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ABSTRACT

Aims: To explore the underlying organisational issues affecting a nurses' decision to leave and 2) to develop a contemporary practice environment measure based on the experiences of nurses working lives.

Background: Turnover had reached unacceptable level in our organization but underlying reasons for leaving were unknown.

Method: In-depth interviews were conducted with 13 nurses who had resigned.

Transcripts were analysed using the constant comparative method. Information from the interviews informed the development a new practice environment tool, which has undergone initial testing using the content validity index and Chronbach's alpha.

Results: Two domains ('work life' and 'personal life/professional development') and five themes ('feeling safe', 'feeling valued', 'getting things done', 'professional development' and 'being flexible') emerged from the interviews. Content validity score for the new instrument was .79 and the Chronbach's alpha .93

Conclusion: The new practice environment tool has shown useful initial reliability and validity but requires wider testing in other settings.

Implications for nursing management: The reality and experiences of nurses working lives can be identified through exit interviews conducted by an independent person.

Information from such interviews is useful in identifying an organization's strength and weaknesses and to develop initiatives to support retention.

Keywords: Personnel turnover, Qualitative research, Questionnaires, Practice environment

INTRODUCTION

Retention of experienced staff is one of the most pressing issues in nursing today. Factors such as an aging workforce (O'Brien-Pallas et al. 2004), lack of autonomy, burnout, stress (Zangaro and Soeken 2007), unsafe nurse-to-patient ratios (Weissman et al. 2007), and the availability of less demanding career choices contribute to the problem. In our own organisation, turnover had reached unacceptable levels with 30 nurses a month (12% per annum) making a decision to leave the organization. Because of this, the imperative to attract new staff and retain experienced staff became the focus of our strategic planning. Early in the development phases, it became apparent we had no information about the reasons why nurses were leaving the organisation. Exit interviews were rare and, where they were conducted, there was no systematic attempt to collate data, disseminate information across the organisation, or act on responses from departing employees. As a first step, a decision was made to begin formal exit interviews to gain an insight into issues affecting a decision to leave the hospital. We also believed that interview data would provide baseline measures against which the success of future interventions could be assessed.

LITERATURE

Exit interviews are conducted in many organisations to identify reasons for employee attrition (Leahey and Henderson 1991) and have been part of organisational culture over half a century (Melcher 1955, Moran 1956). The process may be formal or informal and interviews are generally conducted at a time between notice of resignation and the employees' last working day. Various formats are utilised such as face-to face interviews with or without a guide; written questionnaires, completed either before or after leaving the organisation; or a combination of both approaches.

Well accepted reasons for conducting such interviews include: attempting to change the persons mind about leaving; using the interview as part of an 'image management' exercise (Lefkowitz 1969); documenting specific reasons for the resignation so that nurse managers can use the information to improve the service (Neidermeyer and Neidermeyer 1987, Leahey and Henderson 1991); and, more recently to 'trend' reasons for turnover (Erickson 1996).

Although exit interviews are widely used, validity of the approach has been questioned (Lefkowitz 1969, Jurkiewicz et al. 2001). There are often inconsistencies in the way the interview is managed, and it may be conducted by people who are unskilled in interview techniques. The exercise is also costly, and information may not be analysed and fed back in a timely manner, or may be disregarded completely. More importantly, the information elicited may not be accurate. Particular problems may exist if the interview is conducted by the person's line manager (Lefkowitz, 1969); departing employees may wish to leave a good impression to improve chances of a positive future reference or re-employment (Yourman 1965, Hinrichs 1975); they may feel intimidated about discussing the true reason for leaving, especially if conflict is involved and the interview is conducted well before the person's departure date; or they may feel that disclosing their real reason is a waste of time, based on previous experience with the service (Yourman 1965).

To overcome some of these problems, the value of a post-employment questionnaire has been tested (Yourman 1965, Lefkowitz 1969, Hinrichs 1975). In one study, reasons for termination, recorded from an unstructured exit interview, were compared with responses to a questionnaire posted several months after termination. Results

showed that departing employees were much more likely to disclose their reason for leaving using the questionnaire format (Lefkowitz 1969). Moreover, the author's found that the exit interview was only accurate where an unavoidable termination, such as moving elsewhere etc., was the reason for leaving; in other words factors that were "extra-organisational in origin" (p454). **However, post-employment questionnaires do have their problems. For example, in a recent study that attempted to 'map' the reasons that full-time, qualified nurses voluntarily left the hospital in the previous year, 23% of respondents were unable to be classified. (Morrell 2008).**

In summary, much of the **original research** in the area is very dated and may not reflect contemporary health care contexts. Nurses too have changed in this time, and might be more likely to be honest about their reasons for leaving during an exit interview.

AIMS

- To document the primary reasons that nurses offer as their reason for leaving the organisation or work unit
- To explore the underlying organisational issues affecting their decision
- To develop a new practice environment instrument, based on this information for use in health care settings.

METHODS

Design, participants and setting

The study was conducted in two parts and will be described separately. First was a qualitative study using in-depth, face-to-face interviews with all nurses who either

resigned or moved to another division within the hospital. Qualitative methodology was selected in order to access information about the reality and experiences of nurses' working lives that could not be fully explored through survey methods. The Hospital is a 942 bed general, tertiary referral teaching hospital with a number of specialities including medicine, surgery, orthopaedics, psychiatry, oncology, trauma, obstetrics, gynaecology and neonatal intensive care services. Interviews took place over six consecutive months between March 2006 and August 2007. Ethics approval for the study was granted by the Human Ethics and Research Committee, Royal Brisbane and Women's Hospital.

Procedure

Initial consultation occurred with executive nursing staff, who agreed to support the study. **The most useful methods for recruiting participants for research studies remains unclear (Mapstone et al.2007) but, to encourage nurses to participate,** we used a promotional phase, where posters were displayed in key areas of the hospital and opportunities were taken to speak directly to nurses through ward, departmental and organisational meetings. After this, Nurse Unit managers were asked to forward the names of all resigning nurses to the study investigators. Resigning nurses were then contacted to request an interview. Those who agreed were asked to identify a suitable time and place and assured that the interviews would be completely confidential. An interview guide for the in-depth interviews was developed to gather information on the workplace environment, opportunities for professional development, perceptions of nursing management and reasons for leaving the work unit or the organization. Nurses were encouraged to discuss any issue at all which they thought affected the working lives of nurses in their work unit. We carefully

considered the potential influence of the interviewers' position in the organisation on interview responses. One of us was a line manager **in one of the hospital's units** before involvement with the project. To encourage open disclosure, all interviews with nurses from **that unit** were conducted by an investigator who had no line management responsibilities in the area. It was evident from reading the transcripts and the richness of the data that the participants felt comfortable expressing their opinions to the interviewers. Interviews commenced with an invitation to the participant to describe his or her experience of the workplace. The guide was used where necessary to ensure that all topics were covered. Interviews lasted for ½ to 1 hour **until all topics on the interview guide had been covered to the satisfaction of the interviewer and the interviewee had discussed any other issues not covered in the guide.**

Discussions were often wide ranging, highlighting different levels and types of work place roles and responsibilities. Because of this, some questions varied from interview to interview, and lines of questioning were also modified in response to the insights gained from earlier interviews. When a point was reached where no new information was emerging, we used additional, purposeful sampling to target leavers from non-represented work areas to maximize the variability of respondents' experiences. All interviews were audio-taped and transcribed verbatim until the point of saturation was reached. The Ethnograph v5.0 software for analysis of qualitative data was used in data analysis.

Analysis

We used inductive analysis, building theory up from the data rather than using a specific hypothesis or framework. Data collection and analysis was concurrent. After

each interview, transcripts were closely read a number of times. Two of us examined the text line by line collaboratively, to assign codes to the text and to agree on meanings. Subsequently, new texts were compared with previously coded transcripts; new codes were assigned if both of us agreed that a new concept was mentioned in a transcript. Disputes about coding differences were settled by discussion. Codes were later combined and synthesized into broader, recurrent categories, themes and domains. Emerging ideas and themes were compared and explored within and across interviews according to the constant comparative method of analysis (Glaser and Strauss 1967, Strauss and Corbin 1998). Validation involved confirming the categories and themes during subsequent interviews with other nurses during the study period.

In part two of the study we used the themes that emerged from the interviews to construct a new survey instrument, the Brisbane Practice Environment Measure (B-PEM). It includes six to seven questions for each theme and, where possible, words from the transcripts were used in the survey items. Initial testing involved two phases. First, individual items were examined for content relevance by six nurse experts using the Content Validity Index (Lynn 1986). We used a format with four possible responses (not relevant, somewhat relevant, quite relevant and highly relevant) (Polit et al. 2007). Subsequently, the instrument was administered to all nurses at their exit interview to assess the level of internal consistency between items.

RESULTS

Emerging themes and domains

Thirteen interview transcripts were analysed for the qualitative component of the study; eleven were female, their mean length of service was 4.1 years (SD 5.0 years).

All divisions in the hospital and all nursing levels, from **bedside** nurse to nursing director, were represented. Their overt reasons for leaving varied and included: pursuing better employment opportunities, travelling or moving to another area, dissatisfaction with current employment, and issues around work/life balance.

Five themes emerged from the data and have been grouped into two domains: Domain A: work life and Domain B: personal life and personal development (Figure 1). We propose that a balance between these domains is necessary for a satisfactory work practice environment.

Insert Figure 1 about here

DOMAIN A: Work life

These themes represent participants' experiences with everyday work life, their perceptions of how they are treated and valued, and their reflections on what inhibits or facilitates their ability to conduct their nursing work load effectively and efficiently. Many of the respondents spoke about working in other hospitals or settings, keen to highlight differences and similarities.

Theme 1: Feeling unsafe

Feeling unsafe had four categories. The first was a sense of 'powerlessness'; for example "we have no voice, we have no-one to um, there is no way you can sort of voice it and get some action". A second category was a feeling of 'not being respected as an individual'. This was expressed in statements like: "It can be difficult sometimes

to know who you can go to and feel comfortable, and don't feel like you've been put down for a question that you're asking". 'Negative work place culture' was the third category, with examples such as, "I had a midwife who just walked out and left me standing in the handover room and she said to the senior nurse, I'm not taking this student midwife and I thought she was joking and when she walked out and I realised that she wasn't coming back; I stood there and had no one". The final category in this theme was 'workplace violence' where words such as bullying, aggressive and fear were not unusual: "the manager in charge is unapproachable and quite aggressive when you try to go and negotiate shiftsand I think there's a fair bit of bullying going on". It was disturbing to discover the level of pain expressed by participants when they believed they had been treated unfairly, many cried as they told their stories. They expressed a sense of helplessness to effect change in their workplace and a fear of repercussions if they tried. There was also a tacit acceptance of 'cliques' who were able to individually or collectively get away with bad behaviour without redress from senior staff, for example "You are always going to have your little pockets everywhere which you know, its huge horizontal violence".

Insert Figure 2 about here

Theme 2: Feeling valued

Feeling valued, the second theme in the workplace domain, had both positive and negative sides. The positive side included a sense of 'being rewarded for effort'; for example one person spoke about being funded to undertake further education "they gave us funding this year and that's a big bonus because it encourages you to do it". Other positive aspects were related to 'feeling supported in the workplace' and 'a collegiality with co-workers'. These were the attributes that made coming to work an

enjoyable experience. Phrases such as “I enjoyed nursing here; it's a pretty stimulating environment to work in” and “Everyone is pretty supportive if you're not sure of something there's plenty of people to ask - qualified people”. The negative side, or feeling not valued, was different from feeling un-safe, it was more about simply being ‘not noticed, or not cared about’. Individuals used expression like “I'm just a number” and spoke of a lack of basic courtesy “I've been back now for a year and it's really, really different, ... it's not as friendly, it's not as welcoming ... we're not introduced to new staff you know....”

Insert Figure 3 about here

Theme 3: Getting things done

The final theme in this domain involved factors that facilitated or impeded a nurses' ability to do their job effectively and ‘get things done’. Four categories were associated with this theme. The first was ‘communication’, or the lack of it “We need to get together and talk about what's actually true and what's not because you ask one and it's a different answer to the other so it's very confusing”. This was true for issues around education, patient care and management. Many respondents believed there were insufficient opportunities to express their needs saying, for example “this could be changed if they had regular meetings where they were actually scoping the problems”. A lack of opportunity to discuss issues led to a great deal of frustration, particularly when those nearest to the problem believed they had the answers “Being a clinical nurse on the floor we know what the issues but they're never addressed”. The relationship between nurses and their ‘nurse unit managers’ was the second category. Management style, accessibility and approachability were described as having a major impact on work life. It could be positive, for example, “we had a fantastic nurse

manager and a fantastic team of nursesthe workload wasn't an issue, you didn't mind because you got support". Alternatively it could be negative, for example, "a manager that's approachable would really helpthe last few months we've had problems". Line managers also influence the creativity of staff in developing innovative solutions to problems, as one nurse put it "... and how they communicate actually just shuts stuff down, shuts innovation down, it shuts collaboration down, it sends people doing stuff underground". The final two categories in this theme were the actual 'work that nurses do' and the 'environment' in which the work is undertaken; both impacted on the overarching domain of work life. Direct work issues included skill mix, working with agency staff, being sent as a relief nurse to other wards, undertaking non-nursing duties such as bed making and answering phones "but answering phones is a big one in your day and it's different in different areas" and tracking down information or staff "the time we wasted here and it happens to everyone, we wasted a lot of time chasing paperwork and doctors. I have one patient I would spend maybe 20 minutes chasing doctors to come and write up an antibiotic order". Workloads were also raised frequently in this category "The workload is huge like it really is, you just, it's so busy you know, it's just really, really busy and full on and it never stops". For some this meant that "unfortunately things do get missed due to the amount of work we've got to do". Environmental issues were local, such as a lack of beds or equipment "we've got a major problem with equipment and we never have bowl sets or prep sets and it's very difficult to just start a case without the prep set"; or more general, organizational issues such as "I'm just trying to recruit staffnot only have you got to deal with the vagaries of shared services and the delays and the lost paperwork and the 'you can't do that' because of rule 'X '". These environmental issues all caused considerable frustration for nurses.

Insert Figure 4 about here

DOMAIN B: Personal life

Unlike ‘work life’, which represents organizational culture and structural issues, ‘personal life’ describes nurses’ ability to grow professionally and the extent to which they are able to meet needs and commitments of their life outside the organisation.

Theme 1: Opportunities for professional development

Professional development was the focus of a great deal of comment, both positively and negatively. Organizational attitudes appear to be affected by professional development opportunities available, either formally, through programs and ward based sessions, or informally, through contact with skilled staff. Three categories emerged in forming this theme. The first related the potential for ‘professional advancement’ ‘I’ve done level 2 for years but I’ve never done after hours managing so its something different, I get a bit of experience.’ The second category was about ‘skills development’ and, for some there were many opportunities such as “the transition program for new graduates, which is advanced life support, ventilation competency, the preceptor course ” and “Definitely, definitely I've learnt so much, I've had many opportunities to develop my skills”. Others were dissatisfied with either the quality of education “We had more, I guess in-services but that was more on trialling equipment and stuff” or the quantity “I don't think we get the in-service education that other hospitals may get.... I think that the educators that we've got do a good job but I think they might just be flat out”. The final category in this theme concerned ‘barriers to education, such as the business of the area “I don't think they really want to let people go for a day when they don't know if they can staff theatres

and cancelling lists and stuff” or a perception of a lack of knowledge among senior staff.

Insert Figure 5 about here

Theme 2: Being flexible

Being flexible focused on ‘work scheduling practices’ and ‘work-life balance issues’. We found the ability to maintain control over personal time to be a major concern for nurses but responses by management were paradoxical. Some were rigid with scheduling and leave entitlements “No it's very hard, there's no flexibility there”. This sometimes led to resignations “they need two months off, they need to go and do this and then they would come back and rather than give them the two months off, they've been forced to resign.....I know about two or three instances where that has happened”, or sick leave “once my husband had to have a procedure done and I did ask for it as a family day.....he needed to be driven home and have a person with him and I was told then that I had to swap days off, I probably should have jumped up and down a bit more, I think it was quite within the award I mean, that was probably my fault and I shouldn't have mentioned it I should have just taken a ‘sicky’, but I was trying to do the right thing yea (laugh), they're not that flexible”. Other managers seemed more aware and responsive to the work-life balance needs of their staff and went to great lengths to make sure everyone was satisfied with their schedules. “well it's Monday to Friday 9 to 5, I know that, but I mean one girl can't do anything about childcare and she works 8 to 4.30 and the rest of us do 7.30 to 4.00 because that's what works for us and that's the type of boss that M is”, another said “it's really important for them that you get what you really would like”. ‘Travel time and parking issues’ were also an issue for many “It was the travelling. It was my own choice, I do

live closer to Redlands and I've been meaning to go out there for about seven monthsand I thought it would make a change and the bonuses I looked at wasparking is a big one”.

Insert Figure 6 about here

Reliability and validity of the Brisbane Practice Environment Measure (B-PEM)

Two nurse managers, two nurse educators and four advanced level nurses assessed the B-PEM for applicability of content and clarity of phrasing. An acceptable content validity score should be .78 (Polit, Beck, & Owen, 2007); for the B-PEM it was .79. Fifty seven nurses completed the B-PEM during their exit interview; the Chronbach's alpha for all items was .93. Data from this study, including factor analysis, will be the focus of a later paper.

Insert Figure 7 about here

DISCUSSION

The primary aim of this study was to identify why nurses leave their job. We used in-depth interviews to probe beneath the overt explanations provided by nurses as their rationale for leaving and found we had opened 'Pandoras' box'. Nurses were very frank in their descriptions of work life, which allowed us to view the organization through their eyes. Their stories made our results profound and, at times, overpowering but always insightful. Although work-places may find it difficult to resource exit interviews, which are conducted by an independent person, the opportunities for rapidly identifying problem areas and individuals, makes the investment extremely worthwhile. Moreover, providing an opportunity for nurses to

de-brief or ‘get things off their chest’ before leaving may be beneficial for the staff member involved. This was certainly true for many of those we interviewed **who expressed their gratitude for the chance to safely discuss issues they had been unable to express formally elsewhere.**

Overall, the issues raised by nurses in this study have broad implications for nursing retention. One of the more disturbing findings is that occupational violence between staff remains endemic in nursing (Hegney et al. 2006, Camerino et al. 2007). This is despite attempts to change the culture through the widespread introduction of workplace ‘Code of Conduct’ policies. How this may be successfully addressed remains speculative; especially given the tacit acceptance by nurses in our study of bad behaviour; either from medical staff or other nurses. We are not alone in this; under-reporting of disrespectful, abusive or disruptive behaviour is not uncommon in nursing and may have devastating consequences (Hutchinson et al. 2006).

Correlations with workplace violence experienced by nurses include psychological distress (Eriksen et al. 2006) feelings of anger, dejection, hurt (Oztunc 2006) and absence due to ill health (Kivimaki et al. 2000). There are also implications for safe patient care, particularly in an operating room environment where dangerous mistakes have been linked to bullying and aggressive behaviour (Whittemore 2007). The association between exposure to or experience with workplace violence and a decision to leave an organisation – which our data suggests – has been mentioned in the literature (King and McInerney 2006, Farrell et al. 2006); however it has not been explicitly investigated.

Feeling valued is clearly a salient issue for nurses **and has been the focus of a growing literature (Faulkner and Laschinger 2008, O’Shea and Kelly 2007, Barron et al. 2007,**

Southwick 2005) it is not uncommon for nurses to talk about it, and it may play a moderating role in a nurses' decision to leave. The notion of reward for effort and the consequences associated with an imbalance between the two, such as burnout and poor health, has also received attention (Siegrist 1996). Our results show that the little, personal things, like a manager remembering to ask about a sick relative for example, leave a lasting impression on nurses. Conversely, the sense of not being valued or being 'just a number' contributes to feelings of de-personalisation and, in some cases a sense of hopelessness. The modern structure and role of the nurse unit manager may need to be evaluated if this is how nurses are feeling. Nurse supervisors are often so involved with meetings, justifying budgets and finding relief nurses, that forming any meaningful relationships with their staff is difficult (Southwick 2005).

The ability to 'get things done' was clearly also affected by the attitude of nurse managers and their openness to new ideas. Nurses are often very creative and innovative in their problem solving. This can easily be 'shut down' and discouraged by non-responsive management. Other categories raised by nurses in our study, such as communication, engagement in non-nursing duties, time for professional development and issues around work-life balance have been well documented in the nursing literature (Gershon et al. 2004, Gould and Fontenla 2006, Gregory et al. 2007). These and the other categories we identified were found across the organisation but their relative importance varied across clinical areas. We were able to easily identify where, for example, rostering was a problem and where interpersonal conflict was an issue. This has become important for the development and testing of interventions to address these problems.

In addition, because nursing management found the results so useful in understanding the hospital milieu, we used our findings to develop a new instrument, to be used periodically to measure changes in the work environment. The benefit of the new instrument over commonly used tools to measure practice environment (Kramer and Hafner 1989, Aiken and Patrician 2000, Lake 2002) is that it has been developed in a contemporary context and derived from interview data. More advanced reliability and validity testing is in progress as part of a longitudinal cohort study in which the new B-PEM is being used, along with other measures of organisational environment, to examine risk factors for leaving the hospital. Results of this testing will be the focus of a separate paper.

LIMITATIONS

The findings represent the views of nursing staff working in an acute, tertiary hospital; so it may not be appropriate to generalize findings to other health care settings. In addition, nurses who had particular issues to air before leaving may have been more likely to decide to be interviewed than more satisfied nurses. However, we do not think this was the case. There were very few nurses who left the organisation that we did not interview. Those we missed were likely to be those we were not notified about and, consequently were unable to contact before they left the hospital. Another limitation may be that the findings from the 13 people included in the analysis were not representative of all nurses who left. Although respondents for the in-depth analysis were not randomly selected, we began with the first interview and continued to analyse transcripts sequentially until saturation was reached. We then used purposeful sampling to target leavers from non-represented work areas to maximize the variability of respondents' experiences.

CONCLUSION

The reality and experiences of acute nurses working lives can be identified through an exit interview, conducted by a person who is independent from the individuals' line management structure. Information from these interviews is useful for identifying an organizations strength and weaknesses.

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Domain	Themes	Categories	Example of keywords/phrases
Work life	Feeling safe/unsafe	Powerlessness	Disempowered Helpless No voice
		Disrespect	Humiliation Putdown Rudeness
		Negative culture	Negative behaviour Cliques Unwelcome
	Feeling valued/not valued	Workplace violence	Bullying Coercion Fear
		Reward for effort	Autonomy Just the little things Respecting competence
		Support	Knowledgeable staff Mentor Customer focus
		Collegiality	Positive work culture Morale Enjoy work
		Failure to listen	Blind to reality Hit a brick wall Look after yourself
	Getting things done	Sink or swim	Unsupportive manager
		Communication	Consistent information Documentation Teamwork
Management issues		Accessibility Inaction Budget pressure	
Nursing duties		Adequate staff Skill mix workloads	
Personal life and personal development	Opportunities/no opportunities for professional development	Work environment	Equipment Bed blocking
		Professional advancement	Education opportunities Getting experience Graduate certificate
		Skilled facilitators/educators	Experienced facilitators Preceptor Supportive educator
	Being flexible/inflexible	Barriers to learning	Inappropriate education Skill deficits in mentors Unaware of opportunities
		Scheduling	Night shift Schedule inequity Schedule flexibility
		Work/life balance	Distance to work Emergent leave Parking

Figure 1: Themes, categories and examples of keywords and phrases from exit interviews

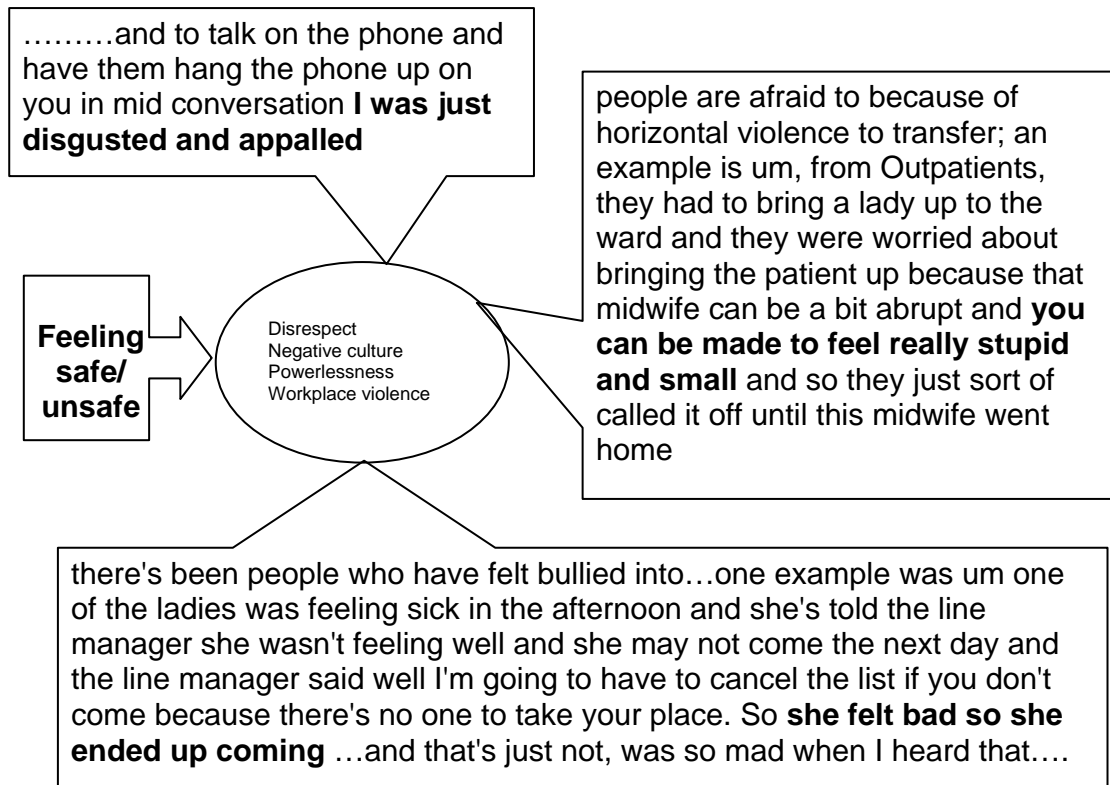


Figure 2. Examples from the theme 'Feeling safe/unsafe'

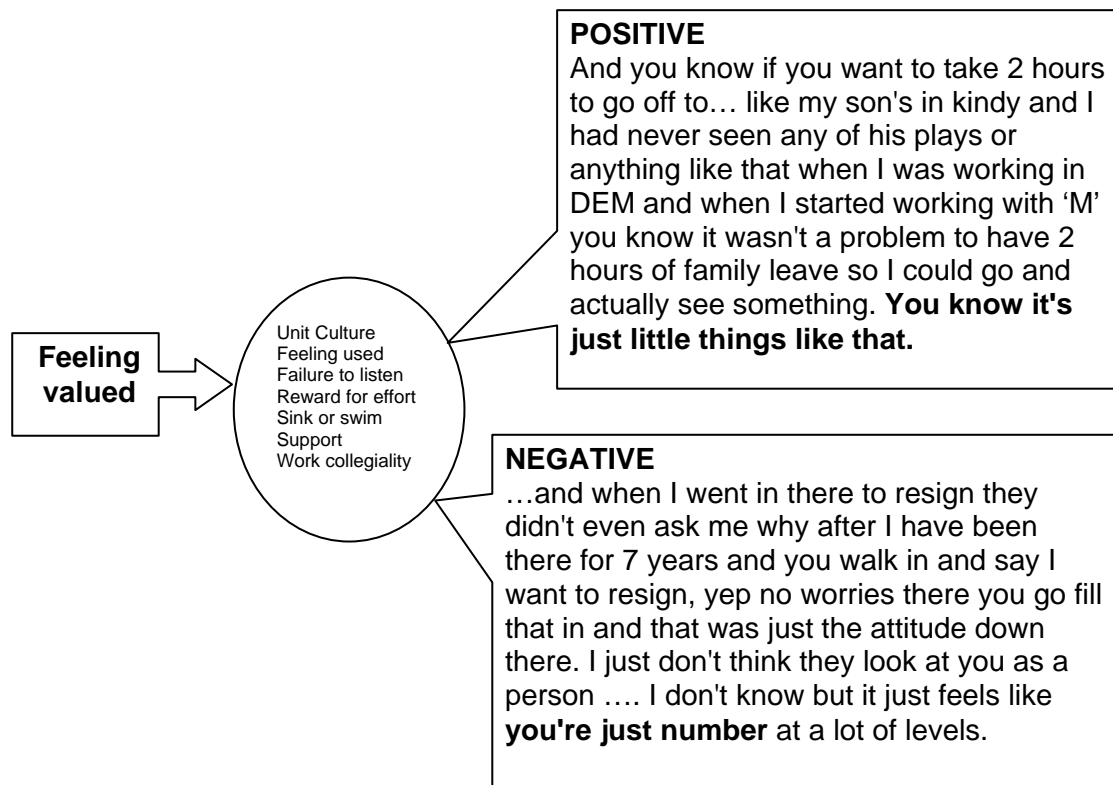


Figure 3. Examples from the theme 'Feeling valued'

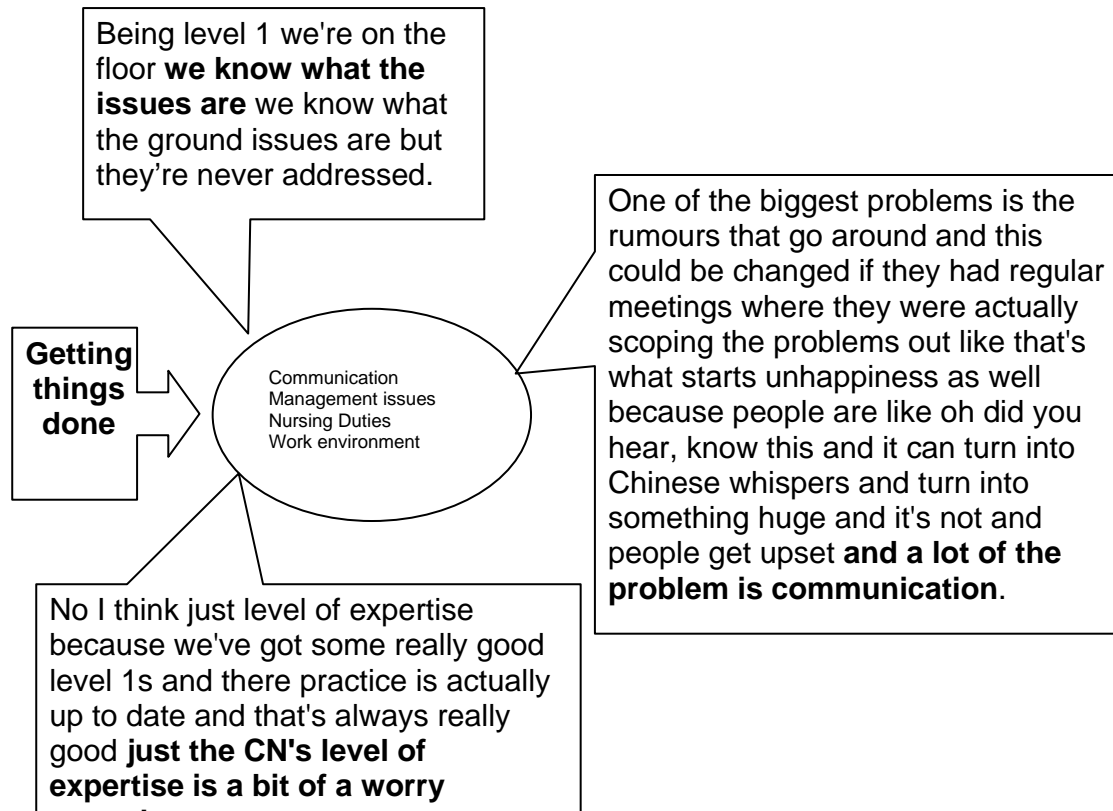


Figure 4. Examples from the theme 'Getting things done'

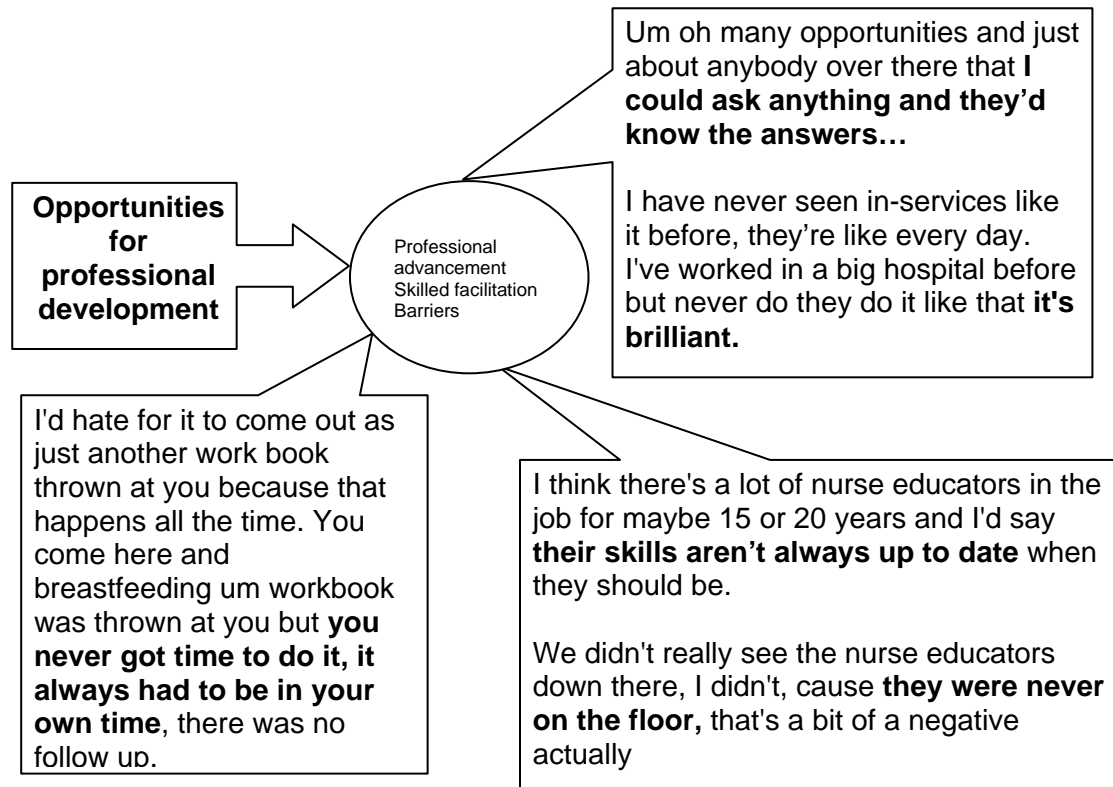


Figure 5. Examples from the theme 'Professional development opportunities

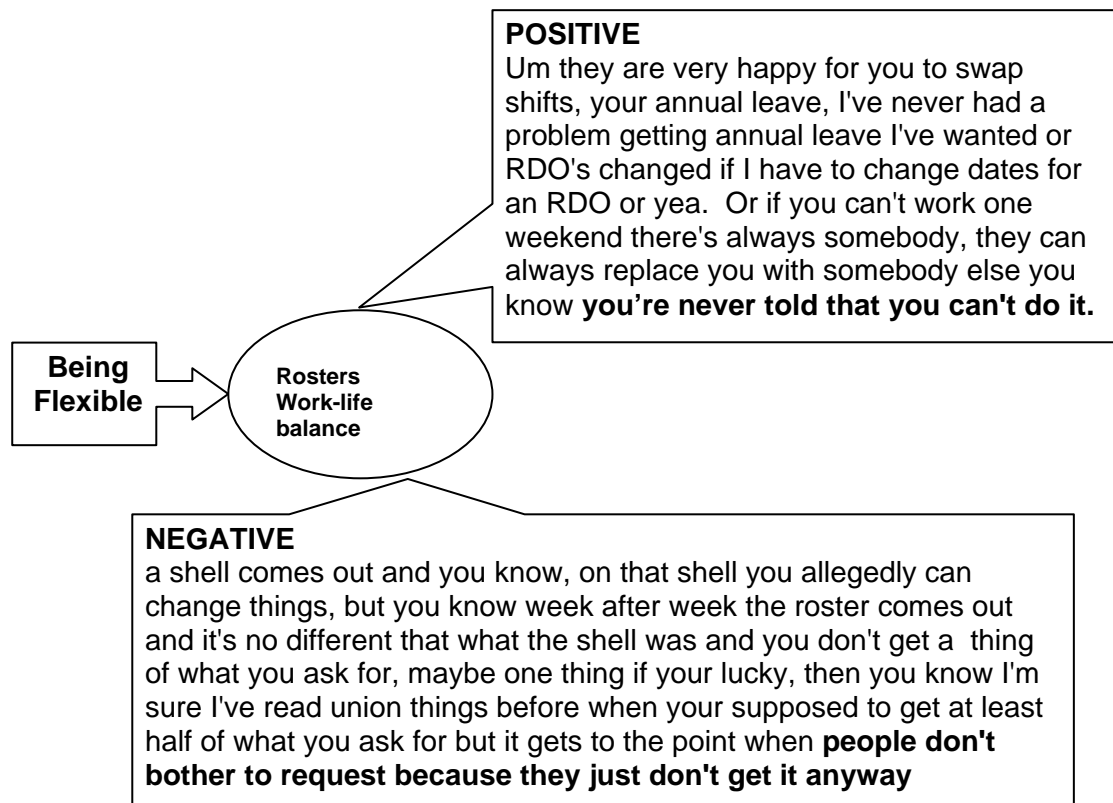


Figure 6. Examples from the theme 'Being flexible'

Brisbane Practice Environment Measure (B-PEM)

Thank you for agreeing to complete this survey; please tick one response for each item.

	Never	Rarely	Sometimes	Frequently	Always
1. I feel supported by my line manager					
2. Performance and appraisal is completed in this area					
3. In this area staff get away with bad behaviour					
4. I feel respected in the way people speak to me					
5. I am able to change my roster if necessary					
6. There is time for staff development					
7. It is difficult to influence change in this area					
8. There is a great team spirit in my work area					
9. My line manager is responsive to emergent leave requirements					
10. I am treated as an individual					
11. There is equity in staff development opportunities					
12. My skills are acknowledged					
13. I participate in roster development					
14. My line manager is approachable					
15. Off line time is offered for professional development					
16. I am thrown in at the deep end					
17. The workload is overwhelming in this area					
18. I have access to the information I need to do my job					
19. I feel intimidated when working in this area					
20. There is equity in rostering in this area					
21. I am acknowledged when I put in extra effort					
22. The skill mix is about right in this area					
23. In this area, clinical resources are adequate					
24. I am asked to operate outside my scope of practice					
25. There is a high level of clinical expertise I can access					
26. I feel just like a number					
27. There is support for professional development in my area					
28. Continuity of care is considered in this area					
29. I enjoy coming to work					
30. Our roster complies with roster regulations					
31. My line manager is ready to help out in the clinical area					
32. Staff workloads are equal					
33. Opportunities for advancement are available in this organisation					

Figure 7. The Brisbane Practice Environment Measure (B-PEM)
(Items 3, 7, 16, 17, 19, 24, 26 are reversed for scoring).