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**Early Career Nurses: The relationship between
Organisational Climate and Job Satisfaction and
Burnout**

A thesis
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of the requirements for the degree
of

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By

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Abstract

In the changing New Zealand healthcare sector, the need for nurses to seamlessly and successfully transition into clinical practice is critical, particularly for organisational success. The worldwide nursing shortage and projected changing demographics of the population make assessing the job satisfaction and burnout of nurses imperative, especially to establish a strong and capable workforce for the future. If provisions are not put in place to ensure that nurses are provided with adequate support in their early careers and that they work within a positive organisational climate, detrimental organisational outcomes may arise.

The current study was designed to identify early career nurses' perceptions of their first two years of clinical practice, and how the organisational climate at a District Health Board (DHB) within New Zealand impacted on their success in clinical practice. The primary purpose of this study was to determine the relationship between three aspects of organisational climate (nursing relationships, charge nurse manager leadership, and staff organisation) on early career nurses' perceptions of job satisfaction and burnout.

Ninety-one individuals completed the mixed method survey. Significant relationships were found between the main study variables. Cohesive nursing relationships, supportive charge nurse managers, and the adequate organisation of staff were found to positively correlate with job satisfaction and negatively correlate with burnout. Significant themes emerged in thematic analysis; namely, supervisor support, emotional labour, workload and staffing relations.

The results of the study suggest that a supportive organisational climate is imperative toward increasing nurse's job satisfaction and positive feelings about their job. Additionally the findings of this study highlight that cohesive nursing relationships, team-building skills of charge nurse managers and the organisation of staff may be something to prioritise. Thematic analyses largely supported quantitative findings indicating that on the whole, nurses would like to receive more support in regard to the emotional labour of nursing and from supervisors. High workloads were acknowledged as a challenging aspect of nursing that was believed to impact negatively on patient care and nurses' work-life balance.

Future research should consider the challenges associated with high burnout in nurses and, where appropriate, explore possible change initiatives. Additionally, a 360° review of nurses' transition to clinical practice may be useful

in highlighting the discrepancies between how nurses believe they fare in their early careers and how their nursing colleagues perceive their transition.

Overall, this study explores the notions of organisational climate and its contribution to the development of proficient and able nurses. This study has provided a strong base for future research, specifically in helping to build a sustainable nursing workforce for the future. Taken together, this research provides a comprehensive review of nurses' experience in their early careers, and importantly, outlines what aspects significantly contribute to their satisfaction.

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Table of Contents

Abstract	ii
Acknowledgements	iv
List of Tables.....	vii
List of Figures	viii
Chapter One: Introduction.....	1
Nursing Past and Present	1
Current situation	3
Importance of the Current Study	5
Purpose of the Current Research	7
Theoretical Model	8
Job Satisfaction.....	10
Burnout	11
Organisational Climate.....	12
Work Relationships	13
Leadership	15
Staffing Organisation.....	17
Summary of Hypotheses.....	19
Chapter 2: Method.....	21
Participants	21
Procedure	21
Measures.....	22
Data Analysis.....	25
Chapter Three: Results	29
Exploratory Factor Analysis.....	29
Descriptive Statistics	32
Reliability Analysis	33
Correlation Analysis.....	33
Regression Analysis	36
Thematic Analysis	38
Summary.....	44
Chapter Four: Discussion.....	46
Hypothesised Research Findings.....	46
Unsupported Findings	51

Thematic Analysis	51
Practical Implications	55
Strengths	56
Limitations.....	57
Future Research	59
Conclusion.....	59
Appendix A	70
Appendix B	75
Appendix C	76

List of Tables

Table 1. Pattern matrix of burnout	31
Table 2. Descriptive statistics	32
Table 3. Pearson product-moment correlations for all variables and Cronbach's alphas.....	35
Table 4. Linear model of predictors of job satisfaction	37
Table 5. Linear model of predictors of emotional exhaustion	37
Table 6. Linear model of predictors of reduced personal accomplishment	38
Table 7. Linear model of predictors of depersonalisation.....	38

List of Figures

Figure 1. Theoretical framework of criterion relationships	9
Figure 2. Theoretical framework of cohesion among nurses.....	9
Figure 3. Theoretical framework of leader team-building skills.....	10
Figure 4. Theoretical framework of staff organisation	10
Figure 5. Framework of the hypothesised relationships for job satisfaction	44
Figure 6. Framework of the hypothesised relationships for cohesion among nurses	44
Figure 7. Framework of the hypothesised relationships for leader team-building skills	45
Figure 8. Framework of the hypothesised relationships for staff organisation.....	45
Figure 9. Scree plot for relationships	74
Figure 10. Scree plot for leadership	75
Figure 11. Scree plot for staff organisation.....	76
Figure 12. Scree plot for job satisfaction	77
Figure 13. Scree plot for burnout	78

Chapter One: Introduction

The first few years of a nurse's career have been described as both difficult and challenging (Laschinger, Finegan, & Wilk, 2009; Parker, Giles, Lantry, & McMillan, 2014) a problematic issue for both the nurse and the organisation. Given the importance of nurses to the health sector, this issue can be deemed too significant to ignore. For this reason, the aim of the current study is to gain a more in-depth understanding of New Zealand nurses' perceived experience during their first two years in clinical practice at a large District Health Board (DHB) within New Zealand.

Nursing Past and Present

The nursing profession is a sector, which, throughout its history has evolved immensely, influenced by an array of factors (Mura & Mura, 1995). In examining the history of New Zealand nursing education, the process of becoming a nurse has been influenced by a rich and complex past. Prior to the 1970's nurses were trained on-the-job, in an apprentice style format. This on-the-job training was part of a programme facilitated and carried out by District Health Boards (DHBs) across the country. Nurses' competencies were assessed through skill level and knowledge (Adlam, Dotchin, & Hayward, 2009), with state examinations leading to registration as a nurse (Wood & Nelson, 2013). The apprentice style model during this time served its purpose, however the programme encountered several limitations. Namely, attrition rates were significantly high, with large numbers of nurses starting their nursing education, yet failing to finish (Adlam et al., 2009). Additionally, the Department of Health and the New Zealand Nursing Association (NZNA) wanted to disengage from on-the-job training, and separate education from the practical training, largely influenced by the 1971 Carpenter Report. These desired changes led to the establishment of the 3-year Diploma of Nursing within tertiary educational institutions in 1973. This process was already well established and running successfully in other areas of the world at the time, particularly in the United States (Gage & Hornblow, 2007).

In 1989 the last basic nurse training programme, facilitated by Auckland DHB, was phased out and in 1995 a comprehensive three-year nursing degree was implemented in all DHB's (Gage & Hornblow, 2007). Completion of this degree

was the sole entry to nursing registration and was carried out within various tertiary institutions nationwide.

This transfer of gaining registration as a nurse from hospital boards to educational institutions represents a fundamental shift in nursing education, philosophy, and policy (Gage & Hornblow, 2007). Despite this shift at the time appearing seemingly necessary and successful, the outcomes have been less than favourable. A major limitation to the new model was the lack of sufficient orientation and support provided to nurses throughout the transfer from tertiary education to nursing practice (Adlam et al., 2009).

Despite following international trends, the orientation systems implemented in New Zealand hospitals failed to reflect international standards, and ultimately failed to facilitate the needs of graduate nurses (Adlam et al., 2009). This failure was seen as a direct reflection of the lack of regulations for nursing orientation programmes. After the implementation of the new guidelines, individual hospitals were required to implement their own orientation programmes, with no set guidelines or instructions. Moreover, these programmes were developed using the hospital's own resources, therefore, those hospitals which lacked sufficient resources were unable to put forward effective orientation programmes (Adlam et al., 2009).

Poor regulation triggered monumental periods of stress for newly registered nurses. Some of the stressors reported by nurses included making mistakes due to increased workloads, encountering new situations, surroundings and procedures, short staffing, frustrations with the work environment and encounters with unhappy nurses and neglectful staff (Adlam et al., 2009). The nursing sector raised concerns regarding the distress new graduates were exposed to, which led to standardised programmes for graduate nurses' first year of practice being implemented in 2006 (Adlam et al., 2009). These new programmes were designed to promote a more successful and seamless transition for new graduate nurses into nursing practice, and continues to be the programmes used in New Zealand today.

The newly developed orientation programme was separated into two distinct programmes: Nurse Entry To Practice (NETP) and Nurse Entry to Speciality Practice (NESP). NETP is a year-long programme with the purpose to support new graduates through their first year in the workforce, helping them to make the transition from student nurse to competent registered nurse (Nursing

Council, 2016). NETP is designed for registered nurses working in the acute hospital and community-based health services setting. NESP, on the other hand, was designed specifically for nurses who specialised in mental health or addiction. The aim of this programme was to,

Enable nursing graduates to begin their careers well-supported, safe, skilled and confident in their clinical practice, equipped for further learning and professional development, meeting the needs of health and disability support service users and employers (Canterbury District Health Board, 2015b, p. 1).

The programme was intended to support registered nurses in developing their professional practice, while simultaneously learning the speciality field of mental health or addiction nursing (Canterbury District Health Board, 2015a)

The introduction of NETP and NESP programmes into hospitals provided graduate nurses with the orientation and support required in their early careers. Whilst the programme was designed to meet the needs of new graduate nurses, evaluations have identified the need for further development (Adlam et al., 2009), specifically in accommodating the needs of nurses as they grow, develop, and adjust to the increasingly dynamic and ever evolving nature of the healthcare sector (Adlam et al., 2009). The need for change and development to current transition programmes has largely been influenced by a significant population of nurses who are still experiencing stressful transitions into practice (Pineau Stam, Spence Laschinger, Regan, & Wong, 2015).

Current situation

The literature on recently graduated nurses' experiences is both large and diverse. Researchers, past and present, have focussed much of their attention on the transition to clinical practice, socialisation, and satisfaction of nurses. It is well reported that often the first few years of clinical practice are stressful (Feng & Tsai, 2012). Stress for the new graduate is described in many forms, such as becoming socialised into the ward (Saghafi, Hardy, & Hillege, 2012), becoming responsible for patient care (Maben, Latter, & Clark, 2006), and learning the formal and informal rules of the hospital (Feng & Tsai, 2012). Additionally, graduate nurses are expected to reach milestones within a very short time period

(Phillips, Esterman, & Kenny, 2015) which can create unnecessary stress for nurses at an already sensitive time in their early careers (Saghafi et al., 2012).

An additional stressor for nurses in their early career may be attributed to the emotional labour of nursing. Emotional labour refers to the notion that nurses are required to regulate the emotions they display in an attempt to meet the organisational expectations specific to their role (Mann & Cowburn, 2005). This can be extremely taxing for an early career nurse, particularly when having to display compassion at all times, and the constant exposure to pain and death. The high emotional cost of caring has a considerable impact on the well-being of nurses, specifically as the suppression of true emotions contradicts internal feelings, which can result in burnout (Cheng, Bartram, Karimi, & Leggat, 2013; Sawbridge & Hewison, 2013). Research suggests that nurses need more support at work to rectify the pressures of delivering compassionate care (Sawbridge & Hewison, 2013).

Although the structured support programmes have been designed to assist graduate nurses in their transition, they continue to experience stress (Dyess & Sherman, 2009). There is, however, a gap in the research regarding nurses' perceptions of the support provided by the organisational climate towards their personal and professional development, as well as their satisfaction. That said, however, nurses who have sufficient support and resources available to them, are known to be more confident in their practice, satisfied in their jobs, have better retention, and consequently lower turnover rates. Furthermore, in a recent study McKillop, Doughty, Atherfold, and Shaw (2015) found that nursing education was particularly valuable to nurses in their early careers. It was acknowledged that nurses' perceived impact of the required continued study during the NETP programme had a positive influence on their clinical practice and transition experience.

While research yields consistent findings in relation to nurses' transition and socialisation into the hospital environment, there is room for further research. Currently there is a lack of research examining nurses' perceived experiences within NETP and NESP, and more specifically, a lack of understanding and knowledge around graduate nurses experience from an organisational perspective in New Zealand.

Importance of the Current Study

Nurses play a significant role in our society; they have a strong influence on the health outcomes of patients, in addition to influencing the overall functioning of the healthcare sector. Pineau Stam et al. (2015) suggest that early career nurses experience multiple challenges and difficulties. Given that nurses are a pivotal unit in the healthcare sector it is, therefore, vital to understand more about nurses' perceptions of their early professional career and what aspects make it more or less challenging. Identifying what factors contribute to nurses' success and satisfaction has become essential in recent years, given their satisfaction largely reflects their turnover intentions (Pineau Stam et al., 2015), and the overall functioning of the healthcare system. In an analysis report written by the Waikato DHB, it is acknowledged that,

The central part of our capability is our people. Providing health and disability services now and into the future depends on having a workforce that is well matched to the health needs of the community and appropriately skilled and located (Marriot, 2015, p. 8).

Turnover. The rate at which new graduate nurses leave the clinical practice environment is unsustainable (McCalla-Graham & De Gagne, 2015). Internationally, nurse turnover is a concern that is both costly and, in the context of the work environment, affects quality and safety (Li & Jones, 2013). Quality and safety are subsequently compromised; as shortage rates rise, nurses do not have sufficient time to care for patients to expected levels.

National research into nurse turnover began after years of nursing shortages, deteriorating employment conditions, and stagnation of pay (North et al., 2013). Given these workforce stability issues, and the ageing workforce, the need for identifying the causes of nurse turnover, can be seen as key for organisational management, strategy, and ultimately success. Nurses contribute high human capital (i.e., assets related to knowledge, information, ideas, and skills), which provide income for the organisation and other useful outputs (Wright & McMahan, 2011).

An estimated 30-40 percent of nurses intend to leave their job within 12 months (Duffield, Roche, Homer, Buchan, & Dimitrelis, 2014). There is a large loss of investment in nurses who leave (Gianfermi & Buchholz, 2011). North et

al. (2013) found that the ratio of registered nurse turnover in New Zealand was about half an annual registered nurse salary (with an average base salary of \$47,000). While the cost of turnover is relatively low in New Zealand compared to Australia and the United States, the turnover rate is significantly higher in New Zealand (44.3%) compared to the United States (26.8%), Canada (19.9%) and Australia (15.1%) (Duffield et al., 2014). This indicates that our comparably low cost of turnover is not due to a less severe epidemic, but rather is related mainly to the salary of nurses affected. It is vital that nursing turnover is reduced to maintain a stable workforce in preparation for an ageing population. While there are many triggers that can induce turnover intentions, Hughes (2007) argues that, “poor working conditions and opportunities have been identified as contributing to over 50 percent of New Zealand nurses ceasing active employment as a registered nurse” (p. 3). For this reason it is important to minimise turnover intentions.

Nursing shortage and retirement. The current challenge facing all DHBs and, more broadly, hospitals around the world, is the changing needs of the population. The age profile of patients is projected to increase over the next ten years, which presents a major challenge at both national and international levels (Marriot, 2015). The ageing population, primarily influenced by ‘baby-boomer’ retirement, is expected to have considerable implications with regard to resources, workforce planning, and the delivery of services (Marriot, 2015).

Given that the ageing population will change the health landscape in the years to come, the need for innovative thinking, more integrated ways of learning, and collaborative and supportive working environments will be required. Failure to meet these requirements may lead to a lack of needs being met, as available human resources will become increasingly pressured (Marriot, 2015). Whilst the population is ageing, the healthcare workforce, particularly the nursing workforce, is also an ageing one. As the baby boomer generation near retirement it presents an urgent case to begin actively supporting career planning, for nurses in particular. Failure to serve the needs of the current nursing workforce, particularly early career nurses, may lead to a large void of nurses in the workforce. Focusing on nurses’ career development will become imperative to the retention of nurses in the profession.

The current situation has led healthcare organisations to reevaluate the recruitment and retention of graduate nurses (Theisen & Sandau, 2013). Nursing shortage rates are steadily rising as baby boomers near retirement. Nurses over 50

years of age make up 40 percent of the New Zealand registered nurse population (Clendon & Walker, 2013). Therefore, the ageing workforce will increase the number of nursing positions available as baby boomer nurses near retirement. The vacancies created by retiring nurses, as well as increased turnover, however, are likely to be filled by newly registered nurses. With little clinical experience, the available resources of the organisation are likely to be stretched, and additionally met with economic stress (Theisen & Sandau, 2013). The ageing population and a large cohort of soon-to-rotate nurses makes understanding graduate nurses' perceptions of organisational climate imperative to graduate nurses retention and job satisfaction (Smith, Andrusyszyn, & Spence Laschinger, 2010). This understanding is essential as it is evident that an ageing workforce will leave a void of nurses in the profession. Additionally, the veritable difficulty in merely securing a NETP or NESP position in New Zealand (due to DHB budget restrictions limiting availability) exacerbates the need to identify nurses' perceptions of the organisational climate and whether it is conducive to ongoing learning, development, and support to help them flourish and grow.

Purpose of the Current Research

Exploring the relationships between organisational climate, nurse job satisfaction, and burnout provides the ability for organisations to manage their employees' feelings about the job and their turnover intentions. The relationship between different dimensions of organisational climate which affect employees' job satisfaction and burnout can provide knowledge of the weaknesses and strengths of the organisation's climate, specifically whether it is an environment conducive to personal and professional development for employees in their early careers. This research will highlight certain aspects of the organisational climate that can then be improved to increase the level of employees' job satisfaction and reduce stress for registered nurses.

The principal aim of this thesis research was to undertake research at a New Zealand DHB, specifically to identify whether early career nurses are well supported to successfully transition from student nurse and develop their competency as a new registered nurse. Early career nurses' early job satisfaction in their careers is important to build a sustainable workforce, who have the capability to deal with the rapidly developing health care sector and population. The analysis of the organisational climate at the DHB will provide insight into

potential areas of concern, as well as the influences of stress for nurses in their early careers. In particular, this research investigates the relationship between facets of organisational climate, specifically, work relationships, leadership, and staff organisation with job satisfaction and burnout.

Recent research has bridged a gap evaluating nurses' perception of the impact of postgraduate education and NETP on early career nurses employed at a New Zealand DHB (McKillop et al., 2015). However, the perceived influence of organisational climate on early career nurses' job satisfaction and burnout is not mentioned. There is a lack of New Zealand based empirical research, since the introduction of structured support programmes (NETP and NESP), which explores graduate nurses' perceptions of the organisational climate. My research intends to fill this gap, adding value to New Zealand nursing literature in a currently under researched area.

There are many reasons why nurses are dissatisfied and prone to burnout in their careers; outcomes can occur due to personal reasons, interpersonal conflict, work overload, the job itself, or even the organisational environment (Parker et al., 2014). The reason an employee may become dissatisfied, stressed, or leave are, therefore, very complex (Eley, Eley, & Rogers-Clark, 2010). Further research evaluating the organisational climate within New Zealand DHB's could prove useful in gaining a better understanding of nurses' early careers, and why they still report feeling stressed and overwhelmed (Chang & Hancock, 2003). For this reason, the research of different facets of organisational climate at a large DHB within New Zealand can provide beneficial knowledge. This can be utilised to help hospitals retain early career nurses in the profession, help graduate nurses reach their full potential, as well as highlight possible developmental opportunities in areas of organisational climate where pressures exceed graduate nurses ability to develop, learn, and grow.

Theoretical Model

Within the following research three aspects of organisational climate were investigated. Preliminary discussions with three early career nurses helped to identify which aspects of organisational climate are most relevant to nurses transition into clinical practice, specifically what aspects aid or hinder their transition. Despite these nurses working within two different New Zealand DHB's, they contributed very similar suggestions. Most important to their

personal transition into clinical practice and their perceptions of the ward environment were the support received from their nursing colleagues, the fairness and approachability of their charge nurse manager, and the staffing/workload.

In addition, on the basis of the literature illustrating connections between work relationships, leadership, and staffing organisation with job satisfaction and burnout, three predictor variables were selected. This research investigates the relations between nurses' perceptions of cohesion with other nurses team-building abilities of the charge nurse managers and staffing organisation along with job satisfaction and burnout (see Figure 1-4). Specifically, this research aims to identify whether these three aspects of organisational climate will relate to nurses job satisfaction or whether a poor perception of organisational climate will lead to burnout.

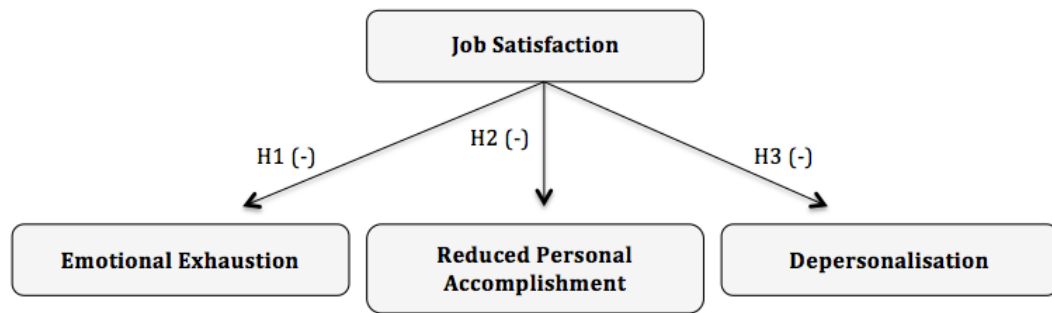


Figure 1. Theoretical framework for job satisfaction and burnout.

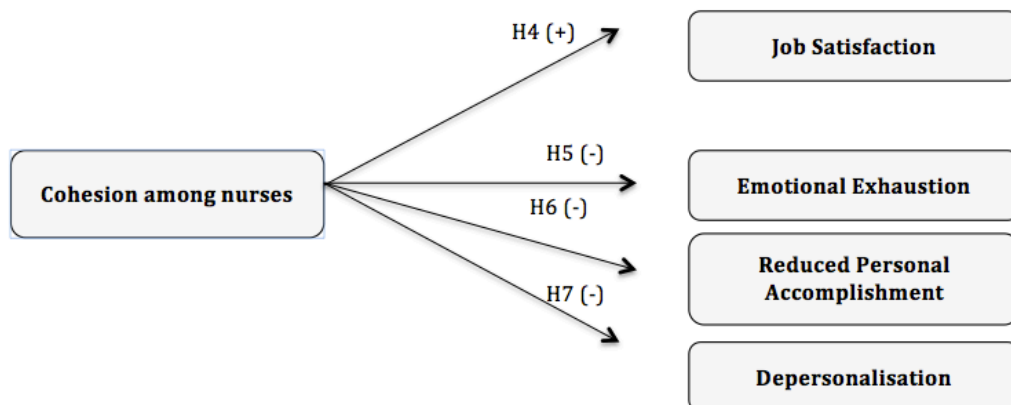


Figure 2. Theoretical framework for cohesion among nurses.

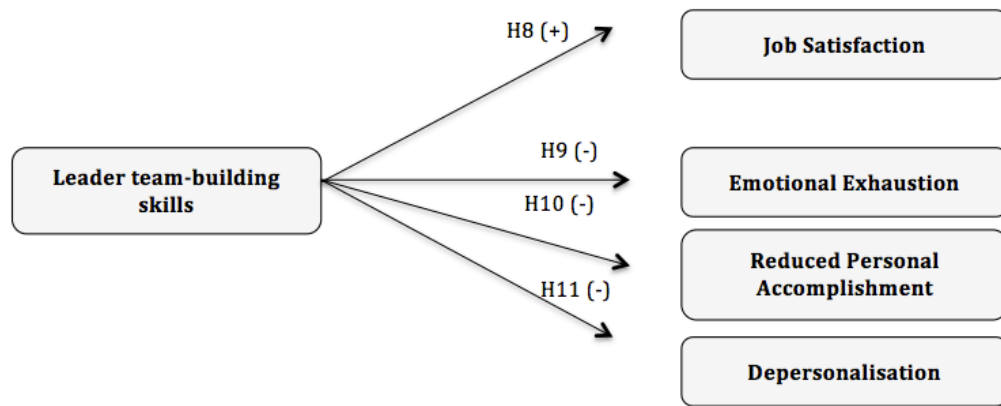


Figure 3. Theoretical framework for leader team-building skills.

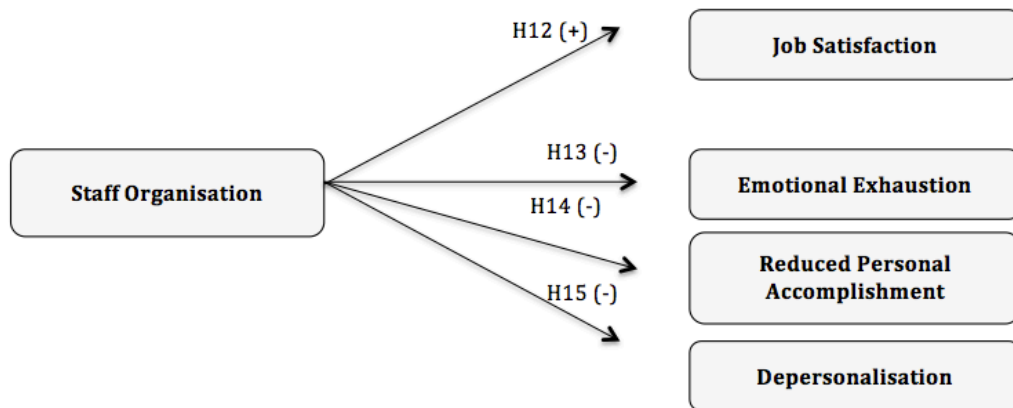


Figure 4. Theoretical framework for staff organisation.

Job Satisfaction

Job satisfaction is defined as a pleasurable or positive emotional state resulting from the appraisal of one's job or job experiences (Locke, 1976). Job satisfaction is measured by specific facets relating to an employee's satisfaction with work, pay, rewards, promotion, and co-workers that contribute to an overall measure of employee job satisfaction. According to Dağdeviren, Musaoğlu, Ömürlü, and Öztora (2011), job satisfaction is an important attitude to measure and monitor in an organisation as it affects individual and organisational efficiency. Thus, job satisfaction has become an object of theoretical interest and extensive research (Belias & Koustelios, 2014). El-Nahas, Eman Mohamed, and Ayman Yehia (2013) note that job satisfaction is the most frequently measured organisational variable because it is an important indicator of how staff feel about their job, how

committed they are to the organisation, as well as being a predictor of turnover intention. Job satisfaction is a complex work attitude that depends on organisational variables, such as relationships, leadership and work conditions, all of which constitute organisational climate.

Job Satisfaction has been well researched in nursing, thus a significant amount is known about what makes nurses satisfied and dissatisfied within their employment (Gianfermi & Buchholz, 2011). Despite the proliferation of job satisfaction literature the concept remains complex due to the multiple variables that have been studied in relation to this phenomenon (Castaneda & Scanlan, 2014). These variables include, burnout, stress, work environment, leadership, team work and social support (Castaneda & Scanlan, 2014).

Burnout

Burnout is defined as “a syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment that can occur among individuals who do ‘people work’ of some kind” (Maslach, 1982, p. 859) As noted in the definition, burnout contains three primary symptoms. Firstly, emotional exhaustion, which refers to the depletion of emotional resources. Thus an individual who is emotionally exhausted feels they lack the adaptive resources to perform their job. It is believed that the core component, emotional exhaustion, then leads to the second symptom, depersonalization or cynicism towards one’s work; a process whereby the individual becomes detached from their job and will often develop callous attitudes towards their position and those associated to their employment (Halbesleben & Buckley, 2004). Finally, reduced personal accomplishment or efficacy occurs when the individual perceives they can no longer perform the job as they once could, epitomised by diminished perceptions of ability. Interest in burnout, from academics and managers alike, has significantly increased as research reveals the negative impact burnout can have on employees. Burnout can manifest from accumulated stress, and when neglected this accumulated stress causes significant negative outcomes. Hall (2001) suggests that nurses, as an occupational group, are at high risk of burnout. Nursing has been considered as a high risk profession for burnout because the working environment involves specific job stressors and high emotional labour such as “exposure to pain and death, role stress, lack of support from supervisors, interpersonal conflicts and so on” (Wang, Liu, & Wang, 2015, p. 78).

Additionally, burnout is cited as a source of job dissatisfaction (Spence Laschinger & Fida, 2014). In healthcare, burnout is found to be a strong predictor of job satisfaction. Therefore, when workplace conditions influence burnout, early career nurses are less likely to be satisfied in their jobs (Spence Laschinger & Fida, 2014). Based on this knowledge, the following hypotheses were formed:

Hypothesis 1: Nurses' job satisfaction will be negatively related to emotional exhaustion.

Hypothesis 2: Nurses' job satisfaction will be negatively related to reduced personal accomplishment.

Hypothesis 3: Nurses' job satisfaction will be negatively related to depersonalisation.

Organisational Climate

Organisational work climate generally refers to “a set of properties of the work environment perceived directly or indirectly by the people who work in the environment, as is assumed to influence work motivation and behaviour” (Gormley, 2011, p. 34). Organisational climate extends to encompass a variety of factors, including, supervisory support, autonomy, job structure, cohesion, interpersonal relationships and managerial relationships (Gormley, 2011).

Due to the effects of organisational climate on burnout and job satisfaction this research will focus on three aspects of organisational climate. The first is work relationships, specifically cohesion among nurses. Secondly, ward leadership, and the team-building skills of the charge nurse manager. Lastly, staff organisation will be investigated specifically on the adequacy of ward staffing, rostering and staff organisation to cope with workload

There are many variables that contribute to the climate of an organisation, however, this research only focuses on three aspects of organisational climate (nursing relationships, leadership, staff organisation) given that literature consistently links these three variables with nurses' job satisfaction and burnout. These variables are discussed below.

Work Relationships

Relationships are a key part of organisational life. Relationships at work can exert strong influence on employees' behaviour, attitude, and attachment; this notion illustrates the importance of studying work relationships (Eby & Allen, 2012; Venkataramani, Labianca, & Grosser, 2013). Literature on work relationships has, therefore, sparked the interest of managers and organisations alike, as the relationship between positive employee behaviour has been found to correlate strongly with positive organisational outcomes (i.e., efficiency, job satisfaction, and employee health) (Stoetzer et al., 2009). Similarly, Eby and Allen (2012) suggest research evidence on work relationships is robust and consistent; positive interpersonal relationships at work are associated with favourable work attitudes, less work related strain and greater well-being. The opposite is true for negative interpersonal interactions between employees, which are related to strain (Eby & Allen, 2012).

In addition, work relationships in the context of nursing are also extremely important to maintain. Nurses' transition to clinical practice is consistently described as the most difficult time in their early careers (Feng & Tsai, 2012; Hatler, Stoffers, Kelly, Redding, & Carr, 2011; Saghafi et al., 2012). The challenges nurses face in their early careers are multifaceted and include assimilating to the new environment, familiarising oneself with the procedure and practices of the ward, and developing knowledge, skills, and abilities to become a proficient and confident nurse, while providing safe and quality care (Scott, Keehner Engelke, & Swanson, 2008). The quantity and quality of interaction in work relationships are particularly important in how nurses regard their work (Adams, Bond, & Arber, 1995; Zangaro & Soeken, 2007). That is to say, despite the known difficulties nurses face in developing their professional careers, the quality of nurse-to-nurse relationships can act as a buffer to stress and strain.

Work relationships are important not only for graduate nurses transitioning into their professional careers but also for even the most experienced nurses. Although the challenges are markedly different, established and proficient nurses in their second year of practice are still prone to experiencing workplace challenges. The value of workplace relationships are equally important for these more experienced nurses as they negotiate the developments and changes to nursing practice with an emphasis on collaboration and person centred care, increased patient acuity and chaotic practice environments (Dyess & Sherman,

2009; Feng & Tsai, 2012; Scott et al., 2008; Theisen & Sandau, 2013). During these early career-defining years the importance and influence of nurse-to-nurse relationships becomes particularly relevant to the successful development of nurses' careers. Furthermore, these first few years of employment in nursing are essentially a learning period during which new graduate nurses enter as novices and receive ongoing education, experience, and support to socialise them into the role of competent and satisfied professional nurse (Scott et al., 2008).

Cohesion amongst nurses. Many aspects and attitudes underpin or characterise the concept of work relationships. Specific to this research is the cohesion amongst nurses. Cohesion is described as a “dynamic process that is reflected in the tendency for a group to stick together and remain united in the pursuit of its instrumental objectives and/or for the satisfaction of member affective needs” (Carron & Brawley, 2000, p. 94).

Similarly, in the context of nursing, group cohesion is defined as the degree of attraction nurses feel towards their work group and their motivation to be a member of that group (Ko, 2011). Having high cohesion between nursing staff is important. Research demonstrates that high group cohesion results in strong social and homogenous feelings among a group's members and can improve co-operation between group members, which initiates positive workplace outcomes (Ko, 2011). Employee well-being was found to be enhanced by cohesion with research supporting the notion that cohesive groups generally seem to outperform non-cohesive groups and have greater job and personal satisfaction (Morrison, 2004; Sánchez & Yurrebaso, 2009). Li, Early, Mahrer, Klaristenfeld, and Gold (2014) and Ulrich et al. (2010) further suggest that work group cohesion is beneficial to nurses in terms of their job satisfaction.

Conversely, most occupational stress studies consider colleagues to be a major source of support for employees. It is suggested that this is due to nursing colleagues being able to provide support in the form of information, practical assistance, and emotional support relevant to the work situation (Joiner, Stanton, & Bartram, 2004; Spooner-Lane & Patton, 2007). Conversely, lack of social support from nursing colleagues appears to be a major determinant of emotional exhaustion (Stordeur, D'Hoore, & Vandenberghe, 2001). Li et al. (2014) similarly found group cohesion to be a protective factor for stress, as group cohesion effectively moderated the negative effects of stress exposure on burnout. Additionally, Janssen, De Jonge, and Bakker (1999) found that emotional

exhaustion was primarily predicted by a lack of social support from colleagues. Based on the literature the following hypotheses have been formed, which predict employees within a cohesive environment with supportive relationships will report high levels of job satisfaction, while those nurses experiencing low cohesion will report higher levels of the facets of burnout.

Hypothesis 4: Nurses' perception of cohesion among nurses will be positively related to job satisfaction.

Hypothesis 5: Nurses' perception of cohesion among nurses will be negatively related to emotional exhaustion.

Hypothesis 6: Nurses' perception of cohesion among nurses will be negatively related to reduced personal accomplishment.

Hypothesis 7: Nurses' perception of cohesion among nurses will be negatively related to depersonalisation.

Leadership

Undoubtedly, leadership is one of the most researched areas of Organisational Psychology; there are more research papers published in this realm than any other (Woods & West, 2010). Leadership is a key component of organisational functioning particularly as leadership symbolises power, power to point followers in the same direction and harness followers' efforts jointly to avoid conflict and the degeneration of team cohesion (Mills, 2005). Woods and West (2010) suggest this is because leadership has such an important place in human society and in our thinking about the world. Approaches to understanding leadership vary greatly and, therefore, a simple definition might be that leadership is steering the activities of followers to a shared goal. The trouble with this definition, however, is that it fails to illustrate the complexity of the relationship between leader and followers. Thus, most definitions of leadership describe it as "a process whereby intentional influence is exerted over other people to guide, structure and facilitate activities and relationships in a group or organisation" (Woods & West, 2010, p. 430).

Leadership is integral to nursing (Carter et al., 2010). Nursing has evolved to encompass a team-oriented approach to healthcare delivery. Leadership in nursing is partly influenced by a charge nurse's ability to be at the forefront of patient care while being accessible to ward staff (Mejia, Vásquez, & Sánchez, 2006). The environment in which nurses work, requires a communicative and collaborative approach to health care, between doctors, surgeons, specialists, and healthcare assistants or between nurses themselves. Constant patient turnover, admission, discharge, transfers, and increases in patient acuity (the level of severity of an illness) are only some of the factors that contribute to the dynamic nature of the nursing environment (Myny et al., 2012). Moreover, merely facilitating the day-to-day operations of the ward and staff is an additional aspect of a charge nurse manager's role; hence an efficient charge nurse manager is key to the success of the ward and to achieving optimal clinical outcomes for patients (Mejia et al., 2006).

Leader team-building skills. Leadership in nursing is the art of viewing nursing as a multidisciplinary team effort (Mejia et al., 2006). Effective leaders possess certain qualities. Team-building skills of a leader are particularly important in a team-based environment. A team is defined as “a group of people that are mutually dependent on one another to achieve a common goal” (Biech, 2008, p. 1)

A leader's ability to establish a cohesive team is important, as is the behaviour of the leader, which is a strong contributor to the development and maintenance of high-performance work teams. Biech (2008) suggests that leader behaviour impacts the success and satisfaction of teams. In line with this, charge nurse managers leadership ability has a major influence on employees' satisfaction (Sellgren, Ekvall, & Tomson, 2008). Heijden, Dam, and Hasselhorn (2009) found that nurses were more satisfied when their leader actively invested in creating a positive working climate. This is because high quality leaders are able to generate a favourable work climate by encouraging team-work (Stodeur, 2001).

On the other hand, team-building skills of the charge nurse manager have not been explicitly researched in nursing literature, however, research has acknowledged that charge nurse managers are critical to the functioning of effective nursing units. This is mirrored by Constable and Russell (1986), Jesse, Abouljoud, Hogan, and Eshelman (2015) and Stordeur et al. (2001) who similarly

found lower perceived social support from superiors to be related to burnout. In addition, Manojlovich and Laschinger (2007) found that if nursing leadership provided a foundation for components of supportive professional practice environments, nurses would experience lower levels of burnout. More specifically, lower perceived supervisor support was found to be a significant predictor of emotional exhaustion (Constable & Russell, 1986; Jesse et al., 2015; Stordeur et al., 2001) and depersonalisation (Jourdain & Chênevert, 2010).

Therefore, it is crucial for charge nurse managers to nurture a harmonious work environment for nurses, to reduce levels of burnout and increase job satisfaction (Manojlovich & Laschinger, 2007). Based on this analysis the following hypotheses were constructed:

Hypothesis 8: Nurses' perception of the team-building skills of the charge nurse manager will be positively related to job satisfaction.

Hypothesis 9: Nurses' perception of the team-building skills of the charge nurse manager will be negatively related to emotional exhaustion.

Hypothesis 10: Nurses' perception of the team-building skills of the charge nurse manager will be negatively related to reduced personal accomplishment.

Hypothesis 11: Nurses' perception of the team-building skills of the charge nurse manager will be negatively related to depersonalisation.

Staffing Organisation

Staff organisation in hospitals is a concerning issue. Nurses are the single largest group of healthcare professionals, and nursing care consumes a substantial proportion of hospital budgets (van Oostveen, Mathijssen, & Vermeulen, 2015). Therefore it is important that staff are organised efficiently and effectively. Staffing organisation comprises of the adequacy of ward staffing, rostering and staff organisation to cope with workload (Adams & Bond, 2003). While staff organisation is obviously important, sound guidance about how many staff are adequate, the range of skills they require and the best way to organise nurses continues to challenge healthcare service (Adams & Bond, 2003). Despite staff

organisation paving the foundation for the provision of effective care and ward functionality, there is a significant gap in an evidence base for effective staff utilization. This presents an extreme challenge for the development of new research initiatives, which lack sound evidence for setting parameters for ward nursing.

Ward staffing adequacy is an institutionalised constraint. Finding the balance between the number of staff available, skill mix, care organisation, rostering practice and the wards workload are all significant influences on how nurses perceive their job, in particular their job satisfaction (Dunn, Wilson, & Esterman, 2005). Additionally, Adams and Bond (2000) and Kalisch, Lee, and Rochman (2010) found that nurses perceived staff organisation to be one of the most important ward organisational features related to their job satisfaction. Conversely, when there is insufficient time available nurses are unable to carry out all their duties. High demands on nurses impacts on the quality of patient care, which leads to expressions of stress and burnout (Dunn et al., 2005). In line with Dunn et al. (2005), Nantsupawat, Nantsupawat, Kulnaviktikul, and McHugh (2015) found that poor staffing levels and each additional patient per nurse resulted in an eight percent increase of nurses reporting high burnout.

Skill mix is defined as “the proportion of different nursing grades, and levels of qualification, expertise and experience” (Ayre, Gerdtz, Parker, & Nelson, 2007). In the nursing sector poor working environments are often created through inadequacies in skill mix. Thus, heavier workloads and acute patients are a direct result of poor skill mix, despite early career nurses experience (Spence Laschinger & Fida, 2014). This is concerning, given that Laschinger et al. (2009) highlight that heavy workloads are stressful for even the most experienced members of staff, who are reporting high levels of burnout and absenteeism. Similarly, insufficient resources to provide quality care, paired with a heavy workload are also stressors for the new graduate nurse (Laschinger et al., 2009). Furthermore, Rafferty et al. (2007) reveal that nurses with the highest patient-to-nurse ratios had higher emotional exhaustion (71%) than hospitals with adequate nurse staffing ratios. For this reason, it is hypothesised that adequate staff organisation on the ward will be positively related to job satisfaction, while a poor staff organisation on the ward will be positively related to burnout.

Hypothesis 12: Nurses' perception of the staffing organisation on their ward will have a positive relationship with job satisfaction.

Hypothesis 13: Nurses' perception of the staffing organisation on their ward will be negatively related to emotional exhaustion.

Hypothesis 14: Nurses' perception of the staffing organisation on their ward will be negatively related to reduced personal accomplishment.

Hypothesis 15: Nurses' perception of the staffing organisation on their ward will be negatively related to depersonalisation.

Summary of Hypotheses

Hypothesis 1: Nurses' job satisfaction will be negatively related to emotional exhaustion.

Hypothesis 2: Nurses' job satisfaction will be negatively related to reduced personal accomplishment.

Hypothesis 3: Nurses' job satisfaction will be negatively related to depersonalisation.

Hypothesis 4: Nurses' perception of cohesion among nurses will be positively related to job satisfaction.

Hypothesis 5: Nurses' perception of cohesion among nurses will be negatively related to emotional exhaustion.

Hypothesis 6: Nurses' perception of cohesion among nurses will be negatively related to reduced personal accomplishment.

Hypothesis 7: Nurses' perception of cohesion among nurses will be negatively related to depersonalisation.

Hypothesis 8: Nurses' perception of the team-building skills of the charge nurse manager will be positively related to job satisfaction.

Hypothesis 9: Nurses' perception of the team-building skills of the charge nurse manager will be negatively related to emotional exhaustion.

Hypothesis 10: Nurses' perception of the team-building skills of the charge nurse manager will be negatively related to reduced personal accomplishment.

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Hypothesis 12: Nurses' perception of the staffing organisation on their ward will have a positive relationship with job satisfaction.

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Hypothesis 14: Nurses' perception of the staffing organisation on their ward will be negatively related to reduced personal accomplishment.

Hypothesis 15: Nurses' perception of the staffing organisation on their ward will be negatively related to depersonalisation.

Chapter 2: Method

This research was granted approval by the School of Psychology Research and Ethics Committee, University of Waikato. Additionally, the DHB Director of Quality and Patient Safety granted approval. The research involved a self-reported survey (Appendix A), which was sent to participants electronically via the survey software platform *Qualtrics*. Given the context of the research, written or signed consent from participants was not required, however, consent was implied based on participation and submission of the completed survey. Additionally, the research was confidential and for this reason, it was not possible for any of the participants to be identified.

Participants

This survey was distributed to the DHB and then forwarded to all nurses currently in a NETP or NESP programme, or who had completed NETP or NESP between the years 2013-2015. Overall, a total of 250 individuals were invited to participate. There was a response rate of 40.9 percent (102 participants) however, 11 participants failed to complete 50 percent or more of the entire survey or individual scale and for this reason, those invalid responses were removed from the final analysis for reasons of preserving the internal validity (McKnight, McKnight, Sidani, & Figueredo, 2007) reducing the total sample for analysis to 91 participants.

Of the final sample, 96 percent were female and 4 percent male. Participants' ages ranged from 21 to 50 years, with the vast majority (60%) identifying as being in the 20-24 age range. The mean age of the sample was 26.31 years ($SD=6.80$). The majority of participants were in NETP 84.6 percent ($n=77$) and while a small percentage of participants 6.6 percent ($n=6$) were in NESP. As for their tenure in the organisation 4.4 percent ($n=4$) began NETP or NESP programme in 2013, 41.8 percent ($n= 38$) began in 2014 and 51.6 percent ($n=47$) began in 2015.

Procedure

A face-to-face meeting with the Director of Midwifery and Nursing, Director of the Professional Development Unit, Project Leader of the Professional Development Unit, and the NETP Coordinator helped communicate the purpose

and scope of the research, finalise the survey content, the sample of the research, and distribute the survey.

Prior to distributing the survey, a pilot study was conducted on a small number of nurses from a separate regional DHB within New Zealand. Their feedback presented an opportunity to provide further clarity to some elements of the survey, while simultaneously ensuring that the flow and layout was designed appropriately to help the sample complete the survey with ease.

Participants' were invited to participate in this study via an email sent by the DHB. The email (see Appendix B) informed participants about the study and provided a URL link to the survey. Prior to beginning the survey, participants were provided the opportunity to review details about the study, including the aims of the research, who was conducting the research, and what was covered in the survey (i.e., organisational climate, job satisfaction, and burnout). Additionally, participants were informed that their identity would remain anonymous, with no identifying information being collected. Once the survey was submitted, participants' answers were imported to the IBM Statistical Package for the Social Science (SPSS 23) for data analysis.

Measures

The survey (Appendix A) investigated participants' perceptions of cohesion among nurses, team-building skills of the charge nurse manager, staff organisation, job satisfaction, and burnout. Importantly, scales used in the study were adopted from nursing and organisational psychology literature and, therefore, validated by previous studies. Small changes were made to some scales for purposes of suitability (i.e., whether or not items aligned with the New Zealand nursing context). Furthermore, the survey collated information on participant's age, gender, NETP and NESP start date, full-time equivalent and hours of overtime worked per week.

Overall, the survey consisted of a total of 72 items. Of the measures five were Likert or frequency scales, while the remaining required participants to provide written responses.

Relationships. Cohesion among nurses was measured via the Ward Organisational Features Scale (WOFS) to assess the participants' perception of the level of cohesion between their nursing colleagues. The scale has a single factor, and includes items such as "nurses on this ward show a lot of respect for

each other” and “there is a lot of unrest simmering under the surface”. The Cronbach’s alpha for cohesion among nurses was 0.79 in the present study, which is considered to be a good level of reliability (Field, 2013).

Items were responded to using a 7-point Likert scale ranging from 1 ‘strongly disagree’ through to 7 ‘strongly agree’ rather than the 4-point Likert scale developed in the original study. This was done to increase the variability and ensure consistency in scale length over the survey. Additionally, one change was made to the scale the question “staff on this ward can be really bitchy towards each other”. This was changed to, “staff on this ward can be really snarky towards each other”. This was done on the premise that it would reduce the risk of offensive terminology.

Leadership. The ward leadership subscale of the WOFS was used to measure perceptions of the team-building skills of the charge nurse manager. The 9-item measure evaluates nurses’ perceptions of how well their charge nurse manager has built the team. The scale has a single factor, and includes items such as “the charge nurse manager creates a good atmosphere on the ward” and “the charge nurse manager always gives praise when praise is due”. The Cronbach’s alpha for this measure was 0.95, which is considered an excellent level of reliability (Field, 2013). This measure was selected as it allowed participants to evaluate how effective, fair, and encouraging their charge nurse manager is.

This scale was assessed using a 7-point Likert scale ranging from 1 ‘strongly disagree’ through to 7 ‘strongly agree’ rather than the 4-point Likert scale developed in the original study. This was done to increase the variability and ensure consistency in scale length throughout the survey.

Staff organisation. The staff organisation subscale of the WOFS was used to measure the staffing and workload on the ward. The 9-item scale measures a single factor, and includes items such as “our nurse/patient allocation system works well for the skill mix we currently have on the ward” and “the skill mix is about right”. The Cronbach’s alpha for this measure was 0.87, which is considered to be a very good level of reliability (Field, 2013). This measure was selected as it allowed participants to assess how well they believe the nursing staff are organised on their ward.

Three changes were made to the wording of the items within this scale. The item “our nurse to patient allocation system works well for the nursing skill mix we currently have on the ward” was altered to omit the word ‘system’

Additionally, the item “our nurse to patient allocation system works well for the type of patients we have on the ward” was similarly altered to omit the word ‘system’, and thus changed to “our nurse to patient allocation works well for the type of patients we have on the ward”. These changes were made based on recommendations from the DHB who stipulated that they do not have a specific patient allocation ‘system’. Finally, the item “the ward off duty roster works well” was altered to “the ward roster works well”. Again, this change was made due to the DHB acknowledging that they do not have an off duty roster. All other items were unchanged.

This scale was assessed using a 7-point Likert scale ranging from 1 ‘strongly disagree’ through to 7 ‘strongly agree’ rather than the 4-point Likert scale developed in the original study. This scale, as previously noted, increases the variability as well as ensuring consistency in the scale length over the survey.

Job Satisfaction. The 10-item generic job satisfaction scale was used to measure participants’ job satisfaction (Macdonald & MacIntyre, 1997). This scale measures a single factor, and was selected as it assesses participants’ overall satisfaction with their job. The scale includes items such as “I get along with my supervisors” and “I feel good about my job”. The Cronbach’s alpha was 0.89, which is considered a very good level of reliability (Field, 2013). This measure was selected for its simplicity, providing a generic job satisfaction measure that provides an overall score of nurses’ satisfaction. The scale was measured on a 7 point Likert scale ranging from 1 ‘strongly disagree’ through to 7 ‘strongly agree’.

Burnout. The 22-item Maslach Burnout Inventory- Human Services Sector (MBI-HSS) was selected to measure burnout (Colff & Rothmann, 2014). This measure indicates how burnt-out participants are in their role as a nurse, specifically through measuring the three dimensions or factors of burnout. These factors include emotional exhaustion (8 items), reduced personal accomplishment (7 items) and depersonalisation (5 items). Items measuring emotional exhaustion include, for example, “I feel emotionally drained from my work”. Items measuring reduced personal accomplishment include, for example, “I can easily understand how my patients feel about things”. Finally, items measuring depersonalisation include, for example, “I don’t really care what happens to some patients”. The Cronbach’s alpha for each factor (emotional exhaustion, reduced personal accomplishment, and depersonalisation) was 0.89, 0.75, and 0.79, respectively. These values are considered as ranging from good to very good in

terms of reliability (Field, 2013). This measure was selected because it was specifically designed for participants who work in the public service sector, such as nurses. The scale was measured on a frequency scale ranging from 1 ‘never’ through to 7 ‘daily’.

Support. A single item question was designed to assess the types of support that early career nurses would like to see. The item asked, “what types of support would you like to see? Be specific.” This measure was included because as an open-ended item it allowed participants to personally suggest possible areas where additional support could be provided to aid in the development of their practice as a registered nurse.

General Experience. A single item question was designed to assess early career nurses general experience and perceptions. The item asked, “Are there any additional comments you would like to make? (i.e. expectations, experience, enjoyment/struggles/concerns etc.)”. This single item was open-ended to enhance the richness of responses.

Demographics. Demographic information, including age, gender and ethnicity were collected in the study as separate questions. The purpose of these measures was to confirm the characteristics of the participants in this study. Age and gender indicate the life stage participants were at, while ethnicity was included as a separate measure to this study to inform the Maori health unit at DHB of the levels of job satisfaction and burnout in Maori nurses.

Additional Questions. Additional questions were included to identify how far nurses were into their careers, whether they were in or had completed NETP or NESP, the hours they work/overtime worked per week and how manageable their workload was. The purpose of these questions was to confirm the additional characteristics of the sample that may or may not contribute to their perceptions of the organisational climate at the DHB, as well as their levels of satisfaction and burnout.

Data Analysis

Several data analyses were conducted on the 91 completed survey responses. The data obtained via *Qualtrics* was exported to the IBM Statistical Package for the Social Sciences (SPSS 23.) as well as Microsoft Office Excel 2013. Results from these analyses will be further explained in the results chapter (Chapter three).

Missing data. Missing data was dealt with using person mean substitution. This method substitutes an individual's missing values for the mean score for the item in which the missing data was found. Downey and King (1998) suggest that person mean substitution is an effective method for dealing with missing data in Likert scales. Downey and King (1998) go on to acknowledge that the replacement of missing data best represents the original data when the number of respondents with missing data and the number of missing items is 20 percent or less. In the current study, less than 15 percent of the total sample had missing data (14 participants), therefore replacing missing data was acceptable according to the above criteria.

Recoding variables. Three items in the study required recoding in order for accurate analysis to occur. Firstly, three items in the cohesion among nurses scale (Items 2, 4, and 7) needed to be recoded to fit with the structure of the Likert response scale as outlined in the hypotheses. These questions asked participants to indicate their level of agreeance on a 7-point Likert scale with a value of 1 indicating 'strongly disagree' and 7 'strongly agree'. These three items were recoded so that 'strongly disagree' was coded as 7 and 'strongly agree' was coded as 1. Secondly, a single item (Item 9) in the leader team-building skills scale needed recoding to fit with the structure of the Likert response scale as outlined in the hypotheses. This item asked participants to indicate their level of agreeance on a 7-point Likert scale with a value of 1 indicating 'strongly disagree' and 7 'strongly agree'. Item 9 was recoded so that 'strongly disagree' was coded as 7 and 'strongly agree' was coded as 1. Lastly, eight items in the burnout scale (Item 4, 7, 9, 12, 17, 18, 19, and 21) needed to be recoded to fit with the structure of the Likert response scale and outlined hypotheses. These items asked participants to indicate their level of agreeance on a 7-point frequency scale with a value of 1 indicating 'never' and 7 'daily'. These items were recoded so that 'never' was coded as 7 and 'daily' was coded as 1.

Exploratory Factor Analysis. Exploratory factor analysis (EFA) was conducted in the preliminary stages of data analysis to define the underlying factor structure of the measures used in the study. Principal Axis Factoring and oblique rotation (Direct Oblimin) methodologies were used. Yong and Pearce (2013) recommend an adequate sample size of 10 participants to one item when conducting factor analyses. In the current study this ratio was 18:1 (91

participants and 5 items) suggesting the participant to variable ratio is adequate for data analysis.

The criterion for factor retention is generally accepted as an eigenvalue greater than 1. Yong and Pearce (2013) recommend that factor loadings must be above or greater than 0.30 to identify significant relationships between variables, hence a factor loading of 0.32 was accepted as significant in the current study. The only measure that required factor rotation was burnout, which resulted in three factors. The results from this analysis suggest burnout should be measured as three separate variables. This will be explained in more depth in the results section (Chapter 3).

Descriptive Statistics. Descriptive statistics were conducted to determine the frequencies, means, skew, and kurtosis of the data. Skew and kurtosis are analysed to examine the normality of the data. A skew statistic larger than +/- 3.0 is regarded as extremely skewed while, a kurtosis statistic larger than +/- 8.0 is regarded as indicating an extreme level of kurtosis (Kline, 2011). Skew values between +/- 3.0 and kurtosis values between +/- 8.0 were considered as acceptable and so would not require transformation. Based on the levels of skew and kurtosis in the current study, transformation of variables to correct for the normality was not required.

Reliability Analysis. Reliability analyses, using Cronbach's alphas, were carried out in order to determine the internal consistency of the measures used in the present study. Kline (2011) identifies the reliability guidelines for acceptability, suggesting alpha coefficient (α) values of 0.9 are considered to be "excellent", 0.8 are considered as "very good" and values around 0.7 are said to be "adequate" (p.70). Measures that produced an alpha coefficient of 0.7 or higher were accepted as reliable. Based on the alpha coefficient values and considering the established criteria, all measures were deemed reliable and no items needed deleting.

Correlation Analysis. Pearson's product-moment correlations (bivariate) were conducted to determine whether the hypotheses in this study were supported or not. All variables were correlated and significant results were indicated by p-values falling below .05, as seen in Table 1 (Chapter 3, page 31).

Friedman (1982) developed recommendations of the sample size needed to provide a given degree of statistical power, statistical power being the likelihood that a study will detect an effect when there is an effect to be detected. In

accordance with Friedman (1982), a sample size of 91 gives the correlations of this study a power of .90 at the .10 level ($r = .30$), suggesting that there is a 70 percent chance of detecting a true relationship between the variables.

Regression Analysis. A post hoc regression analysis was carried out due to the statistically significant results of the correlation analysis to determine whether cohesion among nurses, team-building skills of the charge nurse manager and staff organisation predicted job satisfaction and burnout. Significant results were indicated by p-values falling below .05.

Thematic Analysis. Thematic analysis was conducted to identify, analyse, and report patterns within the data and more specifically to provide richer explanations to aid the survey content. Braun and Clarke (2006) developed recommendations for the interpretation of themes, suggesting that themes can be identified in terms of whether they capture something important in relation to the overall research question. Additionally, themes were also grouped based on the frequency and prevalence between participants' responses. In this study thematic analysis was applied to analyse data from two open-ended questions. The themes will be related to the question on types of support nurses would like to see and nurses' expectations, recommendations and enjoyment.

Data were imported into separate documents in Microsoft Excel in order to assess and group responses into themes. The coding of themes was based on the research questions and by thoroughly reading each individual comment and manually recording reoccurring patterns and comments to form a mind map. The mind map was utilised to identify the most salient themes, these themes are reported in the following chapter.

Chapter Three: Results

This chapter reviews the statistical analyses data and results. The chapter is separated into six sections; (1) exploratory factor analysis; (2) descriptive statistics; (3) reliability analysis; (4) correlations and hypothesis testing; (5) regression analysis; and (6) thematic analysis.

Exploratory Factor Analysis

An exploratory factor analysis was conducted on all the variables using Principal Axis Factoring (PAF) and Direct Oblimin rotation (oblique). Factor analysis was conducted on each of the five variables (relationships, ward leadership, human resources, job satisfaction and burnout). Factor analyses were run to determine the arrangement of factor loadings for each item. Factor loadings were considered significant at 0.32 (Yong & Pearce, 2013).

Cohesion among nurses. Principal Axis Factoring (PAF) was conducted on the 10-items of the cohesion among nurses scale with an Oblique ‘Direct Oblimin’ rotation. The Kaiser-Meyer-Olkin (KMO) value was 0.90, “marvellous” according to Hutcheson and Sofroniou (1999). Bartlett’s test of sphericity, $X^2(45) = 556$, $p < 0.001$, indicated patterned relationships between the items. An initial analysis was run to obtain the eigenvalues for each component. One component had an eigenvalue above Kaiser’s criterion of 1 and explained 58.23% of variance. The scree plot indicated an inflexion that justified retaining the one component (Appendix C, Figure 9). All factor loadings were above .32.

Leader team-building skills. Principal Axis Factoring (PAF) was conducted on the 9-items of team-building skills of the charge nurse manager with an Oblique ‘Direct Oblimin’ rotation. The Kaiser-Meyer-Olkin (KMO) value was 0.93, indicating ‘marvellous’ sampling adequacy according to Hutcheson and Sofroniou (1999). Bartlett’s test of sphericity, $X^2(36) = 701$, $p < 0.001$, indicated patterned relationships existed between the items. An initial analysis was run to obtain the eigenvalues for each component. One component had an eigenvalue above Kaiser’s criterion of 1 and explained 71.85% of variance. The scree plot indicated an inflexion that justified retaining the one component (Appendix C, Figure 10). One factor was retained for the final analysis and thus rotation was not required. All factor loading were above .32.

Staff organisation. Principal Axis Factoring (PAF) was conducted on the 5-items of staff organisation with an Oblique ‘Direct Oblimin’ rotation. The Kaiser-Meyer-Olkin (KMO) value was 0.79, suggesting a ‘middling’ sampling adequacy according to Hutcheson and Sofroniou (1999). Bartlett’s test of sphericity, $X^2(10) = 285, p < 0.001$, indicated there were patterned relationships between the items. An initial analysis was run to obtain the eigenvalues for each component. One component had an eigenvalue above Kaiser’s criterion of 1 and explained 67.82% of variance. The scree plot indicated an inflexion that justified retaining the one component (Appendix C, Figure 11). For this reason one factor was retained for the final analysis and thus rotation was not required. All factor loadings were above .32.

Job satisfaction. Principal Axis Factoring (PAF) was conducted on the 10-items of job satisfaction with an Oblique ‘Direct Oblimin’ rotation. The Kaiser-Meyer-Olkin (KMO) value was 0.88, ‘meritorious’ according to Hutcheson and Sofroniou (1999). Bartlett’s test of sphericity, $X^2(45) = 441, p < 0.001$, indicated there were patterned relationships between the items. An initial analysis was run to obtain the eigenvalues for each component of the data. Two components had an eigenvalue above Kaiser’s criterion of 1 and explained 62.84% of variance. The scree plot indicated an inflexion that justified retaining the one component (Appendix C, Figure 12). For this reason one factor was retained for the final analysis as the second factor contained one item that cross-loaded on both components and thus rotation was not required. All factor loadings were above .32.

Burnout. Principal Axis Factoring (PAF) was conducted on the 22-items of burnout with an Oblique ‘Direct Oblimin’ rotation. The Kaiser-Meyer-Olkin (KMO) was 0.83, ‘meritorious’ according to Hutcheson and Sofroniou (1999). Bartlett’s test of sphericity, $X^2(231) = 881, p > 0.001$, indicating there were patterned relationships between the items. An initial analysis was conducted to obtain the eigenvalues for each component of the data. Six components had an eigenvalue above Kaiser’s criterion of 1 and explained 67.92% of variance. The scree plot indicated an inflexion that justified retaining three components (Appendix C, Figure 13). The pattern matrix revealed one item (“I don’t really care what happens to some patients”) that cross-loaded on factor 2 and 3, for this reason it was omitted from further analysis (Table 1). Additionally, a second item (“I feel energetic”) loaded in correctly compared to the original study.

Table 1.

Pattern matrix for burnout.

	Factor		
	1	2	3
I feel used up at the end of the workday	.836		
I feel fatigued (tired) when I get up in the morning and have to face another day on the job	.797		
I feel emotionally drained from my work	.844		
Working with people all day is really a strain for me	.472		
I feel very energetic	.343		
I feel burned out from my work	.766		
Working with people directly puts too much stress on me	.378		
I feel frustrated by my job	.594		
I feel I'm working too hard on my job	.657		
I feel like I'm at the end of my rope	.561		
I can easily understand how my patients feel about things		.420	
I deal very effectively with the problems of my patients		.699	
I don't really care what happens to some patients		.484	-.354
I feel I'm positively influencing people's lives through my work		.751	
I can easily create a relaxed atmosphere with my patients		.642	
I feel exhilarated after working closely with my patients		.513	
I have accomplished many things worthwhile in this job		.747	
In my work, I deal with emotional problems very calmly		.363	
I feel I treat some patients as if they were impersonal objects			-.430
I worry that this job is hardening me emotionally			-.866
I've become more callous (hard) toward people since I took this job			-.853
I feel patients blame me for some of their problems			-.464

Extraction Method: Principal Axis Factoring

Rotation Method: Oblimin with Kaiser Normalization.^a

a. Rotation converged in 6 iterations

Due to this, this item was omitted from analysis reducing the scale to 20 items. A PAF was then carried out on the reduced scale. The three-factor solution was retained for the final analysis and tested as separate variables. Table 1 shows the

factor loadings after rotation. The items that group on the same components suggests that Factor one measures ‘Emotional Exhaustion’, Factor two measures ‘Reduced Personal Accomplishment’, and Factor three measures ‘Depersonalisation’. Based on these three factors, additional factor analyses were conducted for each subscale of burnout.

Descriptive Statistics

Descriptive statistics for all variables, including the mean, standard deviation, skew, and kurtosis are shown in Table 2.

The means across all variables ranged between 4.41 and 4.79, as illustrated in Table 2. On average participants were either ‘neutral’ or ‘somewhat agreed’ to having cohesive relationships between nurses on their ward (M=4.79, SD=. 92), the leadership of the charge nurse manager (M=4.97, SD=1.42), the staff organisation on the ward (M=4.41, SD=1.46, and their job satisfaction (M=4.94, SD= 1.10). On average, participants reported feeling emotionally exhausted ‘2-3 times a month’ (M=4.27, SD= 1.29), while reduced personal accomplishment (M=2.13, SD= .89) and depersonalisation (M=2.66, SD= 1.28) were reported as being less than once a month. On average participants felt as though their workload was ‘somewhat manageable’ to ‘manageable’ (M= 2.64, SD= 0.7) and had neutral feelings about how well supported they felt within the organisational climate at the DHB (M= 3.31, SD= 1.04).

Table 2.

Descriptive statistics.

	<i>N</i>	Mean	St. Dev	Skew.	Kurtosis
Relationships	91	4.79	0.92	-0.8	1.03
Leadership	91	4.97	1.42	-0.78	0.28
Staff Organisation	91	4.41	1.46	-0.28	-0.59
Job Satisfaction	91	4.94	1.10	-0.67	0.80
Emotional Exhaustion	91	4.27	1.29	-0.21	-0.61
Reduced PA	91	2.12	0.89	1.38	2.33
Depersonalisation	91	2.66	1.28	0.73	0.17
Workload Managability	89	2.64	0.7	-0.21	-0.03
Perception of Support	89	3.31	1.04	-0.61	-0.48

Note. Reduced PA = Reduced Personal Accomplishment

Reliability Analysis

A reliability analysis was conducted on all scales. Using Cronbach's alpha, each scale was examined for internal reliability. Reliability was determined based on the cut-off values or the acceptability criteria as outlined in Chapter 2. This required values of between .7 and .9 to indicate acceptable levels of internal reliability. All scales were acceptable. The reliabilities of each scale are displayed in Table 3.

Correlation Analysis

Correlation analyses were conducted on all the variables using Pearson product-moment analysis. This assessed the relationships between the variables and was used to determine whether there was any support for the hypotheses. Table 3 lists the Pearson product-moment correlation analyses for all the variables in this study. According to Friedman (1982) a sample size of 91 gives a power of .90 at the 0.10 level ($r = .30$), suggesting that there is a 70 percent chance of detecting a true relationship between variables.

Hypothesis 1 proposed that job satisfaction would be negatively related to emotional exhaustion. Nurses' job satisfaction was found to have a negative relationship with emotional exhaustion ($r = -.70, p < 0.01$), thus hypothesis 1 was supported. This illustrates as nurses' job satisfaction increases feelings of emotional exhaustion decrease and vice versa.

Hypothesis 2 proposed that job satisfaction would be negatively related to reduced personal accomplishment. Nurses' job satisfaction was found to have a negative relationship with reduced personal accomplishment ($r = -.28, p < 0.01$), thus hypothesis 2 was supported. This means that high job satisfaction is related to a decreased in nurses feelings of reduced personal accomplishment.

Hypothesis 3 proposed that job satisfaction would be negatively related to depersonalisation. Nurses' job satisfaction was found to have a negative relationship with depersonalisation ($r = -.40, p < 0.01$), thus hypothesis 3 was supported. This shows as nurses' job satisfaction increases their feelings of depersonalisation decreased, and vice versa.

Hypothesis 4 proposed that cohesion among nurses would be positively related to job satisfaction. Cohesion among nurses was found to have a positive relationship with job satisfaction ($r = .52, p > 0.01$), thus hypothesis 4 was

supported. This indicates the better nurses' relationships are with other nurses, the more satisfied they are in their careers.

Hypothesis 5 proposed that cohesion among nurses would be negatively related to emotional exhaustion. Cohesion among nurses were found to have a negative relationship with emotional exhaustion ($r = -.41, p < 0.01$), thus hypothesis 5 was supported. This means that when cohesion among nurses is low nurses become emotionally exhausted from their jobs more frequently.

Hypothesis 6 proposed that cohesion among nurses would be negatively related to reduced personal accomplishment. Cohesion among nurses was not found to have a relationship with reduced personal accomplishment ($r = -.01$), thus hypothesis 6 was not supported. This shows the extent to which nurses feel like they get along, has a non-significant relationship to their level of accomplishment in their employment.

Hypothesis 7 proposed that cohesion among nurses would be negatively related to depersonalisation. Cohesion among nurses was found to have a negative relationship with depersonalisation ($r = -.29, p < 0.01$), thus hypothesis 7 was supported. This illustrates when cohesion among nurses is low, nurses feel a greater sense of depersonalisation with regard to their job.

Hypothesis 8 proposed that ward leadership would be positively related to job satisfaction. Cohesion among nurses was found to have a positive relationship with job satisfaction ($r = .72, p < 0.01$), thus hypothesis 8 was supported. This means the greater the management of the charge nurse manager, the more satisfied nurses are in their careers.

Hypothesis 9 proposed that the team-building skills of the charge nurse manager would be negatively related to emotional exhaustion. Team-building skills of the charge nurse were found to have a negative relationship with emotional exhaustion ($r = -.48, p < 0.01$), thus hypothesis 9 was supported. This shows when charge nurse managers do not inspire team building amongst nurses, they become more emotionally exhausted in their job.

Hypothesis 10 proposed that the team-building skills of the charge nurse manager would be negatively related to reduced personal accomplishment. Team-building skills of the charge nurse manager was not found to have a relationship with reduced personal accomplishment ($r = -.08$), thus hypothesis 10 was not supported. This illustrates the extent to which charge nurse managers engage in

od moment correlations for all variables and Cronbach's alphas.

	Relationships	Ward Leadership	Staff Organisation	Job Satisfaction	Emotional Exhaustion	Personal Accomplishment	Dep
	.79						
	.62**	.95					
	.59**	.51**	.87				
	.52***	.72***	.59***	.89			
on	-.41***	-.48***	-.54***	-.70**	.89		
hmen	-.01	-.08	-.07	-.28**	.20	.75	
	-.29***	-.34***	-.37***	-.40**	.58**	.23*	

$p < .05$, ** $p < 0.01$, *** $p < 0.001$; reliability for each measure in bold on diagonal.

team building has a non-significant relationship on nurses reduced personal accomplishment in regard to their job.

Hypothesis 11 proposed that the team-building skills of the charge nurse manager would be negatively related to depersonalisation. Team-building skills of the charge nurse manager was found to have a negative relationship with depersonalisation ($r = -.34$, $p < 0.01$), thus hypothesis 11 was supported. This means when the team building skills of the charge nurse are poor, nurses feel a greater sense of depersonalisation with respect to their job.

Hypothesis 12 proposed that staff organisation would be positively related to job satisfaction. Staff organisation was found to have a positive relationship with job satisfaction ($r = .59$, $p < 0.01$), thus hypothesis 12 was supported. This indicates the better staff are organised with adequate resources, the more satisfied they are in their careers.

Hypothesis 13 proposed that staff organisation would be negatively related to emotional exhaustion. Staff organisation was found to have a negative relationship with emotional exhaustion ($r = -.54$, $p < 0.01$), thus hypothesis 13 was supported. This demonstrates when staff are organised poorly with inadequate resources, nurses feel more emotionally exhausted in their job.

Hypothesis 14 proposed that staff organisation would be negatively related to reduced personal accomplishment. Staff organisation was not found to have a relationship with reduced personal accomplishment ($r = -.07$), thus hypothesis 14 was not supported. This shows the extent to which staff are organised on the ward will have no relationship to nurses' perception of reduced personal accomplishment in their job.

Hypothesis 15 proposed that staff organisation would be negatively related to depersonalisation. Staff organisation was found to have a negative relationship with depersonalisation ($r = -.37$, $p < 0.01$), thus hypothesis 15 was supported. This illustrates when staff are organised poorly with inadequate resources, nurses feel a greater sense of depersonalisation in their job.

Regression Analysis

A simple linear regression analysis was conducted to determine whether particular variables analysed in the current study predicted other variables. Post-hoc regression was conducted after correlation analyses produced strong relationships and so there were no *a-priori* assumptions regarding the direction of the

associations between these variables in the regression analysis. Namely, it was analysed whether relationships, leadership, and staff organisation predicted job satisfaction emotional exhaustion, reduced personal accomplishment, and depersonalisation.

Job Satisfaction. Results of the regression analysis (Table 4) suggested that leader team-building skills and staff organisation predicted a significant proportion of the total variation in job satisfaction scores, ($F(3, 87) = 40.40, p < .000$), with an R^2 of .582. In other words, nurses' perception of their charge nurse managers' team-building skills and staff organisation predicted job satisfaction.

Table 4.

Linear model of predictors of job satisfaction.

	B	Std. Error	β	t	p
Constant	1.82	0.40	-	4.53	0.00
Nurse cohesion	-0.02	0.12	-0.02	-0.17	0.87
Leader team-building skills	0.44	0.07	0.57	6.33	0.00
Staff organisation	0.23	0.07	0.30	3.43	0.00

Note. $R^2 = .582; n = 91$

Emotional exhaustion. Results of a simple linear post-hoc regression suggest that the team-building skills of the charge nurse manager predicted a significant proportion of the total variation in emotional exhaustion scores (Table 5). A significant regression was found, ($F(3, 87) = 12.03, p < .000$), with an R^2 of .293.

Table 5.

Linear model of predictors of emotional exhaustion.

	B	Std. Error	β	t	p
Constant	7.09	0.62	-	11.52	0.00
Nurse cohesion	-0.08	0.18	-0.06	-0.46	0.65
Leader team-building skills	-0.29	0.11	-0.32	-2.67	0.00
Staff organisation	-0.23	0.10	-0.26	-2.25	0.03

Note. $R^2 = .293; n = 91$

Reduced personal accomplishment. Results of the simple linear post-hoc regression suggest that cohesion between nurses, team-building skills of the charge nurse manager and staff organisation do not predict reduced personal accomplishment (Table 6).

Table 6.

Linear model of predictors of personal accomplishment.

	B	Std. Error	β	<i>t</i>	<i>p</i>
Constant	2.19	.499	-	4.37	0.00
Nurse cohesion	0.10	0.14	0.10	0.70	0.49
Leader team-building skills	-0.07	0.09	-0.11	-0.76	0.45
Skill mix	-0.05	0.08	-0.08	-0.57	0.57

Note. $R^2 = .013$; $n = 91$

Depersonalisation. Results of the simple linear post-hoc regression suggest that cohesion between nurses, team-building skills of the charge nurse manager and staff organisation do not predict depersonalisation (Table 7).

Table 7.

Linear model of predictors of depersonalisation.

	B	Std. Error	β	<i>t</i>	<i>p</i>
Constant	4.63	0.66	-	7.01	0.00
Nurse cohesion	-0.01	0.19	-0.01	-0.04	0.97
Leader team-building skills	-0.18	0.12	-0.20	-1.59	0.12
Skill mix	-0.23	0.11	-0.27	-2.13	0.04

Note. $R^2 = .170$; $n = 91$

Thematic Analysis

Thematic analysis was used to identify, analyse, and report patterns within the qualitative data of this study. Themes were identified in terms of whether they captured something important in relation to the overall research question (Braun & Clarke, 2006).

Thematic analysis was carried out on two open ended questions, namely, “What types of support would you like to see” and “Are there any additional comments you would like to make (i.e. expectations, experience, enjoyment)”. The findings are included in the analysis due to their importance in describing nurses’ experiences in their first year of practice. The criteria for grouping participants’ responses into themes were based on the frequency and prevalence between participants’ responses. Based on these criteria four themes emerged. Of the 49 responses to these individual questions, these themes appeared between eight and 23 times.

Question one. Question one asked, “What types of support would you like to see? Be specific”. A common thread through the various narratives of the participants was their implicit and explicit reference to an increase in support to aid their professional practice. Their narratives demonstrate participants’ beliefs

that nurses would like to have more peer support specifically from supervisors, emotional support, and staffing support. These results are discussed further below.

Senior nursing and management support. An increase in senior nursing and management support was mentioned by 23 of 49 participants'. Upper management, acting/charge nurse managers, nurse educators and mentors were all identified as individual's nurses' would like to receive regular and ongoing support from.

“More senior registered nurse support”

“More support on the floor”

“More input from Nurse Educators”

The specific type of support most frequently mentioned was an increase in feedback, guidance, reflection of practice, meetings and an increase in interaction and input between these figures (specifically nurse educators) and early career nurses. These requests for support are echoed in the following sentiments:

“A mentor, 1 on 1 time, regular meetings with charge nurse re. progress, further education opportunities, and feedback”

“Ensure supervision is organised and in place. I had group supervision, which was extremely structured. I believe 1:1 supervision is important as well”

“Regular meetings with charge nurse manager to discuss progression through NEP year, perhaps once a month to gauge how I am getting on”

In general, the results indicate that an increase in support for early career nurses would be beneficial particularly in providing knowledge of their strengths and areas for improvement.

Emotional labour. Comments indicated that the emotional labour of nursing has considerable influence on nurses' perception of emotional support. Emotional support was referenced by eight of the 49 participants. Grief

counselling and an increase in general support facing death, tragic or new events were mentioned by four participants.

“Grief support - I have an element of palliative care in my work and when someone here dies, because it is community based and we know these patients so well, it’s much harder when they pass on, but yet there is no support to talk you through what happened and the grief process. District nurses have become hardened and show little emotion at times like this. That makes it harder to come to terms with the loss, especially as a new nurse”

Another participant suggested that an external support worker other than their charge nurse manager or preceptor would be useful as venting to, indicating that being honest with their superiors was inappropriate at times.

“A genuine rapport from some sort of support network, a person/people that we can go to too 'vent', talk straight to and be completely honest. Preceptors, charge nurse managers and the NETP coordinators are not appropriate for this”

Question Two. Question Two asked, “Are there any additional comments you would like to make? (i.e. expectations, experience, enjoyment, recommendations)”. A common thread through participants narratives was their implicit and explicit references to workload. Their narratives demonstrate that workload was a significant issue, it also brought about perception of the quality of team relationships. These results are further described below.

Workload. Numerous concerns and challenges were raised in regards to ward dynamics and academic commitments. High workload, short staffing, and NETP/NESP commitments were mentioned by 23 of the 36 participants. Nurses consistently reported challenging workloads, influenced by busy wards and the increasing acuity of patients, which created stress.

“At the moment work has calmed however in winter months it is more busy and stressful. I find the workload challenging as the patients are sicker and often do not finish work on time during these busy periods”

“Absolutely love the work I am privileged enough to do - caring for others is a real joy. However consistent short-staffing and borderline bullying can be highly detrimental for this organisation. We are in this job to care, and when staffing and high acuity issues impact on that ability, it leaves both juniors and seniors emotionally exhausted and scared for patient safety”

“Everyday is a struggle. I feel that the expectations are too high, especially when allocated a patient load that is too high”

Results also indicated that high expectations and high workloads beyond nurses' perceived capability created difficulties in trying to distribute time effectively while ensuring an appropriate level of care was given to patients.

I thrive on making positive differences with my patients. Difficulties lie in distributing my time effectively when 'challenging' time-consuming, ungrateful or threatening/rude patients take away and monopolise my time away from very unwell, high acuity patients. This makes me feel guilty that I am unable to 'care' or do my job to the best of my ability. Adds to the pressure of the job.

Comments indicate that nurses were pleased that NETP and NESP is a compulsory programme, believing that the programme is very important, particularly as it ensures safe practice. Participants remarked that the level of support during orientation was great. However, after this time preceptors fail to provide learning opportunities and teaching elements.

Support during orientation phase of NETP is very good, however once this period is over it is clear that preceptors don't really care anymore and give up on the teaching elements of their role and as NETP we are just expected to push through.

While the NETP and NESP programme is positive, participants critiqued its design. Four participants felt that it was extremely difficult to work fulltime and submit postgraduate work to an expected standard.

“There is a lot of pressure to complete NETP papers all while trying to learn the basics of being a nurse in general in our first year. It is hard to decrease hours of work to compensate for assignment workload.”

“Too much work with the postgraduate paper and the PDRP. It is hard enough to start a full time job, let alone having to do all the extra work in your spare time.”

This was having a major impact on participants’ personal life as they struggle to juggle working and studying full-time while making time for themselves.

“Personally I found it extremely difficult to work full time on an extremely busy ward and submit essays/assignments to the expected standard for the NESP Programme. I believe this had a detrimental effect on my personal well-being; however I am grateful of the opportunity and the resulting learning.”

A few recommendations were made to potentially alleviate the pressure of postgraduate study. Firstly, it was thought that more study time could be allocated to specific areas; in particular areas that are consistently busy. Secondly, nurses could be integrated and orientated to the ward well in advance of commencing academic material; therefore nurses would have time to become familiar with their surroundings and their role before the added pressure of postgraduate study is included.

“I feel the NETP experience can be quite different depending on the area you are in. I felt the academic expectations were more demanding in an area with a high workload/acuity. Programmes could be designed around the area you are in. I felt I didn't produce academic work to my highest standard due to being in a high acuity area. Maybe more study-time could be allocated to specific areas.”

Nursing team relationships. Participants' comments regarding the perception of their nursing team were split, 13 of 36 participants made reference to team relationships. Five participants strongly valued and enjoyed how well their team worked together and how well supported they felt within their ward. Two participants further acknowledged the DHB as an excellent learning facility and organisational climate to work within.

“I feel privileged to have worked alongside my colleagues during my NESP year. They were extremely supportive of me as a new graduate.”

“I love my job, great experience and support within the DHB.”

Conversely, 8 nurses had a less positive perception of their team environment. Being treated as a new graduate with aspects of distrust from senior nurses was identified as an issue for some, while one participant felt a greater appreciation on a personal level from management would be beneficial in building staff morale and reducing stressors which could increase burnout in nurses.

“It would be great to feel appreciated at a personal level from management at times. Simple gestures go a long way for building staff morale. I am concerned that these pressures lead to burnout, and although the importance of self-care is talked about, here is minimal organisational support flowing down to support this. Burnt out nurses make mistakes, and cost more.”

Two participants felt as though the Associate Clinical Nurse Manager (ACNM) engaged in a form of bullying. Additionally ACNM were perceived as unsupportive, which created a real struggle. On the whole one nurse felt as though they should be cared about more.

“I have really struggled this year. I feel burnt out and unsupported. I have found my ACNM very unapproachable and awkward. I feel she is a bully and is very unfair to many staff members including myself. She is good at singling staff members out and not dealing with things fairly. I have felt so unsupported that I have had days where I don't want to go to work due to

the stress I am faced with. I have tried to discuss this with her but I always get pushed to the side or she is always too busy. It has made me not want to be a nurse at times.”

Summary

This chapter has outlined the results of the current study. Overall, the majority of the hypotheses, excluding those relating to reduced personal accomplishment were supported (see Figure 5-8 for the theoretical models and results). The results will be discussed in the following chapter.

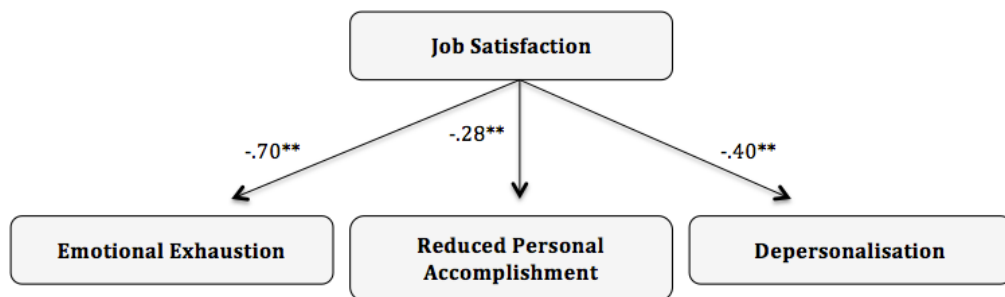


Figure 5. Framework of the hypothesised relationships for cohesion among nurses with correlations (r-value).

Note. * $p < .05$, ** $p < .01$, *** $p < .001$.

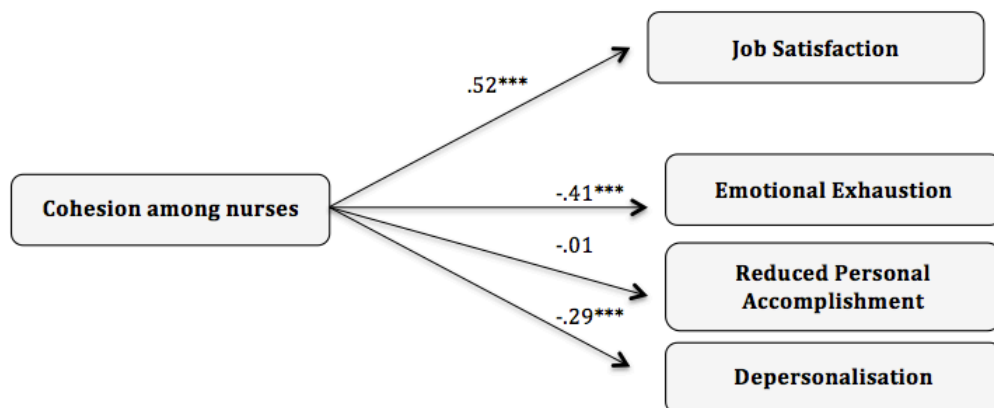


Figure 6. Framework of the hypothesised relationships for cohesion among nurses with correlations (r-value).

Note. * $p < .05$, ** $p < .01$, *** $p < .001$.

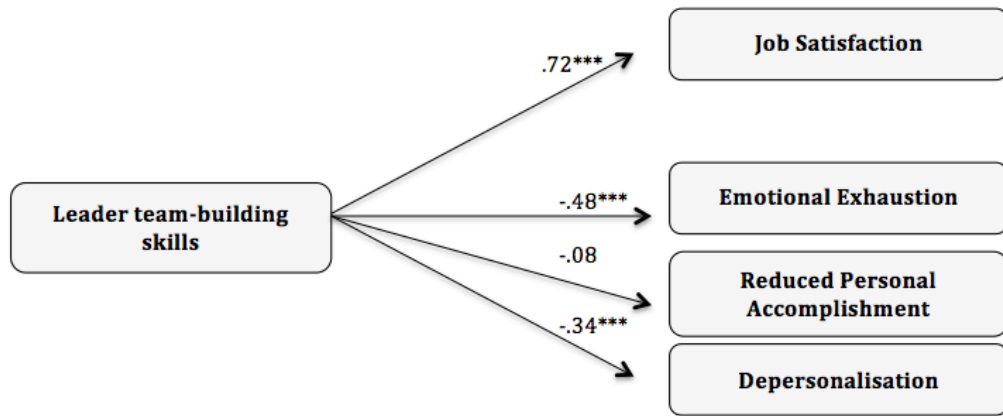


Figure 7. Framework of the hypothesised relationships for leader team-building skills with correlations (r-value).

Note. * $p < .05$, ** $p < .01$, *** $p < .001$.

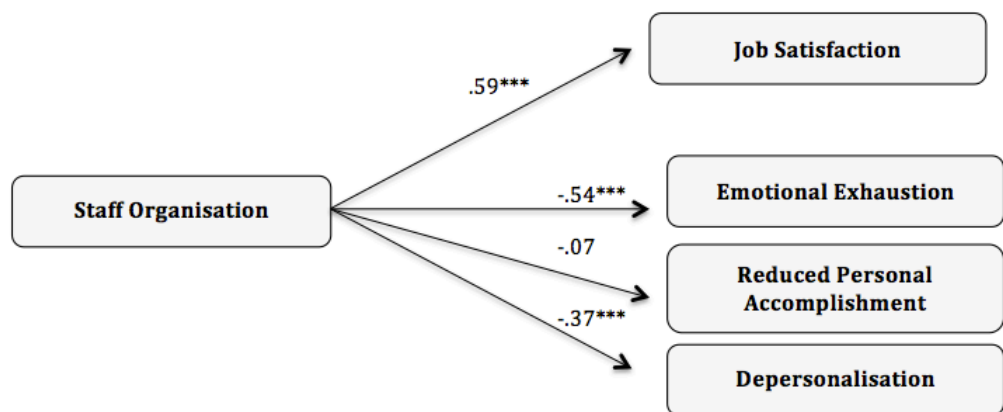


Figure 8. Framework of the hypothesised relationships for staff organisation with correlations (r-value).

Note. * $p < .05$, ** $p < .01$, *** $p < .001$.

Chapter Four: Discussion

The present study sought to gain a better understanding of the successes and potential difficulties nurses encounter during their early careers. The nursing literature consistently highlights that nurses are significantly prone to burnout due to the nature of their role and emotional labour associated to their job (Sawbridge & Hewison, 2013). Therefore, nursing is generally perceived as a stressful profession. Given the global nursing situation characterised by worldwide nursing shortages and high turnover, it is important that DHB's nationally and internationally begin to consider how to retain nurses.

My research primarily examined the relationship between nurses' perceptions of organisational climate while working for a DHB in New Zealand and how this relates to their levels of job satisfaction and burnout. Participants completed a survey covering three aspects of organisational climate (specifically cohesion among nurses, leader team-building skills, and staff organisation) in addition to job satisfaction, and burnout.

Identifying early career nurses' perceptions of the organisational climate at the regional DHB will provide information regarding the aspects that aid or hinder nurses' transition into their professional careers. Additionally, this research provides insight into the job satisfaction and burnout levels of early career nurses.

The results of the present study align with previous research. Early career nurses reported successful transitions into practice when the environment they entered is characterised by a climate of support, most importantly support from nursing peers, charge nurse manager, and staff organisation. This chapter explores the results from the current study, as follows: (1) supported and unsupported hypotheses; (2) thematic analysis; (3) practical implications; (4) strengths and limitations; (5) future research; and (6) conclusion.

Hypothesised Research Findings

The majority of the predicted hypotheses outlined in this study were supported. The following section discusses supported and unsupported hypotheses.

Job Satisfaction, Emotional Exhaustion, and Depersonalisation. It was hypothesised that job satisfaction would be negatively related to both emotional exhaustion and depersonalisation. These hypotheses were supported, and are in line with the work carried out by Healy and McKay (1999) who found that higher

levels of nursing stress were associated with lower levels job satisfaction. When nurses are satisfied in their jobs this acts as a buffer to feelings of emotional exhaustion and depersonalisation; a direct reflection of their positive perception of their job. Capitalising on early career nurses' job satisfaction and engaging in ways to maintain staff satisfaction can be concluded as a factor that would be important to prioritise.

Cohesive nursing relationships. Cohesion of ward nursing colleagues was found to significantly correlate with nurses' job satisfaction. This finding indicates that cohesive nursing relationships are an important organisational concern. The current research provides support for Morrison (2004), Sánchez and Yurrebaso (2009) and Li, Early, Mahrer, Klaristenfeld, and Gold (2014), who all suggested that cohesive work groups have greater job satisfaction. These findings are similar to Ulrich et al. (2010) who found group cohesion had a strong correlation (0.53, $p < 0.0001$) with work satisfaction among a large sample of new graduate nurses in the United States. Furthermore, when the nurse cohesion measure (as used in this study) was applied to nurses in England, similar results were found. More specifically, a high correlation was found between cohesion of the ward nursing team (0.51) and job satisfaction (Adams & Bond, 2000).

While previous research has already indicated that nursing relationships are an important source of support (Beehr, Jex, Stacy, & Murray, 2000) this study is unique because it is one of the first to empirically link nurses views of cohesion to job satisfaction in New Zealand. The current findings highlight the importance of quality nurse working relationships in enhancing job satisfaction among early career nurses in New Zealand as they transition from graduate nurse to proficient registered nurse.

Cohesion of ward nursing colleagues correlated with burnout. Other studies have explored this relationship in the past with a similar sample of newly licensed registered nurses' in the United States. However, rather than directly assessing the relationship between cohesive nursing relationships and burnout, as in my study, Li et al. (2014) assessed the relationship between group cohesion as a protective factor for stress. Group cohesion was found to effectively moderate the negative effects of stress exposure on negative nurse outcomes, specifically, burnout. Additionally, Janssen et al. (1999) found that emotional exhaustion was primarily predicted by a lack of social support from colleagues. While the theoretical underpinnings between social support from nursing colleagues and

cohesion from nursing colleagues are virtually the same, the findings in this study are unique in that they explicitly evaluated the relationship between cohesion of nursing staff and burnout.

Leader team-building skills. Most salient to early career nurses job satisfaction in this sample were the team-building skills of their charge nurse manager. Results from regression analysis indicate the team-building skills of the charge nurse manager were the best predictor of early career nurses' job satisfaction. This result is markedly different from Adams and Bond (2000) study where cohesion among nursing staff was reported as the most significant predictor of job satisfaction among a sample of nurses in England. However, Heijden et al. (2009) in line with this completed research found that nurses were more satisfied when their leader actively invested in creating a positive working climate. This is because high quality leaders are able to generate a favourable work climate by encouraging team-work (Stordeur et al., 2001).

Leader team-building skills were found to predict burnout in the sample of early career nurses in this study. This finding indicates that poor charge nurse manager team-building skills predicts an increase in rates of emotional exhaustion among early career nurses. Team-building skills of the charge nurse manager have not been explicitly researched in nursing literature, however, research has acknowledged that charge nurse managers are critical to the functioning of effective nursing units. This is mirrored in the research conducted by Constable and Russell (1986), Jesse et al. (2015) and Stordeur et al. (2001) who similarly found lower perceived social support from superiors to be related to burnout.

The findings of the current study add value to the nursing literature specifically as they highlight that charge nurse managers' team-building skills are imperative toward developing a harmonious organisational climate to foster job satisfaction and lower burnout for early career nurses. These findings significantly contribute to the breadth of knowledge in nursing literature, specifically in providing New Zealand DHBs with evidence to suggest that aspects of the organisational climate, in particular charge nurse team-building skills, could be utilised to help early career nurses seamlessly transition into clinical practice.

Staff organisation. A 0.59 correlation was found between staff organisation (which includes items about the relationship between staffing and workload) and job satisfaction among nurses in this study. Additionally, staff organisation was found to predict job satisfaction. This means that early career

nurses perception of staff organisation is an important variable contributing to the work climate and their job satisfaction. This finding is parallel to Adams and Bond (2000) study on UK nurses, where nurses considered that when sufficient numbers of skilled staff were rostered and organized appropriately, their job satisfaction was greater. This highlights that although the organisational culture, climate and systems differ around the world, nurses' needs and specifically the ward features that promote their job satisfaction are very similar. These similarities could benefit the New Zealand nursing literature because although it was not within the scope of the current study to develop recommendations for nursing transition programmes, it is plausible that international research conducted in this area may be applicable to the New Zealand nursing context. The similarities among findings could prove beneficial for New Zealand DHB's who are interested in how staff could be better organised to further increase nurses' job satisfaction.

Most salient to early career nurses' feelings of burnout (particularly emotional exhaustion) in this sample were their perception of staff organisation on their ward. When the organisation of staff was perceived as low, burnout in nurses increased and vice versa. Research clearly exploring the relationship between these two variables on early career nurses is non-existent. However, the findings of this study are in line with previous work that independently explored the association between staffing and workload (the two core components of staffing organisation as used in this study) with burnout. Nantsupawat et al. (2015) explored the relationship between nurse staffing levels and nurse outcomes in community hospitals in Thailand and found that each additional patient per nurse resulted in an eight percent increase of nurses reporting high emotional exhaustion. The differences between Thai community hospitals and the large public New Zealand DHB in this sample are significant, although the results are markedly similar. This emphasises that although there are discrepancies between international hospitals by and large the organisation of staff significantly contributes to nurses' emotional exhaustion.

Summary of hypothesised findings. To date, there has been a lack of synthesis in New Zealand nursing literature regarding the effects of early career nurses perceptions of their ward climate in relation to their job satisfaction and burnout. Cohesion between ward nursing staff, team-building skills of charge nurse managers and staff organisation were all identified as ward features that

relate to job satisfaction and burnout. These features are important and valuable to early career nurses for several reasons. Firstly, these factors are particularly important in aiding early career nurses transition into clinical practice and in bridging the relationship between academic and clinical work. Prior to nursing education shifting from hospital boards to tertiary education nurses' attrition was high. High turnover resulting from stress and insufficient support led to the transfer of nursing to tertiary education institutes. However, nurses still reporting a stressful transition into clinical practice, again, influenced by poor orientation programmes, which were unregulated at the time. Ten years later early career nurses are still report stressful transitions into clinical practice, despite modifications to nursing education and clinical transitions over the last 30 years.

Nursing transition programs are still a relatively new phenomenon both in New Zealand and around the world. Therefore, the establishment of best practice around the structure and delivery of nursing transition to practice programmes is still evolving and reliant on further research. More research in this area is key toward building nurse transition programmes that are built on evidence, which is necessary and integral to building models that promote the development of proficient, safe and competent clinical nurses. The findings in this study reinforce there is still improvement required to seamlessly merge the academic clinical partnership and ensure that early career nurses are entering environments that foster their professional development as a clinical nurse. The ward organisational features explored in this study were found to be important to both nurses' job satisfaction and to lowering burnout in early career nurses. Therefore, this requires priority to establish best practice around the structure and delivery of nursing transition to practice programmes.

NETP and NESP are still relatively new programmes in New Zealand. In terms of nurses bridging the gap and breaking the negative cycle it is essential that they be provided the opportunity to develop their competency in a climate characterised by cohesion, teamwork and adequate staffing organisation. Shifting away from the stigma that the academic to clinical transition is challenging is reliant on this. Additionally, the current nursing shortage in New Zealand, projected ageing workforce and population, and an environment of global competition further support the need for cohesive relationships, leader team-building and appropriate organisation of staff on hospital wards to increase nurses' job satisfaction and reduce burnout among early career nurses. Retaining

early career nurses in the profession and building their competency will support the development of a proficient workforce capable of dealing with the projected changes to New Zealand's health care sector.

Unsupported Findings

All correlations and regressions relating to reduced personal accomplishment were not significant (excluding job satisfaction). Literature on reduced personal accomplishment relative to cohesion among nurses, team-building skills of the charge nurse manager and staff organisation is limited and so providing a justification for these unsupported finding is challenging. This highlights a gap in the literature that warrants further research.

Thematic Analysis

A thematic analysis was carried out to identify themes from two open-ended questions. These questions intended to provide insight into the types of support early career nurses would like to see more of, in addition to any other general feelings or comments. The following section discusses these findings.

Question One: Nurse Support. Thematic analysis for the question “what types of support would you like to see?” revealed two areas where nurses identified requiring further support. They are (1) supervisory support and (2) emotional support. While five nurses commented that they “love” working for the DHB, the majority of respondents suggested two areas of improvement that would benefit the delivery of care to patients and aid their safe practice as a proficient registered nurse. Below is a discussion of these two areas.

Senior nurse and management support. Participants revealed a concern with supervisor support and the lack of support in some hospital wards. Parker et al. (2014) emphasise that senior support is particularly valuable to early career nurses. For example, Glaser, Zamanou, and Hacker (1987) report nurses would like critical constructive feedback on their performance. Moreover, Mid Central District Health Board (2008) suggested that when increased support is present, early career nurses have the capacity to flourish and grow into proficient and confident nurses. Support has also been linked to nurses' job satisfaction (Taylor, 2008). The results of the current study are consistent with the aforementioned literature. It is evident that nurses, on the whole, would like to receive more support from senior staff and management. Participants expressed a desire to have

more one-on-one time with mentors and regular meetings with their charge nurse manager. Only then will early career nurses be able to develop their practice and competency. Without this transparency between management and senior staff communication is lost, and early career nurses are left wandering where their strengths lie and what areas they could improve on.

Nursing has been characterised as a stressful profession (Feng & Tsai, 2012). Changes to the healthcare environment with an ageing population (Marriot, 2015), nursing shortages (Theisen & Sandau, 2013), and high burnout (Wang, Liu, & Wang, 2015) contribute to creating a hectic environment. Perhaps, for this reason, experienced nursing staff may not have the time and resources to assist early career nurses in their transition to clinical practice. However, the lack of feedback and support is a detriment to early career nurses development. The current situation at the DHB implies that development of support provided to nurses could be useful in terms of providing early career nurses with the resource support need to excel in their demanding roles. This is essential for the DHB, particularly if the organisation wants to develop a workforce that is capable and ready to embrace the rapid changes that are set to dramatically change the healthcare sector, specifically as “workplaces that are perceived as unsupportive and unhealthy will have difficulty recruiting and retaining new graduate nurses, who seek environments that value professional nursing practice and supportive, collegial work relationships” (Wing, Regan, & Spence Laschinger, 2015, p. 633).

Emotional labour. Nurses’ exposure to pain and death is high. However, what are surprising are reports of unsatisfactory support following death and tragic events. The prevalence of this theme suggests that, following death and tragic events, nurses are provided inadequate support from existing and senior staff. This is substandard for early career nurses who are yet to become assimilated to this aspect of nursing. In my opinion, regardless of how frequently nurses have been exposed to pain and death, grief support of any kind should be available. It appears that nurses require consistent support in their roles because of the stressful nature of their career, which is induced by the emotional labour of nursing (Sawbridge & Hewison, 2013). Nurses consistently have to hide their true emotions and display a front to families and patients regardless of their inner feelings at the given time. This can take a toll on nurses and so it is important that they are provided with organisational support to ameliorate the exposure to the harsh realities associated with their profession. A possible explanation for the

poor advocacy of grief and general support from peers may be that senior staff have already become ‘hardened’ by the realities of nursing, and so are oblivious to the fact that pain and dying may affect early career nurses in a different way. Alternatively, senior nurses perceived lack on sensitivity might be due to undertaking a busy workload. Early career nurses may feel that withholding their feelings and emotions at work is most appropriate, despite inward emotions. This highlights that emotional labour in nursing is important to acknowledge and prioritise, while also appreciating that nurses need sufficient emotional support to assist with adjusting to the emotional nature of their role.

Question two: Workload and nursing team relationships. Thematic analysis for the question “are there any additional comments you would like to make” revealed issues surrounding workload, staff relations, and the NETP programme as whole. Below is a discussion of each of these findings.

Workload. Participants identified short staffing and workload to be problematic at the DHB. A common theme was that nurses felt as though they need more human resource support to balance heavy workloads and compensate for low staffing levels. The assumption underpinning this issue is that the international world wide nursing shortage has led to global competition in hiring nurses (Lambert et al., 2004). Nursing shortages and high workloads have become quite typical of the nursing profession. An implication of this is the challenges that arise from increasingly heavy workloads with inadequate nursing resources. This situation is causing stress and exhaustion among the early career nurses in this sample, and when job stressors accumulate and exceed an individual’s ability to cope, burnout is likely

In addition to the worldwide nursing shortage, high workloads are impacting on the provision of care which nurses are able to give, this has major implications for patient safety. Hinno, Partanen, and Vehviläinen-Julkunen (2012) found that, when there is inadequate staffing, adverse patient outcomes increase. Patient safety is therefore compromised and nurses’ stress exacerbated, which nurses identified in the current study. Early career nurses in this study felt that patient care was compromised regularly because poor staffing levels increased their workload, which consecutively impacts time spent with patients. Furthermore, the number of highly acute patients has increased which demands complex skills and efficient nurses to assume patient care (Theisen & Sandau, 2013). Nurses in this study highlight that although patient acuity is increasing

nursing resources are decreasing and this places stress on early career nurses. The negative outcomes (i.e. turnover) associated with work stressors and burnout are damaging the available nursing resource, which may present challenges in building a capable and robust nursing workforce for the future.

Participants further identified workload as an issue associated to the NETP and NESP programme commitments. Participants appreciated that the programme was very important because it ensured safe practice in nursing. McKillop et al. (2015) similarly found that the clinical-academic partnership positively impacted on the clinical practice and transition experience of early career nurses. However the findings echoed in the sentiments from early career nurses in this study suggest that the clinical-academic partnership presents a major challenge to nurses' workload and work-life balance. Remarks were made about the design of NETP and NESP, specifically in relation to the difficulties associated with working full-time and studying full-time (a compulsory element in the NETP and NESP transition programmes). Nurses understood the need for a structured support programme to assist in their transition from student nurse to proficient nurse, but indicated that they would like to see improvements made to the programme to help alleviate some of the pressure of juggling full-time work and academic commitments. A key suggestion for consideration was orientating newly graduated nurses to the ward well in advance of commencing academic course work as well as tailoring the programme to suit the demands of different wards. The reasoning was that orientation prior to commencing academic work would be beneficial in reducing the demand and alleviating some of the pressure nurses felt early in their transition to clinical practice. This would aid in the development of a positive organisational climate at the DHB, as early career nurses are more likely to come back to work after their days off, ideally feeling refreshed, rather than feeling exhausted after trying to meet study commitments and course requirements. The comments echoed by the nurses' in this study imply that an emphasis on early career nurses' workload and academic commitments may be something to prioritise.

Nursing team relationships. Participants' perceptions of nursing relationships on their ward were mixed. Five participants spoke strongly about the abundance of support from their nursing colleagues and the DHB. When support for early career nurses is strong, their attitude toward their job and experience at the DHB is overwhelmingly positive. Phillips, Esterman, and Kenny (2015) report

that positive work relationships are associated with job satisfaction and positive organisational outcomes. In accordance to Phillips and colleagues (2015), similar results were found in this study, specifically, forging relationships with nurses on the ward seems to play a significant role in the value and enjoyment early career nurses in this study received from their job. Success in clinical practice is largely attributed to the support staff will provide to early career nurses on their arrival to the ward. These sentiments are in line with the quantitative findings of this research. Therefore, an emphasis on the building of relationships and social support should be prioritised.

Conversely, participants revealed concerns regarding negative experiences with charge nurse managers. The expression of dissatisfaction with and maltreatment from senior and supervisory staff is unacceptable and creates an environment of hostility. Stigma toward early career nurses combined with suspected bullying (as noted by two participants) could be influenced by early career nurses' limited nursing experience. When nurses enter the ward with little experience and take on lighter patient loads, compared with their senior peers, they may be stigmatised by the over-worked and understaffed senior nursing resource, to which an in-group out-group environment develops. This presents a different set of challenges as early career nurses could lose a significant amount of confidence from being bullied by staff members and feeling as though they are not trusted to do their job correctly by senior nurses. Attending work commitments may become a real struggle for a nurse who is feeling stigmatised and perceived as being incapable or unsafe in their practice. This situation would be detrimental to the DHB regarding the retention of early career nurses and succession planning. More must be understood about the severity of bullying, perceptions of distrust, and early career nurses general struggle in their first few years of practice. This implies that an emphasis on the staffing relationships between nurses needs to take priority.

Practical Implications

This research has several practical implications to consider. Early career nurses are seeking collegial work environments whereby their contributions to professional nurse practice are valued. A positive, supportive, and healthy climate will help to harness early career nurses development in clinical practice. This

suggests that organisational leadership and co-worker support is vital to nurses, while also an intangible asset to organisational success.

The prosperity of early career nurses is pertinent to the development of a sustainable workforce, which is required to deal with the projected changes and developments that our population will undergo in the foreseeable future. A sustainable workforce will have a greater impact on nurses' job satisfaction.

Short staffing is a global issue that not only impacts early career nurses but all entities of the health care organisation. Therefore it is important that senior staff, nurse educators, charge nurse manager, and management to work together to enhance the organisational climate at the DHB to make it a DHB that is appealing and attracts talent. Staff organisation, poor skill mix and short staffing have been shown to correlate negatively with burnout. This presents negative outcomes to the organisation as emotionally exhausted and depersonalised employees cause retention issues.

Moreover, an increase in staff organisation would lead to safer and high quality care. Specifically as adequacy of ward staffing, rostering and staff organisation to cope with workload will help to ensure that patient allocations match nurses skill level and allow for effective quality patient care.

The results of the present study highlight the need to enhance work relationships, provide support for charge nurse managers to build strong capable teams and make changes to the staffing organisation. This would help to create a positive workplace climate that epitomises and fosters support, cooperation and cohesion. When employees' needs are satisfied and aligned with the organisational climate, burnout will occur significantly less, which will aid in the retention of early career nurses at the DHB. As previously mentioned this is particularly important in the coming years as baby boomers near retirement, which will likely overload the healthcare system if provisions are not in place.

Strengths

The current study identifies organisational factors related to early career nurses' job satisfaction and burnout and thus provides an overall understanding of graduate nurses' transition in their early careers. This research adds to the argument that nurses require sufficient support. Specifically, nurses require an organisational climate that provides an environment for them to flourish, grow, and to develop their competency. This contributes as a primary strength of the

study particularly as it sheds light on aspects that promote job satisfaction as well as aspects that lead to burnout. This knowledge is particularly beneficial for producing a high functioning workforce capable of serving the increasingly acute and growing population.

The current study is beneficial and contributes to existing knowledge, particularly with regard to further understanding the needs of early career nurses. Knowledge in this area is advantageous because, although the introduction of NETP and NESP programmes was designed to aid student nurses' transition into nursing practice, a gap still remains in fully supporting early career nurses and making their transition as seamless as possible. A noted reduction in the well reported assumption that graduate nurses' transition into practice is challenging and difficult (Laschinger et al., 2009) is required. Given that early career nurses are still reporting stress, the findings of the current study are useful in targeting specific areas of hospital organisational climate, which contribute as stressors and hinder nurses' job satisfaction in their early careers.

Moreover, the findings from this study add value to the New Zealand nursing literature as a limited number of studies have looked at this sample of nurses and their perceptions of the environment they work within. Additionally, In order to gather momentum in enhancing early career nurses transition to practice the mixed method design with a small qualitative element was beneficial, particularly as participants were provided the opportunity to elaborate on the aspects of working at the DHB that they found most important.

Limitations

The present study faced limitations, which may be seen as influencing validity. Firstly, the difficulty in obtaining the sample created issues in data collection. The survey was designed to assess graduate nurses at the DHB, however, the survey was sent to a number of people who were not intended to be included in the original sample. This meant that the results obtained were from a larger background to what was anticipated (e.g., community nurses and mental health and addiction nurses who fall under the NESP programme). While this was a limitation of the study as the discrepancies between the acute hospital setting and community nursing are highly variable, this did provide a more expansive review of the current situation in the medical setting. However, these discrepancies do make assumptions and generalising data a challenge.

Additionally, the DHB includes locations based throughout the region and thus gave the study a wider spread than anticipated. This widespread data collection resulted in an inability to identify perceptions of organisational climate, job satisfaction, and burnout levels within individual hospitals. As an example, it cannot be identified whether the prevalence of understaffing is extreme at one particular hospital or whether it is a widespread issue across all hospitals within the DHB. Furthermore, whether the prevalence of the measured outcomes is more predominant at larger or smaller institutions is unable to be concluded.

Another potential limitation of the survey design was that it predominantly assessed graduate nurses' perceptions. Given responses are based on an individual's personal recollection, it is impossible to identify participant's actual behaviours and the accuracy of their recollection of events. In future, a follow up item following personal recollection items could be useful to assess specific instances of particular outcomes. As an example, a participant may believe their charge nurse manager was unsupportive, yet could only recall one incident. This may suggest then that it is likely they have taken something personally. However this was not an important item of interest to this research.

General demographic data were not collected from the sample. For this reason it cannot be determined if participants were experiencing problems solely with work or whether stressors in other areas of their life were affecting their responses and reactions to workplace issues. The spill over effect or impact of the work domain on the home domain (Lourel, Ford, Edey Gamassou, Guéguen, & Hartmann, 2009) may contribute to nurses perception of their work environment, particularly if personal life stressors spill over into the work domain, causing a blurred perception of individuals' work experiences. Additionally, personal information such as the types of external support available to the participant were not collected. A nurse receiving no outside support may find their early career years very challenging and difficult to cope with while, in contrast, an individual who is accustomed to receiving an abundance of support outside of work may have similar expectation within the work environment. While this additional information could have been beneficial, a decision was made not to include in the current study, because it was beyond the scope of this research.

Similarly, it would have been interesting to collect ward type information. This would identify the specific ward where the organisational climate may have been having a detrimental impact on nurses' job satisfaction and burnout.

Although this would have been interesting, it nonetheless would have compromised the confidentiality of this study and could have severely impacted the number of responses, as participants may have feared they could be identified.

Future Research

Future research could potentially explore other members of the organisation that are in contact with early career nurses. It would be interesting to gain insight on nurses' transitions from other individuals within the healthcare sector. Specifically, how they perceive early career nurses to be coping with the realities of nursing, as well as how satisfied and burned out, or supported they perceive this cohort to be. Gaining a full 360° view of graduate nurses' experience in clinical practice would allow researchers to compare and contrast the differences between how nurses believe they fare in the acute setting and how their colleagues and management perceive their transition. However, the scope of my research did not permit collection of these data.

Additionally, further research could utilise the findings of this study and support literature to identify change initiatives that could be introduced at the DHB to assist in further engaging early career nurses. Change initiatives that would be particularly beneficial would be those that are targeted at developing the organisational climate and aligning this with the DHBs long-term vision, of building a sustainable nursing workforce capable of serving the changing and dynamic needs of the future population. The current research could provide a backbone to implementing new nursing standards that better support early career nurses to flourish and grow into proficient and confident practitioners.

Conclusion

To conclude, this study investigated the relationship between early career nurses' perception of the organisational climate at the DHB and their job satisfaction and burnout. The research demonstrated aspects of organisational climate, specifically nursing relationships, ward leadership, and staff organisation, were significantly associated with early career nurses' job satisfaction. Conversely, a poor organisational climate related to reports of higher levels of burnout. Overall, the associations between organisational climate, job satisfaction, and burnout demonstrate that a positive organisational climate, conducive of support, plays a complex and important role in influencing positive organisational outcomes. The

results emphasise that in order to build a sustainable workforce, not only the DHB but also DHBs across New Zealand, need to engage in developing an organisational climate that is welcoming, supportive, and assisting of early career nurses. Lastly, the findings of my research demonstrate that enhancing work relationships, ward leadership and staff organisation to promote job satisfaction and reduce burnout may be something to prioritise at the DHB. The findings of my study highlight that further research is warranted, specifically to identify best practice and further aid early career nurses transition to proficient and confident registered nurses.

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Appendix A

What programme are in you/have completed?

- NESP
- NETP

Are you currently in the NETP/NESP programme?

- Yes
- No

Have you completed NETP/NESP in the last 2 years?

- Yes
- No

Do you work in?

- Hospital Setting
- Community Setting

Section A: Professional Relationships- Cohesion amongst nurses

Firstly I would like you to think about your relationship with the nurses on the ward you are currently working on, and indicate whether you agree or disagree with the following statements.

- 1= Strongly Disagree
- 2= Disagree
- 3= Moderately Disagree
- 4= Neither Agree nor Disagree
- 5= Moderately Agree
- 6= Agree
- 7= Strongly Agree

- A1. Nurses on this ward show a lot of respect for each other
- A2. Staff can be really snarky towards each other
- A3. Nurses are always willing to help each other get through their work on this ward
- A4. There is a lot of unrest simmering under the surface
- A5. Nursing staff on this ward work well together
- A6. Nurses on this ward pull their weight
- A7. I feel nurses do not communicate with each other as well as they should
- A8. Nurses here are cliquey
- A9. Important information is always passed on
- A10. We share similar ideas about priorities on this ward

Section B: Ward Leadership

I would now like you to think about the following question in respect to your

charge nurse manager. Please indicate to what level you agree with the following statements

- 1= Strongly Disagree
- 2= Disagree
- 3= Moderately Disagree
- 4= Neither Agree nor Disagree
- 5= Moderately Agree
- 6= Agree
- 7= Strongly Agree

- B1. Creates a good atmosphere on the ward
- B2. Is always fair in dealings with staff
- B3. Always gives praise where praise is due
- B4. Deals sensitively with interpersonal frictions
- B5. Inspires commitment from staff
- B6. Is good at nipping problems in the bud
- B7. Likes to see staff doing well in their careers
- B8. Knows the strengths and weaknesses of ward staff
- B9. Does not inspire confidence

Section C: Staff Organisation

Thinking about the staffing adequacy and skill mix on the ward please indicate to what level you agree with the following statements

- 1= Strongly Disagree
- 2= Disagree
- 3= Moderately Disagree
- 4= Neither Agree nor Disagree
- 5= Moderately Agree
- 6= Agree
- 7= Strongly Agree

- C1. Our nurse/patient allocation system works well for the nursing skill mix we currently have on the ward
- C2. Our nurse/patient allocation system works well for the type of patients we have on this ward
- C3. The skill mix on this ward is about right
- C4. There are enough permanent nurses on this ward to give a good standard of care to all our patients
- C5. The ward off duty roster works well

Staffing Adequacy

- C6. In the last month how often has short staffing affected your ability to meet your patient/client needs?

- 1=never
- 2=monthly

3= weekly

4= several times a week

5= daily.

Section D: Job Satisfaction

Now I would like to ask you how satisfied you are with various aspects of your present job. Please select the number that best indicates how you feel about each of following aspects of your work.

1= Strongly Disagree

2= Disagree

3= Don't know

4= Agree

5= Strongly Agree

D1. I receive recognition for a job well done

D2. I feel close to the people at work

D3. I feel good about working at this company

D4. I feel secure about my job

D5. I believe management is concerned about me

D6. On the whole, I believe work is good for my physical health

D7. My wages are good

D8. All my talents and skills are used at work

D9. I get along with my supervisors

D10. I feel good about my job

Section E: Burnout

I would now like you to circle the number which best indicates how often each of following aspects of your work have affected your work.

0 = Never

1 = A few times a year

2 = Monthly

3 = A few times a month

4 = Every week

5 = A few times a week

6 = Everyday

E1. I feel emotionally drained from my work

E2. I feel used up at the end of the workday

E3. I feel fatigued (tired) when I get up in the morning and have to face another day on the job

E4. I can easily understand how my recipients feel about things

E5. I feel I treat some recipients as if they were impersonal objects

E6. Working with people all day is really a strain for me

- E7. I deal very effectively with the problems of my recipients
- E8. I feel burned out from my work
- E9. I feel I'm positively influencing other people's lives through my work
- E10. I've become more callous (hard) toward people since I took this job
- E11. I worry that this job is hardening me emotionally
- E12. I feel very energetic
- E13. I feel frustrated by my job
- E14. I feel I'm working too hard on my job
- E15. I don't really care what happens to some recipients
- E16. Working with people directly puts too much stress on me
- E17. I can easily create a relaxed atmosphere with my recipients
- E18. I feel exhilarated after working closely with my recipients
- E19. I have accomplished many worthwhile things in this job
- E20. I feel like I'm at the end of my rope
- E21. In my work, I deal with emotional problems very calmly
- E22. I feel recipients blame me for some of their problems

Demographics

Gender

- Male
- Female

Age

Which ethnic group do you belong to?

- New Zealand European
- Maori
- Samoan
- Cook Island Maori
- Tongan
- Niuean
- Chinese
- Indian
- Other (Please state)

Additional Information

What year did you begin NETP/NESP?

- 2013
- 2014
- 2015

In which intake did you begin NETP/NESP?

- February
- September

What is your registration level?

- RN1

- RN2
- RN3

What is your current work status?

- Fixed term contract
- Permanent

What is your Full-time Equivalent (FTE)?

- 0.6
- 0.8
- 0.9
- 1.0

On average, how many hour of overtime do you work per week?

Generally how manageable is your workload

- 1= Not at all manageable
- 2= Somewhat manageable
- 3= Manageable
- 4= Very Manageable

Overall how well supported do you feel within the organisational climate at the DHB?

- 1= Not at all supported
- 2= Somewhat unsupported
- 3= Neutral
- 4= Supported
- 5= Very well supported

What types of support would you like to see? (Be specific)

Are there any additional comments you would like to make? (i.e. expectations, experience, enjoyment/struggles concerns)

Closing Statement:

Thankyou for participating in my research project. Should you wish to receive a summary of the results please email me with the subject line 'Research Results Summary' to katie.were@hotmail.co.nz. It is expected that the summary will be sent out in March 2016, following the completion of the research project.

While the questionnaire is not designed to cause any discomfort, should you at any stage feel discomfort I encourage you to seek the help of a relevant professional such as the Employee Assistance Program on 0800 327 669.

Appendix B

Hi there,

I am a Psychology graduate student at The University of Waikato. For my thesis research, I am examining newly registered nurses' experiences in clinical practice (NETP/NESP) to better understand how the organisational climate at the DHB relates to your success in clinical practice.

This has been approved by and is fully supported by DHB Director of Nursing & Midwifery and Professional Development Unit Clinical Director

I have created an online questionnaire designed to assess these different variables and would like to invite you to complete this questionnaire.

Data from this questionnaire will be very beneficial in highlighting areas of success and potential areas for development.

To go to the questionnaire please click the following link:

https://jfe.qualtrics.com/form/SV_eFHPjZYOOVCN9ad

The questionnaire is completely voluntary, and you have the right to refuse to answer any particular question(s). Additionally, the questionnaire is designed to be completely confidential, so does not require you to provide your name or any other details which may make you identifiable. The questionnaire should take 10-15 minutes to complete.

(Please note that the questionnaire has been set up to be mobile friendly, however, it may not display correctly on all mobile devices. If you have any issues using your mobile device you may need to try using a computer)

If you have any questions regarding this research or the questionnaire please feel free to contact my supervisors or myself.

Kind Regards,

Katie Were katie.were@hotmail.co.nz

Supervisors:

Prof. Michael O'Driscoll
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Dr Maree Roche
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Appendix C

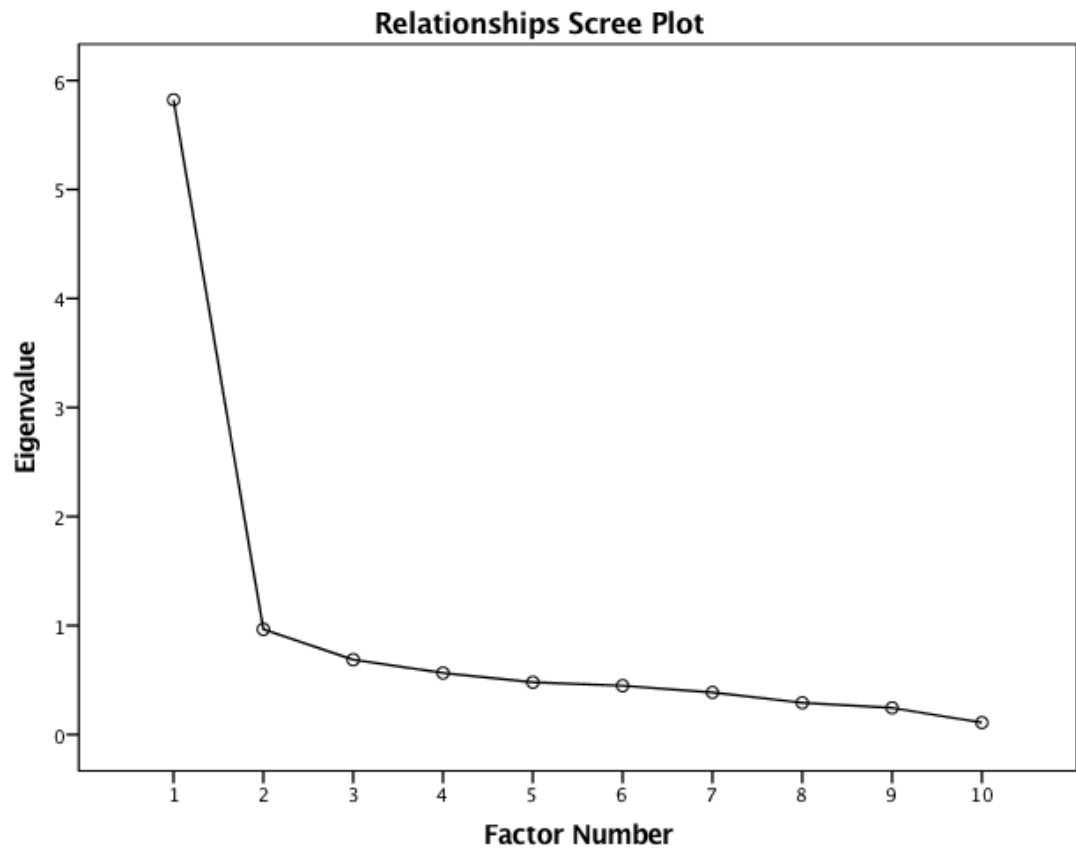


Figure 9: Scree plot for cohesion among nurses.

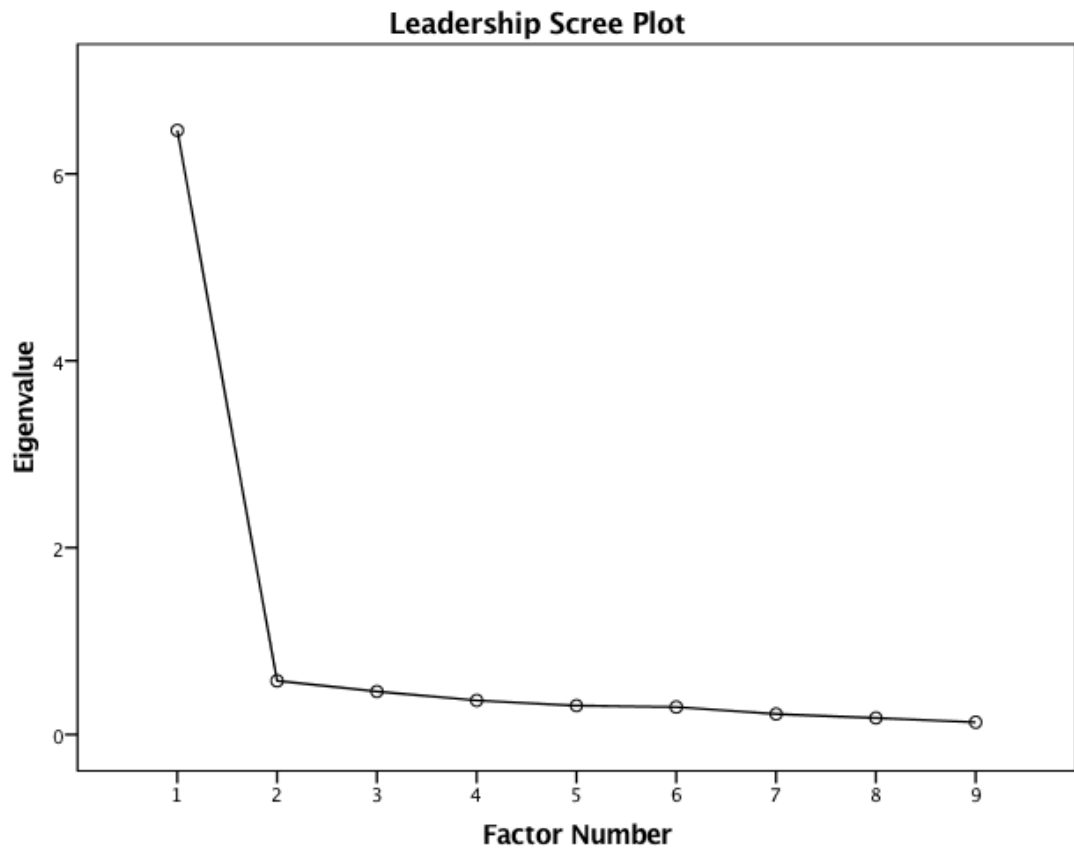


Figure 10: Scree plot for leader team-building skills.

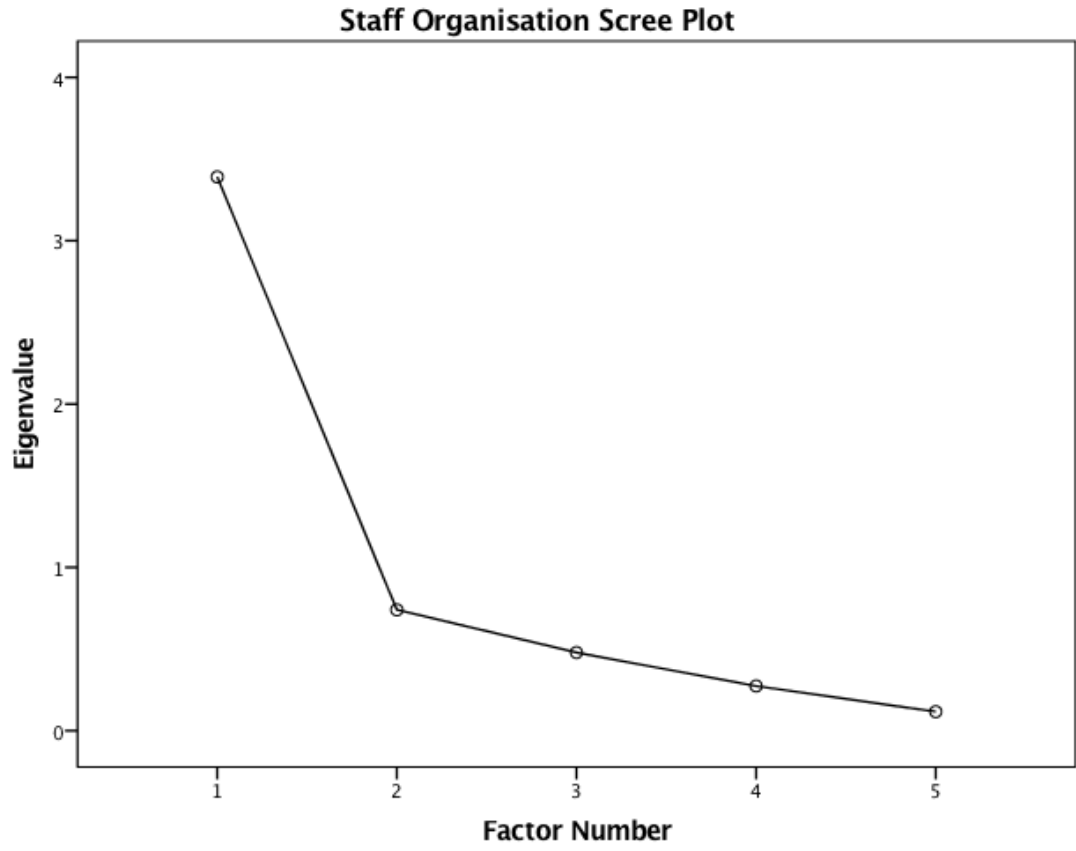


Figure 11: Scree plot for staff organisation.

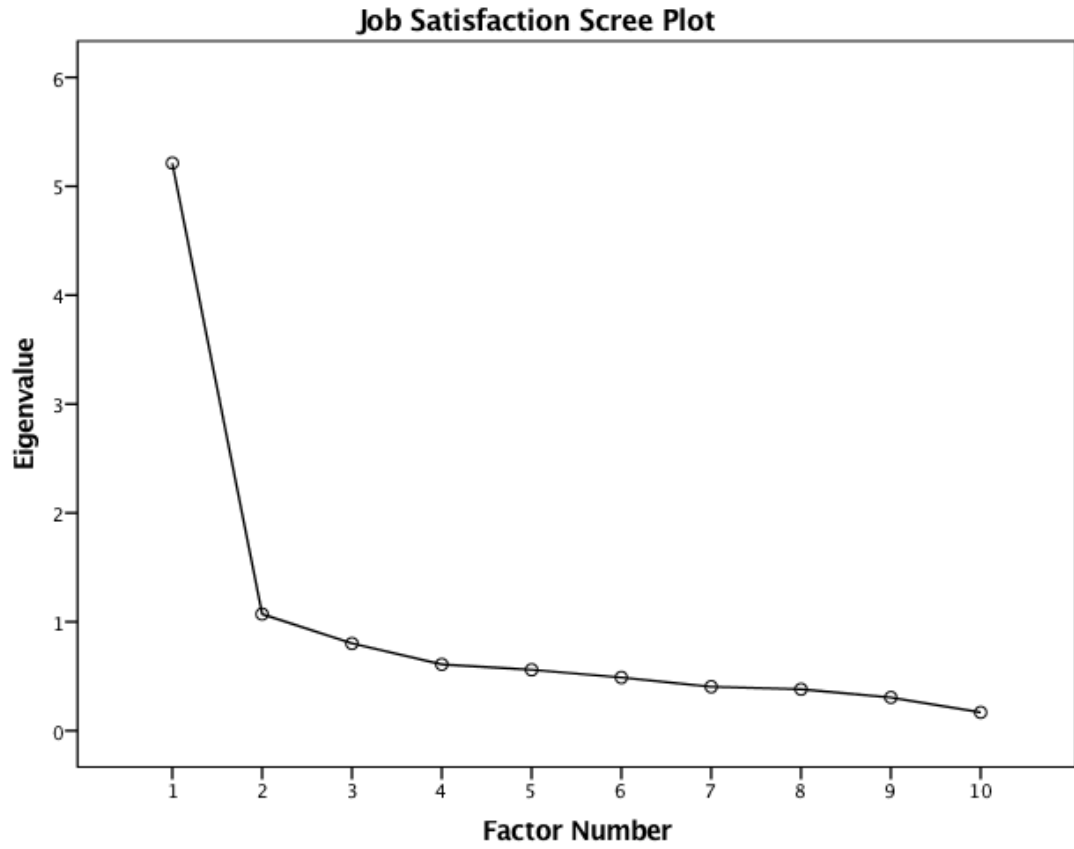


Figure 12: Scree plot for job satisfaction.

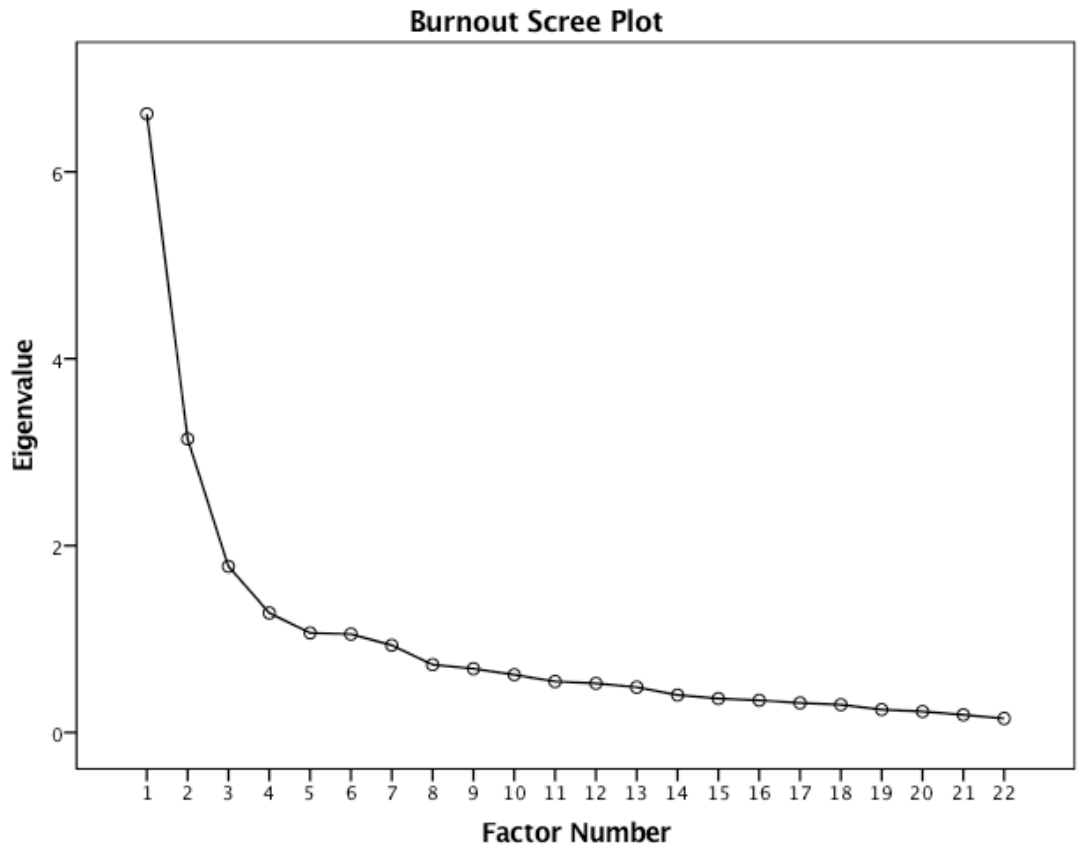


Figure 13: Scree plot for burnout.