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The decision making process involved when changing career: A qualitative study of registered nurses who have left the profession

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Running Head: CAREER CHANGE DECISIONS BY REGISTERED NURSES

The Decision Making Process Involved When Changing Career: A Qualitative Study

of Registered Nurses who Have Left the Profession

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Abstract

Career choice is an important decision an individual has to make during their lifetime. Personal, environmental and organisational factors all assist this decision process as individuals strive for a work-life balance within careers that meet their needs and realise their potential. This research study investigated which factors contributed to the decision process of Registered Nurses (RNs) who have left the profession for a career change. There is currently a global shortage of RNs, which is of major concern to healthcare policy makers in most countries, including Australia. This qualitative study examined the narrative interviews of ten females over the age of 25 years who qualified as RNs but no longer work in nursing. Previously the majority of studies have focused on RNs still employed in the profession and their leaving intentions, rather than decisions made by nurses who have already left nursing. The results suggested that there were several influential factors which related to the work environment, managerial function, and nursing challenges. However, financial remuneration identified in several previous studies as a significant factor, was not supported in this research. Understanding the issues faced by RNs may further assist health organisations, universities and managers to develop strategies to recruit and retain health care professionals.

KEY WORDS: Decision making process, career change, healthcare organisations, registered nurse, job satisfaction, retention, recruitment, turnover.

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Submitted: October, 2010

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"When making a decision of minor importance, I have always found it advantageous to consider all the pros and cons. In vital matters, however, such as the choice of a mate or a profession, the decision should come from the unconscious, from somewhere within ourselves. In the important decisions of personal life, we should be governed, I think, by the deep inner needs of our nature."

Sigmund Freud

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The Decision Making Process Involved When Changing Career: A Qualitative Study

of Registered Nurses who Have Left the Profession

Literature has reported an escalation in the number of different careers explored by

individuals in recent decades (Van Vianen, De Pater, & Preenen, 2009). A *career* is defined

as "the individual's lifelong progression in learning and in work" (Watts, 1998, p. 2).

Previously, work has been viewed as a necessary evil, however its link to happiness, health,

and wellbeing is becoming increasingly recognised and is therefore contributing to the recent

attention surrounding career and lifestyle choices (Barron, West, & Reeves, 2007; Patton,

2005). There has been an expansion in the range of alternative career options available to

individuals including evidence of more diverse working arrangements in recent years

(Australian Bureau of Statistics [ABS], 2005). Consequently, more individuals are deciding

to explore and pursue other career possibilities for a variety of reasons, for example to

experience fulfilment and achieve a work-life balance (ABS, 2005).

Within the health profession, registered nurses (RNs) are no exception with research

surveys indicating that during 2005 approximately 21,000 registered Australian nurses, had

left the profession to pursue other careers (Australian Institute of Health and Welfare

[AIHW], 2008). These results have considerable implications as RNs comprise one of the

largest group of healthcare workers in areas such as emergency departments, critical care

units, operating theatres, surgical and medical wards, mental health, maternity, community

and aged care (AIHW, 2008; Bureau of Labor Statistics [BLS], 2008). Most RNs are

clinicians, and registered to engage in the practice of treating, educating, and providing

support to patients and families in collaboration with other health professionals (AIHW,

2008). In Australia, since 1994 all RNs have been educated to bachelor degree level within

universities (Nurses and Midwifery Board of Western Australia [NMBWA], 2010).

The decision process by RNs to leave the profession is complicated and some research has suggested that it may be due to many factors including: general dissatisfaction with work conditions; cost cutting measures; diminished opportunity for career advancement; continual shortage of nurses and lack of educational opportunities (Cheung, 2004; Rajapaksa & Rothstein, 2009). Australia is not alone in the global shortage of nurses with many countries such as United Kingdom (UK), United States of America (USA) and Canada experiencing challenges in maintaining and providing a sustainable nursing workforce (Camerino et al., 2006).

Numerous research studies of nursing turnover have investigated several topics such as: organisational commitment (Barron et al., 2007); levels of burnout and job satisfaction (Takase, Yamashita, & Oba, 2008); the changing role (Reeves, West, & Barron, 2005); the aging workforce (Camerino et al., 2006); recruitment and retention strategies (Duffield, O'Brian-Pallas, & Aitkin, 2004); early retirement (Blakeley & Ribeiro, 2008) and the global migration of nurses (Armstrong, 2004; Barron & West, 2005). However, many studies have focused on nurses still employed in the profession, rather than decisions made by those who have already left (Duffield et al., 2004).

The following review of the literature is divided into four sections. Section one focuses on elements that attracted nurses into the profession and those factors which have influenced their decision to leave. Section two details the challenges faced by healthcare organisations. Section three reviews the recruitment and retention strategies implemented by government, policy makers and hospital management in an attempt to prevent and improve the nursing shortage. Section four briefly describes normative and descriptive decision models and provides an overview of career decision making framework. This will be followed by a summary which will integrate the previous sections, discuss limitations of previous research and provide the rationale for the present research study.

Section One

    Reasons for choosing nursing.

    There are many proposed suggestions as to why individuals are attracted to the

nursing profession (Duffield et al., 2004). Despite being physically taxing and emotionally

draining, nursing remains an appealing career for individuals who enjoy caring for people

with illnesses, injuries or disabilities (Duffield et al., 2004). Research into choosing nursing

as a career was investigated by Duffield et al. (2004) who analysed 154 questionnaires

completed by Australian nurses no longer employed in nursing, to establish why they entered

and left the profession. Results of the confirmatory factor analysis indicated "altruistic"

reasons for entering the nursing profession i.e., to assist individuals in a caring profession by

36% of participants as the prime motivation for choosing nursing. Moreover, a commitment

to the medical field, job security and the idea that nursing is a respectable career were also

referred to as reasons for entering the profession (Duffield et al., 2004). This view is

supported by the Australian community, with nurses consistently being rated as the most

honest and ethical occupation group (The Morgan Poll, 2008).

    In contrast, factors such as "professional practice" (e.g., autonomy in decision

making) and highly valued work/home life issues were reasons these participants cited for

leaving nursing (Duffield et al., 2004). As suggested by Duffield et al. (2004) of concern is

that 36% of nurses surveyed also stated their motivation had changed since they entered the

profession and they now focused more on salary (39%) and flexibility (20%). Changes to the

image and conditions within the profession have the potential to impact on a large percentage

of the population, namely females who accounted for 91% of the nursing workforce during

2001 (BLS, 2005; Camerino et al., 2006). Therefore, as this trend is unlikely to change,

healthcare organisations and government bodies are mindful of the pertinent issues such as

work flexibility that are relevant to this demographic group (BLS, 2005).

Factors contributing to the decision of nurses to leave the profession.

Nurse shortages worldwide are not a new phenomenon, for example the UK has experienced shortages since the end of World War II (WW II) (Aitken, Smith, & Lake, 1994). Internationally, the current situation in the UK has not improved with a survey reporting 62% of managers found it difficult to fill vacant nursing positions (Gaynor, Gallasch, Yorkstone, & Stewart, 2006). In addition, Canada predicts a shortfall of 78,000 nurses by the year 2011, increasing to 113,000 nurses by 2016 (Gaynor et al., 2006). The most recent survey results available within Australia are comparable, reporting that during 2005 of the 198,315 RNs, approximately 21, 800 were voluntarily not working within nursing at the time (AIHW, 2008). Nationally, of concern is the opinion that this trend will continue with current Australian nursing shortages expected to increase to 30% by 2020 (Hasselhorn et al., 2006). As a consequence, these nursing shortages have been linked to several indicators of inadequate patient care varying from mortality, adverse events, accidents and nosocomial (hospital acquired) infections (Hasselhorn et al., 2006).

Previously, reasons for the nursing shortage have been attributed to a number of factors including: the recent range of alternative career opportunities for females, the limited number of new nursing recruits, an unsatisfactory environment and the ageing workforce (Blakeley & Ribeiro, 2008; Cheung, 2004). The ABS (2005) stated that 40% of employed nurses during 2001 were aged over 45 years, an increase from 18% in 1986. Conversely, for nurses aged 15-24 years, the percentage decreased from 21% in 1986 to five percent during 2001. If this trend continues it may result in an approximate shortage of 40, 000 Australian nurses by the year 2010 (Gaynor et al., 2006).

The literature relating to nurse turnover suggests that most factors contributing to the decision to leave the profession fall within two categories which include: personal and organisational reasons, both of which will be discussed below (Blakeley & Ribeiro, 2008;

Rajapaksa & Rothstein, 2009). "Turnover" refers to an individuals' intention to leave their existing employer and is characterised by the idea of resigning, searching for another job and finally the decision to leave (Takase et al., 2007).

Personal reasons for leaving the profession.

Many personal and socioeconomic characteristics such as age, educational level, gender, and financial considerations are believed to influence a nurses' decision to leave the profession, however many studies vary in their opinion to the extent these factors influence a nurses decision to leave (Barron, West, & Reeves, 2007). There is also acknowledgement that these personal reasons are not unique to nursing, and may apply to other professions.

Individual characteristics such as *age* have been shown to significantly predict nursing turnover (Barron & West, 2005). Earlier studies by Fochsen, Sjogren, Josephson, and Lagerstrom (2005) investigated self administered questionnaires of 1507 nursing personnel who were employed at various country hospitals in Sweden, to determine factors that contributed to their decision to leave. Exploratory factor analysis reported a significant difference in responses relating to the age of nurses (Fochsen et al., 2005). These results indicated that nurses under 45 years of age cited "lack of professional opportunities" and "salary" as more important reasons for leaving, as compared to nurses over 45 years who cited "inflexibility" (Fochsen et al., 2005). The increased level of experience of senior nurses and their more established financial security may be a possible explanation for this result (Fochsen et al., 2005). In addition some respondents may have had difficulty exactly recalling the reasons for leaving nursing as there was a variation in the time delay between leaving and the data collection (Fochsen et al., 2005).

Further studies by Camerino et al. (2006) investigated nurses' perceived "work ability" in a representative sample of nurses in 10 European countries between 2002 and 2003. This cross-sectional study used an analysis of covariance to examine the results of

25,976 postal surveys (Camerino et al., 2006). Work ability was described as the nurses' perception of their capacity to cope with the demands of work such as support from managers, psychological requirements, and other organisational factors (Camerino et al., 2006). In all 10 countries Camerino et al. (2006) reported an association between low work ability and higher intention to leave nursing. Overall results in eight of the ten countries indicated that younger nurses with low work ability reported a higher intention to leave nursing (Camerino et al., 2006). Younger nurses are possibly open to experience greater opportunities as a result of being less committed and more flexible in their ability to change career (Camerino et al., 2006; Parry, 2008). Conversely, lower intention to leave in the older age groups may be related to a concept known as "ecological niche" which refers to a comfortable position which after years of hard work leads to a greater resistance to change (Kaufman, as cited in Camerino et al., 2006).

This study only involved nurses currently working in the profession by investigating their intention to leave (Camerino et al., 2006). These self reported surveys may have been influenced by the current working conditions of participants (Camerino et al.2006). However, a study by Cheung (2004) which examined the leaving factors of nurses who had actually left the profession reported similar results. The semi structured interviews with 29 participants across Australia also concluded that those under 30 years of age were more likely to plan their exit from nursing (Cheung, 2004). This view is supported by Barron and West (2005) who acknowledge that nurses seem to be particularly vulnerable to leaving early in their careers, although this trend may change as we reach an aging population.

In relation to *educational level* various perspectives have been proposed which offer differing opinions. Barron and West (2005) studied the lifetime employment decisions of 5000 participants who responded to postal questionnaires in the UK between 1991 and 2001. This study relied on the accuracy of recall by the participants, to investigate factors which

contributed to the decision of nurses to leave the profession (Barron & West, 2005). The

results suggested that those with degrees were more likely to leave due to the additional

opportunities offered from educational attainment (Barron & West, 2005).

These results contradicted research in Australia by Duffield et al. (2004) in which a

questionnaire was mailed to 150 RNs currently working outside the profession. Results of the

factor analysis during 2001 reported that higher educational level was indicative of

participants staying in nursing (Duffield et al., 2004). This may be due to the personal

investment and financial costs of further education which the participants considered a

worthwhile investment in their nursing careers (Duffield et al., 2004). This was expected to

lead to further financial gain or promotion possibilities and improved job satisfaction

(Duffield et al., 2004; Hasselhorn, et al., 2008). Although different opinions have been

suggested most research supports the view that a greater percentage of nurses have attained

higher post graduate qualifications since the transfer of nurse training to universities and are

more likely to maintain a higher level of qualification in the future (Duffield et al., 2004).

The previously discussed UK study by Barron and West (2005) also investigated the

role of *gender* as a personal factor in the decision to leave nursing. The results suggested lack

of career advancement and financial remuneration were more significant factors for leaving

for males (Barron & West, 2005). These results do not support previous research in Australia

which found no difference between the leaving rates of females and males (Duffield, et al.,

2004). However, currently females dominate the nursing profession and most of the research

is overwhelmingly female (90%). The different results may therefore be attributed to the

significantly fewer males in the data set.

Finally the issue of *financial status* was examined by Buerhaus who completed a

meta-analysis of 42 studies as cited in Barron and West (2005). He proposed that there was

no conclusive evidence of a connection between the income of nurses and job satisfaction. A

weak relationship between job satisfaction and the perceived fairness of reward distribution was reported (Barron & West, 2005).

However, previously discussed studies by Forchsen et al. (2005) suggested that unsatisfactory salaries significantly contributed to the personal decision of nurses to leave the profession. More recently, Barron et al. (2007) reported the results of an exploratory postal survey involving 2880 nurses in London during 2002. This study investigated whether nurses had the tools, time and training to provide high-quality care (Barron et al., 2007). The results also suggested that two thirds of nurses surveyed were dissatisfied with their income level. However, both studies used cross-sectional convenience samples from the UK and Sweden and therefore may not accurately reflect the financial status of Australian RNs. For example an Australian study by Duffield et al. (2006) did not report financial status as an important consideration for Australian nurses leaving nursing. However Duffield et al. (2006) described the "ceiling effect" which has been considered a significant reason many nurses have left the profession. This was defined as a position where RNs have found it difficult to advance to higher paid, more senior positions within nursing (Duffield et al., 2006).

Personal factors such as age, educational level, gender, and financial status all have some role with the decision to leave nursing (Barron & West, 2007; Duffield et al., 2004). Despite differing opinions, results suggest that being a highly educated young male or female with financial commitments, such as a family to support, significantly increases the decision risk of leaving nursing for another occupation (Barron & West, 2005; Duffield et al., 2004). However research proposes that organisational factors contribute more influentially towards the decision of nurses to leave the profession (Barron et al., 2007; Duffield et al., 2004).

Organisational reasons for leaving the profession.

Organisational issues related to nursing turnover include but are not limited to job satisfaction, work flexibility, technological advancements, educational expectations,

organisational commitment, and unsafe work environments (Cohen, 2006; Duffield, O'Brian Pallas, & Aiken 2004). Although many other professions and occupations experience similar reasons for employee turnover, the concern with nursing is the ease with which many RNs are able to leave the profession (Rajapaksa & Rothstein, 2009). This may be due to the qualifications and experiences that are gained whilst employed. Nurses are often sought after internationally and in allied health related occupations such as physiotherapy (BLS, 2008).

Research among nurses has reported that job characteristics are predictive of *job satisfaction*, including physical and psychological distress and burnout (Gelsema, Van der Doef, Maes, Akerboom, & Verhoeven, 2005). In addition, a meta-analysis by Buerhaus (as cited in Barron and West, 2005) reported that higher levels of job satisfaction were significantly associated with lower levels of stress. Of significance is also the positive association between job satisfaction and a RN's commitment to the organisation (Barron & West, 2005).

A cross-sectional postal survey of 2880 nurses in the UK conducted by Barron et al. (2007) reported that nurses were more likely to leave the profession, not just their current employer, if they experienced low job satisfaction. This was also true if these nurses believed their work was not valued by their organisation. Job dissatisfaction was also attributed to unrealistic workloads, mandatory overtime, and hospital administrators perceived lack of responsiveness to the concerns of nurses (Cheung, 2004; Rajapaksa & Rothstein, 2009). Additionally, nurses were dissatisfied with the work environment with regard to administrative issues such as increased paperwork (82%) and government regulations (64%) (Reineck & Furino, 2005).

Job satisfaction is also linked to a number of factors such as reward, flexibility, autonomy and convenient hours (Rajapaksa & Rothstein, 2009). A recent study by Rajapaksa and Rothstein (2009) involved 1,589 self administered questionnaires posted to nurses in the

USA currently employed in other professions. The aim was to determine their personal and

professional characteristics including work activities and preferences (Rajapaksa &

Rothstein, 2009). Results of the regression analysis suggested that job satisfaction

significantly influenced their decision to leave, especially in relation to 47% who found their

current job more professionally rewarding, and 35% who were more satisfied with their

current salary (Rajapaksa & Rothstein, 2009).

However, according to Rajapaksa and Rothstein (2009) job satisfaction is only one

predictor of employee turnover, *inflexibility* was another reported by 46% of respondents.

Previous studies by Morrell (2005) also identified work inflexibility as one of the significant

reasons why nurses had left the profession. This UK study involved analysing responses of

352 participant questionnaires using cluster analysis. They investigated the decision process

to leave the nursing profession prior to changing career (Morrell, 2005). In most cases the

strain of shift work, involving weekends and nights was incompatible with a fulfilling home

life (Morrell, 2005).

Moreover, in an attempt to increase the level of "professionalism" in nursing, the

educational level has been increased in many countries over the past decade (Morrell, 2005).

This has been in response to the need for nurses to perform an increasing range of, and more

technologically advanced medical tasks (Blakeley & Ribeiro, 2008). Blakeley and Ribeiro

(2008) studied 200 randomly selected nurses over 45 years of age in Canada to investigate

factors that influence nurses to retire early. Results of the multiple *t*-tests indicated that lack

of education and training with advanced new technology was significant to their decision to

retire early (Blakeley & Ribeiro, 2008). Within Australia, studies have concluded that RNs

agree that this increased technology has impacted on the profession with many nursing tasks

becoming more stressful, complex and time consuming (McIntosh, Palumbo, & Rambur,

2006).

It is also widely understood that nursing shortages are the result of continuing shifts in both organisational "supply" and "demand" (Duffield et al., 2004; Takase et al., 2007). The *demographic ageing workforce* is an important explanation for changes on the labour supply side of nursing, as Rajapaksa and Rothstein (2009) suggest that, by 2010 approximately over 40% of the USA nursing workforce will be over 50 years of age. On the demand side the primary change is due to the *demographic ageing population* in most Western countries (Duffield et al., 2004). This has led to a gradual increase in the demand for health services, which is of concern when nursing levels are likely to be inadequate (Takase et al., 2007). These changes are predicted to be particularly pronounced as the baby boomers reach their 60's and 70's within the next ten years (Parry, 2008; Takase et al., 2007).

An employees' attitudinal and emotional link to an organisation is described as "organisational commitment" (Landy & Conte, 2006). According to Takasa et al. (2007) this has implications for the decision to continue or leave an employer. Workplace *violence* and abuse have previously been significantly linked to low organisational commitment. According to Lyneham (2000) in a 1999 report by the Australian Institute of Criminology, nurses recorded the second highest number of violence related workers' compensation claims, second only to security guards, and higher than police and prison officers. A study in Queensland by Kelly (cited in Chapman & Styles, 2006) reported that 90% of nurses reported experiencing verbal abuse and 75% physical abuse especially in areas such as emergency, mental health and aged care.

Therefore nurses with high levels of work place violence experience low morale, which makes the already challenging task of retaining nurses even more difficult (Fochsen et al., 2005; Hasselhorn et al., 2008). To address this situation many states in Australia have introduced "zero tolerance" policies which expressly state that violence is unacceptable and it

is the responsibility of employers to implement strategies to prevent and manage occupational violence (Chapman & Styles, 2006).

Organisational characteristics such as: management style, workload, autonomy, stress and job strain may be more related to nurses' decision to leave nursing than economic and individual differences (Barron et al., 2007). Previous research by Rajapaksa and Rothstein (2009) proposed three main issues contributing to their decision to leave nursing: rewarding job characteristics, flexible working hours and better salaries. In view of this interest within the current literature, the complexity and challenges surrounding healthcare organisations will be discussed in more detail.

Section Two

Healthcare challenges and organisational structure.

Organisational researchers have sought to establish a link between organisation characteristics and outcomes such as the performance, effectiveness, and satisfaction experienced by patients and staff (West, 2001). Aiken, Clarke, and Sloan (2002) defined the primary function of "healthcare services" as the provision of health care across the continuum including health promotion, prevention, diagnosis and treatment of injury and illness.

Within the last 10 years the Australian healthcare sector has undergone complex organisational reform due to a range of external factors (Burke, 2005) which include altered political and economic states such as decreased funding, costly technology and dynamic consumer expectations (Duffield, Kearin, Johnson, & Leonard, 2007). Patrick and Laschinger (2006) reported that health care providers and managers have therefore been compelled to find more proficient and effective ways of producing health care whilst improving the quality of patient care.

There have been optimistic developments with improvements in effectiveness and restructuring, however there are also reports of high stress levels leading to exhausted nurses,

increased sick leave and reduced job satisfaction, all of which contribute to higher staff

turnover (Duffield et al., 2007; Patrick & Laschinger, 2006). A popular healthcare

restructuring model used within Australia has recently resulted in the downsizing of middle

management in order to improve efficiency (Duffield et al. 2007). As a consequence of this

centralisation process, hospital organisations face ongoing challenges to provide direct

leadership and support to nursing staff, as managers are not always available and located on

site (Duffield et al., 2007).

Organisational researchers have identified a number of pertinent differences which

present challenges in hospital function as compared to other organisations. First, Roan,

Lafferty and Loudon (2002) refer to an absence of a single line of authority and as a result,

hospitals often endure conflict among professional streams. Administrators may be

accountable for managerial problems and capital investment (Patrick & Laschinger, 2006).

Conversely the responsibilities of nurses and physicians' align more with patient care,

research, and education (Patrick & Laschinger, 2006). Each profession has its own

communication networks, hierarchies and varying aspirations, all of which sustain a level of

autonomy and sovereignty over their own vocation (Patrick & Laschinger, 2006; Roan et al.,

2002).

Second, public hospitals focus on patient care, not corporate profits (Duffield et al.,

2007). The availability of healthcare is expected amongst the community as the right of all

citizens, which is placing immense strain on hospitals who are under resourced for the

increasing ageing population (West, 2001). Finally, hospitals are considered people industries

and technology can only complement, not replace the efforts of healthcare professionals

(Aiken et al., 2002). As suggested by Patrick and Laschinger (2006) the realisation of

successful hospital function is dependent on the integrity, skill, motivation and behaviour of

its employees to work together congruently. Hospitals in the nature of their work require far

more emphasis on human relations than many other organisations (Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002).

Understanding how the organisation and management of hospitals affect the retention of nursing staff and quality of patient care is challenging (Burke, 2005). According to Duffield et al. (2007) although many variables such as individual, organisational and environmental appear relevant there is no clear theory that reflects the complexity of the relationship. Additionally, Patrick and Laschinger (2006) believe the previous absence of nurse participation in organisational decision making has left nurses with minimal power to establish positive nursing work environments or influence change, both of which are crucial in ensuring patient safety.

Research has attempted to link organisational characteristics such as managerial processes to a number of important outcomes for nursing staff and patients (Burke, 2005; Duffield et al., 2007). There have also been numerous studies proposing that "management matters" are important considerations as they significantly contribute to the experience for employees and the success of organisations, however there is little awareness about the nature of the relationship (West, 2001).

Several studies have explored the factors that influence the attraction of a workplace (Aiken et al., 2002). Crucial factors central to job satisfaction include: reasonable wages, a flexible working schedule, job prospects and a high nurse-to-patient ratio (Aiken et al., 2002; Needleman et al., 2002). Moreover, many organisational factors have been identified as important for health care outcomes such as leadership style, staff recognition, continuing training, organisational trust, educational support and hospital management strategies (Aiken et al., 2002; Duffield et al., 2007).

Much research is currently underway which will strengthen the evidence on which recommendations about the organisation and management of hospitals can be based (Duffield

et al., 2007). However, research by Burke (2005) indicates there is a need to become more consciously aware of the way nurses work together within health organisations in order to retain nursing staff and ultimately improve the experience of patients within the healthcare system. There are factors beyond external conditions that are of relevance to the retention of health care employees and job satisfaction (Duffield et al., 2007). Research by Burke (2005) also suggests many of those factors include quality improvement, knowledge development and inter professional teamwork. Research involving "magnet hospitals" provides further evidence that these organisational factors which create job satisfaction and efficiency through improved work conditions can and have been achieved (Aitken et al., 2002; West, 2001).

Magnet hospitals.

In the early 1980's the American Nurses Association acknowledged a group of hospitals that were accepted by reputation as "good places to work". These international and Australian hospitals had little difficulty recruiting and retaining nursing staff and became known as magnet hospitals (West, 2001). Magnet hospitals were found to share a number of organisational characteristics absent from non-magnet hospitals that were common elements of a professional nursing practice model (Aiken et al., 2002). These included adequate staff levels, decision making decentralised at ward level, autonomy, organisational trust, influential nursing executives, well established communication between nurses and physicians, implementation of salaried status (rather than hourly rates), primary nursing care (which promoted accountability and continuity of care) and investments in the education and expertise of nurses (Aiken et al., 2002; West, 2001).

Research by Spence, Laschinger, and Thomson (2001) acknowledged that the cardinal features of the magnet hospitals were related to decrease mortality rates, lower burnout rates and increased staff and patient satisfaction. The most compelling evidence was produced from a study by Aitken, Smith, and Lake (1994) who after adjusting for patient severity,

documented that magnet hospitals demonstrated a significantly superior outcome of 4.8%

lower medicare mortality rate. The outcomes reflected not only the result of staff patient

ratios but were related to the level of nurse autonomy, important characteristics of the

organisation such as trust, control over practise and nurse/physician collaboration (Aiken et

al., 1994). This enabled international researchers to estimate the relationship between

structural characteristics of the organisation and outcomes for patients and staff (West, 2001).

Multiple interventions at different organisational levels to increase job satisfaction are

required not only to address flexible working hours, pay and job prospects, but also to help

nurses to develop their potential, achieve their goals and increase their sense of autonomy

(West, 2001). Organisational processes such as innovative human resource management

practices and procedures to facilitate trust, communication, conflict resolution, and

participation are all important (Aiken et al., 1994; Duffield et al., 2007).

Many of the approaches previously introduced by health organisations and

government bodies may be considered as either "recruitment" or "retention" strategies

(Blakeley & Ribeiro, 2007). Recruitment strategies focus on how to motivate individuals to

choose nursing as a career, where as retention strategies are more concerned with keeping

those qualified nurses within the profession (AIHW, 2008). The issues of recruitment and

retention are discussed in the following section.

Section Three

Recruitment strategies.

To maintain an adequate nursing workforce, the Australian Nurses Federation [ANF]

(2010) estimates that 10,000 nurses need to graduate every year in order to replace over

100,000 nurses who are due to retire over the next 20 years. There are two main approaches

namely, increasing the enrolment of individuals at university which is time consuming and

costly and by recruiting from third world countries such as the Philippines (Barron & West, 2005; Shields & Ward, 2001).

It is estimated that 20% of nurses leave within the first year of qualifying perhaps due to "reality shock", a term described by Gaynor et al. (2006) as the gap between the realities of the job and the undergraduate nursing program. Therefore, unless the environment into which these newly educated nurses are delivered can provide support, the situation may not improve (Gaynor et al., 2006). Moreover, there is no assurance that graduating nurses will stay in the profession, therefore other strategies such as implementing incentives for older nurses to delay retirement will help retain the knowledge, guidance and mentoring within the profession (Blakeley & Ribeiro, 2008). Retention, according to Gaynor et al. (2006) is therefore considered as important as recruitment.

Retention strategies.

Many staff surveys and research studies have been published that identify the issues that often lead to low job satisfaction and increased employee turnover among nurses (Cheung, 2004; Rajapaska & Rothstein, 2009). A study by Hart (2001) stated that low morale in the workplace was reported by 68% of working nurses and 81% considered changing careers. According to Hart, 56% of nurses leave patient care to seek a job that is less stressful, less physically demanding and less violent. Additionally, 74% of nurses alleged they would stay in their jobs if changes such as increased staffing, less paper work and fewer administrative duties were implemented (Reineck & Furino, 2005).

Globally the average age of nurses has increased, additionally within Australia there is an estimated 30,000 qualified nurses who have left nursing, and of those remaining 49% chose to work part time (ABS, 2005; Blakeley & Ribeiro, 2008). A number of retention strategies have been proposed one of which involves increasing the retirement age for nurses (Camerino et al. 2006). A study by Kuhar, Miller, Spear, Ulreich, and Mion (2004) identified

the following measures to meet the specific needs of nurses aged over 56 years: respect from physicians and administration, retirement and healthcare benefits, adequate education, open-door policy, and flexible rostering. Additionally, McNesse-Smith, and Crook (2003) established that as workers aged they appreciated the aesthetics of the work environment while attributing less worth to economic returns. However, 33% of RNs over the age of 50 years plan to leave their nursing positions in the next three years (Cohen, 2006). Therefore identifying factors that contribute to a nurse's decision to leave the profession may assist with remodelling successful retention strategies in the future (Rajapaska & Rothstein, 2009).

There is a need to acknowledge that there are many personal reasons for leaving the nursing profession such as individual value systems which are unavoidable (Duffield et al., 2004). Improved benefits, more power to implement change, a safer workplace, less work related stress and importantly more support from managers may increase retention (Blakeley & Ribeiro, 2008; Duffield et al., 2004). According to the Australian Department of Education, Science and Training [DEST] (2001) it takes four years of educational investment to replace qualified and highly skilled RNs who leave the profession.

This review has presented a comprehensive account of the personal and organisational factors that have contributed to RN's decisions to change career, including recruitment and retentions strategies faced by challenged healthcare organisations. However, the actual decision process involved when changing career requires further discussion. There are diverse ways in which individuals make decisions, for example, many are influenced by an awareness of choices available and knowledge of how to evaluate these choices (Weber & Johnson, 2009). Conversely, other decision making processes may be impacted by critical points in life such as "shock events" where there is little search and evaluation of other alternative choices which may greatly impact our decisions (Morrell, 2005). However, in

order to fully understand this leaving process it is necessary to first examine the

contemporary career developmental framework and theories that underlie decision making.

Section Four

Career developmental framework and theory.

Career development and change is part of the employment cycle (Brown & Brooks,

1990). Traditionally a "career" has been described as the process by which people narrow

their life choices as a way to create and find the self (Gottfredson, 2002). The literature

suggests there are varied characteristics of a suitable career decision (Chernev, 2009).

Research by Chernev (2009) proposes that appropriate decisions are those that yield the best

consequence for achieving an individual's goals. Within the work setting individual, cultural,

organisational, environmental and social factors assist the decision process (Averbeck &

Duchaine, 2009). The mainstream career decision theories that fundamentally portray the

principles that guide career decisions will be discussed in more detail (Gottfredson, 2002).

During the early 1900's Frank Parsons, regarded as the founder of career development

was best known for his identification of three key elements relating to career selection

(Hartnug & Blustein, 2002). First the individual has a clear understanding of themself in

relation to their aptitudes, interests, resources, limitations and other qualities (Hartnug &

Blustein, 2002). Second, knowledge of the requirements and conditions of success,

disadvantages, compensation, and prospects in different lines of work (Hartnug & Blustein,

2002). Third, individuals required "true reasoning" in relation to the previously described

elements (Hartnug & Blustein, 2002). Through these three key elements, Parsons presented a

major contribution to career theory and practise (Hartnug & Blustein, 2002; Patton &

McMahon, 2006).

The trait-factor theory of career development originated as a result of its association

with vocational theorist Parsons (Rounds & Tracey, 1990). According to Scharf cited in

Patton and McMahon (2006) "trait" referred to the assessments of characteristics of the individual and "factor" involved elements of the job. Many basic assumptions that underlie this theory proposed that the closer the match between personal traits and job factors, the greater the likelihood for successful job satisfaction (Rounds & Tracey, 1990). In addition, it is possible to identify a fit or match between individual traits and job factors using a straightforward decision making process (Singh & Greenhaus, 2004). This can be achieved by objectively identifying each individual's unique pattern of traits that make up their interests, abilities, values and personality characteristics in order to represent an individual's potential (Singh & Greenhaus, 2004).

During the 1950's other challenging theories such as developmental and social learning approaches matured as a number of shortcomings related to the trait-factor approach emerged (Rounds & Tracey, 1990). First, this theory did not account for the way in which there was a broad range of individual differences in every occupational group (Rounds & Tracey, 1990). Second, several criticisms arose in relation to the assumption that individuals used reasoning in all career choices (Patton & McMahon, 2006). Moreover, Zunker (2002) was critical of the failure to account for growth and change in traits such as interests, values, aptitudes, personalities and achievements. Despite the criticisms the trait-factors approach is still a widely used career development theory (Chen, 2003). The introduction of psychometric tests provided through psychology to understand individual differences, contributed to the improvement of the trait-factor theory (Rounds & Tracey, 1990).

An alternative approach to career choice and development was suggested by Donald Super (1957) (Savickas, 1995). Super believed that individuals are anything but static and that personal change is continuous (Patton & Lokan, 2001). Super's life-span/life-space theory is based on a comprehensive developmental model that attempts to account for the various important influences on an individual as they experience different life roles and

various life stages (Savickas, 1995). Super believed "self knowledge" was the key to career

choice and job satisfaction (Savickas, 1995). Individuals reached career satisfaction through

work roles in which they can express themselves and develop their self-concept (Patton &

Lokan, 2001).

Super also proposed that career development is continuous during an individual's life

span occurring during five major life stages: growth, exploration, establishment, maintenance

and disengagement (Savickas, 1995). Individuals are believed to cycle through each of these

stages when they go through career transitions from career entry to retirement (Savickas,

1995). Super later added that individuals cycle and recycle throughout the life span and adapt

to their decisions based on their own changes as well as trends in the work place (Savickas,

1995). In addition, Super contributed to the understanding of age related stages of career

developments and introduced the concept of a life-work balance (Patton & Lokan, 2001). The

positivistic approach to career theory as represented by Holland and Super is characterised by

a linear and rational methodology (Chen, 2003). Conversely, the social constructivist

approach views career as a socially constructed process that accounts for a person's

individual actions and interactions with others (Chen, 2003).

More recently, John Holland's (1985) theory of vocational personalities represented a

person-environment fit approach focusing on individual characteristics and occupational

tasks. Holland (1985) proposed that personalities fall into six broad categories: realistic,

investigative, artistic, social, enterprising and conventional (RIASEC). Although each

individual may comprise all six types, one is ultimately dominant. Individuals gravitate to

particular careers that match the overriding personality type (Holland, 1985; Tracy, 2008).

However, evaluation of Holland's theory in practical application revealed possible

weaknesses when applied to cultural minorities, as the structural assumptions of Holland's

theory tend to fit the majority (Gottfredson, 1999). Despite this perspective, Holland's career

typology has been influential in vocational counselling and employed by popular assessment tools such as the Vocational Preference Inventory, taking a cognitive problem solving approach to career decision making (Patton & McMahon, 1999; Tracey, 2008).

Another comparable theory known as Schein's (1996) theory of career anchors also emphasised that individuals search for environments that match their abilities, attitudes and values (Danzieger, Rachman-Moore, & Valency, 2008). However, Schein organised individual's motives and personality into a higher order pattern of eight career anchors which guided career directions and decisions (Danzieger et al., 2008). These include: autonomy and independence, security and stability, technical-functional, managerial, entrepreneurial creativity, service or dedication to a cause, lifestyle, and challenge (Danzieger et al., 2008).

Schein's model has been criticised for being descriptive, not predictive with regard to career decisions and movement (Arthur, 2008). However, Schein has demonstrated useful heuristics for understanding the reciprocity of influence between the individual and the organisation (Rounds & Tracey, 1990). In addition, Schein's theory raised the notion that pursuit or change of career requires "self-reflection" (Rounds & Tracey, 1990). Much of the criticism that has also centred around the person-environment fit approach is their perceived static nature (Rounds & Tracey, 1990). However, Rounds and Tracey (1990) dispute this critique claiming that it has never been assumed that individuals are incapable of change and dynamic interplay is evident in the descriptions of most of these described theories. Overall, the previous theories all propose that an individual's personality should be congruent with the psychological features of the job (Danzieger et al., 2008; Rounds & Tracey, 1990). Conversely, during their career individuals will find and fulfil the job that best fits their personality profile (Singh & Greenhaus, 2004).

Lastly, Krumboltz (1994) proposed a social learning theory of career decision making and suggested that individual's career choices are impacted by their social learning through

encounters with people, events, and institutions in a particular environment. Krumboltz (1994) proposed that there are four main influences that affect career choice which include genetic, environmental conditions, learning experiences and individual task approach skills, such as self observation. The consequences of these factors, in particular learning experiences lead individuals to develop beliefs about the nature of careers and their role in life (Krumboltz, 1994). His belief was that these learning experiences arise from observations of significant role models such as parents, which make some occupations more attractive than others (Krumboltz, 1994).

Future career decision theories may need to adapt and become more holistic as a result of the changing job markets, the majority of which require rapid adaptation of knowledge and skills (Savickas, 2000; Woodd, 2000). For example, more recently Bloch (2005) recognised the role spirituality played in career decision and development. Research by Savickas cited in Bloch (2005) proposed that the traditional rational approach of career decision fails to consider complex human qualities such as spirit, consciousness and purpose. The conventional path of career development which led to stability may be replaced by a concept of careers characterised by lifelong learning and change (Bloch, 2005).

There are many unmentioned career decision and developmental theories equally as important in their contribution to this field, and the acknowledgement that no one theory can independently explain individual career choices (Brown & Brooks, 1990). The actual decision making process will now be discussed, together with a brief explanation of normative and descriptive decision making models. The research emphasis is on how individuals' choose a particular course of action, such as changing career, especially in situations of uncertainty where the consequences of their actions are unknown (Williams, 1996).

Decision making process.

Decision making occurs in all aspects of human thought and action and as a result many disciplines dating back four decades have actively been concerned with theorising, analysing and systemising the decision process (Halberstadt & Catty, 2008; Klein, Orasanu, Calderwood, & Zsambok, 1995; Vos & Baumeister, 2007). Decision making is defined as a judgement or position reached after consideration involving cognitive processes used in selecting, choosing, judging, evaluating and resolving various alternatives (Cooksey, 1996).

Many factors play a part in decision making which include: the roles of individuals and significant others (Beck, 2005; Felps et al., 2009); level of risk or crisis (Slovic, Peters, Finucane, & MacGregor, 2005; Sweeny, 2008); environment (Tracey, 2008); rational thinking (Hastie & Dawes, 2001); self efficacy (Bandura, 1977; Maurer, 2001); social cues (Averbeck & Duchaine, 2009); intuition (Singh & Greenhaus, 2004); and personality, age, beliefs, values, desires, and emotions (Chernev, 2009; Schick, 1997; Vos & Baumeister, 2007). There are varying opinions regarding the decision process, however many researchers agree that decision making has previously been classified in terms of normative and descriptive models (Cohen, O'Connor, & Breen, 2004; Mullen & Roth, 1991).

Normative (or prescriptive) theory searched to discover logical rules for making decisions concerning how individuals' ought to think (Ferreira, Garcia-Marques, Sherman, & Sherman, 2006). For example, a normative decision theorist would ask how a "rational" decision maker would act in order to make the "best" decision (Cohen et al., 2004; Mullen & Roth, 1991). Psychological studies of human decision making began with normative models, however there was also a growing interest in the cognitive and evaluative processes behind a particular choice or judgement that also involved the role of emotion and motivation (Hastie & Dawes, 2001).

In contrast the *descriptive (or empirical)* model encompasses a more cognitive perspective endeavouring to determine what decisions an individual would make (Cohen et al., 2004; Mullen & Roth, 1991). Descriptive theory, was concerned with "what is", not "what ought to be" (Ferreira et al., 2006). This theory searched to discover patterns, regularities, or principles in the way individuals actually make decisions based on their goals, values, state of knowledge, and prejudices (Ferreira et al., 2006; Mullen & Roth, 1991). The question of whether the decision was good or bad was not so relevant (Ferreira et al., 2006).

Researchers agree that most decisions involve a complex interplay of many factors and involve a highly specific set of circumstances (Sweeny, 2008). According to Svenson (1979) human decision making could not be understood merely by considering final decisions. Rather, perceptual, emotional and cognitive decision processes that ultimately result in the *judgement* or *choice* of a decision alternative (Svenson, 1979). Decisions then, in one form or another involve several levels of brain function (Payne, Bettman, & Johnson, 1994). The process used in choice and judgements may be referred to interchangeably, however further discussion will outline the differences between these similar terms (Chernev, 2009; Maule, 2001 Payne et al., 1994). Researchers such as Payne et al. (1994) indicated that *choice* involves looking for similarities among features that distinguish between alternatives. For example one may wish to purchase a laptop, when considering price and features unsuitable laptops may be ruled out and the first acceptable brand chosen. A choice response requires only that one alternative is selected and the rest rejected (Cohen et al., 2004; Payne et al., 1994).

The economic prosperity of Western society has provided many individuals with the freedom to choose (Hastie & Dawes, 2001). Although it has been argued that this "self determined" behaviour and available opportunities may seem beneficial to career satisfaction (Iyengan, Wells, & Schwartz, 2006), research on decision making reveals a somewhat

different picture (Anderson, 2003). Research by Iyengar et al. (2006) proposes that when

individuals are confronted with more choices, they can be less content.

There may be different explanations for these results. The more choice options are

presented the more individuals strive for the best one (Iyengar et al., 2006). This indicates

that they set higher norms for their choice (Iyengar et al., 2006). When thinking about leaving

nursing for example, an RN could opt for another job that pays well, is exciting and offers

optimal career opportunities (Iyengar et al., 2006). Unfortunately few jobs exist with all such

criteria (Iyengar et al., 2006). Alternatively, if individuals have too many choice options there

is a greater risk of making the incorrect decision (Iyengar et al., 2006).

Judgement however is described as an "assessment between alternatives" (Williams,

1996). For example, when assessing options and considering different careers in terms of

income and lifestyle. Maule (2001) suggested that the process of judgement involves the

integration of different aspects of information about a situation to arrive at an overall

evaluation. Judgement and choice although closely linked, generate independent cognitive

demands and present unique challenges to researchers (Maule, 2001).

Studies by Spicer and Sadler-Smith (2005) have recognised the role of individual

differences in decision making behaviour and identified five decision making styles: *rational,*

*intuitive, dependent, avoidant, and spontaneou*s. The style used may depend on the individual

and the circumstances surrounding the decision (Spicer & Sadler-Smith, 2005). For example,

a rational strategy would be difficult under time pressure especially if the decision is highly

complex (Hastie & Dawes, 2001). Nevertheless it is apparent that individuals often do their

best to approach decision making in a rational manner by thorough thinking, simplifying the

decision task, or developing straightforward decision making rules (Hastie & Dawes, 2001).

Recently cognitive psychologists have studied the role of unconscious thought in

decision making (Dijksterhuis, 2004). This approach examines whether cognitive decision

making processes also take place outside conscious awareness and established that

unconscious processes occur and influence an individuals' decisions (Dijksterhuis, 2004). For

example, individuals often decide to delay a difficult decision (Dijksterhuis, 2004).

According to Dijksterhuis (2004) after a period of what seems to be cognitive inactivity

concerning the decision dilemma, an individual may unexpectedly have a feeling about what

to decide. Research has shown that this unconscious processing led to improved and more

coherent decisions than rational thinking alone (Dijksterhuis, 2004). The combination of

rational thinking and "gut feeling" or intuition, may according to Dijksterhuis (2004)

ultimately lead to optimal decisions.

Conversely, the dependent, avoidant and spontaneous styles of decision making are

all expressions of *indecision* (Spicer & Sadler-Smith, 2005). In general research by Anderson

(2003) suggests that individuals become indecisive when two conditions are not fulfilled.

First, a chosen option must be a least minimally appealing and second, the chosen option

must be comparatively better than other available options (Anderson, 2003).

According to Lee (2005) two critical components of career decision making relate to

an individual's degree of self-awareness including their understanding of the world of work.

In addition, self efficacy beliefs and more specifically perceptions of competence have long

been linked with career interest development (Bandura & Schunk, 1981). Considered to be

highly relevant to career behaviour, self efficacy is defined as an individual's belief or

confidence in their ability to perform a given behaviour or a set of tasks (Bandura, 1977). The

theoretical link between self efficacy and career choice is that self efficacy expectations serve

as a motivational factor. Without the belief that an individual would be somewhat successful

at a vocation, that individual would have little incentive to approach and persevere in that

career (Bandura, 1977; Lee, 2005).

More recently, contextual factors such as siblings, parents and peers have also been studied independently to investigate how they shape the career decision process (Zimmerman & Kontosh, 2007). Systems theory framework (STF) integrates both this contextual system and the individual system which are believed to be the key to the decision process (Zimmerman & Kontosh, 2007). STF proposes that career development is a lifespan phenomenon and requires ongoing decision making. This process of arranging information is continually being received throughout the system, consciously and unconsciously to initiate the individual to make evaluations subjectively and objectively about their career (Zimmerman & Kontosh, 2007).

The majority of career theorists emphasise that individuals themselves are active shapers of their career decisions and no one factor can determine the variations in this process (Singh & Greenhaus, 2004). The decision process is influenced by a number of internal or external factors which create some level of discomfort for individuals who then attempt to search for career environments that match their personality, abilities, attitudes and values based on previous social and cognitive learning experiences (Singh & Greenhaus, 2004).

There is much literature and research related to career developmental framework and decision making (Chen, 2003). A number of studies have attempted to examine the factors that contribute to a nurse's decision to leave the profession for other careers (Cheung, 2004; Rajapaska & Rothstein, 2009). However the limitations of the previous research studies are discussed in the next section.

Limitations of previous research.

The Bureau of Labor Statistics (BLS, 2008) recognised the difficulty in estimating the number of times an individual may change career during their working lives. There is no consensus as to what represents a career change as many job descriptions can often be blurred (BLS, 2008). For example, consider whether a construction worker who starts his own

painting and renovation business has made a career change. One must also consider how long

an individual needs to stay in a particular line of work in order for this to be considered their

career.

In relation to RNs, although there are extensive studies on nurses' intention to leave

the profession (Barron & West, 2005), it is difficult to distinguish between those nurses who

are momentarily considering leaving the profession and those who follow through with this

process. Additionally many studies are small scale and not representative of the general

nursing population and factors that affect the UK or USA may not necessarily be pertinent to

the Australian context (Barron et al., 2007). The variety of study populations, inconsistent

definitions and measurements of nursing turnover also make it difficult to combine studies

(Barron et al., 2005). Furthermore, the majority of previous data collected is cross sectional,

therefore making it difficult to assume any direction of causality among the variables

(Duffield et al., 2004).

In addition, DEST (2001) commented that there are limitations with regard to nursing

labour force surveys. There is a time lapse of approximately two years between data

collection and the available publication resulting in outdated data (DEST, 2001). Moreover,

methodological problems such as multi state registrations and unpredictable response rates

limit the use of nurse labour statistics (Duffield et al, 2004; Rajapaksa & Rothstein, 2009).

Many of the studies presented refer to "nurse participants" however these often

include nurse assistants and enrolled nurses who may have a different perspective of work

experiences due to the diversity in job definitions, education and training. This research aims

to only identify the experiences of RNs, as a specific group as this does not appear to have

been previously explored. The majority of the research published has also incorporated

quantitative techniques by analysing surveys to examine the factors leading to the decision

for nurses to leave the profession. As there is limited research currently available in the form

of qualitative methodology, this study will contribute to the research employing narrative interviews.

Overview of the current study.

Although previous literature appears to focus on nurse's "intention" to leave the profession (Barron & West, 2005; Camerino, Muller, & The Next-Study Group, 2008) there is little research that examines the decision making process associated with "actually" leaving nursing. This premise is supported by Duffield et al. (2004) who stated they were unable to locate any studies that investigated nurses who were working in different careers and the reasons for leaving the profession.

There are two benefits to examining nurses who have left the profession as stated, "research into turnover should focus on actual leavers - these after all, are those who have gone through with the decision to leave. Although this may seem commonsense.......most research on turnover has been conducted with existing employees" (Morrell, 2005, p. 316). Morrell (2005) stated that this method is flawed as many nurses may have the intention to leave without actually following through with this decision. A further benefit involves recognising the chain of events that lead to the leaving process (Morrell, 2005). Nurses decide to change careers and leave their jobs in diverse ways, for some this is a lengthy evaluated process changing wards, then hospitals and finally the profession (Morrell, 2005). However, for others this may be a rapid decision within a short period of time possibly due to a shock event (Morrell, 2005).

The aim of this research is therefore to investigate nurses who have left the profession and examine the decision making process employed when deciding to change career. As supported by Morrell (2005) a decision based approach is most appropriate when analysing nurses leaving the profession, given that nurses are able to move between varying jobs far more easily than other employees. The specific research question for this research study is:

What are the factors which contribute to the decision making processes of registered nurses when they decided to leave the profession?

Methodology

Methodological Approach

Previous development of research methodology has been concerned with the application of two complementary but distinct approaches. First, quantitative research applies statistical analysis to ascertain results which are then reported in an objective and unbiased manner (Patton, 2002). Second, qualitative research defined by Stauss and Corbin (1990) as "any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification" (p.17). With either approach, questions need to be addressed within the context of the setting, and consideration given to the traditional concepts of reliability, validity and objectivity (Henwood & Pidgeon, 1992).

Reliable studies are concerned with the extent to which the research will achieve the same results when repeated (Liamputtong & Ezzy, 2005). Internal validity allows for the rejection of alternative explanations for the results and external validity refers to the generalisability of the experiment to other settings, conditions, and participants (Liamputtong & Ezzy, 2005). An audit trail according to Nagy and Viney cited in Cohen et al. (2004) is the best way to ensure that the research process is open and available by allowing others to assess, evaluate and form their own judgment of the research. In addition, Nagy and Viney suggest feedback loops and repetition of the research cycle that incorporates rigour and researcher awareness all contribute to the internal validity (credibility), external validity (transferability), reliability (dependability), and objectivity (conformability) of the research (Cohen et al., 2004).

The naturalistic paradigm within qualitative research maintains that individuals encounter diverse life experiences that require an interpretive approach to these varying world views (Strauss & Corbin, 1998). More specifically, within qualitative research "narrative methodological analysis" which has been applied to this study, "offers expression to experience and feelings but within the framework of a story and its telling (Cohen & Shires, 1988, p.1). Cohler described narratives as "the most internally consistent interpretation of presently understood past, experienced present and anticipated future (Cohen et al., 2004, p.261).

Standard interviewing in qualitative research relies on participants answering specific questions which may be expanded upon, however this method may not elicit the essence of each individual's experience (Riessman, 1993). However, narrative methodology examines the participant's account first hand enabling the researcher to consider not only the content but also the context, construction and delivery of their personal story (Cohen et al., 2004; Riessman, 1993). According to Riessman (1993) of particular interest to narrative researchers is witnessing how participants impose order on the flow of experience to make sense of decisions in their lives, therefore examining "why the story was told that way".

Narrative analysis methods are considered time consuming and therefore not appropriate for studies involving large numbers in which researchers seek a simple and unobstructed study of participant's lives (Riessman, 1993). There are criticisms of narrative analysis in relation to how closely the results of research match reality (Boje, 2002). An attempt to achieve high credibility (internal validity) during the current study was achieved through a process of rechecking transcripts with the participants and in collaboration with university supervisors who were experienced with qualitative research.

Additionally, as proposed by Lincoln and Guba cited in Cohen et al. (2004) by providing "thick descriptions" of participant accounts there is more chance of generalising

these findings and improving the transferability (external validity) of this study. Moreover, as interpreters and witnesses in the lives of others, researchers need to be mindful of doing justice to an individual's narrative account (Riessman, 1993). This may be achieved by facing complexities and biases in our own judgement, by being objective and resisting the academic pull towards a "simple" consistent story (Riessman, 1993).

According to Tappan, cited in Patterson (2002) the narrative approach is particularly suitable for those whose goal is to understand complex human behaviour such as decision making. This study aimed to validate the research enquiry of RNs by adopting Riessman's (1993) five levels of representation in the narrative research process (Appendix A). As proposed by Cohler, cited in Cohen et al. (2004) one of the most significant ways that people make sense of their experience is through telling their story. The purpose of using Riessman's narrative analysis guideline was therefore to provide value and meaning through a comprehensive account of participants' unique events and personal reflections which influenced their decision process to change career (Riessman, 1993).

The participants' stories will be presented in the form of vignettes. Each vignette symbolises a variety of experiences expressed by the RNs to ensure that their anonymity and confidentiality was maintained. The vignettes are not stories of specific RNs but were structured to enable the reader to gain a more accurate picture of factors that contributed to their decision to change career.

Participants

Ten females met the following research criteria and agreed to participate in narrative interviews (see Table 1). These participants were over the age of 25 years, had all previously worked as RNs for a minimum of five years and were not currently employed in the nursing profession. This included employment where the participants were not required to be RNs even if this qualification may have been useful. Participants had also left nursing within the

last six years which helped prevent the inclusion or omission of vital information such as

trigger events that may have changed over time. In addition this study did not include

participants who left due to pregnancy, to distinguish between factors relating to the nursing

profession rather than personal circumstances such as starting a family. The mean age of

participants was 39 years ($SD = 7.06$).

Table 1

Participant Demographics

Participant	Age (Years)	Years employed In Nursing	Years Since Leaving Nursing	Current Profession
1	53	32	3	Small business owner
2	31	6	5	Physiotherapist
3	44	18	4	Naturopath
4	36	10	5	Psychologist
5	44	15	6	Lawyer
6	41	12	4	School Dental Therapist
7	28	5	1	Medical Representative
8	37	10	6	Occupational Health & Safety Representative
9	39	16	2	Photographer
10	38	11	5	Paramedic

It is estimated that ten informants was reasonably sufficient to achieve data saturation,

as outlined by Strauss and Corbin (1998), and more recently in Liamputtong and Ezzy's

(2005) discussion of saturation theory. In addition, while it is acknowledged that there are

many RNs who are male (Rajapaksa & Rothstein, 2009) research has indicated it is an

overwhelmingly female profession (ABS, 2001; Rajapaksa & Rothstein, 2009).

Consequently, only females were selected for the study.

Ethics

Permission was granted for this study from the Faculty of Computing, Health and Science Research Ethics Committee prior to the commencement of the research. Ethical considerations were taken into account throughout the research process, and participants were made aware of their right to withdraw at any time. To aid with de-identification participants were requested to provide a pseudonym, however the details in Table 1 are not linked to the pseudonyms in order to further protect the identity of participants.

Materials

An advertising flyer (Appendix B) invited individuals to participate in this research, interested participants then received an information letter (Appendix C). A consent form (Appendix D) and demographic data sheet (Appendix E) were completed by participants. A storyboard (Appendix F) was presented to participants prior to the interviews. All participants were provided with the contact details of support services (Appendix G).

Procedure

Recruitment of the ten participants was carried out with the assistance of advertising flyers placed at Edith Cowan University, Joondalup and Mount Lawley campuses, as well as shopping centre notice boards. Four suitable participants responded to the flyers and a further six participants were recruited through snowball sampling. Therefore, current participants identified other individuals of the population who also met the necessary participation criteria previously mentioned.

After initial introductions, an information letter was posted to the four individuals who initially contacted the researcher via mobile phone or email in response to the advertising flyer. Additionally, these four participants were able to provide information about the study to a further eight potential subjects. Individuals who were interested in participating

in the research, contacted the researcher directly, six of whom met the necessary criteria and

agreed to participate after receiving the information letter.

Prior to the commencement of the interview, participants were provided with the

opportunity to ask any further questions before signing a consent form. Permission was

obtained to audio record the interviews. The consent form also requested permission to

contact them, if necessary, at a later date for feedback in relation to the researcher's

interpretations of their interview. A summary of the research will be made available to the

participants if requested. Participants completed a demographic data sheet providing

information regarding their age, years spent working as a RN, current profession and years

since leaving the nursing profession. Interviews were conducted at a mutually agreed location

between July and August 2010 and lasted up to an hour.

To facilitate recall the interviewer presented a storyboard to the participants that

provided suggestions on how to structure and discuss their personal experience. The

researcher began the interview by reading the following paragraph to each participant:

> *"I would like to hear your story of leaving nursing, how you came to the decision to*
> *change career and what factors influenced or may have changed your decision. I have*
> *no set questions, l would just like to hear this in your own words. There is no*
> *incorrect way of telling your story just talk in a manner that is a relaxed style for you*
> *... please now tell me about your career change experience from the beginning".*

The narrative interviews were audio recorded and subsequently transcribed verbatim to

ensure an accurate representation of the conversation, prior to data analysis. This interview

process was not expected to be uncomfortable or stressful, however all participants were

provided with the contact details of career and psychological support services should they be

required.

Analysis

As recommended by Riessman (1993) the analysis started with a draft on paper of the complete transcriptions, also documenting any essential non verbal features such as sighing or pauses. As suggested by Boje (2002) a journal was kept in which notes and comments were recorded which formed part of the audit trail. Also included were recommendations by Josselson (1996) who suggested that while reading these transcriptions the researcher should endeavour to acknowledge her own biases noting these reactions in the audit trail to ensure later reporting. The interview tape recordings were deleted after transcription and computerised documents were adequately secured and password protected.

Significant statements were noted and a list of recurring concepts and themes highlighted (e.g., family reasons for leaving). The statements were grouped in units of meaning later defined through cross-case analysis and the common relational themes grouped together as suggested by Hill, Thompson, & Williams (1997) and Strauss & Corbin (1998). The emerging categories and sub-themes were formed around the common issues that affected RNs and led to their decisions to change career (Appendix H). In order to ensure that all themes were included, the researcher went back over previous interviews. The researcher with the help of her supervisor then revisited the transcripts and analysed data to ensure accuracy and consistency.

In line with Cohen et al. (2004) this research used vignettes to present the participants' stories. These three vignettes are not individual stories, rather a collated depiction and interpretation of the factors which contributed to the decision by the RNs to change career. This method provided a more precise account of the factors that contributed to RNs decision to leave their profession whilst maintaining anonymity and confidentiality.

Findings and Interpretation

Description of Vignettes

Vignette One.

Megan is currently a 37 year old physiotherapist who left nursing six years ago after working with spinal rehabilitation patients for over five years. Although challenging, the nursing was described by Megan as "heart breaking watching the patients go through months of agonising therapy and painful rehab." The line between Megan's personal and work life became blurred as she found herself caught up in the tragedy of each patient stating she felt "useless and guilty about her own freedom." Megan recalls the turning point for her was after witnessing an event with a male quadriplegic patient she had been nursing for six months. Megan remembers "the way he looked with such despair when his wife walked out of the room after telling him she was leaving permanently." The following weeks Megan spent vomiting, unable to eat and experienced episodes of memory loss. According to Megan a number of other factors contributed to her situation. First a lack of manager support in regard to counselling which was available but not encouraged. Second the nursing culture of "putting up with it as though it's all part of the job." Physiotherapy enables Megan to still help people and provides her with a sense of purpose as she can effectively contribute to her patient's recovery. Megan has no regrets about her decision to change career, but occasionally reminisces about the spinal patients and "hopes they have nurses that are better able to cope with the demands of the job."

Vignette Two.

Ellen a 44 year old mother left nursing four years ago to work as a school dental therapist after nursing for 18 years. Ellen moved from the hospital setting to live in the country and worked in areas such as midwifery and surgical nursing. Although Ellen initially loved the variety in her work, she also encountered numerous episodes of verbal and violent

abuse. "Many of the patients came in drunk or on drugs and there wasn't any support." Ellen

began to feel vulnerable and later described her frustration at working with locum doctors

who were also verbally abusive and demanding. Ellen started to resent her job but she did not

leave until her husband was transferred back to the city when she decided to work as a

community health nurse. Ellen enjoyed the autonomy and freedom of home visits. However,

a series of unexpected events lead to Ellen's decision to change career. Ellen witnessed a

deceased patient during one of her home visits and struggled with the realisation that she was

the last to see this lady who had died alone several days earlier. The following week Ellen

was assaulted by a patient's son, a drug addict, who wanted morphine presuming she carried

this prescription drug. "He had me pinned against the wall, I can still remember the stale

smell of the cigarettes on his fingers." After the event Ellen began to suffer panic attacks and

despite counselling did not return to nursing. Dental therapy suits Ellen's lifestyle, she can

still work autonomously and safely in the community. Ellen has no regrets and will not return

to nursing, she especially appreciates the school holidays and family friendly hours in her

new career.

Vignette Three.

Cathy is a 39 year old photographer who has worked in the hospital system for 16

years. Initially, Cathy spent four years working in a busy emergency department (ED) and

was eager to face the challenges of trauma nursing. However, the pace was hectic and Cathy

often nursed critically ill patients in corridors over a number of days. "There just wasn't

enough resources ... and in ED the patients don't stop coming so there ends up being a

backlog which affected patient care ... I personally struggled with this." The heavy workload

and shifts involving nights and weekends began to affect Cathy's health and she started to

have difficulty sleeping and later suffered a back injury. Once recovered, Cathy decided to

work in intensive care (ICU). Although at times rewarding, in ICU Cathy experienced limited

education and training support, fearing for the safety of her patients. "There was a phenomenal amount of ventilators, pumps and machines that we were expected to use and 1 just did not feel confident in the training 1 received to do this safely." Cathy also struggled with her work roster, getting days off when her son was in day care and then having to organise babysitting for weekend shifts which was not financially viable. Cathy then tried oncology nursing which she enjoyed until her father was admitted as a patient onto the ward she worked. "I had to cope with my dad who became terminally ill and remain professional on the ward within my nursing role, 1 failed at not being able to do either of these one hundred percent." After Cathy's father passed away she started to realise how nursing had consumed her life. "All my nursing career 1 have been surrounded by illness, looking back 1 also struggled to balance my family life and for very little recognition." Cathy left nursing two years ago, she did not come to this decision easily, in her opinion this was the result of many contributing factors over a significant period of time.

The stories described above discuss diverse factors which may have contributed to the RNs decision to leave the nursing profession. These attributes have been combined to compile stories, which represent different themes of all ten participants interviewed. Table 2 contains four main categories and further subthemes identified from the analysis of participant's responses which include: work environment, management, challenges and remuneration.

As Riessman (1993) proposed "narratives are interpretive and, in turn, require interpretation" (p.22). Therefore the following section discusses the interpretation of significant factors analysed and documented by the researcher and supervisor who contributed to the validity of the findings. Reference is made to previous research as the findings are presented.

Table 2

Identified Categories and Sub-themes contributing to RNs Leaving Decision

Main categories	Sub themes
Work environment	Nurse/physician relationship
	Nursing culture
	Technology
	Reality versus expectations
Management	Administration
	Increasing workload
	Staffing levels
	Education and support
Challenges	Family impact
	Personal health and safety
	Autonomy
	Shiftwork
Remuneration	Financial recognition
	Personal recognition

Work environment

There were four sub-themes that RNs in this study attributed to the work environment as factors that influenced their decision to leave nursing. These included nurse/physician relationship, nursing culture, technology and reality versus expectations.

Nurse/physician relationship.

Historically the nurse-physician relationship has been complex and challenging (Aitken et al., 2002). Previously, nurses were seen as less superior with doctors rarely being questioned regarding patient care (Aitken et al., 2002). More recently however the relationship between these professions has improved with more congruent, interactive and effective communication between nurses, doctors and other healthcare professionals

(Blakeley & Ribeiro, 2008). Despite this several RNs in this study disagreed and spoke of the

difficulty that still occurs especially in remote communities when working with several

physicians:

> *"Many of the junior nurses were wary of the experienced surgeons and reluctant to admit when they had made a mistake for fear of reprimand." (P 10.)*

> *"I could sense that if I had not been there the graduate nurse may easily have been bullied into not following the correct hospital procedure." (P 5.)*

Nursing culture.

Many participants of this study did not only refer to this relationship with doctors but

also commented on their frustration with other nursing co-workers especially involving

standards of care that many participants felt was inadequate. In addition the participants also

commented that they often felt a lack of control and were powerless to change the culture of

nursing. This opinion is not isolated and supports research by Burke (2005) suggesting that

RNs are seeking a culture that supports and empowers them in the practise of professional

nursing. This culture requires the support of hospital organisations, governing boards,

physicians, co-workers and management teams that have the passion and vision to make it

happen (Barron et al., 2007; Burke, 2005; Kuhar et al., 2004). As commented by participants:

> *"I tried to teach the students the correct techniques do but then other nurses would cut corners to save time and not do the things properly... l remember how the beds had to be made perfectly with all the corners folded a certain way, no creases and all that... the standard of care was excellent ... this is not the case anymore." (P 1.)*

> *"I tried to set an example by not wearing heaps of jewellery it looks so unprofessional, but many nurses came to work covered in bling." (P 5.)*

> *"The nursing culture attracts mainly women who can be extremely bitchy ... we are not very good at looking after each other." (P 9.)*

> *" I know so many nurses who are looking for other jobs because they don't believe it will get better, don't have the resources to improve the situation and feel powerless ... l am worried about the future of this profession." (P 10.)*

Technology.

The advancement in technology within nursing is concerning many RNs especially those nearing retirement (Blakeley & Ribeiro, 2008; Cheung, 2004; Hasselhorn et al., 2008). Inadequate training on complex and rapidly changing equipment has not only directly impacted on patient safety, according to Blakeley & Ribeiro (2008) many nurses as a result are experiencing a lack of confidence in their ability to work safely and effectively. Several participants in this study supported previous research on nursing turnover suggesting that this increase has directly contributed to the decision for many to RNs to leave the profession:

> *"There are so many machines, pumps and monitors to figure out, l wasted so much time worrying about whether l'd done this properly which frustrated me, l felt l wasn't giving my patients the best care this did impact on my decision to leave." (P 7.)*

> *"I was often put in situation where l had to run cell saving machines to reinfuse blood and other equipment that l wasn't adequately trained on ... we should have been sent on a course ... l know in some situations this just wasn't happening." (P 9.)*

Realities versus expectations.

Previously, there has been much controversy concerning university versus hospital based nursing training (Aiken et al., 2002). As discussed many believe that university trained nurses experience "reality shock" when faced with the reality of nursing work, which is incongruent with their expectations of the profession (Gaynor et al., 2006). However the results of this study do not support this perspective as the majority of participants stated that in general new graduates seemed well prepared for the demands of the job. In addition many commented that the hospitals and universities seemed to be working together to provide adequate support and training during their first graduate year as RNs:

> *"The nursing work was just as l had envisaged, l didn't get any huge surprises and during my first year as a RN l felt recognised as being fairly inexperienced ... there was lots of support and education provided." (P 7.)*

> *"The university l went to about 15 years ago didn't send me on prac until the last year, l thinks this has changed thankfully ... l got a real shock when l started working." (P 10.)*

> *"I was one of the first university trained nurses and I found the transition really difficult ...but recent graduates I worked with before leaving seemed better prepared."* (P 5.)

As suggested in the above comments, initiatives introduced by universities and hospitals appear to be successfully closing the gap between the reality and expectations of the nursing profession. A recent article published by the Joondalup Times supports this perspective stating that Edith Cowan University (ECU) nursing students would be among the first involved in a pilot program at Joondalup Health Campus to include "night shift" in their training later this year (Willoughby, 2010). Ramsay Health Care state manager Kevin Cass-Ryall suggested that universities are keen to introduce night shift experience to provide greater reality, therefore supporting the practical content of their courses (Willoughby, 2010). In addition, ECU Associate Dean of Health Professor Cobie Rudd stated that the scheme intends to develop student's clinical skills, confidence and provide enhanced decision making opportunities within their scope of practise thus preparing them for out-of-hours work (Willoughby, 2010).

Management

As previously discussed, according to Duffield et al. (2007) there has recently been considerable transformation within hospital management. Hospital restructuring such as the introduction of directorates (e.g., medical, surgical and ancillary care) which employ business managers responsible for overseeing individual cost centres is one example (Duffield et al., 2007). A significant impact of current approaches to this reform, is the loss of, and change to, nursing management identity. In addition nurses and physicians are more recently referred to as "providers" and patients commonly known as "consumers" (Quinn, 2002). This has become a language of business rather than healing (Quinn, 2002). In addition, many hospital employees are becoming increasingly frustrated with managerial decisions that seem business orientated, profit related and not centred around patient care (Patrick & Laschinger, 2006).

Studies by Branham (cited in Cohen, 2006) found that in an exit interview of 20,000

employees, poor managerial behaviour was cited as the top reason for leaving. The results of

this study indicate that a number of management issues were also contributing factors in the

decision to change career for these participants. The four managerial sub-themes identified

included: administration, education and support, increasing workload and staffing levels.

Administration.

A number of participants supported previous research referring to a lack of

organisational trust. High levels of organisational trust are inevitable when employees feel

the administrators have created work conditions that allow them to feel confident in their

ability to act based on their expert judgement (Aiken et al., 1994). Research by West (2001)

has shown that trust in management has been linked to nurses' commitment to the

organisation and job satisfaction. This in turn has been correlated to a patient's perceptions of

quality care, therefore indicating that in an environment of mistrust, patient care could

ultimately suffer (Aitken, 2002; West, 2001). As some participants commented:

> *"I had been let down by my hospital over a number of incidents ... despite my efforts*
> *to communicate concerns, nothing was ever done ... the trust just wasn't there."*
> *(P 10.)*

> *"I put myself on the line a number of times l don't know if management would have*
> *backed me if l needed support, in the end l know that patient care was compromised."*
> *(P 6.)*

Studies by Andrews and Dziegielewski (2005) also report that turnover rates among

"nursing managers" are comparable with those experienced among nursing staff. Therefore

one could conclude that the nurse manager, on whom the organisation relies, is at times ill

equipped to meet that challenge (Andrews & Dziegielewski, 2005). As commented by

participants:

> *"I also see failures on the part of my managers who in so many ways may have*
> *provided more emotional support to all the staff but seemed to be more concerned*

about the doctors, maybe they didn't know where to start themselves ... but then who is takes responsibility in the big picture." (P 5.)

"My manager didn't know what to do ... she was caught between us and the hospital powers to be." (P 2.)

Lastly, a further administration issue for many of the participants involved understanding where their loyalties lie and who they considered their employer to be (Patrick & Laschinger, 2006). A nurse's sense of employer commitment may include one or a number of the following, the government (public sector), the public (patients), the organisation (health service) or the hospital where they are employed (Patrick & Laschinger, 2006; Roan et al., 2002). This employer confusion was supported by many participants in this research study, who also commented that they have little faith in the government's understanding of the real issues facing public hospitals:

"I found it difficult to know who l was answerable to .... I believed l was there for the patients but then there was also the health service that paid me, the hospital itself, my manager and the doctors." (P 5.)

"I worked in a public hospital so l guess you can say l was employed by the government ... but the politicians have no idea what really happens ... l don't think they have a clue as to how serious the situation is ... or they do and don't want to deal with it." (P 4.)

"I was caught a number of times between the doctor's orders, the patient's wishes and hospital policy and procedure.... sometimes it was hard to keep everyone happy." (P 10.)

As commented above many nurses feel disillusioned by politician's previous management and handling of healthcare issues. However a recent article in The West Australian (2010) reported that Queensland Premier Anna Bligh had volunteered to work as an overnight orderly in Brisbane's Princess Alexandra Hospital (Berry, 2010). As stated by Anna Bligh "we did everything. I went to theatre, l mopped the floor, l went into intensive care and talked to nurses ... it was a full on night and my feet are feeling it" (Berry, 2010,

p.1). Mrs Bligh also spoke to a number of staff about a range of issues such as staffing and received several ideas on how to improve the healthcare situation. As commented by Mrs Bligh " there's some pretty heart-wrenching cases you come across in a hospital and people are often pretty vulnerable at night time ... l feel very honoured to have shared their work place ... this is a very important part of our government connecting with community" (Berry, 2010, p. 1). Although the success of this government initiative is yet to be realised, the efforts by Premier Anna Bligh to understand the issue faced by healthcare professionals were encouraging and well received by hospital staff (Berry, 2010).

Education and support.

There has been little argument in relation to the importance of ongoing education and training (Hasselhorn, 2008; Takase, 2008). However, managers are required to consider several financial implications in relation to staff professional development. The costs incurred in facilitating professional development and the availability of staff to replace the nurses attending this training (Cohen, 2006; Takase, 2008). For example, as a result of nursing shortages, experienced nurses often have the greatest difficulty attending educational opportunities (Cohen, 2007). Consequently, many nurses over 55 years of age experience reduced levels of confidence as they fall behind in acquiring new skills (Cohen, 2006).

This study supports previous research stating that RNs who do not receive this education and training become very disillusioned and dissatisfied with work (Barron et al., 2007; Camerino et al., 2006). As research by Cohen (2006) states, it is in the manager's best interests to make a concerted effort by encouraging experienced nurses to continue their professional development. Unfortunately this was not reflected in the experience of several participants. For example:

> *"We were only allocated a one hour session each week for in service training and that was not enough to keep up to date with all the changes and training ... if you were rostered off on this day it was tough luck." (P 10.)*

"The hospital did have professional development days but we could only attend two a year which l didn't think was enough for nurses who worked full time."(P1.)

"Initially l was so motivated to learn ... but it was too difficult to get the time off work." (P 3.)

Increasing workload.

Research suggests that the nature of nursing work has changed considerably over the last decade (Reineck & Furino, 2005). Nurses are now expected to complete more paperwork, manage more patients with less staff and have acquired a number of roles that would traditionally have been performed by other hospital employees (Rajapaksa & Rothstein, 2009; Reineck & Furino, 2005). For example, the lack of administration staff particularly after hours results in nurses answering phones and attending to clerical duties creating constant interruptions to nursing care (Blakeley & Ribeiro, 2008; Fochsen, 2005). This view was supported by participants of this study who commented that:

"We seem more concerned with the patient notes rather than hands on care in the way that l was taught there is a general fear of legal action if incidents are not documented in detail" (P 1.)

"I worked night shiftwork in operating theatre, at night we were expected to do the job of orderlies such as cleaning and lifting patients, we also cleaned all of the instruments normally done during the day by other staff and on public holidays such as Christmas a nurse had to sit in the office so that the secretaries could have the day off ... l was quite happy to do my job but not everyone else's as well." (P 7.)

Staffing.

Recently, more universities and hospitals are reporting potential results in their efforts to recruit nurses. Willoughby (2010) reported, Joondalup Health Campus was overwhelmed by the expression of interest by nurses to the hospitals recent careers open day. This event was part of a recruitment drive for some of the 800 new staff required by 2013 due to hospital expansion (Willoughby, 2010). Despite this encouraging report, previously, new entrants into nursing have not been increasing at a rate sufficient to meet the demands of the profession

(BLS, 2008). In addition to the unsatisfactory number of graduate nurses available, there is

also a lack of experienced staff (Gaynor et al., 2006). An essential element of an effective

nursing retention strategy is a culture that appreciates the knowledge, experience and

perspective that older nurses can provide to an organisation (Blakeley & Ribeiro, 2008;

Cohen, 2006). Several participants of this study supported this opinion:

> *"I remember approaching my manager when the staffing levels became ridiculous, at first she was very supportive but over time she became less interested, it was as though she did not see any possible change to the situation in the near future." (P 4.)*

> *"This particular hospital l have heard since leaving are reducing more staff levels on the floor this is why the majority of senior nurses are going ... l can't believe it." (P 9.)*

Challenges

According to results of this study the nurses are legitimately concerned about patient

care, patient safety, professional opportunities, staffing, and work/life balance (Barron et al.,

2007; Cheung, 2004; Rajapaksa & Rothstein, 2009). However the challenges faced by many

RNs contribute significantly to their decision to change career (Hasselhorn, et al., 2008). Four

sub-themes were expressed as professional challenges by the participants of this study which

included: family impact, personal health and safety, autonomy and shiftwork.

Family impact.

Nurses according to Holtom and O'Neill (2004) were found to assign particular value

to family and the work-life balance. In addition research by Rajapaksa and Rothstein (2009)

commented on the importance of hospitals to coordinate more flexible work arrangements in

order to achieve this balance and retain nurses. Several of participants of this study agreed:

> *"The main reason l left nursing was because of my family l wanted to be there for them after school and on the weekend." (P 6.)*

> *"In theatre l often started at seven in the morning and there was an expectation that l would always stay until the end of the list... surgery was always over booked and this made it difficult for me to leave on time and pick up my kids from day care which closed at six ... " (P 5.)*

Personal health and safety.

As the vignettes suggested, incidents of work related violence were contributing factors for 90% of the participants in this study. This supports research by Chapman and Styles (2006) stating that the health industry has been found to be the most violent within Australia. In addition a West Australian report by Pen indicated that during 2006 there was an increase of 30% of nurses attacked by patients (Chapman & Styles, 2006). Although the Western Australian government has invested $750,000 implementing strategies such as police presence and duress alarms, according to the results of this study the success of these initiatives are yet to be realised (Chapman & Styles, 2006). However as suggested by Chapman and Styles (2006) nurses are also reluctant to report violent behaviour as they perceive a lack of real benefit, the paperwork is time consuming and many tolerate and justify this violent behaviour as the nature of nursing. Recent research in New South Wales (NSW) reported that RNs face on average two to 46 incidents a year, with 80% remaining unreported, suggesting this work related violence is still prevalent (NSW Nurses Association, 2010).

Studies by Morrell (2005) involving 352 questionnaires of nurses who had left the profession, propose that in many cases a single shock event results in a nurses decision to quit. This study does not support the view that the majority of nurses leave due to a shock event, rather as a planned decision over time. However of the few participants in this study who did leave due to a shock event, violence and abuse at work was indicated as a significant factor:

> *"Although l loved the country many patients came in high on something and would hurl abuse even though we were trying to help treat them." (P8.)*

> *"I understood that some areas l worked in were high risk but not the fact that management were not supporting me 100 percent ... at the last place l worked l was punched by a guy in the middle of the night and it took over a week for my manager to check on me." (P 9.)*

In addition to personal safety, the physical impact on health due to the shift work demands and heavy lifting requirements also contributed to nurses' decision to change career in this study. This supported previous research stating that the physical demands on the health of nurses were mentioned as contributing factors to low levels of job satisfaction and increased nurse turnover (Blakeley & Riberio, 2008; Morrell, 2005). As commented by participants:

"I started nursing in my early twenties but I later suffered from a chronic back injury due to the continual lifting and moving of heavy patients ...unfortunately l ended up on a work rehab program which never looks great on your CV." (P 6.)

"The emotional and physical effects of what we do, see and experience just got to me... l stopped sleeping, probably also because of the different shifts but l was also so stressed and found it hard to switch off when l got home ...looking back l definitely suffered some form of breakdown." (P 3.)

"The nursing was emotionally draining ... the dialysis patients would wait and hope for the transplant phone call that that many would never get ...it was heartbreaking." (P 7.)

Autonomy.

Research suggests that those within the profession and the wider organisational system should encourage and provide nurses with the freedom to be autonomous within their professional role (Cohen, 2006; Duffield et al., 2007). As supported by Spence et al. (2001) who stated that when nurses are provided with the flexibility and autonomy to use their judgement and make discretionary decisions, their trust in management increases. This ultimately transpires into feelings that nurses are able to provide high quality care for their patients and they subsequently experience greater satisfaction with their work (Aiken et al., 2002). The desire to be autonomous in regard to patient care and have control over their career path was supported by several participants in this study:

"In my current job l love the challenges l face, also the variety of work and being able to use my brain ... in nursing l always felt l was following orders and answerable to someone else." (P 8.)

"I needed to be the master of my own fate l could not stand not being in control of my life ... so that's why l searched for a new career." (P 9.)

"The fact that l would have more control over work practice in my new profession instead of being stuck with in the nursing system also appealed." (P 8.)

Shiftwork.

The demands of shiftwork were mentioned by 90% of participants in this study as a contributing factor in their decision to leave nursing. There is overwhelming support from a number of previous research studies suggesting that inflexible working hours and shiftwork are challenges faced by hospitals with regard to the retention of nurses (Morrell, 2005; Rajapaksa & Rothstein, 2009). Although it is acknowledged that shiftwork will always be a necessary element within the nursing profession, hospital organisations do have the ability to make these arrangements more flexible and family friendly (Morrell, 2005). In addition many nurses understand and are committed to shiftwork, however they feel they do not have enough control or individual consideration in the matter (Morrell, 2005; Rajapaksa & Rothstein, 2009). As mentioned by participants:

"My husband also worked night shift, l was happy to do my fair share but not when he was also working, one of us had to be home for our kids ... my manager was not that understanding and expected me to constantly swap with other nurses... l didn't mind for a while but then l just got sick of it." (P 3.)

"I absolutely hated not being in control of what l was working, l had no choice in my shifts whatsoever ... this made it very hard for my job to not affect my personal life." (P 9.)

"The shiftwork was crappy it involved nights, weekend and on call ... I missed out on so much which l still feel guilty about." (P 4.)

Remuneration

A lack of career advancement including personal and financial remuneration has also been previously linked to the leaving intentions of several nurses (Barron et al., 2007). This view was only partially supported by the participants in this study.

Financial recognition.

The results of this study do not support previous research which suggested that income was a significant contributing factor to nurse turnover (Barron et al., 2007; Forchsen et al., 2005). This study did support Australian research by Duffield et al. (2006) who suggests there is reasonably strong consensus that nurse turnover is unresponsive to wage changes. In addition, as research by Reineck and Furino (2005) reported, 40% of nurses cited family reasons for leaving the profession of which 65 % were not the primary wage earners in the household. This is important to consider when determining retention strategies, as evidently just targeting the issue of salary, is not a suitable solution particularly for those nurses whose economic need for work is secondary. As commented by the participants:

> *"The pay and working hard did not bother me but the fact there was so much pressure to work quickly is mainly why l ultimately left nursing there was no thanks and .. it was unsafe." (P 5.)*

> *"I can't complain about the money or the team work for me l just go too caught up in the whole illness experience and was mentally and emotionally taking my work home." (P 10.)*

> *"l didn't go into nursing for the money, l loved the work until it became too stressful." (P 1.)*

Personal recognition.

Several research studies suggest that nurses' satisfaction increases when they are empowered to attend to matters such as quality patient care and when their role is recognised (Reineck & Furino; 2005; Takase, 2008). In addition many nurses feel trapped within a career structure that does not easily enable promotional opportunities (Forchsen et al., 2005). The majority of participants in the current study support the importance of this personal recognition:

> *"In contrast with nursing, my current profession has far more promotional opportunities ... where as in nursing you reach the end of a level and there is nowhere to go until someone leaves ... this can take years." (P 7.)*

"The upper levels are capped so even if you are deserving of recognition there is not the positions available." (P 10.)

"I still have stressful days but l am much more part of a team with a voice that is heard." (P 2.)

At a collective level, government and hospital administrators need to communicate to their organisations and the public about the roles of nurses and their contributions to health care. If this idea is promoted then according to Takase et al. (2007) it will enhance the policy makers and public's understanding of the commitment level of nurses and their work values even thought they are confronted with numerous challenges.

Overview of the Decision Process to Change Career

As evident from this research study the majority of nurses who elect to leave the profession for other occupations left for specific reasons (Rajapaksa & Rothstein, 2009) However, it is important to acknowledge that worldwide there is movement within the work force which is a natural phenomenon that will continue to occur in the future (Van Vianen et al., 2009). As previously discussed, career theorists such as Krumbolz (1994) propose that individuals will search for career environments that match their personality, identity, abilities, attitudes and values based on previous social and cognitive learning experiences (Singh & Greenhaus, 2004).

Nevertheless, despite not regretting their decisions to leave the profession, of concern, is that several participants in this study commented that if circumstances had improved, they may have stayed in nursing. This supports research by Barron and West (2005) who reported that many nurses have left the profession for organisational reasons, not because they disliked the specific work. As Morrell (2005) proposed, of the12 incentives identified through questionnaires to prevent nurses leaving early, 11 may have been addressed by the hospital organisation. For example, some of these incentives included a lighter workload, more role

recognition, flexible work schedules and being heard in relation to work matters. As

commented by participants in this study:

> *"I did not leave nursing because of the work itself, the main reason l left nursing was the inflexible shifts there was no individual consideration and because of this my life at home became difficult." (P. 10)*

> *" I look back on my career with special beautiful memories l am not bitter ... but l may not have left nursing if it was less stressful, if l'd felt safe, and if there was a bit more appreciation too." (P 6).*

The earliest literature that attempted to explain why individuals decide to change

career was by March and Simon (1958) who proposed that two factors determined whether an

individual would leave their current career (Felps et al., 2009). First, the perceived

desirability of the employing organisation conceptualised as job satisfaction and

organisational commitment. Second, the perceived *ease* of leaving the organisation

conceptualised as the quality of career alternatives. (Felps et al., 2009). The participants of

this study generally supported this view suggesting that although the decision to leave

nursing was difficult, actually finding an alternative career was relatively easy:

> *"... I was quite surprised at how easy it was to actually change profession ...when l looked into other occupations being a nurse was really well received this definitely influenced my decision." (P 2.)*

> *"It was almost too easy for me to leave nursing ... the medical company l work for were actually approaching me to apply for a position whilst l was still nursing."*
> *(P 7.)*

An interesting possibility is that work attitudes may also be affected by the experience

of the job change process itself, particularly how an employee's job attitudes change after

obtaining the new position (Singh & Greenhaus, 2004; Van Vianen et al., 2009). In addition,

the realisation that one has attractive alternatives may decrease the satisfaction with the

current job (Landy & Conte, 2006). As participants in this study stated:

> *"Many of my friends seemed to have more enjoyment and freedom at work ... one friend in particular travelled as part of her job ... l started to compare her work situation with mine, this definitely influenced my decision to leave nursing." (p 7.)*

"Looking back l don't know how l put up with nursing for so long." (P 9.)

During this study both normative and descriptive decision making theories were involved in the participant's decision process. Many RNs followed a logical approach supporting the normative (prescriptive) theory. Several participants planned their career change by also continuing to work in nursing while funding the expense of further qualifications. Other participant's decision process was more supportive of the descriptive (empirical) theory and incorporated their individual goals and values, in relation to issues such as patient care.

As discussed, Spicer and Sadler-Smith (2005) also identified five decision making styles. Few participants in this study displayed impulsive, avoidant or spontaneous approaches to leaving the nursing profession. The majority of these RNs decided to change career gradually with a rational and intuitive decision approach, often after several years of planning. This supports previous research by Cheung (2004) who interviewed five nurses working in different careers. The results suggested that for most nurses the decision was complicated with many deliberating for years about their own personal and professional value systems. As participants of this study remarked:

"For me a number of incidents that happened over a long time until l decided enough ... it was not easy and l really struggled with my decision for a long time." (P 1.)

"It took me six years to leave nursing completely once l had decided ... which took ages, l then also did agency nursing to pay for my way through uni." (P 4.)

Lastly, in regard to career choice decisions, this study supports research (Duffield, et al., 2004) which suggested that of those nurses who do leave the profession, the majority continue to work in allied health related occupations. This implies that many of the traditional attractions to nursing such as the altruistic elements still motivate nurses in their career choices (Duffield, et al., 2004). In addition, this supports John Holland's (1985) theory of

vocational personalities, suggesting that individuals continue to gravitate towards particular

careers that match their dominant personality type. Seventy percent of participant in this

study who left nursing are still currently working within healthcare and commented that they

do not regret their leaving decision:

> *"I get to meet new people and yet l still feel as though l contribute to patient's recovery though l don't work with them directly ... l have not entirely left health care." (P 7.)*

> *"So much was uncertain ... but l knew l still wanted to help people." (P 2.)*

> *"No regrets but l was completely over nursing and worn down by the end ... l am pleased to still work in health but in a capacity that suits me better." (P 8.)*

Limitations of the Current Study

The results of this study need to be considered in light of some methodological and

conceptual considerations. Including the narrative methodological approach meant the

researcher did not ask a series of several specific questions which may have provided more

detailed information. However by allowing the participants to freely tell their story, each RN

was able to individually decide to disclose the issues that they believed were most significant

to them. The advantage of this ensured the true essence of participants experience was not

inhibited by any structured questioning.

In addition, the sample in this research was limited and this study only comprised

females. Therefore the results of this study may not be generalisable to male nurses. There

was also a varied timeframe between nurses leaving the profession and conducting these

interviews. It is possible that the private lives of participants and current working conditions

may have influenced their responses. Moreover, the results relied on the accuracy of recall

and the paucity of information about individuals and their jobs. As this study was

retrospective, respondents may have had difficulty exactly recalling the reasons for leaving

nursing due to the time that had lapsed since leaving the profession.

Recommendations for Future Research

This research chose to focus on the decision process of females, although several studies have reflected on the different career paths of both genders working within health care (Duffield et al., 2004). Research suggests that females often interrupt their careers in order to have families and commonly return in a part time capacity therefore potentially attaining less in terms of career advancement (Rajapaksa & Rothstein, 2009). Conversely, if the nurse is the primary income earner in the family then salaries and career advancement may be more significant (Rajapaksa & Rothstein, 2009). Further research in this area may be of interest to assist in modelling appropriate retention and recruitment strategies tailored to both primary and secondary income earners (Rajapaksa & Rothstein, 2009).

Given the challenges presented by projected nursing shortages and staff aging, healthcare organisations need to ensure they continue to research ways of providing nurses with job quality and a work environment to reduce the rate of voluntary turnover. In addition, previous research indicates that the most desirable incentives which will entice inactive nurses in their employment decisions are under employer control (Duffield et al., 2004; Takase et al., 2007). For example, the accessibility of flexible work schedules and low cost customised re-entry programs tailored to the experience level of the nurses (Barron et al., 2007; Duffield et al., 2004). Therefore, there is much research that hospital organisations and policy makers could undertake into the development and implementation of benefits that address employee's needs, encouragement towards professional involvement in the hospital organisations, attending to issues of personal health and safely and importantly managerial support initiatives, all of which should contribute to the work-life balance for nurses (Felps et al., 2009).

As West (2001) suggested, that although research in this area is increasing, little is known about the relationship between healthcare workers and the processes and outcomes

within hospitals. Moreover, as demands on the profession are unlikely to end, research needs to be based on effective organisational processes that may assist with the recruitment and retention of nurses, therefore improving hospital efficiency and ultimately the care patients receive (Duffield et al., 2007). Therefore, further research into the function of hospital organisations and the cohesion between multidisciplinary healthcare workers would be beneficial. As stated by Morrell (2005) given the costs associated with nursing turnover, it is likely that even a modest improvement would result in gain for the future of healthcare.

Although the aim of qualitative research is not to generalise findings, an investment in detailed longitudinal data collection including large groups of nurses from other states in Australia may be valuable. This would enable researchers to more explicitly examine and explore the factors, which are most influential in the career choices of nurses. This information may prove useful to retain nurses in the profession. In addition, further research that involves triangulation of data (such as including a quantitative study) would also prove beneficial, however this was beyond the scope of this research.

Summary

Given that decision making occurs at all levels of human thought and action, it is not surprising that this topic dominates so many disciplines (Hastie & Dawes, 2001). Decision making may be related to, contrasted with and influenced by several factors such as: a problem solving process, general judgemental or choice mechanisms, emotions, personality, and self esteem (Singh & Greenhaus, 2004). Moreover, what individuals believe to be the rights and wrongs of various decision processes has a great influence on their behaviour (Hastie & Dawes, 2001)

Importantly, a discussion about decision making cannot ignore those contextual factors that impact on the decision. Within the work environment, personal, environmental and organisational factors all contribute to the individual decision process (Singh &

Greenhaus, 2004). In addition, career decision theorists hypothesise that there are critical points in our lives when decisions and choices are made that greatly influence career development, such as changing jobs (Singh & Greenhaus, 2004).

Career change decisions for RNs has been the focus of this research as statistical prediction suggests that by 2020 current Australian nursing shortages are expected to increase by 30% due to several factors. Many of these consist of the ageing workforce, levels of job satisfaction and other more attractive career opportunities (Hasselhorn et al., 2008). Therefore the aim of this study was to examine factors that influenced and contributed to the leaving decisions of Western Australian RNs and identify those that may be avoided in the future.

This study recognised that nurse's career decisions are complex and affected by a number of personal and organisational factors. The present study found that these included the extent to which nurses are over worked, the quality of care they witness their patients receiving, their health and personal safety, educational support and most importantly organisational characteristics such as an effective management structure and personal recognition. However, more positively, the RNs in this study did not refer to income as a contributing factor, suggesting that financial remuneration was adequate or not a personal motivator for these participants. In addition many participants approved of the current engagement by universities and hospitals which have congruently implemented programs to prepare graduates for the realities of work.

A nursing shortage according to Buchan and Calman (cited in Hasselhorn et al., 2008, p.76) "is not merely about a numbers game or economic model, it is about individual and collective decision making and choices." The question of how to solve persistent and increasing nurse shortages is an important issue currently facing policy makers across the world. Despite nurses representing one of the largest occupational groups, the last few decades have produced little economic research into examining the nursing labour market.

This research study concluded that by making genuine changes within healthcare such as flexible work arrangements, effective personal safety measures and more effective managerial support and training it may be possible to realise a renewed and sustainable nursing profession in the future.

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Appendix A

Levels of Representation in the Research Process (Riessman, 1993. p.10)

Reading Level 5
Analyzing Level 4
Transcribing Level 3
Telling Level 2
Attending Level 1

↖ ↑ ↗

Primary Experience

Appendix B

Advertising Flyer

The Decision Making Process Involved When Changing Career: A Qualitative Study of Registered Nurses who Have Left the Profession

My name is Kate Gallager, and I am an Honours in Psychology student at Edith Cowan University. As part of my degree, I am required to undertake a research project. The Faculty of Computing, Health and Science Human Research Ethics Committee has approved this research. I am interested in talking to females over 25 years of age who have previously worked as Registered Nurses for a minimum of 5 years and no longer work in the profession (excluding those who have left to start a family). I am interested in what contributed to your decision to leave the profession.

Participation in this research would involve a single interview of approximately 30-60 minute duration. All information will be treated as strictly confidential, with interviews tape recorded and transcribed verbatim. No names or identifying information will be used to ensure privacy. A pseudonym may be used if required.

Your participation is entirely voluntary. You are free to withdraw from the study at any stage without any adverse consequences. At the end of the study, a report of the results will be available upon request. This report may also be published, but in no way will you or any other participant be identifiable.

If you are interested in participating in this research or if you have any questions please feel free to contact me, Kate Gallager on 9307 3654 or mobile ▮▮▮▮▮▮▮▮▮▮▮▮▮▮ or my supervisor at the School of Psychology, Associate Professor Lynne Cohen on 6304 5575. If you are interested in speaking to someone independent of this research, please contact Dr Justine Dandy, the Fourth Year Coordinator on 6304 5105.

I look forward to hearing from you.
Kate Gallager

Appendix C

Information Letter

The Decision Making Process Involved When Changing Career: A Qualitative Study of Registered Nurses who Have Left the Profession

My name is Kate Gallager, this project is being undertaken as part of the requirements towards completing my Psychology (Honours) Degree. The Faculty of Computing, Health and Science Human Research Ethics Committee at Edith Cowan University has approved this study.

The aim of this research is to investigate the decision making processes of Registered Nurses when deciding to change career. The focus of this research is on Registered Nurses who have left the health profession. Understanding the issues faced by Registered Nurses may in the future assist health organisations, universities and individual employees develop strategies to retain and recruit health care professionals.

I hope to include you in this research if you are female, over 25 years of age, have worked as a Registered Nurse for a minimum of five years, have not left for the purpose of starting a family and no longer employed within nursing. Participation in this study will involve completing an interview that is expected to take approximately 30-60 minutes.

All information will be treated as strictly confidential, with interviews tape recorded and transcribed verbatim. No names or identifying information will be used to ensure privacy. A pseudonym will be used. Your participation is entirely voluntary. You are free to withdraw from the study at any stage without any adverse consequences. At the end of the study, a report of the results will be available upon request. This report may also be published, but in no way will you or any other participant be identifiable.

Thank you for your interest in this research if you have any further questions please feel free to contact me, Kate Gallager on ▮▮▮▮▮▮▮▮▮▮▮▮▮ or email kgallager@our.ecu.edu.au, or my supervisor at the School of Psychology, Associate Professor Lynne Cohen on 6304 5575. If you are interested in speaking to someone independent of this research, please contact Dr Justine Dandy, the Fourth Year Coordinator on 6304 5105 or the Research Ethics Officer on 6304 2170. I will contact you shortly to follow up your interest in this research and arrange a suitable time for an interview if you agree to participate.

Yours Sincerely

Kate Gallager
HUMAN RESEARCH ETHICS COMMITEE

Appendix D

Informed Consent

(CONFIDENTIAL)

The Decision Making Process Involved When Changing Career: A Qualitative Study of Registered Nurses who Have Left the Profession

I _____ agree to participate in the above titled research thesis by Kate Gallager of Edith Cowan University.

- I have read the information sheet provided, understand the nature and purpose of the study and have freely agree to participate.
- I give permission for the data to be used in the process of completing an undergraduate Psychology Degree and acknowledge that the research may be published.
- I understand that my details and information provided will remain confidential and that l may not be identified.
- I grant permission for the interview to be audio tape recorded and understand that the recording will be erased once the interview is transcribed.
- I give permission to be contacted by the researcher to clarify information.
- I understand l am participating voluntarily, will not receive payment and at anytime may withdraw with no penalty.
- l am aware l may obtain a copy of the research if requested.
- I confirm that l am over 25 years of age, have in the past worked as a Registered Nurse for over 5 years, did not leave nursing to start a family and not currently working in this profession.

Printed Full Name   _____

Signature   _____

Date   _____

Kate Gallager (Honours Researcher)
Email: k.gallager@student.ecu.au
Mb: ████████

Associate Professor Lynne Cohen (Supervisor)
Email l.cohen@ecu.edu.au
Ph: 63045575

Appendix E

Participant Demographic Form

Given name _____

Surname _____

Age _____

Contact number _____

Email _____

Years Worked as Registered Nurse _____

Years Since Leaving Nursing _____

Current Profession _____

Appendix F

Interview Structure

Narrative Format

First the research interviewer read out instructions to the participants as follows:

"I would like to hear your story of leaving nursing, how you came to the decision to change career and what factors influenced or may have changed your decision. I have no set questions, 1 would just like to hear this in your own words. There are no incorrect ways of telling your story, just talk in a way that is a relaxed style for you ...please now tell me about your career change experience from the beginning"

To facilitate recall for the participants the interviewer described the following techniques with this example of a story board:

"Telling your story may help by starting with a:

beginning (such as your background and childhood experiences),

middle (for example your experiences and career in nursing) and

ending (your current and future career aspirations and how you arrived there including

whether in hindsight you believe you made the correct decision)"

or

In order to recall events you may also wish to you follow a storyline such as this storyboard. A story line for career change may include some of these questions:
- What factors lead to your decision to change career?
- How long did this process take?
- Are there any particular event or incident that occurred which triggered your decision to leave nursing?
- What factors may have altered your decision to change your career?
- How many career changes have you had?
- And are you content with the decisions you have made or would you return to nursing in the future?

Appendix G

Support Services Information

This brochure has been compiled to provide you with a list of available support services that you may wish to contact if you want to further discuss any concerns.

Psychological Support Services

ECU Psychological Services Centre   **9301 0011**
Joondalup House
8 Davidson Terrace, Joondalup
Provides psychological counselling, treatment and assessment

Centrecare   **9300 7300**
Level 1/85 Boas Ave, Joondalup
Provides workshops, in home visiting and individual, couple and family counselling

Telephone Support

Crisis Care   **9223 1111**
24 Hour emergency line

Mental Health Direct   **1800 220 400**

Career Advice and Counselling

Career Advising-Life Path Career Services   93891999
25a Clark St, Nedlands

Career Development Centre   9224 6500
Level1/166 Murray St
Perth

Career Information Centre   1800 026 134
Level 2, City Central Building
Murray St Mall, Perth

Insight Career Management   9450 8544
45a Marsh Ave, Manning

Appendix H

Example of Cross Case Analysis

Statement	Category	Sub-theme
l didn't go into nursing for the money	Remuneration	Financial recognition
There are so many machines pumps and monitors to figure out	Work Environment	Technology
l was one of the first university trained nurses and l found the transition really difficult ...but recent graduates l worked with before leaving seemed better prepared	Work Environment	Realities versus expectations
We were only allocated a one hour session each week for in service training and that was not enough to keep up to date with all the changes and training ... if you rostered off on this day it was tough luck	Management	Education and support
Although l loved the country many patients came in high on something and would hurl abuse even though we were trying to help treat them	Challenges	Personal safety
The upper levels are capped so even if you are deserving of recognition there is not the positions available	Remuneration	Personal recognition
I could sense that if l had not been there the graduate may easily have been bullied into not following the correct hospital procedure	Work Environment	Nurse/physician relationship
The main reason l left nursing was because of my family, l wanted to be there for them after school and on the weekend	Challenges	Family Impact