. This led the participants to perceive the appraisal as merely an exercise that the Nurse Manager was compelled to engage in, and saw little or no benefit for them. Further concerns related to Nurse Managers using the formal appraisal session as a punitive exercise. The Nurse Managers in this situation were perceived to have based the appraisal on what amounted to work unit gossip, leaving the staff member no ability to explain or defend the accusation as no formal incident report process had been undertaken.

The participants’ other major concern was related to the failure of the Nurse Manager to address supposed lack of performance in a timely manner. The participants described experiences whereby poor performance was either not addressed at all or
addressed 12 months later at the time of a formal performance appraisal, or addressed many weeks or months later. The participants commented that up until that appraisal they had no knowledge that there was a problem with their performance. These situations left some participants emotionally traumatised or they left the organisation or they were still struggling to work in what they perceived as a dysfunctional work unit. The lack of performance management during the participants’ experience of being managed, were understood by them as influencing their organisational commitment in a negative way and, hence, their retention at the hospital.

Discourse in the existing literature also confirms the importance of timely performance management. Khaliq, Zia-ur-Rehman and Rashid (2011) believe that performance management is a vital skill for Nurse Managers as it enables the manager to inspire, motivate and lead their nurses to achieve clinical excellence. A thorough individual performance review should be a beneficial exercise for both the employee and the manager. Having agreed on a performance plan the manager and employee can then use this plan as an ongoing guide to share their objectives and development needs (Khaliq, Zia-ur-Rehman & Rashid 2011).

Research undertaken by O’Brien-Pallas, Murphy, Shamian, Li and Hayes (2010) supports the concerns of the participants in this study in relation to the impact of lack of performance management on the part of Nurse Managers. The focus of their research was the impact and key determinants of nurse turnover and implications for management strategies in nursing units. The study was guided by the patient care system and nurse turnover model. This model posits that system inputs such as characteristics of patients, nurses and the nursing unit interact with throughput such as environmental complexity, staff utilisation such as the patients, nurse and organisational outcomes and turnover rate to produce system outputs which feed back into the entire
patient care system (O’Brien-Pallas et al. 2010). The research was conducted in the United States of America and consisted of two phases, with the first phase encompassing 182 units in 41 hospitals and the second phase 163 units in 39 hospitals. The research showed that nurse turnover was influenced by role ambiguity and role conflict within the unit. Role clarity and feedback regarding job performance expectations and the understanding of reciprocal role expectations of nursing and non-nursing work group members was found to be vital. Outcomes of the research indicate that an organisational environment which provides open communication and joint problem solving between staff and their manager is required (O’Brien-Pallas et al. 2010).

Performance management is a core responsibility of the Nurse Manager role and a critical factor in staff development, and should be a beneficial exercise between the Nurse Manager and the nurse (Parkes et al. 2007). Participants in this study discussed the performance management of the Nurse Manager themselves as being essential to the smooth running of the work unit and management of employee performance. Participants also described the psychological impact poor performance management can have on the individual nurse. These were that the nurse did not want to come to work, they considered alternative employment or they actually left the organisation. Therefore, the lack of performance management behaviour by the Nurse Manager will inhibit the development of organisational commitment and negatively impact on retention.

**CONCLUSION**

This chapter discussed the substantive theory of ‘how RNs understand organisational commitment and its link to retention’ developed from this study utilising a Grounded Theory method. The substantive theory was explained in relation to how
RNs understand organisational commitment from the localised aspect of their work unit. The RNs were simultaneously committed to their nursing and the patients on the work unit. Their organisational commitment was linked to their retention at the hospital at which they were employed. The RNs’ organisational commitment and retention was enabled or inhibited by the behaviour of the Nurse Managers. The Nurse Managers were identified as the participants’ main concern with respect to their understanding of organisational commitment and the link to retention.

Organisational commitment was then discussed as a construct utilised in management and organisational research. The links and relevance to this study were then discussed utilising the established body of knowledge found in the literature. The participants’ very specific understanding of organisational commitment within the context of this study was supported and explained by an examination of existing literature.

The link to retention and the influence of management behaviours on organisational commitment was also discussed, again utilising existing knowledge relevant to the findings of this study. Finally, the enabling and inhibiting behaviours of the Nurse Managers which influence organisational commitment and retention were discussed, supported by existing literature in relation to how these behaviours impact in the workplace.
CHAPTER SIX

CONCLUDING STATEMENTS AND RECOMMENDATIONS

INTRODUCTION

The aim of this research was to understand how Registered Nurses understand organisational commitment and its link to retention. The impetus of this study has been the dramatic changes which have occurred in the healthcare environment over the last decade. Hospitals are now run like a business, requiring health care organisations to change their traditional management models to enable them to initiate cost controls and improve efficiency and health outcomes. As discussed in this thesis, during this period there has also been an increase in the shortage of available nurses in the workforce and a decrease in nurse retention within health care organisations. These nursing workforce issues have become a prime concern of both government and health care organizations. The Australian Government has undertaken multiple investigations into the nursing workforce. Chapter Two examined how the loss of nurse employees within hospitals is a significant problem as the ability to replace these employees with skilled, knowledgeable and experienced nurses is limited. This problem is compounded by the longer life expectancy of the population, resulting in increasing numbers of patients living with chronic diseases, together with advances in medical technology and the expanding roles of nurse practitioners further increasing the demand by acute care hospitals for increasing their numbers of nurse employees. Therefore, the retention of existing nurse employees is of great importance to health care organisations as this will
stabilise the nursing workforce within that organisation.

Thus, the importance of this research that focused on discovering how RNs’ understand organisational commitment and its link to retention. There has been a plethora of research on organisational commitment but limited studies on nurse organisational commitment in Australia. This research, which was conducted in an ethical manner consistent with the National Statement on Ethical Conduct in Human Research using a Grounded Theory approach, is unique in that it focused specifically on RNs working in acute care hospitals in Australia.

Informing nurse managers how they may be able to reduce avoidable, dysfunctional turnover is both feasible and desirable. Nurse Managers have a powerful source of influence on employees’ work behaviours. Thus, organisational commitment as a construct is an important area of research as organisational commitment is linked to employee retention. Before they can act and put strategies in place, Nurse Managers need to know what it is that their RN employees are committed to and whether this is indeed linked to retention; hence, the importance of this research.

A central category was identified as a result of a systematised rigorous analytical process. The central category of Nurse Managers was informed by seven subcategories and their properties. The first and second subcategories comprised enabling and inhibiting management behaviours. The properties nested within the subcategory of the enabling behaviours were trustworthiness, credibility, supportive, communicative and enthusiastic. The properties nested within the subcategory of inhibiting behaviours were being invisible, reactionary, lack of professional respect and lack of performance management. The third subcategory was identified as organisational commitment. This defined the participants’ very specific understanding of their organisational commitment. The fourth, fifth and sixth subcategories were identified as work unit,
patients and nursing. These three subcategories formed the specific way in which the participants understood their organisational commitment. Thus, the RN participants’ understanding was simultaneous commitment to their nursing, the patients and their immediate nursing unit. The seventh subcategory was retention which the participants understood as linked to their organisational commitment. This link is identified as the RN’s choice to either stay or leave the organisation depending on whether their organisational commitment is enabled or inhibited by the management behaviours of the central category of Nurse Managers.

**SUBSTANTIVE THEORY OF REGISTERED NURSE UNDERSTANDING OF ORGANISATIONAL COMMITMENT AND ITS LINK TO RETENTION**

![Diagram showing substantive theory of RN understanding of organisational commitment and its link to retention.](image)

Figure 22: Substantive theory of RN understanding of organisational commitment and its link to retention.
RECOMMENDATIONS FROM THIS RESEARCH

Based on consideration of the extensive literature review mostly undertaken post data collection and analysis as per methodological fit, and of the research findings, the following recommendations are made:

Recommendations for Consideration by the Executive Managers of Acute Care Hospitals:

A. Executive managers need to acknowledge that the construct of organisational commitment can be utilised to increase RN retention.

B. Executive managers of acute care hospitals can use the substantive theory from this research to help develop strategies based on evidence pertaining to how RNs understand organisational commitment and its link to retention.

C. The development of retention programs with particular focus on the management behaviours of the Nurse Managers is necessary to increase RN organisational commitment and retention rates and so stabilise the nursing workforce within the hospital.

Recommendations for Consideration by Nursing Management in Acute Care Hospitals:

A. It is imperative that nursing management exert greater control with regard to how the nursing division is managed by individual Nurse Managers.

B. This can be accomplished by the establishment of an education program for Nurse Managers, which presents the organisational culture the nursing division wishes to establish. This education program should
provide tools, techniques and procedures in human resource management that the Nurse Managers can use in everyday practice to ensure better management practices that are able to enable and not inhibit the RNs’ organisational commitment and thus assist in retention.

C. Nurses appointed to management positions should possess tertiary management qualifications to provide them with theoretical knowledge with regard to managing human resources to enhance their ability to enact enabling management behaviours.

D. Nurse Managers should be supervised and mentored by other, more senior and experienced Nurse Managers to provide them with support and guidance in their management role.

E. Processes need to be established to enable RNs to voice their concerns to nursing management with regard to inhibiting behaviours of Nurse Managers without fear of reprisal. This will enable these behaviours to be corrected before they impact organisational commitment and retention.

Recommendations for Further Research and Work:

A. Undertake research in individual hospitals to establish whether RNs at these facilities also understand organisational commitment and its link to retention in the same way as established in this Grounded Theory study.

B. Undertake a study to understand the perspectives of managers to establish their understanding of organisational commitment and its link to retention.

C. Develop a quantitative study which uses key elements identified in this
research to gain an appreciation of RN organisational commitment and its link to retention from an international perspective.

D. Explore the nature of the relationship between organisational commitment and retention for other specific discipline areas in nursing, such as mental health and emergency.

LIMITATIONS OF THE STUDY

The main limitation of this study is the very specific participant inclusion criteria which required that participants be working in acute care hospitals in Australia. The participants voluntarily nominated themselves by contacting the researcher after reading information about the research in various nursing journals and nurse association websites. Therefore systematic bias in non-responses is unknown.

CONCLUSION

The findings of this Grounded Theory study enabled the researcher to build a substantive theory of how RNs working in acute care hospitals in Australia understand organisational commitment and its link to retention. The RNs understood organisational commitment as localised to their work unit and simultaneously to their nursing within the work unit and the patients within the work unit. The participants’ main concern was how they were managed by their Nurse Managers. The enabling or inhibiting management behaviours of their Nurse Managers either enabled or inhibited the strength of the participants’ organisational commitment and, hence, retention.

The findings of this study contributed to the formulation of recommendations to be made to executive managers of acute care hospitals. These recommendations were in relation to the importance of the construct of organisational commitment and its link to retention and the establishment of an RN retention program that targets the management
behaviours of Nurse Managers. Further recommendations were also made for nurse management in acute care hospitals. These were in relation to education programs for Nurse Managers; the requirement for tertiary management qualifications for nurses appointed to management positions; the need for support and mentoring of Nurse Managers by more senior and experienced Nurse Managers and the establishment of processes to enable RNs to report inhibiting management behaviours. The final recommendations were focused on possibilities for future research that would also contribute new knowledge in this area.

This thesis makes a significant original contribution to new knowledge related to Registered Nurse understanding of organisational commitment and its link to retention. It also provides evidence of the major role that Nurse Managers in acute care hospitals, play, in relation to enabling or inhibiting the Registered Nurse’s organisational commitment. The social process of ‘choice’, that is to leave or stay with the organisation is enacted by the Registered Nurse, dependent on whether their organisational commitment is enabled or inhibited by the Nurse Manager. This is the ‘link to retention’ highlighted through this research.

The predicted continuing nursing workforce shortage and the increasing need for services related to the growing elderly population, requires a better understanding of factors that influence Registered Nurse organisational commitment and retention. A stable and committed nursing workforce will be central to the provision of quality health care in the future.
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APPENDIX A: HUMAN RESEARCH ETHICS COMMITTEE APPROVAL

4 May 2010

Mrs Pamela Hogan
9 Maple Court
Timberlands QLD 4740

Dear Mrs Hogan

HUMAN RESEARCH ETHICS COMMITTEE APPROVAL: PROJECT H10/04-057 HUMAN RESOURCE MANAGEMENT STRATEGIES FOR THE RETENTION OF NURSES IN HOSPITALS IN AUSTRALIA

The Human Research Ethics Committee is an approved institutional ethics committee constituted in accord with guidelines formulated by the National Health and Medical Research Council (NHMRC) and governed by policies and procedures consistent with principles as contained in publications such as the joint Universities Australia and NHMRC Australian Code for the Responsible Conduct of Research. This is available at http://www.nhmrc.gov.au/publications/synopses/_files/r39.pdf.

On 27 April 2010, the committee met and considered your application. The committee is pleased to tell you that they have granted approval for your research project, Human resource management strategies for the retention of nurses in hospitals in Australia (Project Number H10/04-057).

The period of ethics approval will be from 4 May 2010 to 11 November 2012. The approval number is H10/04-058; please quote this number in all dealings with the Committee. HREC wishes you well with the undertaking of the project and looks forward to receiving the final report and statement of findings.

The standard conditions of approval for this research project are that:

(a) you conduct the research project strictly in accordance with the proposal submitted and granted ethics approval, including any amendments required to be made to the proposal by the Human Research Ethics Committee;

(b) you advise the Human Research Ethics Committee (email ethics@cqu.edu.au) immediately if any complaints are made, or expressions of concern are raised, or any other issue in relation to the project which may warrant review of ethics approval of the project. (A written report detailing the adverse occurrence or unforeseen event must be submitted to the Committee Chair within one working day after the event.)

(c) you make submission to the Human Research Ethics Committee for approval of any proposed variations or modifications to the approved project before making any such changes;
(d) you provide the Human Research Ethics Committee with a written "Annual Report" by no later than 31 January each calendar year and "Final Report" by no later than one (1) month after the approval expiry date; (A copy of the reporting pro formas may be obtained from the Human Research Ethics Committee Secretary, Sue Evans please contact at the telephone or email given on the first page.)

(e) if the research project is discontinued, you advise the Committee in writing within five (5) working days of the discontinuation;

(f) A copy of the Statement of Findings is provided to the Human Research Ethics Committee when it is forwarded to participants.

Please note that failure to comply with the conditions of approval and the National Statement on Ethical Conduct in Human Research may result in withdrawal of approval for the project.

In the event that you require an extension of ethics approval for this project, please make written application in advance of the end-date of this approval. The research cannot continue beyond the end date of approval unless the Committee has granted an extension of ethics approval. Extensions of approval cannot be granted retrospectively. Should you need an extension but not apply for this before the end-date of the approval then a full new application for approval must be submitted to the Secretary for the Committee to consider.

The Human Research Ethics Committee is committed to supporting researchers in achieving positive research outcomes through sound ethical research projects. If you have issues where the Human Research Ethics Committee may be of assistance or have any queries in relation to this approval please do not hesitate to contact the Secretary, Sue Evans or myself.

Yours sincerely,

[Signature]

Associate Professor Kristy Richardson  
Acting Chair, Human Research Ethics Committee

Cc: Project File  
A/Prof Lorna Moxham and Dr Trudy Dwyer (Supervisors)

Application Category: A
APPENDIX B: RESEARCH CONSENT FORM

Human Resource Management Strategies for the Retention of Nurses in Hospitals in Australia

CONSENT FORM

I consent to participate in this research project and agree that:

1. An Information Sheet has been provided to me that I have read and understood;
2. The Information Sheet and any further verbal explanation provided has answered any questions I had about the research to my satisfaction;
3. I understand that my participation or non-participation in this research will not affect my employment;
4. I understand that participation in this research is completely voluntary and that I have the right to withdraw from the research at any time without penalty;
5. I understand the research findings will be included in the researcher’s publication(s) and this may include conferences and articles written for journals and other methods of dissemination stated in the Information Sheet;
6. I understand that to preserve anonymity and maintain confidentiality of participants that identifiable data will be transferred to coded data and it is the unidentifiable coded data that will be utilised in this research;
7. I am aware that a Plain English statement of results from this research will be available upon request to the Principal Researcher;
8. I agree that I am providing informed consent to participate in this research.

Signature: ______________________
Date: ______________________
Name (please print): __________________________________________
Human Resource Management Strategies for the Retention of Nurses in Hospitals in Australia

DEMOGRAPHIC QUESTIONNAIRE

1. In which Australian state do you work?
2. What is the name of the town/city in which you work?
**APPENDIX D: ADVERTISEMENT CALLING FOR PARTICIPANTS**

**Research to understand Registered Nurse’s perspectives on Organisational Commitment and how this links to retention**

Retaining the nursing workforce is not only a challenge but within a global shortage of nurses is a priority for today’s health care managers and nurse leaders. Many reasons have been postulated about this shortage but the development of a more pro-active approach to find a resolution is required. A consolidated approach which includes identifying those Human Resource Management (HRM) practices which foster and support attachment to the organisation is a positive approach to address the problem. As health care organisations battle to gain the most from their existing nurse employees in an environment characterised by nurse and nurse skills shortages, the role of HRM in fostering employee attachment and commitment is paramount. Identifying what matters to nurse employees in terms of commitment is an important step in creating an environment that encourages nurse employees to want to stay.

This research will use Grounded Theory methodology. Applied to this research Grounded Theory requires the researcher to interview Registered Nurses working in a clinical unit and employed in an acute care hospital in Australia. The data from the interviews will be analysed to generate a clear picture which illuminates patterns, concepts, properties and dimensions of the Registered Nurses understanding of organisation commitment and its link to retention. Identifying what matters to nurse employees in terms of commitment is an important step in creating an environment that makes most nurse employees want to stay. Gathering this data and understanding it, is the focus of this research.

Organisational commitment may be one way to not only understand the nursing shortage but contribute to the answer to improving nurse retention. This research may provide health care managers with information that is transferable between hospitals and able to be built upon to provide a commitment/retention program to assist in retaining their organisation’s RN employees. The improved retention of nurses will have a follow on effect by maximising positive health outcomes for patients and assist in reducing the direct and indirect costs associated with staff turnover.
Call for participants

The interview will be via telephone link-up and will take approximately sixty minutes. Any Registered Nurse working in a clinical unit in an acute care hospital in Australia who wishes to participate in this research please contact Pamela Hogan via email at p.hogan@cqu.edu.au
Human Resource Management Strategies for the Retention of Nurses in Hospitals in Australia

INFORMATION SHEET

Principal Researcher: Pamela Hogan
p.hogan@cqu.edu.au

Principal Supervisor: Associate Professor Lorna Moxham
l.moxham@cqu.edu.au

Supervisor: Dr Trudy Dwyer
t.dwyer@cqu.edu.au

Research Overview

The aim of this research is to understand Registered Nurse’s (RN) perspectives on organisational commitment and how this links to retention. Retaining the nursing workforce is not only a challenge but a priority for today’s health care managers and nurse leaders. The development of a more pro-active approach to find a resolution is
required, rather than just accepting it as a recognised major problem with little that can be done to rectify the situation. A consolidated approach which includes identifying human resource management (HRM) practices which foster and support attachment to the organisation is seen as a positive approach to address the problem. Employee commitment can increase the level of loyalty an employee experiences towards the organisation, which can help reduce absenteeism and employee turnover.

Organisational commitment develops during employment in the organisation therefore the challenge is to design and implement HRM practices that positively influence commitment to the organisation with the co-commitment flow on of increased employee retention. Organisational commitment also has important consequences in health as it plays a major role in delivering high quality health care as without the required number of nurses available to accurately assess a patient’s condition and intervene appropriately, negative patient outcomes may occur. As health care organisations battle to gain the most from their existing nurse employees in an environment that is characterised by nurse and skills shortages, the role of HRM in fostering employee attachment and commitment is paramount.

The depth of knowledge of an organisation’s employees gives its strength but personnel can also contribute to its weakest link. When a competent health care employee resigns it is increasingly difficult to replace their position with someone of comparable competence, even with an effective succession planning process and wide marketing. Competition is fierce with organisations often forced to hire persons with less experience. If this process of staff loss is repeated often enough then the competence and capacity of the organisation’s workforce will gradually diminish along with the ability to meet health care consumer expectations.

Nursing forms the largest body of employees in the health care system, so a
shortage of nurses jeopardises many aspects of health care delivery. The nursing profession has a duty of care, bound by legislation, morals and ethics to treat patients competently and in a caring and professional manner. The major issue of the impending impact of a rapidly maturing nursing workforce who are approaching retirement age will create a situation whereby there will be a dramatic loss of acquired knowledge and expertise. Loss of job satisfaction and clinical safety will be issues of concern for the nurses remaining in the workforce, which could have a devastating effect on the quality of health care that is able to be provided. A further impact of the nursing shortage for health care organisations is the high cost in actual dollars, as the turnover costs of one employee is up to two times a nurses’ salary.

Organisational commitment may be one way to not only understand the nursing shortage but contribute to the answer to improving nurse retention. This research may provide health care managers with information that is transferable between hospitals and able to be built upon to provide a commitment/retention program to assist in retaining their organisation’s RN employees. The improved retention of nurses will have a follow on effect by maximising positive health outcomes for patients and assist in reducing the direct and indirect costs associated with staff turnover.

**Benefits and Risks**

The study sample is purposive. Participants will be registered nurses (RN) who are currently working in a clinical area in an acute care hospital in Australia. The risks associated with this research are considered quite low and one mainly of inconvenience. RN's will be required to give up their time - approximately 1 hour. This will however be conducted at a time that is suitable to the participant so as to mitigate this. Given the research is not of an emotional nature, nor asking questions about complex care or patient outcomes, negative sequelae as a result of participation are not anticipated. If
though, a participant does become upset as a result of, or during an interview, the interview will stop and the participant given time to recover composure. Participants will also be given the number of Lifeline at the beginning and end of the interview in case they need to seek assistance.

Participants can request a brief summary of findings and this will enable them to gain knowledge, insight and understanding of organisational commitment and its link to retention. Participants also have the opportunity to express their perceptions of organisational commitment and its link to retention. A possible long term gain, if the results of this research are applied to a commitment and retention program at a hospital, could be an increase in the retention of registered nurses.

**Confidentiality/Anonymity**

Potentially identifiable coding is required during data collection so that the researcher can go back to that same participant in the event that clarification is required. Contact details are also required to enable the researcher to provide a plain language summary to participants if requested. However, to protect the participant, identifiable data will be transferred to coded data and it is the unidentifiable coded data that will be utilised.

Participants will be asked to respond to demographic questions at the beginning of the study. The demographic data will then be used to select the initial purposive sample. The initial purposive sample will include a cross section of participants with a range of demographics so as to engage a wide range of RNs who are working in an acute care environment who can inform the study. The remaining demographic data will be stored in a locked filing cabinet and on a password protected computer and will be drawn upon only by the principal researcher as required during the theoretical sampling phase of the study. As per Grounded Theory methodology not all initial respondents
may be selected. The demographic data of respondents not selected will be discarded by shredding at the completion of the study when saturation of data is confirmed.

Information collected for, used in, or generated by this research project will not be used for any other purpose. The Principal researcher and Supervisors will be able to access coded data as required for ongoing review purposes. Information will be stored predominantly as digital audio recordings and password protected computer files. Limited amounts of paper records will also be utilised. Digital audio files will be downloaded from a recorder to the hard drive of the researchers password protected computer that is located within a locked office. After each download, the recorders memory relating to participants will be erased. The recorder will be stored in a locked filing cabinet in the researchers locked office at CQUniversity. Electronic files will be stored on the researchers password protected computer and backed up to researchers password protected personal computer. Any paper files/records will be stored in a locked filing cabinet in the researchers locked office at CQUniversity. All data will be coded to prevent misuse and to ensure confidentiality of participants. Coded data will be stored securely and separate from un-coded data which will also be stored securely in a locked filing cabinet in the researchers locked office at CQUniversity.

The information will be stored after the completion of the research for a period of 5 years as per CQUniversity requirement. After a 5 year period in accordance with CQUniversity guidelines for the ethical conduct of research involving humans, the paper documents will be shredded and electronic and audio files will be erased.

**Outcome/Publication of Results**

Results will not be reported to participants, as specific information will not be utilised, the data will be used in an aggregated and collective form. The results will be published as part of the researchers PhD thesis. It is also expected that the results will
be presented in de-identified form at academic conferences and published in academic journals.

No identifying information will be included in any research results and no identifying information about individual participants or organisations will be disclosed. Participants will be de-identified in all reports, which will include the dissemination of results. Should direct quotes be included, pseudonyms will be used to replace names of participants/organisations and no site specific information will be used in any publication.

Consent

Given the nature of the research and the fact that participants will be employed within an Australian hospital, it is not anticipated that participant's capacity to consent will be a potential risk of concern. Participants will be advised they have the right to withdraw from the research at any time without prejudice and that no incentive/payment will be offered.

An Information Sheet will be sent to the potential participant and verbal explanations will be provided to answer any further questions they may have. The participant will be asked to acknowledge that they have had all their questions regarding this research answered to their satisfaction. They will also be asked to acknowledge that they have read and understood all aspects of their participation in this research.

The participant will also be asked to consent that they understand that their participation or non-participation in this research will not affect their employment. They will also be consenting that their participation is completely voluntary and that they are providing informed consent.

Feedback
Plain language summaries will be made available to participants and also to other interested parties for example hospital executives upon request to the Principal Researcher.

Questions/Further Information

Participants will be asked to participate in a telephone interview lasting approximately 60 minutes. The interview will take place at a time suitable to the participant. Questions will be answered and further information provided by the Principal Researcher upon request.

Contact: Pamela Hogan at p.hogan@cqu.edu.au

Concerns/Complaints

Please contact CQUniversity’s Office of Research should there be any concerns about the nature and/or conduct of this research project.

Phone: 07 49232607

Email: research-enquiries@cqu.edu.au

Mailing Address: Building 32

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