LOOKING WITHIN: REGISTERED NURSES CONSIDERING RETIREMENT IN INTERIOR HEALTH

By

CANDIS F. EIKERMAN
BA Honors, University of Manitoba, 1979

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In
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We accept this thesis as conforming to the required standard

_____
Christine Bonney, MA, Project Sponsor

_____
R. Nancy Greer, EdD, Project Supervisor,

_____
P. Gerry Nixon, PhD, Committee Chair,

ROYAL ROADS UNIVERSITY
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ABSTRACT

This action research project investigated how the Interior Health Authority (IH) could support the engagement and retention of mid- to late-career Registered Nurses. Approximately 59% of all staff in IH will be eligible for retirement in 2010; in 2007 vacant nursing positions are already categorized as "hard to fill". This research explored how working conditions, organizational culture, family and financial pressures, and finding significance in midlife affected the engagement and retention of older nurses. A Polarity Mapping session, a Learning Circle, and an Appreciative Inquiry focus group brought together nursing management and older front line nurses in a hermeneutic dialectic process for qualitative data collection. Senge's (1990) Shifting the Burden archetype was the conceptual framework used to illustrate the long-term fundamental responses required to address underlying organizational issues regarding engagement and retention. Recommendations to IH were based on research findings addressing space issues, ergonomics, job redesign, and leadership initiatives.

DEDICATION

In loving memory of my father...

G. Dale Eikerman
1937 – 1996

If you are searching for something in your life, you have to find it in yourself. Find your fears - step into them and acknowledge you are afraid. Through this challenge you will find yourself.

ACKNOWLEDGEMENTS

I would like to say "Thank You" to the many people who willingly gave up their time and expertise to assist me in successfully completing this research project. It has been my great privilege to have Dr. Nancy Greer as my project supervisor. Thank you for your inspirational feedback – it always made my work stronger and your encouragement in me gave me faith in myself. Christine Bonney honoured me by acting as project sponsor in Interior Health. Thank you Christine for your mentorship and your friendship. Your vision of the role my research could play in the organization kept me grounded and moving forward.

Thank you also to Ann Ferguson for your conversations that inevitably lead to a deeper level of thinking and new way of looking at my work. Thank you Bruce Mol for your technical expertise and for patiently guiding me through the challenges associated with pulling this project together. Thank you Carole Falkner and Juanita Yuill for assisting me in the focus group sessions; having you there contributed to bringing out the best in the participants.

Thank you to all research participants for your time given telling the stories that will make a difference for future nurses. Thank you to my colleagues at Interior Health for taking an interest in my research, cheering me on, and celebrating each of my small successes along the way.

Thank you family and friends for patiently waiting for this lifetime achievement to be concluded. It is with heartfelt appreciation that I thank my husband Rod Wark for sharing with me each moment of this journey as advisor, reviewer, and best friend.

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CHAPTER ONE - FOCUS AND FRAMING

Introduction

Workforce demographics are changing radically and rapidly and new realities are forcing organizations to re-think their human resource strategies. I am a departmental manager with over 22 years experience in what is now the Interior Health Authority in the Province of British Columbia, which will be referred to as Interior Health or IH in this document. Over the past several years I have witnessed a substantial investment of IH resources aimed at developing creative strategies to attract and retain employees. I am also aware of the disengagement of some IH employees resulting from factors such as change fatigue, workload issues, continual restructuring and shifting priorities.

Soon after its inception in 2001, IH identified becoming an "organization of choice" as one strategy to attract and retain top professional human resources. In its journey to attain this goal, IH engaged the consulting services of Watson Wyatt to assist in understanding the quality of work life for its employees. The results of their *2005 Organizational Survey* (Watson Wyatt, 2006) indicated particularly low levels of motivation for employees with six to 25 years of service to the organization. This group of mid- to late-career employees provides the bulk of the direct care and indirect services for patients, residents and clients in our multifaceted health care organization. Dychtwald, Erikson and Morison (2006) characterize mid-career employees as "productive, highly professional, the kind of long-term presence who holds an organization together; not on the fast track to the executive suite, but nonetheless the kind of employee the company

should retain" (p. 66). In reviewing the survey results, I found this description contrary to how employees with six to 25 years of service report how they experience work at IH.

As an IH employee in the same capacity for the term of my employment, I am firmly a member of this mid-to late-career group and can identify with many of the issues surrounding this employee demographic. My research focused on one particular professional group of mid- to late-career employees, the front line Registered Nurse. The research question for this project was "How does Interior Health support the engagement and retention of skilled mid- to late-career Registered Nurses who are between the ages of 55 and 64 years and are considering retirement?" Using action research methods my goal was for all stakeholders to co-formulate meaningful practices to address existing roadblocks and create innovative approaches to capture employee engagement and increase retention.

Holter and Schwartz-Barcott (1993) state that in action research "practitioners involved gain a new understanding of their practice and the changes implemented tend to have a more lasting character than just the immediate enthusiasm caused by the change itself" (p. 301). By understanding the needs and expectations required to fully engage mid- to late-career Registered Nurses, I believe my research results may have the ability to influence employees in other health care sectors to also enjoy meaningful and fulfilling work for longer tenures within IH.

Related questions which supported this research project were: "What interventions would create synergy between the personal goals of these employees and the goals of Interior Health?" and "What implications does this have on how Interior Health modifies employment practices to fully utilize mid- to late-career employees?"

The Opportunity

IH was formed by the Province of British Columbia through the amalgamation of three independent health regions and sixteen local health areas. Securing competent leadership talent is crucial for all complex organizations and therefore attracting quality candidates was an immediate and obvious organizational priority. Soon after its creation, IH embarked on a journey and published a report called *The Genesis Project – Our Quest to Become an Organization of Choice* (Eggleston, n.d.). Within an 'organization of choice', "employees choose to work for that employer when presented with other choices of employment...[it] attracts, optimizes, and holds top talent for long tenure because of its status and reputation" (Eggleston, n.d., p.1). Watson Wyatt has periodically measured and tracked the progress of IH towards this goal by surveying employees, physicians and volunteers. The first survey in 2002 (Watson Wyatt, 2002) measured IH's performance in the following areas: (a) work environment, (b) quality of supervision, (c) communication, (d) management effectiveness, (e) compensation and benefits, (f) career development, and (g) training programs. Subsequent surveys were administered again in 2003 (Watson Wyatt, 2003) and 2005 (Watson Wyatt, 2006). In comparing these successive survey results only modest gains were made in the overall performance of IH. This would indicate the potential for significant opportunities for improvement in critical areas such as employee motivation and alignment with IH goals.

The latest *2005 Organizational Survey* (Watson Wyatt, 2006) collected responses from 5,144 respondents out of a possible 17,433 employees (30%). This response rate was rated as considerably lower than the general Canadian working population and the WorkCanada® 2004/2005 Overall and Health Sector norms (Watson Wyatt, 2006). Of

the survey respondents, 58% were within the six to 25 years of service grouping; this percentage also represents the same demographic of the employee group that reported a low level of motivation and commitment to IH. Since this last 2005 survey, IH has not communicated any further desire or emphasis on attaining 'organization of choice' status, although it continues to initiate strategies that are consistent with the principles of an organization of choice.

Mid- to late-career employees with over six years of service have acquired a vast amount of skill and tacit knowledge and are a major asset to organizations. If issues affecting mid- to late-career employees' motivation and organizational alignment are not addressed, it will be here that IH may expect its next significant employee shortage through early retirements and possibly, the resignation of frustrated employees. Losing these employees will exacerbate already severe staff shortages, will negatively impact the ability of IH to recruit employees, and affect the organization's knowledge base through a steady decrease in tacit knowledge. Dychtwald et al. (2006) sum up the win-win created by engaging mid-career employees in their book Workforce Crisis:

> Engagement is about passion and commitment – the willingness to expend one's discretionary effort in the employer's success. For engaged employees, time flies. They identify with the task at hand, their enthusiasm infects others, the activity generates as well as consumes their energy, and they care deeply about the outcome. (p. 208)

IH cannot afford to overlook the critical group of mid- to late-career employees; organizational strategies must be developed and appropriate resources allocated to secure their tenure.

Significance of the Opportunity

Within IH there are 19,000 employees serving a population of 717,545 people living in 717 communities (Interior Health, Okanagan Health Service Area Profile, 2006). Figure 1 shows the 2006 demographics of the permanent workforce within IH according to age categories: (a) 40% is over 50 years, (b) 35% is between 40-49 years, (c) 18% is between 30-39 years, and (d) 7% is under 30 years. (Interior Health, Retention, 2007, p. 1).

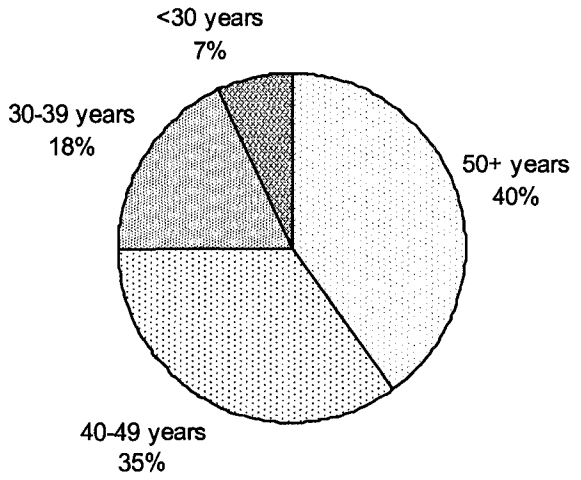

Figure 1: 2006 demographics of the permanent workforce in IH by age in years.

The Canadian Institute for Health Information (CIHI) collects and provides analyses on health care information in Canada. In the publication *"Workforce Trends of Registered Nurses in Canada 2005"* (2006) CIHI describes the current state of Registered Nurses (RN's) in the workforce. They state the annual number of working RN's has again increased over previous years and represents a total of 251,675 nurses. In 2005, the

average age of an RN was "44.7 years" and there are "more RNs aged 55–59 years in the workforce in 2005 than RNs aged 30–34 years" with "more than one-sixth (19.7%) ...aged 55 years or older" (Canadian Institute for Health Information, p. 3). A local example of the impact of these statistics was seen within the Vernon Jubilee Hospital nursing departments where 39.96% of all nursing staff had the potential to retire in 2007. (D. Webber, personal communication, February 16, 2007).

All organizations need to utilize multiple advantages to compete for scarce human resources and an obvious leverage would be to retain existing employees. IH recognizes that "Engagement = Retention" (Interior Health, Retention, 2007, p. 1) and has posted a tool kit for managers to address these issues. A joint Federal and Province of British Columbia initiative was announced to retrain nurses who are seeking to retire by "creating 20 new spaces for nurses who want to get their master's degrees" (CBC News, 2007). Retaining unengaged employees, as indicated from the results of the *2005 Organization Survey* (Watson Wyatt, 2006), may not be a corporate advantage; "the problem of burned-out, turned-off employees who stay is even more threatening to corporate productivity than the problem of turnover" (Morison, R., Erickson, T., & Dychtwald, K., 2006, p. 81).

Anticipating the ability to increasingly hire younger nurses, and specifically graduate nurses to fill our labour shortages is not a guaranteed solution. CIHI report that "more than forty percent (40.8%) of new graduates – entered...with a baccalaureate in nursing" (Canadian Institute for Health Information, 2006, p. 3). Having a higher educated nurse entering the workforce does not address the number of nurses required to fill the many positions left vacant by retirees. Dychtwald et al. (2006) predict "we have

too few young workforce entrants to replace the *labor, skills, and talent* of boomer retirees...even when they successfully hire and retain young workers, they are still trading experience for inexperience" (p. 12). They also describe what these younger workers will expect from their employers:

> They expect to be treated individually, they want flexible schedules, they know that their careers belong to them (not their employers), and so they value knowledge and skill more than tenure. Given their ambition, they want to contribute quickly, not work in the background. Given their technological proficiency, they appreciate up-to-date technology in the workplace...morphing the rules to suit the situation...frequent and useful feedback...make their work fit in with other life commitments and pursuits. (p. 104)

A Vancouver Sun article characterizes mid-career employees as "less threatened by technology, they like to multi-task, they work in teams, they want interesting meaningful work, they want recognition and respect and more work-life balance" (Shaw, 2006, p. G1). Engaging employees with these skills and work ethic has the potential to bring a multitude of benefits to the organization. Without exploring the conditions that will engage employees IH will not be able to address its concerns of employee motivation and alignment.

Systems Analysis of the Opportunity

Bolman and Deal (2003) suggest that "since organizations depend on their environment for the resources they need to survive; they are inevitably enmeshed in relationships with external constituents whose expectations or demands must be met" (p. 229). There are three interlocking systems that primarily influence the structure and organizational direction of IH. A brief examination of the role of the provincial and municipal government, the various labour relations bodies, and the interests of the Canadian Council on Health Services Accreditation, demonstrate how divergent the

demands for accountability are for IH. Each of these three constituents provides unique and stringent boundaries for operating and managing IH, and one does not truly have primacy over the others.

The application of a systems view to understand the issues of retention and engagement in IH is required to discern leverage points for action. For this report I used Senge's (1990) Shifting the Burden archetype as the conceptual framework to understand the competing and often incompatible efforts used to address engagement and retention.

Provincial and Municipal Government

Each year the Ministry of Health (MOH) prepares an *Annual Service Plan* which outlines the goals and objectives for the delivery of health care in the province. Each health authority develops specific plans for how the organization will meet these guidelines; a Performance Agreement is signed with the MOH on the specific performance benchmarks to be measured and reported on. These benchmarks provide the framework for the goals and objectives that each core business function within IH will develop in order to meet the MOH's specific requirements within budget parameters. A *Health Services and Budget Management Plan* (HSBMP) is IH's comprehensive report of initiatives established to address local priority issues and provincial goals. IH's annual budget of $1.2 billion is spent on key and major service delivery initiatives, with some of the capital projects co-funded by various joint regional/municipal bodies.

Labour Relations

The Health Employers Association of British Columbia (HEABC) is an organization accredited by the Labour Relations Board of British Columbia. It was

formed under provincial legislation to coordinate the human resources and labour relations interests of health care employers and currently represents 315 publicly funded health care employers. HEABC is legislatively authorized to bargain collectively and bind by Collective Agreement the employers and the multitude of unions operating within the health care field (Health Employers Association of British Columbia, 2006). Within IH there are two categories of employees; the Executive and Excluded employees who do not have membership in a trade union due to the nature of their work or work relationships, and those employees who are a member of a specific union regulated by one of four Collective Agreements. Collective Agreements are between IH and: (a) the British Columbia Nurses Union (BCNU), (b) the Paramedical Professional Bargaining Association, (c) the Health Services and Support – Community Subsector Association, and (d) the Health Services and Support Facilities Subsector Association. These Collective Agreements strictly regulate employment terms and conditions for employees from each of these sectors. Each collective agreement must be considered and interpreted by IH Human Resource professionals for contract language prior to re-designing work, developing new projects, reassigning staff, or accommodating variations to an employee's existing working conditions.

Canadian Council on Health Services Accreditation

The Canadian Council on Health Services Accreditation (CCHSA) is a national program designed to assist health organizations to voluntarily improve their quality of care and service delivery through a comparison to a set of national standards of excellence. In IH, the Performance Management division - Accreditation Office was established to "evaluate the organization and identify areas for improvement through

collaboration with staff, physicians, volunteers, the public, and community partners" (Interior Health, Accreditation Office, 2006, p. 1). For accreditation, each program within IH initiates a self-assessment process involving all of its stakeholders. Upon completion of this assessment, surveyors from CCHSA meet with staff and physicians to critically evaluate and review relevant organizational documents; interview community partners, clients, and residents; and tour the facilities to gain information for a final report. This final report contains detailed recommendations for improvement and is submitted to the organization with time frames for completion.

As a former Team Leader for Cancer Care Accreditation in 2005, it has been my experience during final report-out sessions that CCHSA surveyors take into account and comment on their perceptions of the culture of the organization. The surveyors routinely include personal anecdotes and candid comments regarding the level of satisfaction they gauge from physicians, staff, volunteers, and the clients they have interviewed during focus groups or on their facility tours.

In the *2005 Accreditation Final Report* (Canadian Council on Health Services Accreditation, 2005), the CCHSA surveyors recommended IH investigate its internal communication systems to address identified gaps in service delivery and concerns voiced by employees. A *Staff Communications Survey* (Rosaura Consulting, 2005) was commissioned to assess staff's perceptions of the communication needs and gaps in IH. Surveys were collected from 1,155 respondents from a baseline of 16,664 employees (7%). Highlights of the survey results indicated respondents wanted organizational communication to: (a) be readily accessible, balanced and timely; (b) include a cross section of information on educational opportunities, HR issues, and on the corporate

vision and future direction of IH; (c) contain bad news as well as good news; and (d) the reasoning behind all major decisions.

The survey also identified that respondents felt there was a lack of time during scheduled work for them to find printed information or to search for information published on the IH InsideNet website. They felt their supervisor did not pass on organizational information as they (a) did not have the information, (b) did not have the time, or (c) did not feel it was relevant to their employees.

Recommendations to enhance communications for IH managers included more opportunities for staff to connect with management and have their input heard, implement a change management process for all new projects, create opportunities for staff to gain a better understanding of the vision and strategic objectives, and for managers to share more information with their staff through diverse mediums (Rosaura Consulting, 2005).

Systems View: Shifting the Burden

The theoretical framework for this research was Senge's (1990) Shifting the Burden archetype which describes how short-term solutions applied to systemic organizational problems lead to an "increased need for more and more of the solution" (p. 61). This structure identifies two balancing or stabilizing processes which are both trying to address the same issue from two perspectives: (a) a symptomatic solution, and (b) a fundamental solution (Senge, 1990). Symptomatic responses apply short-term solutions through a series of 'quick fixes' while presenting the appearance of sustainability. Fundamental responses propose longer-term solutions based on strategic leverage points to address underlying issues, while at the same time recognizing this may take longer to realize desirable change.

Currently in IH, an ever increasing amount of operational funding is spent on staffing and overtime budgets; and the role of external recruitment consultants focuses on more creative means to recruit staff in a competitive global market. The goal of my research was to identify leverage points in fundamental responses in order for IH to broadly address current and looming shortages of professional staff. The challenge for IH will be to simultaneously continue to manage the financial costs related to existing critical staffing issues in the short-term, and investing appropriate resources to identified leverage points for the long-term.

The Shifting the Burden archetype in Figure 2 demonstrates the dynamic relationship between a symptomatic response and a fundamental response. It clearly describes the issue of the significant number of IH staff who are eligible to retire or will retire, and the current and anticipated future labour shortages. Using the same initial premise depicting the current mix of IH staff in the center of the archetype, each loop represents this information using a different and distinct lens. The top symptomatic loop demonstrates the circular effect of an organizational strategy based on an inability to deviate from applying increased financial resources to cover the consequences of staff shortages, and the costs required to widen the scope of external recruitment strategies. The fundamental response loop views the same staff demographic through a different lens; one of a strong core of mid- to late-career professionals who are "motivated, flexible, and people oriented. Their accumulated experience and knowledge are valuable" (Dychtwald et al. 2006, p. 70). The fundamental response requires an organizational shift from a financial and recruitment focus to one of retaining and engaging staff through

strategies utilizing providing a safe environment, people-focused leadership, and principles of a Learning Organization.

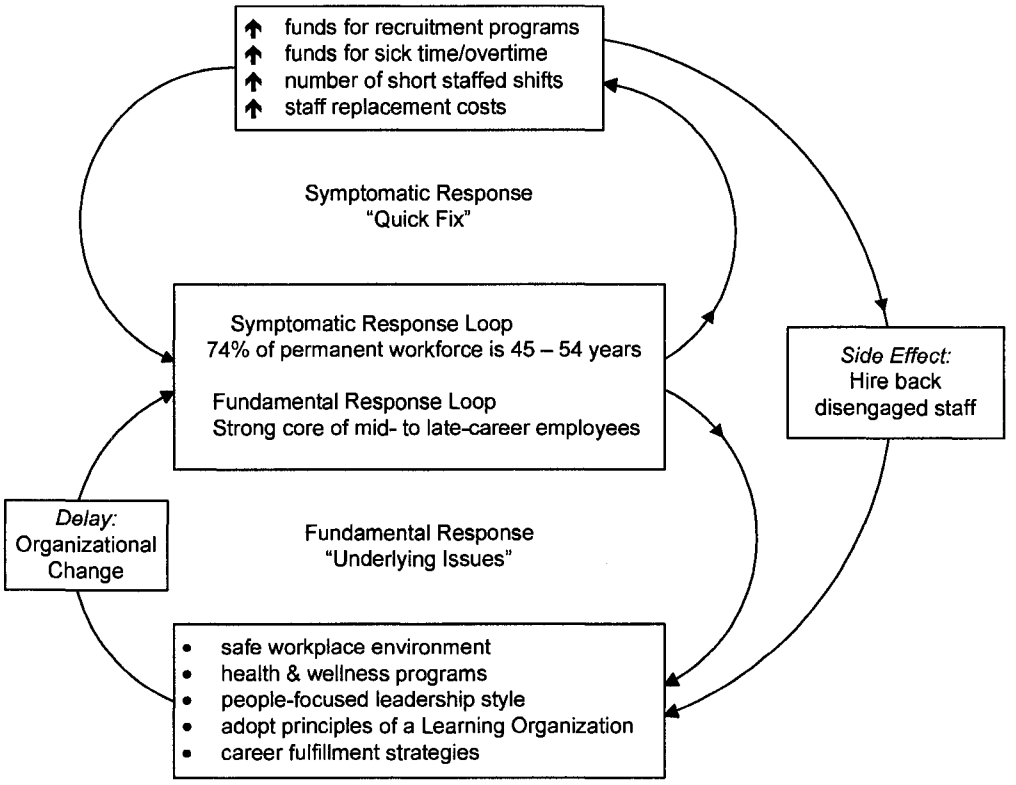

Figure 2: Shifting the burden archetype is used to contrast a symptomatic response and a fundamental response in reaction to pressures from the high percentages of staff eligible to retire or who will retire.[1]

From the symptomatic response cycle, the likely side effect of hiring back retired staff has the undesirable potential of rehiring disengaged staff. Senge (1990) describes the side effect produced by the symptomatic response as an "additional reinforcing [amplifying] process ... [which] often make it more difficult to invoke the fundamental

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[1] Note. From *The Fifth Discipline* (p. 106), by P. Senge, 1990, Toronto ON: Currency. Copyright 1990 by Peter M. Senge.

solution" (p. 106). If these same retired staff were hired back into the fundamental response system, they would benefit from the changes to the organizational culture this response produces and may become re-engaged in their area of practice. The application of systems thinking through using this archetype in my research, may simplify the factors influencing symptomatic responses by assisting in "discerning high from low leverage change" (p. 69).

Bolman and Deal's (2003) multiframe model also represents a valid systems model to analyze the various aspects of this issue within IH. Bolman and Deal uses four distinct lenses or frames as a basis to understand organizational issues. These frames are structure, human resources, political and symbolic and are used to view "the same organization *simultaneously* as machine, family, jungle, and theatre" (p. 433). This perspective would be valuable as a holistic view of all interacting systems, but would not distil specific leverage point for action as Senge's (1990) Shifting the Burden archetype does.

Organizational Context

The Interior Health Authority is one of six health authorities in British Columbia, covering a geographic area of over 200,000 square kilometers and serving over 700,000 people. It is divided into four Health Service Areas (HSA's): Thompson Cariboo Shuswap; Okanagan; East Kootenays; and Kootenay Boundary. IH is governed by a nine member Board of Directors appointed by the Ministry of Health (MOH) , and is managed by a 15 member Senior Executive Team (SET).

The IH Board of Directors established the vision, mission, and strategic objectives to align core business functions with the MOH. Values forums, made up of working

groups of diverse employees were held during 2006 at various locations across IH. These were to provide input to the Board of Directors from the employee sector, though at the time of writing, values have not been set for the organization. The vision of IH is "To set new standards of excellence in the delivery of health services in the Province of British Columbia". Its mission is to "Promote healthy lifestyles and provide needed health services in a timely, caring and efficient manner, to the highest professional and quality standard" (Interior Health, Vision and Mission, 2005, p. 1).

There are 12 Strategic Objectives set by the Board of Directors to define standards of performance for core business functions. These are supported by 56 Key Initiatives developed to: (a) focus on improving population health, (b) provide a network of hospital care, (c) ensure choices for Home and Community Care services,(d) modernize outdated health care infrastructures, and (e) become an 'organization of choice' (Interior Health, 2005/06 Key Priorities, 2006).

One of the IH strategic objectives states: "To systematically address the initiatives required to: recruit, develop and retain adequate, professionally qualified staff who are dedicated to their profession, attracted to their working environment, and motivated to excel in meeting patient/resident/client needs" (Interior Health, Vision and Mission, 2005, p. 2). IH is at a critical juncture concerning its ability to recruit external candidates for a cross section of vacant professional positions. As an example, at August 31, 2006, the total professional external vacancies numbered 529, representing an accumulation of permanent and temporary, part-time and full-time positions which had been unsuccessfully filled by existing external or intemal postings. In addition to the crisis these current vacancies represent to IH, "6,488 or 59% of the workforce are either

eligible for retirement (reached age 55) or will be retiring (reached age 65) by the year 2012" (Interior Health, Human Resources Strategic Services, People Management Plan (draft), 2006, p. 7).

This trend in employee demographics is not unique to IH or to other health care providers in today's workforce. It will be the successful recruitment of scarce professional and skilled human resources that will define the level of health care IH can provide to our communities. Morison, Erikson and Dychtwald (2006) state "midcareer employees and managers, who should be at their peak of productivity, are the most disaffected segment of the workforce. Companies need to find ways to rekindle the fires of this vast, neglected group of people – or risk losing them altogether" (p. 79). My goal for this research was to assist IH in understanding, engaging, and retaining nursing staff from this valuable sector of mid- to late-career employees.

During the fiscal year 2005/06, IH focused on five Key Priorities (Interior Health, 2005/06 Key Priorities, 2006) : (a) Emergency, (b) Surgery, (c) Patient Safety, (d) Recruitment and Retention, and (e) Standardization. For the purposes of this major project it is relevant to note Key Priority # 4: Recruitment & Retention:

> Our Goal: To attract excellent clinical and administrative healthcare professionals and support staff to meet the growing demand for services compounded by the "boomer" retirements. Interior Health has an exceptionally dedicated, compassionate and knowledgeable staff. They work thousands of hours with thousands of vulnerable people every day. We need to continue to recruit good people, and even more important, keep the good people we already have. We are facing huge demographic challenges, with both an aging population and an aging workforce. We are working to create an environment where staff want to work and where staff want to encourage others to come work. (IH, 2005/06 Key Priorities, 2006, p. 2)

Employee engagement and retention across IH is a large and broad topic in a complex system with many avenues to investigate. IH has a Human Resources Planning

portfolio to comprehensively review and address recruitment and retention, training and development, the workplace environment, work design, and the classification of bargaining unit positions. In February 2007, a new Employee Retention Resources section was introduced on IH's internal web site the *InsideNet*. The information on this site provided a retention 'tool-kit' for all managers to assist them in engaging their employees as a key to improving employee retention.

Within this organizational context I focused my research in the administratively distinct North Okanagan region, and used the action research process of "look, think, act" (Stringer, 1999) to assist front line Registered Nurses and nursing management "in extending their understanding of their situation" (p. 10) in an organizational and personal context. I brought together a group of Program Directors/Nurse Manager stakeholders and facilitated an exploration of issues blocking engagement, motivation, and organizational alignment as it related to the retention of Registered Nurses. Following this I used a Learning Circle to discuss issues of engagement and retention with a group of front line Registered Nurses between the ages of 55 and 64 years. Finally, I facilitated a joint session of representatives from each group to discuss what they all felt currently worked well in supporting and retaining mid- to late-career Registered Nurses and what a desired future would look like.

It was important to consider the caution that by utilizing both an individual and a collaborative approach, "the changes tend to be connected to the individuals directly involved...the interventions tend to be short lived when these individuals leave or when new people enter the system" (Holter & Schwartz-Barcott, 1993, p. 301). Considering this premise, special attention was made to the organization-wide recommendations

extrapolated from the combined insights of these stakeholder groups and all other research data. Herzberg's (2003) conclusions from his research on motivational and hygiene factors, supports the caution of applying job enrichment to employees involved in the research:

> Avoid direct participation by the employees whose jobs are to be enriched. Ideas they have expressed previously certainly constitute a valuable source for recommended changes, but their direct involvement contaminates the process with human relations hygiene and, more specifically, gives them only a sense of making a contribution...it is the content that will produce the motivation, not attitudes about being involved ...a sense of participation will result only in short-term movement. (Steps for job enrichment section, ¶ 1)

Ethical considerations in this project included advising participants that IH may not or cannot address or implement any or all the recommendations stemming from this research (Block, 2000). Conducting this form of "backyard research" (Glesne, 2006, p. 31) should not raise participant expectations or imply guarantees for solutions to mid- to late-career employee engagement in IH. However, it remains the goal of this research to have contributed in making a positive difference in the working lives of these employees through their contribution in this project.

CHAPTER TWO - LITERATURE REVIEW

The issue of employee retention has become a prominent theme in analyzing today's labour force and is predicted to be the major focus of workforce strategies over the long term (Dychtwald et al. 2006; Ulrich, Buerhaus, Donelan, Norman, & Dittus, 2005). Leadership strategies on the effectiveness of addressing retention are varied and multi-layered in their approach (Schein, 1992; Yukl, 2006). In this literature review section I gathered information to address my research questions: How do skilled mid- to late-career Registered Nurses who are between the ages of 55 and 64 years and are considering retirement, become engaged in their profession and continue their employment with Interior Health? What interventions would create synergy between the personal goals of these employees and the goals of Interior Health? and What implications does this have on how Interior Health modifies employment practices to fully utilize mid- to late-career employees?

After a review of organizational documents, consultant's surveys, and the many studies acknowledging an imminent labour shortage, I believe my research focus is justifiable and timely for IH (Interior Health) and could be applied to a broad range of professional disciplines in health care. The Robert Wood Johnson Foundation's white paper *Wisdom at Work: The Importance of the Older and Experienced Nurse in the Workplace* (2006) makes this comment regarding the mass retirement of baby boomers:

> In spite of what is already known about the aging of the U.S. population and the growing impact this will have on the nation as the first baby boomers reach retirement age in about five years, there is scant evidence that key leaders, institutional representatives, and policy-makers - much less society at large - are preparing for, or even fully grasp the implications of, these seismic demographic changes. (p. 5)

The issue of retirement is complex involving multiple and often unique variables in any one individual's life. In order to gain an understanding of the complexities involved, I applied a process of mind mapping the multiple factors that could impact my research questions and created four main subject areas for this literature review. Each of these subject areas contributes information pertinent to the retention and engagement of the older nurse which I will link to viable recommendations for IH. The four literature search subject areas I document are: (a) The workplace environment in health care, (b) organizational culture, (c) family and finances: external issues and pressures affecting retention, and (d) finding significance in midlife.

The Workplace Environment in Health Care

A discussion of the workplace environment is significant in understanding the context that defines an individual's employment and reveals the variety of elements contributing to factors in employee retention. Lowe (2006) has developed a resource for health care organizations to improve health care work environments and he acknowledges "a high quality work environment is being accepted, albeit slowly, as a prerequisite for building the human resource capacity needed to sustain the health system" (p. 2).

There are abundant examples in the literature that suggest linkages between leadership responsibility, the working environment, and the ability to engage and retain workers within varied employment sectors. Early studies researching the link between decisions to retire and working conditions found "the nature of the job and the conditions under which the work is performed do influence the early retirement decision" (Quinn, 1978, p. 323). Andrews, Manthorpe, and Watson, (2004) discuss 'push and pull' factors

(p. 302) that influence retirement decisions in older nurses. Negative aspects of work such as the pace of technological change and work-related stress were viewed as 'push' factors. 'Pull' factors such as flexible working hours and financial incentives were viewed as positive influences in keeping nurses working longer.

Some studies (Andrews et al. 2004; Cohen, 2006; Coile, 2001; Healy, 2001; Letvak, 2002; Reineck & Furino, 2005) suggest companies need to address strategies to integrate the needs of the older worker into their job duties. Recognizing there are often many diverse health risks associated with older workers, Healy (2001) suggests incorporating into the workplace "health management programs to minimize those risks and support a high level of aging employee wellness and productivity" (p. 523).

Administrative concern for employee retention is demonstrated in a study by Letvak (2002). She surveyed North Carolina administrators in 160 hospitals and nursing homes in light of a rapidly aging nursing workforce and a current critical nursing shortage. When administrators were asked about their concern regarding the nursing shortage, the results indicated 88% of respondents were "very concerned", while 8% were "concerned, but this shortage too will pass" (Findings section, ¶ 6).

Losing tacit knowledge held by experienced staff and incurring high costs associated with replacing employees also negatively affects the quality of the work environment and staff retention. Identifying and understanding the mitigating factors that effect older nurses within the workplace environment is one of the challenges and one of the opportunities in health care today. The Robert Wood Johnson Foundation's white paper *Wisdom at Work* (2006) states that only a portion of nursing knowledge is actually documented and:

> Losing the knowledge of expert older nurses can negatively affect organizational performance and productivity. The costs of lost knowledge are difficult to quantify, and most organizations do not know where they are vulnerable in terms of the loss of knowledge...[research] found few descriptions of health care organizations seriously considering the high cost of losing intellectual capital in the coming years. Yet over the next two decades, health systems are at risk of losing significant knowledge as the baby boomers retire. (p. 10)

In the health care sector current research supports a link between physical working conditions, the quality of peer support mechanisms, the presence of internal health/wellness promotion programs, and the degree of injustice and unfairness as factors which influence and support an employee's decision to remain in their job for a longer tenure (Andrews et al. 2004; Cyr, 2005; Geiger-Brown, Trinkoff, Nielsen, Lirtmunlikaporn, Brady, & Vasquez, 2004; Letvak, 2002; McLennan, 2005; Ulrich et al. 2005).

Implementing strategies to address challenging working conditions has the potential to provide employers with long term success in their retention efforts over current short term strategies such as signing bonuses, creative benefits, and relocation incentives (Holtom & O'Neill, 2004; Magee Gullatte & Jirasakhiran, 2005; Ulrich et al. 2005). In a UK study, older nurses considering retirement rated better working conditions as their number one concern over salary increases, better management practices, or improved training, education and career opportunities (Newman, Maylor, & Chansarkar, 2002).

This literature review section explores the pertinent factors within the workplace environment such as the working conditions of nurses, conditions which keep nurses engaged such as peer and patient relationships, workplace health and wellness programs, injustice and unfairness, and the influence these factors have on nursing staff who may be considering retirement.

Working Conditions of Nurses

This section highlights current research into the relationship between working conditions and the retention of older nurses from studies in the United Kingdom (UK), the United States (US) and Canada. Discussions of specific working conditions and the associated descriptors vary between researchers, but all reflect varying degrees of negative impact on the physical health, mental health, and well-being of nursing employees. Using information from 2002 Statistics Canada, McLennan (2005) states "in Canada, nurses are the most overworked, stressed, work-life-unbalanced, and sickest workers in the country, with absenteeism rates 80% higher than other workers" (¶ 1). Geiger-Brown et al. (2004) discuss nurses' work life in terms of excessive or demanding working conditions causing physical injury. Demanding working conditions include "long hours, heavy lifting, low staffing, and a lack of support from coworkers and management" (p. 18). This US based research study reported nurses having "higher rates of musculoskeletal disorders (MSDs) than construction laborers...[in 1999] suffered from more than 13,000 neck, shoulder, and back injuries requiring days away from work" (p. 16). Hand written comments from a survey of Texas RN's done by Reineck and Furino (2005) support this concern for heavy workloads with the following quotes from respondents: 'powerfully overwhelming'; 'nightmares about inadequate staffing and unmanageable workload'; 'make me want to leave nursing'; 'taking great tolls and made me quit because of it'; and 'the nurse-patient ratio is not safe' (p. 29). Cyr's (2005) research on older nurses found:

> Work intensity will be the most influential factor in their decision to remain working or retire. Nursing leaders who recognize this and implement work load reducing strategies will be successful in keeping beds open and patients safe. (Conclusion section, ¶ 1)

Violence and harassment were also seen as an ever-present threat to the physical and mental well-being of nurses. Ulrich et al. (2005) looked at RN's experiences with sexual harassment, discrimination, acts of violence, and general hostility in the workplace. From the research of a 2002 study and a 2004 follow-up study, they reported only a slight decrease in reports of personal attacks from 19% to 16% (Workplace health and safety section, ¶ 2). Geiger-Brown et al. (2004) also found nurses experiencing "complaints [that] range from minor annoyances from insensitive managers, to real injury from physical abuse" (p. 20). Andrews et al.'s (2004) research concludes "the main factors identified ...as influencing older nurses' decisions to retire were work-related stress, lack of flexible hours of work, and pension considerations" (p. 304). These findings are also consistent in the research conclusions of Cyr, (2005); Geiger-Brown et al. (2004); McLennan, (2005); Reineck and Furino, (2005); and Ulrich et al. (2005).

In an attempt to define mitigating solutions to challenging working conditions, Cyr (2005) surveyed 1,553 New England nurses to identify factors that would influence their decision to retire. Eleven changes to the work environment were proposed by Cyr and rated for interest by the respondents. The results indicated: (a) 78% would consider part-time or per diem work, (b) 49% were interested in working winters with the summers off, (c) 61% would like a preferred schedule, (d) 54% would like to eliminate weekend shifts, (e) 49% would like a premium hourly rate, and (f) 63% were interested in a Less-Work for Less-Pay program (Proposed changes to the work environment section, ¶ 3). Researchers also proposed utilizing appropriate equipment such as mechanical lifting devices, and instituting a Workplace Health and Safety committee which

monitored and promoted ergonomically safer working conditions (Cyr, 2005; Geiger-Brown et al. 2004; McLennan, 2005).

Peer and Patient Relationships

Some researchers (McLennan, 2005; Newman et al. 2002; Ulrich et al. 2004) found evidence of peer support mechanisms as an integral component in both the working environment conditions and the level of job satisfaction for nursing professionals. McLennan (2005) found "when asked to identify the best thing about their workplace, 'colleagues' were identified by one third of respondents" (Strengths section, ¶ 1). Newman et al. (2002) reported respondents stated "the people I work with" as the third top factor influencing job satisfaction, which they say "supports a direct link between nurse satisfaction, the quality of care given and patient satisfaction" (p. 281). Ulrich et al. (2005) found "peer support has been positively related to decreased job burnout" (Working relationships section, ¶ 2).

Letvak, (2002), McLennan, (2005), Newman et al. (2002), and Uhrynuk, (2000) commented on the direct relationship between the perceived ability to provide quality patient-centered care and the retention of nursing staff. Newman et al.'s (2002) qualitative research reported "all those of our interviewees with direct daily contact with patients... said that caring for and helping patients, seeing patients get better, patient satisfaction ... were crucial to their enjoyment and satisfaction with nursing" (Factors influencing nurse job satisfaction section, ¶ 2). McLennan (2005) found nurses ranked "patient outcomes observed as a result of what I do" (Strengths section, ¶ 1) high in identifying the best factors in their workplace. Perry's research (as cited in Uhrynuk, 2000) found "making positive differences in the lives of their patients and the patients'

families is one of the ways the nurses found meaning" (p. 129), as well as "the belief that the patient is the primary consideration seemed to sustain them in their practice" (p. 137).

Nogueras' (2006) research looked at professional commitment in nurses and concluded "as RN age increased, RN occupational commitment increased" (p. 91). She speculates this commitment may be as a result of RN's having "a unique profession in that they are essentially caretakers in nature...they are inherently committed to the nursing profession and that natural commitment is the basis for remaining in the profession" (p. 91). She also states "there may also be a sense of guilt for abandoning the profession" (p. 91). This is consistent with Letvak (2002) who found older nurses "felt a moral obligation to deliver quality care" (Research on older nurses section, ¶ 1).

Workplace Health and Wellness

Bulaclac's (1996) research describes a work site wellness program in a small community hospital that viewed this program as an opportunity to "contribute in a positive manner to employee recruitment and retention" (p. 19). Employees who completed the wellness program were asked "Do you consider the program an employee benefit that will positively influence your decision to stay employed at the hospital?" The results of this question indicated 41.1% of the respondents replied "definitely yes", and 25.9% replied "yes" (p. 20). Reineck and Furino (2005) suggest stress has an "adverse effect on general health and elective early retirement", and further state "employer programs in stress reduction and management strategies to reduce stress were recommended" (p. 28). Andrews et al. (2004) comment on the link between wellness programs and mental health, and suggest nursing staff need "to be supported through strategies that promote the reduction of occupational stress" (p. 304). Cyr (2005) found

that nurses' own poor health was a contributing factor in early retirement decisions and suggests "hospitals that develop and support health promotion and return-to-work programs...may see such programs as the difference between closing beds or keeping them open" (Early retirement section, ¶ 2). Wellness programs were suggested by a number of researchers as an organizational strategy; I found no research directly studying the effects of employer supported wellness programs on employee retention.

Injustice and Unfairness

Geiger-Brown et al. (2004) included the theme of injustice and unfairness resulting from adverse working conditions in the work environment in their research. This was described as the lack of ability to have control over working conditions and the "personal devaluing by both management and other nurses" (p. 19). Ulrich et al. (2005) include "professional practice, and working relationships" in their definition of work environment (Discussion section, ¶ 2). This definition captures issues regarding the degree to which nurses feel they have the ability to "influence decisions about workplace organization and about patient care" (Professional practice section, ¶ 1).

McLennan (2005) uses a Stress/Satisfaction Offset Score (SSOS) to support this issue and found "too much demand with too little job control and high effort with few rewards resulted in stress, numerous illnesses, and injuries" (Instrument section, ¶ 3). This study reported that the highest priority for addressing nurse retention was making improvements in management and leadership. McLennan's study provides examples of free text comments reported by respondents around this issue: 'more communication and collaboration', 'more active involvement in decisions', 'free to vocalize and make improvements', and 'more feedback on work' (Priority changes section, ¶ 1).

Letvak (2002) suggests organizations engage in dialogue regarding policies around the treatment of nurses and a "strategic plan needs to be developed to address the specific needs of older nurses and to promote retention" (Developing personal views of aging section, ¶ 1). Letvak concludes her study by saying "the older nurse does not want special treatment – only to be treated fairly" (Conclusion section, ¶ 3). Consensus in the literature suggests prompt administrative action addressing issues unique to aging nurses will increase nurse engagement, job satisfaction, productivity and retention. The research regarding working conditions in relation to nurse engagement and retention is summed up by Ulrich et al. (2005) in the following statement:

> Organizations that truly want better work environments for their nurses and better outcomes for their patients and who want to attract the best nurses will take the information from surveys such as ours, ask their nurses what resonates with them, listen to the answers, and then accept ownership of the problems and fix them. (Conclusion section, ¶ 2)

Organizational Culture

Organizational culture is a significant factor in creating a positive workplace environment and a quality of work life for employees. Organizational culture directly influences the employee's level of job satisfaction and motivation, as well as enhancing commitment to the employer. Understanding organizational culture in terms of facilitating an alignment of employee goals with organizational goals is central to the development of key engagement and retention strategies.

Schein (1992) defined organizational culture as "a pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration" (p. 12). Detert, Schroeder, and Mauriel (2000) refine the definition to include "a system of shared values defining what is important, and norms, defining

appropriate attitudes and behaviors, that guide member's attitudes and behaviors" (p. 852) where the culture becomes the "social glue" (p. 851) of an organization. Snow (2002) states organizational climate is the atmosphere found in the workplace or how the workplace 'feels', and as such "represents the current state of the culture...climate is also indicative of how well the organization is realizing its full potential" (The concept of organizational climate section, ¶ 2). This literature review section outlines the relationship between organizational culture and the retention of nursing staff through the influences of people-focused leadership and patient-centered care philosophies.

The research within the field of nursing seems to echo industry labour shortage predictions, and indicates the current trends seen in nursing shortages may not be typical cyclical fluctuations. These may represent a permanent reality with significant ramifications to the overall state of health care and to the culture and climate within health care organizations (Cohen, 2006; Coile, 2001; Gifford, Zammuto, & Goodman, 2002; Holtom & O'Neill, 2004; Magee Gullatte & Jirasakhiran, 2005). Retention issues in general will demand an ever increasing administrative priority. In the nursing profession, Snow (2002) sees how "putting leadership into action to create a 'compelling workplace' is vital and necessary for nurses, given the challenges faced by the nursing profession and hospitals today" (Impact of organizational climate on organizations section, ¶ 6).

Impact of People Focused Leadership on Organizational Culture

Understanding the current culture of an organization and the role leadership has in creating culture is integral to the discussions of remedial actions required to promote a culture of retention. Yukl (2006) states the role of leadership is multifaceted, complex

and requires a broad set of leadership behaviors and strategies. Yukl outlines Schein's concepts of how leaders can influence and shape culture through considerations of "primary and secondary mechanisms" (p. 165). Primary mechanisms are: (a) what things are attended to by the leader, (b) ways of reacting to crisis, (c) role modeling, (d) criteria for allocating rewards, and (e) criteria for selection and dismissal. Secondary mechanisms include factors such as: (a) design of the management systems and procedures; (b) design of the organization structure; (c) design of the facilities; (d) the stories, legends, and myths; and (e) any formal statements. Yukl concludes any attempt to implement change is best facilitated by involving "people-oriented actions" for "motivating, supporting, and guiding people" (p. 178). Deluga's (1988) research used people-centered leadership to refer to "behavior in which the leader shows friendship, trust, respect, and warmth...emphasize the needs of the subordinate and are viewed as strongly concerned with supportive human relations as well as interactive-facilitative behaviors" (Introduction section, ¶ 3).

Within the context of organizational culture, leadership is responsible for establishing a culture and a working environment that supports and motivates its employees. Lowe's (2006) report for the Canadian Nurses Association states:

> Achieving significant breakthroughs in quality of work life and health service quality requires a systemic strategy that builds a people-centred culture. One of the hallmarks of health-care organizations that have embarked on sweeping cultural change is a relentless pursuit of improvement through measurement, accountability and follow-up actions. Everyone understands that excellence in health service delivery is achieved by enabling and supporting employees to be physically, mentally, emotionally and socially healthy and well. (p. 22)

Herzberg's (2003) motivation-hygiene theory of job attitudes suggests job enrichment strategies are required to stimulate employee motivation as these provide the "opportunity for the employee's psychological growth" (Eternal triangle section, ¶ 6). He

describes motivational factors intrinsic to the job as, "achievement, recognition for achievement, the work itself, responsibility, and growth or advancement" (Hygiene vs. motivators section, ¶ 5). Accordingly, he states by attending to job enrichment, "the return in human satisfaction and economic gain would be one of the largest dividends that industry and society have ever reaped through their efforts at better personnel management" (Steps for job enrichment section, ¶ 5).

Osterloh and Frey's (2000) research concluded "knowledge transfer is intimately connected to motivation and that sustainable competitive advantage requires a corresponding motivation management" (p. 538). To foster conditions of intrinsic motivation for employee's, "the ideal incentive system is in the work content itself, which must be satisfactory and fulfilling for the employees" (p. 539). Tacit knowledge they state, is a "crucial source of sustainable competitive advantage", and "the contribution of a particular employee's tacit knowledge to a team output cannot be measured and paid accordingly" (p. 539).

Osterloh and Frey (2000) also see the "behavioral view of organizations" supporting intrinsic motivation in the "form of identification with the firm's strategic goals, shared purposes, and the fulfillment of norms for its own sake" (p. 540). Successful leadership models are found in "organizational forms that emphasize participation and personal relationship" (p. 547). Cohen's (2006) research also supports the value of tacit knowledge and states successful retention strategies are found in a "culture that appreciates the knowledge, experience, and perspective that older nurses can provide to an organization. Creating this culture may necessitate combating preconceived notions about older workers" (p. 234).

Gifford et al. (2002) studied the culture of labour and delivery units in seven US hospitals using the competing values framework and concluded the human relations model "has the strongest statistical relationship with the QWL (quality of work life) measures and is positively related with commitment, job involvement, empowerment, and job satisfaction" (p. 20). Leadership styles in this model are described as participatory, supportive, open and honest, use decentralized decision making, and focus on "dynamics within the organization" (p. 17).

This view is supported by Coile's (2001) review of nationally recognized United States magnet hospitals known for promoting "their nursing staff's job satisfaction, both professionally and personally" (p. 226). Coile found "competitive wages are important...but they are not the ultimate factor. Philosophy and organizational culture are much more significant in these magnet institutions whose turnover rates are less than half of their counterparts" (p. 226). The attributes of magnet hospitals were described by Haven and Aiken (as cited in Uhrynuk, 2000) as:

> These organizations acquired their reputations for excellent patient care and professional working environments for nurses partly because they provide organizational support that empowers nurses to use their professional knowledge and skills on behalf of the patients. The organization of nursing in these institutions has demonstrated consistently three distinct core features that are elements of a professional nursing practice model: professional autonomy over practice; nursing control over the practice environment, and effective communication between nurses, physicians, and administrators. (p. 22)

Manion (2004) researched how nurse managers created a "culture of retention" and concluded "the way to create a culture of retention is, in fact, to create a culture of engagement and contribution" (p. 30). These strategies include: (a) put the staff first, (b) forge authentic connections, (c) coach for and expect competence, (d) focus on results, and (e) partner with staff. Izzo and Withers (2002) state that " employee empowerment is

a passé management strategy...today's employees expect to be treated like partners....the four most powerful words for engaging employees in the new work ethic are, 'What do you think'" (p. 54).

Magee Gullatte and Jirasakhiran (2005) suggest retention is influenced by a manager who "understands diversity and promotes an atmosphere where everyone can be engaged in working together", and where "nurses feel they make a difference, their talents are tapped, and their contributions are acknowledged" (p. 599). They support creating an organizational culture that adopts a "culture of caring" where the responsibility for creating this environment is "the manager, backed by the senior level management" (p. 600). To retain the nurse manager the organizational management philosophy must include "an opportunity to participate in decision making and empowerment to manage" (p. 600). Research by Kangas, Kee and McKee-Waddle (as cited in Uhrynuk, 2000) found supportive environments enhance self-recognition of successful job performance and give nurses a sense of doing well, leading to higher levels of job satisfaction.

The pressures that labour shortages and mass retirements will create on the health care system are enormous. Margaret Wheatley (2002) discusses how intense change creates new organizational dynamics that must re-focus on the quality of relationships and states:

> There is only one prediction about the future that I feel confident to make. During this period of random and unpredictable change, any organization that distances itself from its employees and refuses to cultivate meaningful relationships with them is destined to fail. (One prediction about the future section, ¶ 1)

Family and Finances: Issues and Pressures Affecting Retention

Every individual belongs to a myriad of interconnected and often complex systems: families, workplaces, neighbourhoods, communities, social, socio-economic, and cultural groups. In addition to understanding the professional pressures experienced by nurses in their workplace, it is imperative to explore the variety of personal, family, and financial pressures facing mid- to late-career nurses in order to develop appropriate retention strategies. Newman et al. (2002) state "a piecemeal approach to any isolated component will not improve nurse recruitment and retention...it seems clear that a holistic approach is mandatory" (p. 289). Issues and pressures external to the work environment may individually or collectively influence an employee's decision to consider retirement. The organization must be cognizant of these pressures in order to identify potential leverage points that may influence an employee's decision to remain working. At the same time, they must acknowledge those factors which are outside the organization's sphere of influence. This section reviews the literature regarding (a) the influences of job embeddedness, (b) financial considerations, and (c) family pressures on considerations to retire from nursing.

Job Embeddedness

Research by Holtom and O'Neill (2004) use the business management concept of job embeddedness theory as a lens to view retention issues. They studied the concept of job embeddedness in health care to determine its value in predicting the retention of nursing staff and in understanding if factors influencing nursing staff retention were

similar to factors that could be used in retaining other health care employees. The premise of job embeddedness is:

> An employee's personal values, career goals, and plans for the future must "fit" with the larger corporate culture and the demands of his or her immediate job (eg, job knowledge, skills, and abilities). In addition, a person will consider how well he or she fits the community and surrounding environment. The better the fit, the higher the likelihood that an employee will feel professionally and personally tied to the organization. (Voluntary turnover and job embeddedness section, ¶ 12).

Holtom and O'Neill's (2004) research measured key aspects of job embeddedness such as: (a) the extent to which the job and community are compatible with other aspects of employee's lives (the fit), (b) the employee's links to other people or activities (the links), and (c) the ease with which these links could be altered (the sacrifice). They concluded that "the totality of the embedding forces that keep a person on the job [is greater than] the negative attitudes that prompt one to leave" (Summary and hypotheses section, ¶ 1). Their suggestions to enhance retention through job embeddedness include: (a) offering mentoring relationships, (b) providing more flexible work arrangements, (c) developing managerial leadership skills, and (d) supporting employee involvement in their community.

Holtom and O'Neill (2004) suggest organizational retention strategies need to go beyond traditional methods for increasing employee satisfaction and job commitment, and should include a broader understanding of the relationship of the individual to their community. Cohen (2006) also supports utilizing job embeddedness to understand the retention of older nurses and suggests organizations offer experienced nurses opportunities to "represent the organization within the community...with educational institutions, professional groups and community resources" (p. 236).

Izzo and Withers (2002) suggest new work values are influencing employee expectations in the workplace; "employees today want to achieve balanced lives, partnership with their employers, experience personal and professional growth, feel they are making a worthwhile contribution [to the world] in their job, and enjoy a sense of community at work" (p. 53). Grossman and Valiga (2005) see the benefits to health care of having nurses who are active members of the larger community. They suggest that nurses who form strong community networks "maintain a social and professional identity and provide a means of working toward organizational, professional, or societal reform" and are more able to suggest someone to "fill a key position in an organization [or] nominate for appointment to a community board" (p. 178).

Dychtwald et al. (2006) state mature workers "want time for recreation and volunteerism, doing what their previous working lives did not allow" (p. 136). They make a strong case for developing flexible work arrangements in order to attract and retain staff and cite a philosophy in Hewlett-Packard as "flextime is not just a company perk or a negotiation...it's a strategic business tool that improves productivity and quality of life" (Dychtwald et al. 2006, p. 141).

Financial Considerations

Financial considerations are a key component for employees who are contemplating retirement. Issues determining retirement decisions focus on: (a) the ability to save money, (b) an adequate retirement income and pension, (c) a spouse's financial situation, (d) expenses for tuition and other family demands, and (e) an expectation of maintaining a certain standard of living while retired. Individuals must consider the financial impact on the family in each one of these areas if one or more

family member adjusts their income by reducing their working hours or retiring fully. People are looking at a "new retirement paradigm...[that has] a balance of work, education and leisure appropriate to their own situation" (Salter, 2004, p. 268).

Market's (2005) research indicates baby boomers will stay in the workforce longer as "few are financially ready for retirement so are likely to continue to work for economic reasons" (¶ 5). McCune (as cited in Market, 2005) states three-quarters of baby boomers have no idea of how much money they need to save for retirement. Studies by Blendon, Benson, Brodie and Wainess (as cited in Market, 2005) indicate in their survey "more than half of the working adults say they are either not saving for retirement at all (31 percent) or are saving inadequately (26 percent)" (Need to work section, ¶ 2). Sleyster and Waldeck (2006) also support this premise and suggest financial strategies for retirement need to consider "what is needed during retirement – it is the difference between accumulation and income". (Help participants secure their retirement section, ¶ 1). Moore and Biordi (as cited in Andrews et al. 2004) conclude 'nurses who do not actively manage personal finances or attend to details of employment benefit packages place themselves at distinct risk for economic crisis during their decades of retirement' (p. 301).

Nogueras' (2006) research used the Three-Component Model of Occupational Commitment to predict nurse's intentions to leave the profession. These three components are: (a) affective (attachment), (b) normative (obligation), and (c) continuance (penalty for leaving). Her research concludes that "greater continuance occupational commitment was associated with less intent to leave the nursing profession" (p. 90), or the higher the penalty for leaving the more likely the individual would remain

working. This penalty includes the loss of wages, benefits, and pension considerations that retirement would create. Further studies cited in Nogueras (2006) by Blau, (2003); Irving, Coleman, and Cooper (1997); and Meyer, Allen, and Smith (1993), concluded that continuance committed individuals "do not manifest the same ties to the profession...[and they] are not inclined to promote their occupation to the public or adhere to professional standards" (p. 87).

Reineck and Furino (2005) found the "adequacy of spousal income and benefits packages" was a deciding factor to remain employed in an unacceptable work environment. In their study, the 289 nurses who left nursing did so based on (a) family responsibility (40%), (b) retirement (28%), and (c) stress (26%). Of these nurses who were not working, 65% were not the primary wage earners in the family suggesting these nurses have a "low economic need to work" (p. 30). Therefore, financial enticements would not be the appropriate strategy for recruitment in these situations. Andrews et al. (2004) support the links between financial security and retirement decisions, and state financial considerations for those older nurses who are "the sole breadwinners for their household...[due to] rising divorce rates...meant that nurses in this largely female workforce are increasingly faced with such [financial] challenges" (p. 303). Under these circumstances, this group would likely remain in the workforce longer.

Cyr's (2005) research found "financial independence was the factor most frequently cited (75%) by respondents as encouraging early retirement", and "financial incentives were cited most frequently (65%)" as factors for choosing to work after retirement (Factors affecting early retirement section, ¶ 1). Pozzebon and Mitchell (as cited by Cyr, 2005) found "women with spouses in poor health remained employed to

keep health insurance benefits" (Influence of spouse section, ¶ 1). Cyr also recognized financial independence is a factor that organizations can do little to influence.

Family Pressures

Often older workers have special considerations in balancing leisure time, family demands, and their own mental health requirements on top of the time they spend at work (Andrews et al. 2004; Berman Brown & Adebayo, 2004; Hammer, Neal, Newsom, Brockwood, & Colton, 2005; Healy, 2001; Larkin, 2007; Naumanen, 2006; Timmermann, 2006). Occupational health models for older workers address issues that effect job performance such as a worker's physical, social, and psychological situation. Naumanen (2006) states that "according to the 8+8+8+ model, the time spent on work, leisure-time activities and rest should be in equal proportions" (p. 39). The occupational health model for health promotion evaluates and follows both the health of workers and the workplace. Naumanen (2006) suggests an important component in this monitoring process is to "solve human relations problems at work and in one's personal life" (p. 42). Berman Brown and Adebayo's (2004) UK study on attitudes of work-time and leisure-time in field nurses and management personnel, found the more senior the employee the more frequently work encroached on home life and that "work-time has fewer boundaries" (p. 372).

Roberts and Friend (1998) studied women's career momentum, which they defined as an individual's "increasing, maintaining, or decreasing investment in her career" (p. 195), and conclude family factors are often associated with low career momentum. They found "in midlife, women often assume the responsibility of caring for aging parents…[which] is related to increased stress and decreased well-being and life

satisfaction" (p. 197). Recognizing nursing is predominantly a female occupation, Larkin (2007) states "nurses describe how 12-hour shifts leave little room for flexibility, often conflicting with personal responsibilities and interests. This is especially true for older nurses with caregiving demands at home" (p. 162). These increased pressures give rise to stress, burnout, and an inability to continue working. Spouses who are in poor health or who are financially secure also contribute to decisions to retire.

Hammer et al. (2005) studied the utilization and efficacy of workplace support systems offered by organizations in order to "decrease the conflict between work and family demands, leading to improved attitudes and behaviors of employees" (p. 799). Workplace supports were defined as (a) policies around flexible work arrangements, (b) services providing resource and referral information, and (c) benefits including child care subsidies. Their study concluded:

> Using supports may serve to exacerbate wives' own work-family conflicts by enabling wives, the traditional family caregivers, to take on even more family care responsibilities rather than increasing their own ability to manage existing work and family demands....[time increased] on average [by], 9.5 hr per week for wives and 7.6 hr per week for husbands (p. 807).

They also found "employees who use workplace supports are more satisfied on the job" and an "enhanced understanding of the relationship between use of family friendly workplace supports and work-family outcomes may increase organizations' willingness to provide such supports" (p. 808).

Elder care is fast becoming a dominate issue in the lives of baby boomers. Timmermann (2006) cites a 2005 National Alliance for Caregiving survey which states 21% of the adult US population is a caregiver. The caregiver profile is described as: (a) an average of 46 years of age, (b) 61% are women, (c) provide an average of 21 hours of care per week, (d) provide care for an average of 4.3 years, and (e) 59% of these

caregivers are employed. Companies such as AT&T and Ceridian Corp. are actively discussing elder care issues in their organizations as part of their retention strategies; 'elder care is likely to become as prevalent as child care'(Fletcher, 2001, Elder care a concern of aging workforce section, ¶ 4). While in the workplace, Healy (2001) suggests occupational and environmental nurse practitioners use appropriate external community and social service resources when supporting the 'sandwich generation' nurse:

> Middle age workers are not only addressing parenting issues but are increasingly faced with caring for grandchildren or parents, putting them at risk for 'middlescent burnout.' Middle aged workers may find themselves caring for their parents longer than for their children. Elder care responsibilities can have a devastating impact on an employee's ability to contribute fully at the worksite and be productive team members. (Healy, 2001, p. 524)

The Robert Wood Johnson Foundation report *Wisdom at Work* (2006) provides a list of the optimum human resource benefits that have significant value to older nurses. These include: (a) counseling and support for career placement, (b) paid additional time off for caregiving, (c) special features for older workers in Employee Assistance Programs, and (d) elder-care options with financial support. Alternately, they suggest a scaled-down version could include: (a) unpaid leave for caregiving, (b) elder-care referrals or other options without financial support.

Clearly organizations cannot change an individual's financial or family pressures, or predict the associated stresses on individual employees. Still organizations must account for these influences when designing employee support programs, developing educational opportunities, and structuring or re-structuring the workplace environment.

Finding Significance in Midlife

Paramount in leadership literature is recognizing the essential role of leaders to support the engagement of employees in order to (a) foster collaboration and team work, (b) increase productivity, (c) inspire trust, (d) gain loyalty and commitment, and (e) retain staff (Goleman, Boyatzis & McKee, 2002; Herzberg, 2003; Kouzes & Posner, 2002; Schein, 1992; Senge, 1990; Quinn, 2004; Yukl, 2006). To fully capture all of the factors influencing retention and most importantly, support the engagement of mid- to late-career Registered Nurses requires an acknowledgment of the role of personal introspection processes in midlife adults. If organizations are to develop successful engagement strategies for mid- to late-career employees, they must understand the evaluation processes embedded in adult development at this life stage. Much has been written regarding life review, transition points, and the major life changes experienced by individual's, and Buford (2007) supports the position of individuals "having two lifetimes...Life I is what occurs before halftime, and Life II comes afterward" (¶ 2).

In the study of human development, Demo (1992) defines self-concept as a "set of structured self-attitudes that is relatively stable and 'characteristic' of an individual....[and] is characterized by both stability and change over the life course" (p. 303). He further states "a number of social and personal events that typically occur during mid-life elevate consciousness and trigger a major self-reassessment. Among these events are a realization of one's own mortality ... aging parents, deaths of parents and/or close friends, divorce, [and] remarriage" (p. 316). In terms of attitudes to work, Demo also states "job involvement and job satisfaction are highest between ages 40 and 65 ...and performance in the work setting, occupational conditions, and socioeconomic

attainment are tied to personal efficacy and self-esteem" (p. 317). An awareness of the potential for change in an individual's "self-concept" at midlife may influence what engagement practices an organization may find successful in supporting employee engagement.

Studies in adult development have identified many theories to account for the radical changes often found in the personalities of people undergoing middle age (Jung; Jacques; Levinson, Darrow, Klein, Levinson & McKee; & Karp; as cited by Stewart & Ostrove, 1998). Stewart and Ostrove (1998) suggest that not all changes need to be profound:

> Midlife may often be a period of change or transition but one that is neither universal nor necessarily as dramatic as 'crisis' suggests. Instead, perhaps many individuals make modest (and some not so modest) 'corrections' in their life trajectories – literally, 'midcourse corrections'. (p. 1188)

Midlife transition in adult development is defined by O'Connor and Wolfe (1991) as "a crucial time that holds possibilities for growth and development....a time which bridges two major eras of life, early adulthood and midlife...that impacts a person's career, family, and self" (p. 324). O'Connor and Wolfe's research focused on understanding factors enabling personal growth through a paradigm shift at midlife transition. They describe "midlife, as a time of inevitable changes both internal and external [that] strains the adaptive capacity of the old and established paradigm" (p. 326). Their research concludes that in an organizational context this paradigm shift results in midlife employees exhibiting the following characteristics:

> Increasing awareness of self and world leads to greater choice and realistic confidence on a range of issues: in working interdependently, in re-defining one's work in wider perspectives, in joining others in collaborative rather that coercive relations, and in more openly dealing with authority and handling conflict. (p. 337)

Goleman et al. (2006) suggest employees are "addressing many aspects of their lives rather than just their work...[and] older colleagues are coming to the same conclusions, but for them it is part of aging, midlife, and midcareer crises" (p. 120). Dychtwald et al. (2006) describe midcareer employees as looking for "meaningful and personally fulfilling work that incorporates responsibility, recognition, and personal progress... [and] since many of them remain idealistic and cause oriented, they most enjoy work that contains a service component and coincides with their 'life mission' (p. 74).

Self-reflection or life review involves looking inward at the social context, workplace, and personal factors that constitute the current state of an individual's life. Kouzes and Posner (2002) write that through self-reflection comes self-awareness which captures the desire to find meaning and purpose; through this process individuals discover their lives' central theme. Goleman et al. (2002) broaden this view to include "having a deep understanding of one's emotions, as well as one's strengths and limitations and one's values and motives" (p. 40).

Finding significance and meaning at midlife includes a sense of generativity (Stewart & Ostrove, 1998) and the season of 'now what' (Buford, 2007). The motivational influences contributing to moving towards a personal vision include the opportunities available, career momentum (Roberts & Friend, 1998), discrepancy between the actual and the ideal self (Holahan, Holahan & Wonacott, 1999), and the level of individual determination to achieve one's goals. Engagement and commitment result from levels of self-efficacy (Maurer, 2001), a commitment to self-directed learning (Vaill, 1996), and the discipline of personal mastery (Senge, 1990). This literature review

section examines the influence of each of the following processes - self-reflection, finding significance and meaning, motivational influences, and engagement on the midlife transition of older workers.

Figure 3 depicts a composite of the processes of midlife evaluation and integration as a continuous cycle moving through self-reflection, finding significance and meaning, understanding motivating influences, and engagement practices.

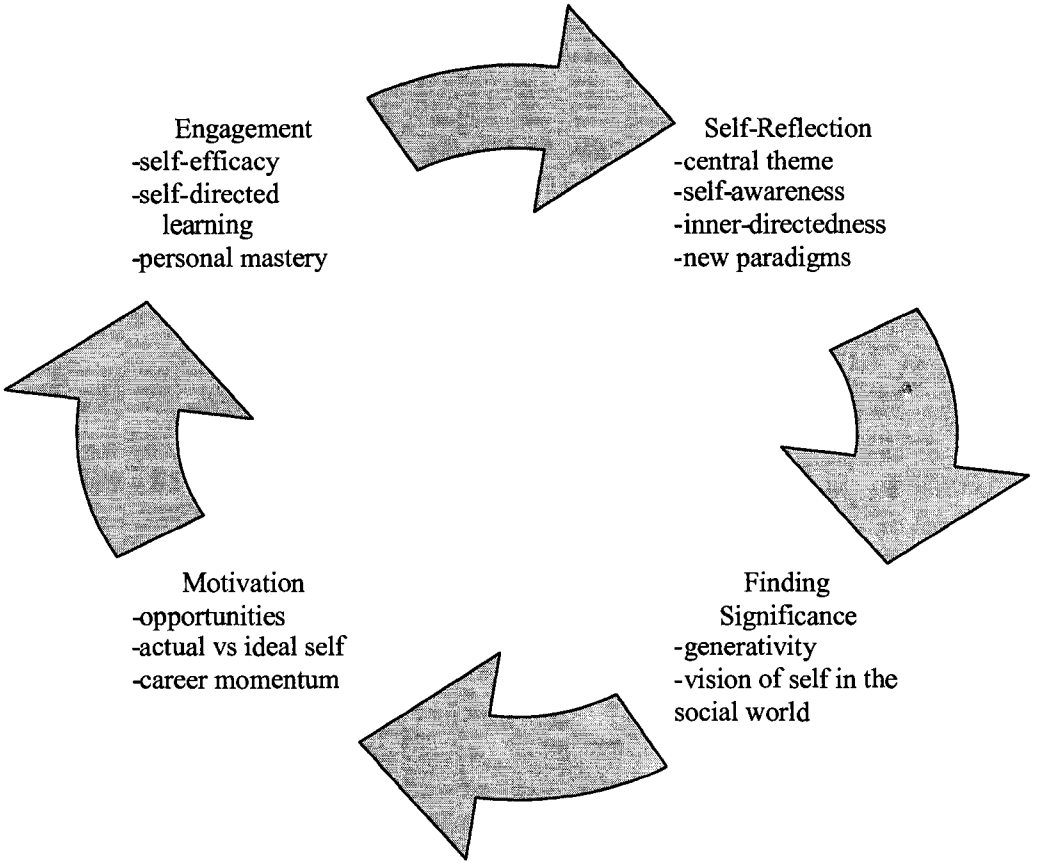

Figure 3: Cycle of midlife evaluation and integration processes

Each of these processes is marked by the individual's intense internal exploration for self-identification and relevance. Movement through this cycle can be applied to mid- to late-career Registered Nurses in their deliberations to retire.

Self-Reflection

Quinn (2004) suggests self-change is a six stage process of: "precontemplation, contemplation, preparation, action, maintenance, and termination ... [and] while we are moving toward change, we are in the nonaction stages 80 percent of the time" (p. 201). Quinn states the process of "*self-reevaluation*" (p. 209) focuses on negative aspects of the present which push individuals forward simultaneously with the positive pull of the future. The goal of this process is for individuals to attain a fundamental state of [personal] leadership where they are purpose-centered, internally driven, other-focused, and externally open. Quinn suggests it is in this state that we "attract new flows of energy...overcome entropy and slow death. We become more fully alive" (p. 23). Individuals increase their personal integrity through authentic engagement, by "being engaged in the world of action with love for what we are doing" (p. 113). To effectively make significant life choices, Quinn states "we go inside ourselves, not to the problem or our feelings about it, but to our purpose" (p. 167).

> When people make a fundamental choice to be true to what is highest in them or when they make a choice to fulfill a purpose in their life, they can easily accomplish many changes that seemed impossible or improbable in the past. (Quinn, 2004, p. 118)

Kouzes and Posner (2002) discuss envisioning the future as a process that requires a "look first into the past...when you do, you're likely to find that your central theme...has been there for a long time" (p. 119). This central theme contains an individual's "concerns, desires, questions, propositions, arguments, hopes, dreams, and aspirations – core concepts around which they organize their aspirations and actions" (p. 115). Kouzes and Posner endorse the validity of practicing self-reflection as a means to

"find some way of reaching a contemplative state in which you can hear your own voice speaking to you about what truly matters" (p. 86).

O'Connor and Wolfe's (1991) concur with other researchers (Schott; Wolfe & Kolb; Kolb & Wolfe; as cited in O'Connor & Wolfe, 1991) who found "there is a general movement from outer – to inner-directedness from early adulthood to midlife" (p. 333). Their research describes a paradigm shift process where "the letting go of the high outer-directed approach to managing one's self and circumstances and the inevitable search for new sources of direction acts as a powerful catalyst in developing a new paradigm at midlife...[involving] a questioning of core values, beliefs, and assumptions" (p. 333).

Finding Significance

Buford (2007) describes midlife as "halftime...the beginning of a whole new beginning...the richest and most meaning-filled season of all" (¶ 2). Buford (1994) also suggests "significance need not be a 180-degree course change. Instead, do some retrofitting so that you can apply your gifts" (p. 89) then "begin to creatively find ways to turn those externals into opportunities" (p. 154). Peter Drucker (as cited in Buford, 2007) encourages individuals who are experiencing midlife transition to ask themselves what they have achieved in their lives, and what they care deeply or passionately about. Buford (2007) advises individuals "to reposition *when you're a success*" (Find out who you are section ¶ 1) in order to accomplish the transition. Charles Hardy (as cited in Buford, 1994) suggests "the secret to constant growth is to start a new Sigmoid Curve before the first one peters out...where there is the time, as well as the resources and energy, to get the new curve through" (p. 109). Buford (2007) suggests individuals in transition should "set your sights on achievements that really matter, that will make a difference to the

world" (Make your life your endgame section, ¶ 1) which Buford (2007) calls "*socially productive aging*" (The code breakers section, ¶ 2).

Both Huberman and Lam's (as cited in MacKeracher, 2004) research found "adults are more concerned with whether they are changing in the direction of their own idealized self-concept than with whether they are meeting objectives established by others" (p. 40). Stewart and Ostrove (1998) discuss midlife individuals as having a sense of generativity or "an enlarged vision of one's role in the social world and a sense of responsibility and commitment" (p. 1189). Erikson (as cited in Stewart & Ostrove, 1998) suggests both men and women undergo a "desire to make a lasting contribution to the next generation" (p. 1190) and this desire is experienced more in midlife than in early adulthood. Stewart and Ostrove's research of women born during the baby boom, concluded generativity "does *not* depend on a lifetime of economic and racial privilege ... [it] may even be more likely without such privilege...[as] this sense of competence derives...from successfully handling difficulties" (p. 1192).

Motivational Influences

Goleman et al. (2002) state developing emotional intelligence begins with "connecting with one's dreams...uncovering your ideal self...what you want in your life...[and that] requires a reach deep inside to one's gut level" (p. 116). They suggest what inspires and motivates individuals most to change is the recognition and differentiation "of your ideal and real self, your strengths and gaps" (p. 138). Managers can also discern areas of employee motivation by observing "wherever people gravitate within their work role indicates where their real pleasure lies – and that pleasure is itself motivating" (p. 42).

Roberts and Friend (1998) researched how women's personal identity is achieved through career momentum defined as "the degree of motivation and stimulation that the career provides" (p. 197). They suggest women with "high career momentum, to consider work as a more central defining role than women with maintaining or decreasing patterns of career momentum" (p. 197). Women planning retirement can be characterized as having diminished career momentum. Roberts and Friend (1998) also discussed the concept of "social clocks" representing the norms and expectations surrounding an individual's development in their social role. They found "people can feel either on-time or off-time when it comes to major life transitions and stages of life. These feelings are subsequently associated with a person's personality and psychological adjustment [rather than chronological age]" (p. 196). Their research concluded "psychologically, the majority of these women viewed their occupations as a source of stimulation and future possibilities. Hence, for their cohort and sample, it was 'on-time' to continue to advance one's career at age 52" (p. 204). This conclusion was in contrast to low career momentum women who:

> Had the lowest occupational status and considered work to be relatively unimportant to their sense of self....they rated their physical health lower...and scored lowest across the measures of self-acceptance, independence, and well-being....[and were] most likely to have a partner who was retired. (p. 205)

Holahan et al. (1999) researched gifted individual's midlife assessment of having lived up to their intellectual abilities in the context of the role of self-concept and motivation. Studies by Higgins, and Roese and Olson (as cited in Holahan et al. 1999) suggest "frustration from unfulfilled desires underlies the motivational aspect of the actual-ideal self discrepancy. The negative emotion cued by life regrets, in turn, motivates further efforts to cognitively undo aversive events" (p. 238). This reflected the

"significance of life regrets in the aging years... [and] the valence of unfinished business, because the choice responses overwhelmingly indicated regrets over omissions rather than actions taken" (Holahan et al. 1999, p. 243).

Engagement Process

Maurer's (2001) research acknowledges "rapid changes in the nature of work...suggests that workers in mid- and late-career stages will need to increasingly be involved in continuous learning at work" (p. 126). He also suggests older workers traditionally do not "participate in training and development activities as much as younger employees" (p. 123). Maurer discusses self-efficacy (self confidence) as one of the challenges faced by older workers in the development and improvement of career-relevant skills. He states "for employees to feel good about a developmental feedback program, perhaps they should believe that they are actually capable of developing skills" (p. 129). Maurer also advocates for organizations to recognize self-efficacy as (a) an important variable in building a continuous learning culture, (b) a component in promoting expectations of self-directed learning, and (c) managing age diversity in training and development activities.

Brookfield (as cited in Merriam & Caffarella, 1999) states "the most complete form of self-directed learning occurs when process and reflection are married in the adult's pursuit of meaning" (p. 291). Vaill (1996) supports an attitude of "learning as a way of being" (p. 56) for individuals in the workplace, and concurs with Maurer (2001) that continual learning through self-directed learning is an expectation in most organizations. Vaill (1996) supports self-directed learning as one adaptation for employees who are "living and working in a productive and healthy way in the extremely

turbulent environment of modern organizations" (p. xi). O'Conner and Wolfe (2007) suggest corporations engaging in both "self study and collaborative inquiry will encourage individuals to develop to higher levels and such personal growth will tend to become a catalyst for skill acquisition" (p. 338).

Dychtwald et al. (2006) state "the organization creates the conditions under which individual career initiative can flourish or be stifled" (p. 76). They suggest organizational benefits from continued career development opportunities will be the "renewed commitment and productivity on the one hand, reduced replacement cost on the other" (p. 93). O'Connor and White (1991) caution organizations to recognize "as the person struggles to grow and rejects the old paradigm, he or she may be perceived as rejecting the organization ... because we are dealing with a basic *self-creative* process, some tolerance for change and mistakes is necessary" (p. 337).

Senge (1990) discusses the role of personal growth training in organizations and defines the discipline of personal mastery as "continually clarifying what is important to us.... [and] continually learning how to see current reality more clearly" (p. 141). Senge states individuals with high personal mastery "live in a continual learning mode" (p. 142), and suggests organizations can benefit from supporting a climate that fosters "encouraging personal vision, commitment to the truth, and a willingness to face honestly the gaps between the two" (p. 173). O'Brien (as cited in Senge, 1999) has experienced the benefits of personal mastery at an organizational level through employees who (a) exhibit increased levels of commitment and initiative, (b) have a broader and deeper sense of responsibility to their work, and (c) demonstrate an ability to learn faster. O'Brien also states:

> [Another] important reason why we encourage our people in this quest is the impact which full personal development can have on individual happiness. To seek personal fulfillment only outside of work and to ignore the significant portion of our lives which we spend working, would be to limit our opportunities to be happy and complete human beings. (p. 144)

This literature review section reminds organizations of the normal evaluative processes expected from midlife adults. The white report, *Wisdom at Work,* (2006) initiated by the Robert Wood Johnson Foundation suggests organizations adopt a number of strategies for supporting the engagement and the retention of the older nurse. These strategies pay attention to the growth and development of individual nurses and include: (a) investing in continuing education programs for expanded nursing roles, (b) designing career paths for enriched opportunities, (c) designing knowledge management programs, and (d) developing awareness and educational programs aimed at older nurses.

Cumulation of the Literature Reviews from a Systems Perspective

It is strategically important for organizations to identify and understand the number and variety of systems by which an individual who is contemplating early retirement may be influenced. It is a distinctive advantage to policy makers to understand the impact of the four interconnected systems identified in this literature review: (a) the workplace environment in health care, (b) organizational culture, (c) family and financial pressures, and (d) finding significance in midlife. Looking at engagement and retention issues through a systems view may identify opportunities and leverage points in job redesign, leadership roles, human resource processes, and learning organization concepts. Senge (1990) defines system thinking as a "conceptual framework, a body of knowledge and tools... to make full patterns clearer, and to help us see how to change them

effectively" (p. 7). Each one of the parts or systems presented in this literature review provides insights in supporting engagement and influencing retention.

Figure 4 is an overview of the interrelated parts of an individual's life or system, as it is related to engagement and retention strategies in this research. Through systems thinking one can view all components relevant to an individual's life; each component composed of and reflecting the individual's unique circumstances. It is through a system's view that leverage can be found and fundamental responses can be designed. This model can be applied widely across IH, from understanding mid- to late-career Registered Nurses to understanding any other group of employees within IH. The final word describing the inter-connectedness of individuals to their work, family, and community belongs to Wheatley and Kellner-Rogers (1998):

> As we create communities from the cohering center of shared significance, from a mutual belief in why we belong together, we will discover what is already visible everywhere around us in living systems. People's great creativity and diversity, our desire for contribution and relationships, blossom when the heart of our community is clear and beckoning, and when we refrain from cluttering our paths with proscriptions and demands. (¶ 29)

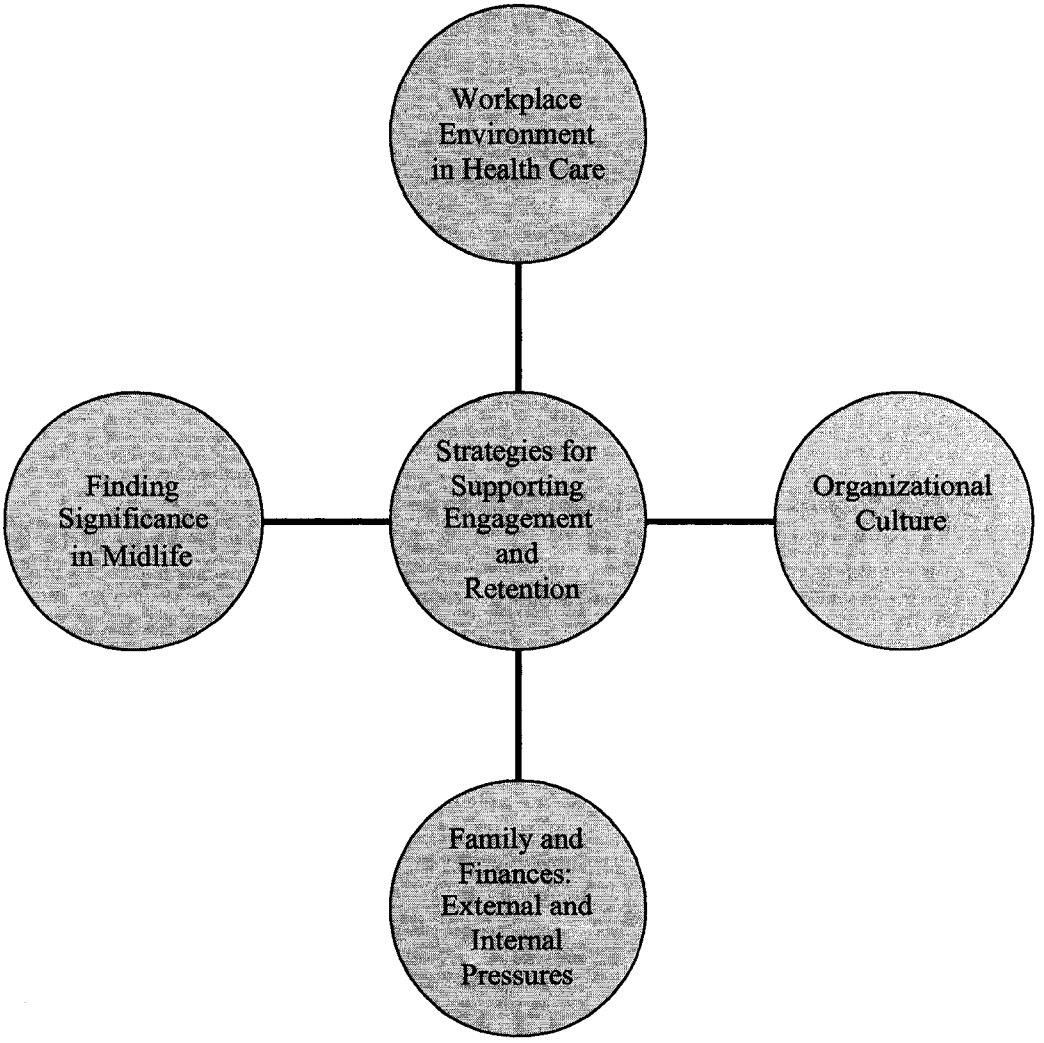

Figure 4: Systems affecting strategies for supporting engagement and retention of Registered Nurses considering retirement.

CHAPTER THREE – CONDUCT OF ACTION RESEARCH PROJECT

This section integrates the principles of participatory action research with my research project and is a description of the methodological framework used in gathering my research data. In this section I (a) identify research participants and outline how they were selected for the three focus groups, (b) provide a discussion of the qualitative data collection methods used, and (c) discuss the ethical principles that provide the foundation for this action research project.

My research question was "How does Interior Health support the engagement and retention of skilled mid- to late-career Registered Nurses who are between the ages of 55 and 64 years and are considering retirement?" Related questions which support this research project are: "What interventions would create synergy between the personal goals of these employees and the goals of Interior Health?" and "What implications does this have on how Interior Health modifies employment practices to fully utilize mid- to late-career employees?"

Research Approach

This research was based on participatory action research methods where the primary objective was to act "as a practical tool for solving problems experienced by people in their profession" (Stringer, 1999, p. 11). Action research is a style of research designed to "encourage an approach to research that potentially has both practical and theoretical outcomes but that does so in ways that provide conditions for continuing action" (Stringer, 1999, p. xviii). Action research is a series of continual feedback loops of observe, think and action (Stringer, 1999), and therefore a suitable approach to fully

examine the issue of engagement and retention of mid- to late-career Registered Nurses in IH. The action research cycle in Figure 3 represents how selected Interior Health stakeholders were integrated into focus groups for data collection continuing through to the strategic planning function in the organization. Stringer (1999) supports the inclusion of multiple stakeholders in research as it is "consonant with the constructivist philosophy...it defines outcomes in ends that are acceptable to stakeholders" (p. 132).

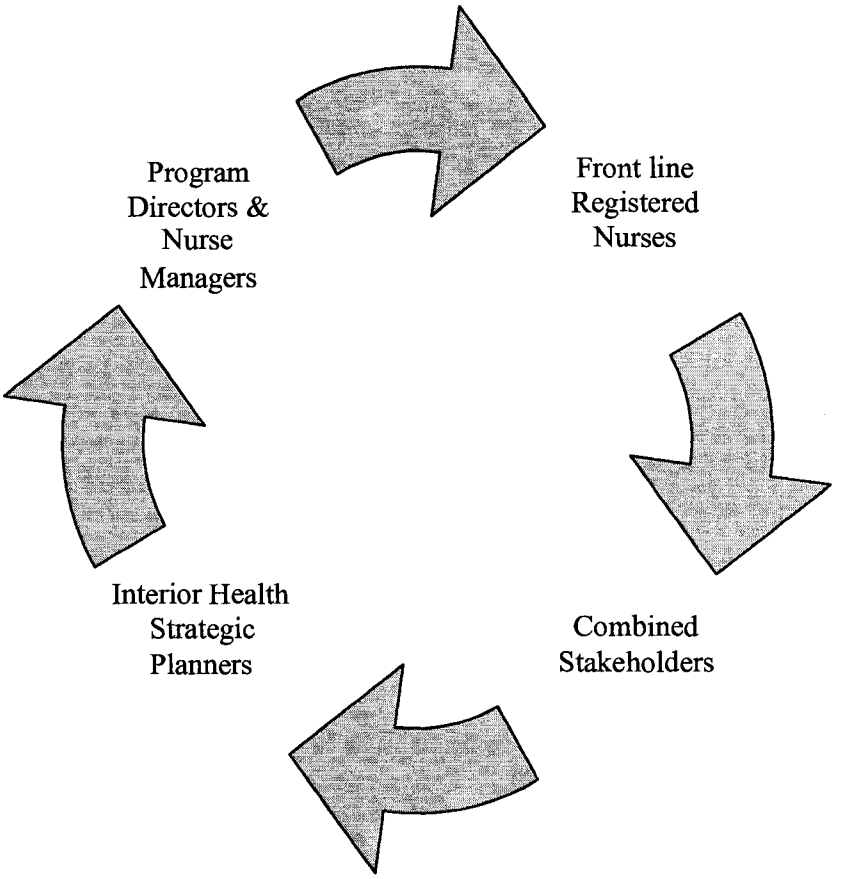

Figure 5: Action research cycle of this research

Through action research processes additional knowledge is contributed to the subject matter of engagement and retention and the results are applied to improving conditions or practices across the organization. Meyer (2000) affirms that "most definitions of action research incorporate three important elements: its participatory character; its democratic impulse; and its simultaneous contribution to social science and social change" (p. 178).

From a constructivist prospective this research brings together the different realities of individuals, groups and organizational systems in a hermeneutic dialectic process or a joint construction of meaning (Stringer, 1999). The goal of this research was to produce a report that presents "detailed, thickly described accounts that enable readers to empathetically understand the lived reality of research participants" (Stringer, p. 178). Oja and Smulyan (as cited in Miles & Huberman, 1994) refer to this process as collaborative action research "where the researchers join closely with the participants from the outset. The aim is to transform the social environment through a process of critical inquiry – to act on the world, rather than being acted on" (p. 9). In order to achieve this objective, I applied a qualitative data analysis approach to my research methodology utilizing three different focus group techniques to collect data from three different groups of stakeholders in the research.

Qualitative methodology was best suited to this research project of investigating the varied and individual circumstances involved in retirement decisions for mid- to late-career Registered Nurses. Miles and Huberman (1994) outline the advantages that qualitative research can provide to an area of study:

> With qualitative data one can preserve chronological flow, see precisely which events led to which consequences, and derive fruitful explanations...lead to

> serendipitous findings and to new integrations; help researchers to get beyond initial conceptions and to generate or revise conceptual frameworks...Words, especially organized in to incidents or stories, have a concrete, vivid, meaningful flavor that often proves far more convincing to a reader...than pages of summarized numbers. (p. 1)

I did not use any quantitative methodology in my research as I was not: (a) using a deductive approach to my research question - starting with a theory to create situations to test a hypothesis; (b) proving cause and effect; (c) maintaining objectivity through social distance and an analytical stance; or (d) predicting or showing statistical associations between any variables (Palys, 2003).

To ensure validity and reliability of data, the criteria of trustworthiness and authenticity were important considerations for demonstrating rigor in qualitative inquiry (Tobin & Begley, 2004). Rigor in research "is a means by which we show integrity and competence: it is about ethics and politics" (p. 390), and a high standard of rigor is required in all research approaches. Tobin and Begley discuss Lincoln and Guba's refinement of the concept of trustworthiness through their introduction of the "criteria of credibility, transferability, dependability and conformability" (Tobin & Begley, 2004, p. 391).

In my research methodology I inserted a cyclic feedback system in each focus group process whereby I verified summarized data, transcriptions, and analyses with co-facilitators and participants for their confirmation and clarification before using them in the final analysis. These personal accounts captured by various data collection tools ensured trustworthiness as focus group participants were invited to "check and verify the accuracy of the information recorded" (Stringer, 1999, p. 176) at each stage of data collection. As well, it is my hope the results of the research will be applicable to other professional groups in the health care sector concerning engagement and retention issues.

The authenticity of the research data stems from honestly capturing significant elements of the data and reflecting on the conceptual or personal bias I brought to the research. Tobin and Begley (2004) state authenticity is demonstrated if "researchers can show a range of different realities (*fairness*), with depictions of their associated concerns, issues and underlying values" (p. 392). Rowan (2000) describes how researchers deepen their authenticity when they "disclose their assumptions, as well as aspects of the research procedures and conclusions that favour the view of any one group, culture, or subculture over another" (p. 107). To facilitate the authenticity of my research findings and conclusions, and stay true to the principles of participatory action research, I emailed to all focus group participants a copy of the accepted draft version of Chapter 4 for feedback and comments prior to finalization.

The goal of attaining objectivity in reporting findings from qualitative data was influenced by my experiences, values, and understanding of the information. I agree with Kirby and McKenna (1989) that "research tools have been developed by people who see the world in particular ways...be aware that it contains the bias of its creators" (p. 44). I trust I was vigilant in avoiding blind bias and acknowledged feedback on areas where my bias may have been reflected throughout this research. Throughout my research I remained open to feedback from participants, co-facilitators, my Project Sponsor and Project Supervisor regarding any perceived researcher bias.

Project Participants

My research project was situated in the Okanagan Health Service Area (HSA), which has the largest population of the four HSA's in IH (Interior Health) exceeding 300,000. This area is expected to experience rapid growth over the next five years, most

significantly in the senior (85 + years) population (Interior Health, Okanagan Health Service Area Profile, 2006). This anticipated growth will place a multitude of pressures on existing health care resources and will exacerbate already critical staffing issues. The North Okanagan region represents a distinct administrative area within the Okanagan HSA and consists of the Local Health Areas (LHA) of Vernon, Armstrong, and Enderby. My research participants were selected from within the North Okanagan region. Invitations were sent to nursing professionals from the nursing management group and front line nurses from three distinct areas of nursing practice - Acute Care, Residential Care, and Home and Community Care.

All participants in my research were front line Registered Nursing staff, Program Directors, or Nurse Managers who were employed in an IH health care facility or program. There are seven main health care facilities/programs in the North Okanagan region from which I invited research participants. These included: (a) Vernon Jubilee Hospital, (b) Polson/Alexander Residential Care, (c) Noric House Residential Care, (d) The Gateby Residential Care, (e) Polson Special – Mental Health Residential Care, (f) North Okanagan Home and Community Care, (g) Pleasant Valley Manor Residential Care in Armstrong, (h) Parkview Place Residential Care in Enderby, and (i) the Enderby Community Health Centre.

The goal of action research is to improve practices by including individuals who are concerned with the issue, and that the "data are interpreted and the multiple viewpoints are communicated and discussed among those with a stake in the process" (Glesne, 2006, p. 17). To achieve this process I facilitated three focus groups using three different methodologies. The first focus group consisted of nursing management

representatives, two Program Directors and five Nurse Managers, using Polarity Management (Johnson, 1992) methodology. The second focus group consisted of seven front line Registered Nurses between the ages of 55 and 64 years in a Learning Circle focus group format. The last focus group consisted of three representatives from the nurse management polarity mapping focus group and three front line Registered Nurse representatives from the Learning Circle focus group. These individuals came together in one final session using an Appreciative Inquiry technique. None of the participants in any of the focus group sessions were offered or received remuneration for their participation in the research project.

Selection of Program Directors and Nurse Managers

During the time I undertook my research there were18 staff in the nursing management group in the North Okanagan region, five Program Directors and 13 Nurse Managers. I invited all 18 individuals by email to participate in the focus group session with the goal of selecting a maximum of 8 participants; three participants from the Program Director group and five from the Nurse Manager group (see invitation in Appendix A). I used a quota sampling technique to select participants from each group as I wanted a "heterogeneous sample but don't need true representativeness" (Palys, 2003, p. 145). This Program Director/Nurse Manager group was heterogeneous in nature. Not all the Program Directors were Registered Nurses, but all were responsible for areas utilizing nursing professionals. All the Nurse Managers were Registered Nurses, but each managed staff in a different area of health care practice. Collectively they qualified as equivalent representatives in the quota sampling technique as "all people within a given

stratum are equal...[and] will have pretty much the same attitudes regarding the phenomenon of interest" (Palys, 2003, p. 145).

The selection of participants for the Program Directors and the Nurse Managers was done on a first received - first accepted basis within that group. I received the required five participants from the Nurse Managers group on the first issue of my invitation. My first attempt to have three Program Directors participate resulted in only two acceptances. Following my established protocol, I issued a second invitation electronically to all Program Directors five days after sending the first invitation in hopes of getting the three representatives I desired. I ultimately had two Program Directors and five Nurse Managers attend this focus group session.

The invitation sent to this nurse management group included the provision for voluntary withdrawal, assurance of their privacy, and stated the confidential nature of their participation and of the data I collected. Due to the small and visible nature of this management group the invitation list was not confidential; those individuals who accepted the invitation to participate in the focus group was not disclosed to anyone other than to the participants themselves as a group, once they met one another. With the invitation I included a copy of the letter of free and informed consent for their records. This letter outlined the purpose of the research and the goal of the focus group; provided information on voluntary withdrawal, privacy and confidentiality; described the role of the co-facilitator; and ensured them of the security of the data (see letter in Appendix B).

Maintaining confidentiality among the members of the focus group took special considerations. Berg (2004) suggests that all focus groups have distinct issues regarding maintaining confidentiality within a group. Having this confidentiality is critical to the

trustworthiness of data gathered. Berg suggested including a statement of agreement for maintaining confidentiality "among *all* group members and the moderator/researcher" (p. 140) in the body of all consent forms, which I followed for all my letters of informed consent.

Selection of Front Line Registered Nurses

During the time I conducted my research there was a total population of 1143 Registered Nurses in the North Okanagan with 112 (10%) Registered Nurses between 50 and 54 years, and 133 (12%) Registered Nurses between 55 and 64 years (P. Metcalf, personal communication, April 3, 2007). My target participants for the second focus group session were front line Registered Nurses between 55 and 64 years who were considering retirement. The initial selection process for participants was done using the non-probabilistic technique of purposive sampling to "generate strategically chosen samples" (Palys, 2003, p. 128). Purposive sampling identified the Registered Nurses in the specific age range of 55 and 64 years that was required for this "inductive, exploratory research...to get a preliminary feel for the people or phenomenon being studied" (Palys, 2003, p. 143). Morgan (1997) reinforces using this sampling technique in choosing participants for a focus group methodology:

> In selecting participants for a focus group project, it is often more useful to think in terms of minimizing sample bias rather than achieving generalizability. Focus groups are frequently conducted with purposively selected samples in which the participants are recruited from a limited number of sources (often only one). Such 'bias' is a problem only if ignored – that is, interpreting data from a limited sample as representing a full spectrum of experiences and opinions. (p. 35)

Inclusion criteria used for issuing an invitation to this Learning Circle focus group included participants who: (a) were a Registered Nurse, (b) between the ages of 55 and 64 years, and (c) were working at one of the seven IH health care facilities in the North

Okanagan. The Registered Nurses in this group self-selected for the final criteria of considering retirement before the age of 64 years as per instructions in the invitation (see Appendix C for a copy of this invitation). My goal was to select nine front line Registered Nurses, representing 10% of this North Okanagan contingent to participate in my research.

The specific participant selection process followed the guidelines of a probabilistic disproportional stratified random sample method (Palys, 2003). My intention was to categorize those individuals who accepted the invitation into their particular nursing area of practice category: Acute Care, Residential Care, or Home and Community Care. The original protocol for selection of individual participants would be done by randomly drawing three names from each area of practice. This was to ensure the Learning Circle would have an equal number of participants from each nursing area of practice, even though there were not an equal number of Registered Nurses within each of these areas of practice invited to the focus group.

My sponsor mailed out 119 invitations from a Human Resources selected staff list of 133 qualifying Registered Nurses in the North Okanagan. The actual number mailed out was reduced from the original list of 133 Registered Nurses as some staff had retired prior to receiving the invitation in mid June, or their name had appeared on the list more than once due to working in multiple facilities. These invitations were mailed to each Register Nurse's home department where he or she worked on a full time, part time or casual basis. The mail out of the invitation to this Registered Nurse group directly from the Project Sponsor protected the confidentiality of the names of all who met the criteria from me. Candidates accepting the invitation sent their confirmation to participate

directly to me for follow up. This ensured the anonymity of the individuals who accepted the invitation from the organization (the Project Sponsor) by allowing only those interested individuals to identify themselves and consent to their participation directly with the researcher.

The invitation contained the following information: (a) description of the research project, (b) intent of the Learning Circle focus group, (c) voluntary participation and withdrawal process, (d) intent to digitally record the session, (e) provision of anonymity and confidentiality, and (f) instructions to register for the focus group session (see invitation in Appendix C). Upon acceptance to participate, I sent each respondent a confirmation of participation notice giving the location of the focus group session and a copy of the letter of free and informed consent for their record. This letter contained the following information: (a) a statement of informed consent, (b) the provision for voluntary withdrawal, (c) assurance of privacy of their contribution, (d) the confidential nature of their participation and of the collected data, (e) description of the role of the co-facilitator, and (f) discussed the digital recording and the security protocol in place for the storage of the digital recording and all other data collected (see letter in Appendix D).

The Bonner Curriculum on Learning Circles (Bonner, n.d.) states Learning Circle formats "are small gatherings of people" (p. 3). I chose to have a maximum number of 10 people for my Learning Circle focus group to ensure participants could fully "explore their own ideas, views, and experiences" (p. 2) within my timeframe. As I was included as a participant in the Learning Circle, my intent was to select nine Registered Nurses from those who accepted my invitation based on their areas of nursing practice. I did not get the required 3 participants from each area of practice group, so I followed my

established protocol of selecting acceptance letters until I reached my desired number; I ultimately had seven front line Registered Nurses participate in my Learning Circle focus group session; five from Acute Care and two from Home and Community Care nursing practice areas resulting in a response rater of 5.8% of all those who received the invitation to participate.

Selection of Participants for the Mixed Group

The intention of the third and final focus group was to have a total of 8 participants consisting of two Program Directors, two Nurse Managers, and four front line Registered Nurses, all who had participated in one of the previous two focus group sessions. My selection protocol was to ask each group at the closing of the focus group session for volunteers to participate in the final focus group. Any interested individuals would write their name and phone number on the bottom of the 'concluding thoughts' document (see template in Appendix E), and I would randomly chose participants if I received more volunteers than spaces. This procedure protected the anonymity of those individuals who were volunteering to participate in the final focus group from the rest of the group. This process also protected the anonymity of those participants who did not volunteer for the final session as both groups were informed I would randomly draw names for the final focus group. Individuals participating in the final focus group session would not know the identities of the members of the other focus group session who did not volunteer for this final session.

From the first polarity management focus group session my intention was to randomly draw names if more than two Program Directors and two Nurse Managers volunteered. Due to a retirement of one of the two participating Program Directors, there

was only one Program Director available to attend. This created the potential of accepting one Program Director and three Nurse Managers for the final mixed focus group session. From the Learning Circle focus group I was prepared to randomly draw the names of four Registered Nurses from all those who volunteered for the final session. My original intent was to have a total of 8 participants at the final focus group. Ultimately I did not have to randomly draw names and I had a total of 6 participants in the final focus group: one Program Director, two Nurse Managers, and three front line Registered Nurses representing Acute Care and the Home and Community Care practice areas.

I contacted each participant who volunteered for this final session by email to confirm their participation, give the location of the session, and provided a copy of the letter of free and informed consent for their records. This letter reviewed the purpose of the research, the goal of the focus group, and contained the following information: (a) informed consent, (b) the provision for voluntary withdrawal, (c) assurance of privacy for their contribution, (d) the confidential nature of their participation and of the collected data, (e) described the role of the co-facilitator, and (f) outlined the security protocol in place for all data collected (see letter in Appendix F).

Research Methods and Tools

My research design was to involve a variety of the stakeholders to produce a wide scope of research data. In order to accomplish this I chose three self-contained (Morgan, 1997) focus group sessions to collect data with care to match "the goals of the research with the data that the focus groups can produce to meet these goals" (p. 3). Initially I gathered data from three distinct sets of participant stakeholders using two different focus

group methodologies; then I brought together representatives from each session in a final focus group session using a third methodology.

Palys (2003) reinforces the role of the researcher in these sessions "plays a more facilitative and less directive role...typically acts only to initiate, prompt, and referee the discussion" (p. 163). He also states there are inherent complications arising from the use of focus groups: (a) some people may be uncomfortable or unwilling to share their honest thoughts, and (b) one person or group may dominate the discussion and create a biased sample. Awareness of these potential pitfalls was crucial in order to attain a situation as Morgan (1997) describes where focus groups excel at the "explicit use of group interaction to produce data and insights that would be less accessible without the interaction" (p. 2). In order to effectively accomplish a high level of participant interaction and comfort, I carefully selected the methodologies of Polarity Mapping, Learning Circle and Appreciative Inquiry for each unique group session I held.

These three methodologies were chosen for their suitability to the specific audience of each focus group and the goal of the session. All three focus group methods were reviewed and endorsed by my Faculty Supervisor and my Project Sponsor in my project proposal. None of these methods were pilot tested prior to running the focus group session, but I undertook extensive research on each technique and detailed the development of each session.

The nursing management representatives in the first focus group session required a tool to assist in examining the current organizational culture and process. A polarity mapping process provided a new paradigm to look at high level organizational issues and assisted the participants in "seeing a more complete picture of the situations and

respecting the wisdom of those who are resisting our 'solutions'" (Johnson, 1996, p. xviii). Morgan (1997) states the "broad source of strength for focus groups is their reliance on interaction in the group to produce data...the comparisons that participants make among each other's experiences and opinions are a valuable source of insights into complex behaviors and motivations" (p. 15).

Front line Registered Nurses who spoke of their personal feelings about the nursing profession needed the respect, time and safe surroundings to tell their stories that a Learning Circle environment would provide. The use of "homogeneous strangers" as participants in this focus group "allows for more free-flowing conversations among participants within groups [and] also facilitates analyses that examine differences in perspective between groups" (Morgan, 1997, p. 35). The front line Registered Nurse participants may not have known each other individually or practice in the same area of nursing, but as homogeneous strangers they shared common professional knowledge, language, issues, and history. The Bonner Curriculum (n.d.) states Learning Circles "can prompt an exchange of ideas that may support participants' deeper learning or lead to the formation of action steps and plans that participants can take back to their own communities or organizations" (Overview section, ¶ 1). Learning Circles excel at shifting conversation from "informal socializing or opinionated discussion into a receptive attitude of thoughtful speaking and deep listening" (Baldwin & Linnea, 2001, ¶ 2). Using a more structured approach to this focus group is "useful when there is a strong, pre-existing agenda for the research" (Morgan, 1997, p. 39). In the twenty plus years I have worked in health care, I have heard anecdotally that there are nurses who are bitter and negative about their work experiences in the health care profession and within IH as a

health care employer. In order to maintain a positive and forward-looking dialogue in this group, I used the controlled setting of a Learning Circle as a "higher level of moderator involvement will keep the discussion concentrated on the topics that interest the researchers rather than extraneous issues" (Morgan, 1997, p. 40). The authenticity and trustworthiness of the data was ensured by a digital voice recording of this session which I had professionally transcribed. All information that directly or indirectly identified an individual participant was removed from the transcription and all first names were given a code before it was sent to each participant for verification.

My goal in the final focus group session was to have this mixed group of participants create a sense of what is currently working well in the workplace, and what were the future dreams and realities for mid- to late-career Registered Nurses in IH. An Appreciative Inquiry focus group method suited this less structured approach to the focus group. Morgan (1997) states the advantages of a less structured focus group is as a "strong tool for exploratory research...participants can spark a lively discussion among themselves without much guidance...if the goal is to learn something new from the participants, then it is best to let them speak for themselves" (p. 40).

Tools

Three different focus group methods of inquiry were used to collect data for this research project: Polarity Management, Learning Circle, and Appreciative Inquiry. The focus group session for Program Directors and Nurse Managers used polarity mapping (Johnson, 1996) to explore the paradox of retiring mid- to late-career Registered Nurses in the face of looming staff shortages. Front line Registered Nurses participated in a Learning Circle focus group to share their feelings regarding the nursing profession, to

envision their professional role if they prolonged their career, and to discuss how IH could support their efforts. The final mixed focus group session broadened these discussions in an Appreciated Inquiry format. In this session participants collaboratively discovered what was currently working well in IH, then dreamed possibilities for positive changes in the organizational culture to achieve an exceptional workplace. Each focus group technique is described below.

Polarity Management and Mapping

This tool was developed by an independent consultant Barry Johnson (1996) from his career in management and organizational development. He recognized that polarities are interdependent opposites of each other that can not be addressed without the interplay between both sides of the issue. The objective of polarity management is "to get the best of both opposites while avoiding the limits of each" (Johnson, 1996, p. xviii). Polarity management requires separating paradoxes or dilemmas from problems. The ability to do this enhances individual leadership skills by "increasing your ability to distinguish between problems you can solve and those you cannot [and] increasing your ability to manage those unsolvable problems" (p. xix). Polarity mapping involves identifying two distinct and opposite poles, placing the positive and negative aspects of each side by side. By filling in the four quadrants of interdependent opposites one gets an overview of the positive and negative aspects of each of the two poles. Johnson states by viewing all four quadrants, map creators can apply "Both/And" thinking to manage the issue, replacing the problem solving thinking of an "Either/Or" (p. 86) stance.

Once the structure of the polarity map has been determined by filling in each quadrant, the dynamics of the dilemma can been observed by the patterned movement

from one quadrant to another in a sequential motion. The methodical process of creating the map is to start filling in information in the lower left quadrant (L-) moving to the upper right quadrant (R+); from the upper right quadrant (R+) move down to the lower right quadrant (R-); from the lower right (R-) move up to the upper left quadrant (L+); and from the upper left quadrant (L+) drop back down to the lower left side (L-). Following this sequence Johnson (1996) states "the normal movement through the four quadrants can be pictured as an infinity loop (∞)" (p. 11). The management of a dilemma requires the constant movement of this pattern between the quadrants and becomes an "ongoing process which, like the infinity loop, is never-ending" (p. 12). Optimal management of the polarity is produced by moving between factors in the top two quadrants (L+ & R+) using the lower quadrants (L- & R-) as warning signs:

> In a well-managed polarity most time is spent experiencing the positive aspects of one pole or the other. When the downside of a pole is experienced, it is used as a signal to move to the positive of the other pole" (p. 106).

Once the overview or structure of the map is completed individuals can "begin to anticipate outcomes because there is a predictable, normal movement through the map....the push for movement in a polarity is for a shift to the other [opposite] pole" (Johnson, 1996, p. 14).

The second phase of managing a polarity is to identify and dialogue the tensions created between the individuals representing the "oppositional forces at play" (Johnson, 1996, p. 72) between each of the two poles of the dilemma. Johnson calls these oppositional forces the crusading force and the tradition-bearing force. The crusaders are the "change agents...they see some problems with the present and want to make things better for the future" (p. 60), while the tradition-bearers are the "preservers of what is best from the past and the present" (p. 61). In a well managed polarity, "there is an

effective alliance going on between the crusading forces and the tradition-bearing forces" (p. 114). By identifying all of the stakeholders in the polarity, and by charting their beliefs, fears, and goals, both sides can anticipate and work with the resistances from the other.

By applying a polarity management technique to this focus group session I was able to achieve my goal of acquiring organizational data on the related questions which supported my main research question: (a) What interventions would create synergy between the personal goals of these employees and the goals of IH? and (b)What implications does this have on how Interior Health modifies employment practices to fully utilize mid-career employees?

Learning Circle

Learning Circles are an ancient design for story telling and sharing of experiences. They have the ability to generate deep reflection and rich dialogue for circle participants around a meaningful issue and can help to formulate plans for action (Bonner, n.d.). This methodology does have limitations in its application. The Learning Circle is a structured activity steeped in symbolism and ritual. It may be unfamiliar and initially intimidating to participants without prior supporting handouts and an in-depth introduction. An important aspect of using a Learning Circle for this focus group was participants viewed themselves as colleagues thus ensuring that "democracy in action research usually requires participants to be seen as equals" (Meyer, 2000, p. 178). A circle composed of individuals with direct reporting relationships or organizational power differentials may not be conducive to participants openly sharing thoughts and feelings. Without complete trust and respect within the group the circle may lose its effectiveness.

In deciding to use this methodology some understanding of the culture of the group or the organization must be ascertained; toxic cultures or negative working groups may not be able to focus on the cathartic benefits of the circle and may dismiss this methodology as inappropriate. Individuals must feel confident that they will be participating in the safe environment of a non-judgmental and supportive circle called for a common purpose. The circle is not functioning when participants stop being vulnerable or authentic and pull back from contributing, or when the atmosphere is "charged with underlying energies that cannot be explained" (Baldwin & Linnea, 2006, p. 21). Diversity of backgrounds, thoughts and opinions are assets in the composition of circle participants. A pre-determined focus or topic provided prior to the circle will ensure the dialogue stays on track and participants can express their views and share relevant experiences.

It was also important to make clear to participants the reasons why a Learning Circle was the best means of getting relevant information, so not to seemingly exploit their feelings. The intention of the Learning Circle is to create "a forum for inclusion, deep listening, and honouring our diversities ~ a safe haven for true dialogue" (McKenzie, 2003, Learning Circle section ¶ 1). The Learning Circle requires commitment, intention and cooperation among the circle participants to be an effective tool for organizational change. Bonner (n.d.) states the "goal of Learning Circles is to help participants develop new practices or action plans....Learning Circles have proven to be powerfully effective tools of creating vital social change" (p. 7).

When individuals gather to participate in a Learning Circle the facilitator sets the stage by reviewing the necessary elements for creating a successful circle. These include: (a) the circle intention; (b) how the circle functions and the basic ground rules; (c) equal

responsibility by all members for the experience; (d) the symbolic and ritual aspects of the circle such as the spirit of circle, the talking piece, and the direction of conversation; (e) the circle agreements, principles, and practices; (f) and the role of the facilitator or guardian in keeping the circle a safe place to share.

The format of the Learning Circle I used followed the guidelines from PeerSpirit; these concepts first appearing in *Calling the Circle, the First and Future Culture* by Christina Baldwin, published by Bantam, 1998. The circle begins with a guiding question or statement posed by the researcher/facilitator who is a full participating member of the circle. The facilitator holds an item symbolizing a talking piece that is appropriate for the group or topic and has meaning to the participants. The talking piece for my Learning Circle was carefully chosen after discussion with a nurse friend who stated:

> It needs to be round and fit in their hand, as nurses do their craft with their hands using touch and feel. It should be glass with some color in it for life. It needs to have some weight to it; this weight and the physical shape is meaningful to the weight and depth of the decisions nurses make in caring for others" (J. Macnabb, personal communication, July 2, 2007).

Only the individual who holds the talking piece is allowed to contribute their thoughts through words or silence. The talking piece is passed clockwise around the circle, with one speaker at a time in an uninterrupted fashion. Some Learning Circles open up the conversation to cross talk after the circle has gone around two or three times. The Learning Circle for my research was controlled with only one speaker at a time for the entire length of the circle. Participants acknowledged and built on each other's thoughts and stories as the circle went around.

Learning Circles open with a check-in of how the participants are feeling, and close with a similar check-out; they can last for one to two hours. The facilitator can subtlety guide the conversation around the intention or purpose of the circle with a series

of questions or statements placed in the dialogue at his or her turn. These questions or statements used in the circle should be open-ended and full of possibilities and should not be a question "to which the facilitator knows or thinks she knows the answer and suspects that others don't" (Bonner, n.d., p. 14).

As a researcher, gaining the trust and acceptance of the circle members and having the participants share their experiences and feelings openly and honestly were crucial components in generating data for this research project. Data I collected in this focus group supported my research questions: (a) How can front line Registered Nurses become engaged in their profession and extend their careers in IH? and (b) What interventions would create synergy between the personal goals of these employees and the goals of IH?

Appreciative Inquiry

Appreciative Inquiry (AI) is a technique which integrates "a practical change process and a new paradigm view of how we shape our future" (Magruder Watkins & Mohr, 2001, p. 24). Developed by Cooperrider and Srivastva in 1987, this intervention approach is grounded in social constructionist theory and the power of image as a basis for transformational organizational change. The underlying principle of AI is "as people of an organization create meaning through their dialogue together, they sow the seeds of the organization's future" (p. 26). Bushe (1998) describes the process of appreciative inquiry as one that starts "with a grounded observation of the 'best of what is', then through vision and logic collaboratively articulate 'what might be', ensuring the consent of those in the system to 'what should be' and collectively experimenting with 'what can be'" (Introduction section, ¶ 2).

The AI process takes an integral organizational issue and moves stakeholders from a focus of its negative perspectives to focusing on creating its positive expressions in a preferred future while sustaining this effect over the long term. Stories are told by the participants that reveal the exceptional circumstances or events that had a profound impact on their life. Magruder Watkins and Mohr (2001) believe that AI's central premise is:

> Human beings and organizations move in the direction of what they inquire about. Thus, inquiry into 'empowerment' or into 'being the best organization in the field' will have a completely different long-term, sustainable impact for positive action than will a study into 'low morale' or into 'process breakdowns' done with the idea that those conditions can be 'cured'. (p. 39)

AI is the antithesis of problem-solving methodologies which tend to re-state issues as "it is not that organizations *have* problems, but that they *are* problems... and are infused with deficit consciousness" (Cooperrider & Whitney, 1999, p. 23). The Appreciative Inquiry 4-D cycle begins with: (a) Discovery - appreciating and valuing the best of 'what is'; (b) Dream - envisioning 'what might be'; (c) Design - dialoguing and co-constructing 'what should be' through provocative possibility statements; and (d) Destiny/Delivery - how to empower and sustain the change for a preferred future.

Finding the "affirmative topic choice" (Cooperrider & Whitney, 1999, p. 12) is fundamental to initiating the AI process in an organization. Magruder Watkins and Mohr (2001) state "topic choice is a fateful act. Your organization will move in the direction of the topics it inquires about" (p. 89). Engagement and retention were two positive aspects of work-life I wanted to explore. My goal for this focus group session was to have these diverse stakeholders share the best experiences they each had in their work-life and co-create opportunities where these could be extended into their day to day practice. This required participants determining what conditions within the organization would facilitate

the creation of the "social architecture" (p. 44) or infrastructure which would support this desired future.

In this focus group session the participants worked on the Discover and Dream phases of AI through a series of small group story telling and theme formulation. The stories participants related represented "the most creative, exciting, life-giving experiences that they have had in their life and work" (Magruder Watkins & Mohr, 2001, p. 84). Any negative data describing the absence of an idea or essence valued by the participant would have been reframed into positive images of what it could be. Magruder Watkins and Mohr support the concept of story telling as a form of gathering of data and theme identification:

> The use of the story as the primary format for conducting an Appreciative Inquiry is not an inconsequential choice. Stories have a depth and breadth that allows meaning to be conveyed much more effectively that would a list of key points or other more analytical reports. Stories engage the imagination in ways that analytic discussions cannot. (p. 77)

Theme identification from the stories is the process of articulating the positive life-giving forces that participants describe from their organizational experiences. These "themes become the basis for *collectively imagining what the organization would be like if the exceptional moments that we have uncovered in the interviews became the norm* in the organization" (Magruder Watkins & Mohr, 2001, p. 115).

In the Dream stage participants generate provocative propositions from the stories and themes created in the Discovery stage. These statements represent the possibilities of a preferred future that are grounded in actual past experiences in the organization which participants want to be re-created and frequently experienced. Annis Hammond (1996) states the transformative nature of AI reflects the idea that the "group creation of propositions is to move the individual will to *group will*" (p. 47).

Contrary to the AI process, the Design and Deliver stages were not done by participants in this research project. The data and themes collected in the Discover and Dream stages were incorporated into my data analysis to address processes in the Design and Delivery stages. Magruder Watkins and Mohr (2001) strongly suggest that consultants (and by extension, researchers) avoid the data analysis function in the Design stage as "you will, by that act, have theoretically moved yourself and the system out of an AI process" (p. 122). Time limitations in the structure of this focus group session precluded having the participants remain together to address the Design and the Delivery stage. As well, a wider cast of stakeholders from IH would need to be involved in the AI process to effectively address both the design and delivery stage. The themes and provocative possibilities statements created by the participants in the Dream stage influenced the recommendations section of the final report. I placed these recommendations and action plans into the Shifting the Burden (Senge, 1990) framework as fundamental responses to discover leverage points within the organization to initiate strategies for organizational change.

Study Conduct

Polarity Management Focus Group

This focus group session consisted of two hierarchical levels of nursing management, Program Directors and Nursing Managers, and had a total of 7 participants. I facilitated the three hour session with a co-facilitator who acted as an assistant and scribe. My goal for the focus group was twofold: (a) to facilitate a new skill for these nursing management participants which could enhance their leadership and management

skills, and (b) to understand the paradox of retiring mid- to late-career Registered Nurses in times of projected nurse shortages. We met at 8:30 a.m. for a social continental breakfast; I introduced the co-facilitator and during this time the informed consent forms were signed which I kept for my records. We started the session at 9:00 a.m. and I used the first 1 hour and 30 minutes for introducing the research project and the concept of Polarity Management and Mapping (Johnson, 1996), working through the development of a sample polarity map together, and finally providing an opportunity to map out a work related issue of their own choosing.

After a short break the group worked together to map the polarity of actively supporting the retirement of mid- to late-career Registered Nurses versus actively supporting engagement and retention strategies for this group. The overarching question for the context of the polarity map was "What are the positive aspects of having mid- to late-career Registered Nurses on the unit?" The two poles I had established and placed on a template for this polarity map were (a) retirement, and (b) engagement and retention. This polarity typifies the definition of a paradoxical situation as it has "conflicting choices or conditions, each desirable in theory but seemingly impossible to reconcile in practice" (Stroh & Miller, 1994, p. 30).

The group filled out all four quadrants of the polarity map in the sequence prescribed by Johnson (1996) in order to visualize the dynamics of this dilemma. My corresponding questions with each quadrant were: (a) lower right quadrant: "what are the negative outcomes from focusing only on the engagement and retention of mid- to late-career RN's and neglecting their retirement?"; (b) upper left quadrant: what are the "positive outcomes from focusing on the retirement of mid- to late-career RN's"; (c)

lower left quadrant: the "negative outcomes from only focusing on retirement of mid – to late-career RN's and neglecting their engagement and retention"; and (d) upper right quadrant: the "positive outcomes from engaging and retaining mid- to late-career RN's" (see focus group polarity map template in Appendix G). I captured the group's ideas and thoughts on a template flip chart while the co-facilitator took notes on the conversation. Once the map was completed we discussed the overall effect this produced in viewing the bigger picture and traced the dynamic of the movement from one quadrant to the next using the infinity pattern (∞) in the same sequence we filled out the polarity map.

Next I used flip charts to record the responses to a series of new questions relating to the information contained in the polarity map (see questions for the polarity management focus group listed in Appendix H). One of the focus group questions I had originally planned to ask at this point was "What do you feel mid- to late-career nurses would like to do with their remaining years in the profession?" (see the focus group questions in Appendix I). At this point in the session I was aware that the time remaining would not allow for a meaningful dialogue around this question therefore I did not ask it. The question seemed out of place in the current conversation and this sudden shift may have confused the participants by having them speculate on what some *other* individuals *may* want to do with their careers.

The session concluded by participants completing a 'concluding thoughts' handout. I invited any of the participants who were interested in attending the final focus group session to write their names on the bottom of this handout. I explained I would randomly draw names to fill the session in accordance with my set procedures for

participant selection for the final focus group. The handouts were collected by the co-facilitator and a token of appreciation was given to all participants.

After the session I reproduced exact copies of each flip chart and added other information I found reading through the co-facilitator's notes on the session. The name of each participant was given a corresponding number for data analysis and where a particular participant made a comment this number prefaced her statement. True to the process in the action research cycle feedback loop, these reproduced flip charts were emailed to all participants, including the co-facilitator, for verification of authenticity and reliability seven days after the focus group session. No corrections or clarifications were sent back to me by any of the participants regarding the content of these flip charts.

Learning Circle Focus Group

This focus group session had seven Registered Nurses from two areas of nursing practice in the North Okanagan participating in the circle along with the researcher. The co-facilitator acted as technical backup and scribe for the session. Participants had received and reviewed *Basic Guidelines for Calling a Circle* (Baldwin & Linnea, 2001) as an attachment to their invitation. This document contained a full description of: (a) the Learning Circle's history, process, and intention; (b) the value of story telling, (c) and the expected benefits from participating in this format (see handout in Appendix J). This level of transparency of the focus group methodology prior to the session increased researcher authenticity, and assisted in gathering trustworthy data by ensuring participants were aware of, and were comfortable with, the ritualistic nature of the circle.

The Learning Circle was held at a quiet location during which time participants had the opportunity to share thoughts, experiences, and ideas related to: (a) their feelings

around their profession, (b) their perceptions of being in mid-life and finding significance in their lives at this point, and (c) envisioning their perfect work world. We met at 8:30 a.m. for a continental breakfast where participants, the researcher, and co-facilitator met each other and socialized. During this time the informed consent forms were signed and each participant chose a glass token for the circle ritual. Questions from participants guided the conversation around the components and the purpose of my research. Although this was social time, participant's curiosity dictated this discussion be held informally during the socialization process rather than at the beginning of the circle as planned.

At 9:00 a.m. the group sat in a circle and I reviewed the ritual aspects and purpose of the Learning Circle. I also participated as a full member of the circle. Kirby and McKenna (1989) discuss the researcher as a participant in the research process and state "do not be afraid to incorporate yourself, your emotions and your experience into the research process" (p. 123). The role of the Guardian and responsibility for the leadership in the circle was reviewed. My role in the circle was to act as the Guardian who is a "tool for aiding self-governance and bringing the circle back to intention" (Baldwin & Linnea, 2001, Guardian section, ¶ 1).

I introduced a round glass ball with light colors in the center that acted as the talking piece for our circle. Baldwin's *3 Practices of Council* were reviewed and the group focused their attention on the glass token they had chosen while thinking about their intention for participating in the circle. Each participant placed the token in the centre table to declare their intention; the centre also contained a candle, a vase of flowers, and the digital voice recorder.

The co-facilitator sat outside the circle surreptitiously monitoring the recording device and taking notes on the emotional cues that occurred in the circle. Cues captured were those which would not have been captured by the digital recorder include body language, shifts in the mood or energy, or any disruptions to the circle.

I explained that each time the circle came around to my turn I would introduce a new framework or topic to the circle. Their contribution for that round was to follow this new topic while building on each others story. The circle went around five complete times with a new statement initiated by me each time it was my turn to speak.

My initial check-in statement which started the circle was: "My name is …and right now I feel…". I posed the following questions/statements for the proceeding rounds in the following order: (a) "Here I am at midlife…"; (b) "…where do we go from here…finding that significance in our lives…"; (c) "…there are things that we need as an organization to do better…what would this look like…"; and my final check-out statement was (d) "At the close of the circle I feel…..". The participant's responses were genuine, authentic, and cathartic. There were many respectful silences and thoughtful contributions which built on other's stories. This heterogeneous group of nurses found great empathy for one another, and afterwards commented on the personal support they felt during this Learning Circle.

At the end of the 1 hr 45 min Learning Circle, the digital voice recorder was shut off and participants were invited to stretch and have some refreshments while continuing on with the next part of the session. The next 30 minute exercise was to individually and quietly place as many one worded "post-it" notes as they wanted on all of the following four flip charts. Each flip chart contained one question as follows: (a) What I love about

my profession is..; (b) Envisioning my Role: I can use my skills to benefit my profession by..; (c) Professional skills I would like to acquire..; and (d) Personal skills I would like to acquire.

After the group completed this exercise they came back into the circle for closing. Their individual tokens of intention were taken from the centre to be kept as a keepsake of the Learning Circle experience. The process of soliciting volunteers for the final focus group session was explained and a 'concluding thoughts' handout was given out for completion. I invited anyone interested in participating in the final session to write their name and phone number on the bottom of this handout. I explained I would chose participants for the final session by randomly drawing a maximum of four names from those who expressed interest. These were collected by the co-facilitator and the participants were thanked for their contributions with a token of appreciation from the researcher. The session formally concluded and broke up into small conversation groups lasting well past the 12:00 ending time; the participants seemed reluctant to leave the fellowship of the circle.

Data for this focus group session were collected by a digital voice recording of the actual 1 hr and 45 min circle. This recording was professionally transcribed to obtain an accurate transcript which I verified by listening to the recording. A copy of the Learning Circle transcript was sent to each participant for verification of their contribution to ensure authenticity and trustworthiness. I themed and analyzed the data from the Learning Circle transcripts by using the following methods: (a) pawing for themes, (b) finding key words and indigenous phrases, (c) identifying metaphors and similes, and (d) marking, cutting and sorting the text. The second means of data collection for this focus

group were the participant's contributions on the four flip chart questions. I sorted the data by placing all similar statements together to produce themes from the list of all of the contributions on each flip chart.

Appreciative Inquiry Focus Group

This final focus group session consisted of members from all three representative stakeholder groups, Program Directors, Nurse Managers and front line Registered Nurses. This mixed stakeholder session was an important component in my research and data collection process. Each person in this group had experienced a previous session which focused on aspects of retention and engagement of mid-to late-career Registered Nurses. Now coming together they worked to "build collaboratively constructed descriptions and interpretations of events that enable groups of people to formulate mutually acceptable solutions to their problems" (Stringer, 1999, p. 188). It is important to acknowledge the reciprocal and hierarchical relationships that existed between the members in the focus group sessions and to recognize that they were all vital stakeholders in any attempts to effect organizational change addressing engagement and retention in IH. During this session I was successful in not pairing individuals together who had a direct reporting relationship. As the session continued on, I was aware of the interactions and discussion between all individuals, and I was sensitive to any obvious interpersonal dynamics and the levels of participation by all members of the group. I did not observe any problems or issues arising between any the participants during this focus group session.

The group came together socially at 8:30 a.m. over continental breakfast to meet each other and the new co-facilitator for this session and to become comfortable in the

environment. They all signed a copy of the informed consent form which had been previously mailed to them and these were collected for my records. As the session convened, I briefly revisited the purpose of this research project and the tenants of the informed consent; then presented flip chart summaries of the prominent themes of the discussions of the first two focus group sessions.

The Appreciative Inquiry methodology was introduced highlighting the Discover and Dream stages which participants focused on in this session. Appendix K: AI Researcher Notes outlines the entire focus group process complete with times for the exercise. To begin experiencing the positive focus of AI in the Discovery stage, the group was divided into three diads consisting of a front line nurse and a management representative and each shared a concrete experience of "a time you felt you contributed your best quality work or practice – something you were proud of or really made a difference at work". Significant items of each story were listed on flip chart paper.

In the next activity the group was re-organized into two trios and given the direction to each share "a time when someone within the organization really engaged you or encouraged you in your work". Each participant rotated through the story teller, the interviewer, and the recorder position in the trio. These discussions resulted in three separate flip charts containing the most significant items of each story. After a short break, the trios came back together and from these three flip charts they produced one flip chart outlining the major themes from all of the stories. Each trio then presented their theme flip chart to the larger group and provided relevant background information on their selection process. From these two theme charts, the entire group co-created six main themes representing the significant items of all the stories told in the Discovery stage.

Moving to the Dream stage, the group moved back into their original trios and using the six major themes held "possibility conversations about the organization's position, it's potential, its calling, and the unique contribution it can make to global well-being" (Magruder Watkins & Mohr, 2001, p. 134). Their task was to develop a series of provocative propositions for the future of their work-life. This activity provided the participants with the "invitation to imagine an organization in which those special moments of exceptional vitality found in the stories become the norm rather than the exception" (p. 133).

Instructions to the trios were to use any technique, word format, or picture, to address the following questions: "What would the very best place to work feel like?", and "How will you structure or add to your work-life to create that feeling from now on?" They framed each of their statements or stories starting with the words "exceptional engagement is....." and placed these on flip charts. These flip charts were collected for my data analysis. The session concluded with participants completing a 'concluding thoughts' handout and all were given a token of appreciation for their contributions to my research.

After this final focus group session I sent a copy of the six major themes and the provocative propositions the groups produced to each participant to verify for accuracy and completeness. Data analysis procedures used in this focus group were participant theme charts. One other option would have been to capture this focus group on video or digital voice recording. A huge amount of data would have been produced using either of these procedures and therefore was not seriously considered for this research project. I had invited participants to use whatever means they desired to document their

provocative propositions, but only written lists were produced so I did not have to interpret or reproduce drawings for data analysis.

Data Analysis

A variety of strategies and methodologies have been developed to analyze qualitative data. Miles and Huberman (1994) describe multiple processes that guide researchers through sorting disassembled information through to drawing conclusions from qualitative data that withstands the rigorous tests of reliability and validity. They assert that "the creation, testing, and revision of simple, practical, and effective analysis methods remain the highest priority for qualitative researchers" (p. 3). Silverman (1993) states "'authenticity' rather than reliability is often the issue in qualitative research. The aim is usually to gather an 'authentic understanding of people's experiences" (p. 10). Kirby and McKenna (1989) discuss the importance of the researcher's reflections on the content of the data collected. These reflections are the "beginning of the evolving analysis" (p. 125) and enable the researcher to "become more skilful and intuitive" (p. 126). Morgan (1997) states the "fundamental message here is that learning what the participants think is important should be built into the data collection itself – not left to the analyst's post hoc speculation" (p. 62). I have attempted to incorporate the wisdom of all the above authors into my data analysis process.

Miles and Huberman (1994) define data analysis as "consisting of three concurrent flows of activity: data reduction, data display, and conclusion drawing/verification" (p. 10). Data reduction is a multi-technique process involving discerning themes and patterns from raw data. Relevant information is selected from all the data that pertains to the researcher's questions, conceptual framework, and

contributes to understanding the participant's perspectives. Glesne (2006) states "within the sociological tradition, the most widely used means of data analysis is *thematic analysis* ...[involving] coding and then segregating the data by codes into data clumps for further analysis and description" (p.147). Stringer (1999) suggests a threefold process of analysis: (a) identify key elements or significant items of information, (b) formulate categories by grouping similar items, and (c) formulate themes by grouping similar categories. All of these processes generate both specific and general patterns for data comparison and drawing conclusions.

I used data reduction early in my data collection process in two ways: (a) To summarize flip chart information from the Polarity Management and Mapping focus group session which was sent to participants for verification, and (b) to develop an overview presentation of the first two focus group sessions for the participants of the final mixed focus group. This early data analysis also assisted me in sharpening my focus for delivering the final focus group session. I re-visited my original research question and reviewed the summarized data to ensure the processes I designed would continue to align with my research questions. Wolcott (1990) affirms the importance of this alignment:

> The critical task in qualitative research is not to accumulate all the data you can, but to 'can' (i.e., get rid of) most of the data you accumulate. This requires constant winnowing. The trick is to discover essences and then to reveal those essences with sufficient context" (p. 35).

The creation of themes is a significant aspect of data reduction. Ryan and Bernard (2003) outline a number of techniques for identifying themes in qualitative data based on four strategies: (a) An analysis of words by looking for word repetition, indigenous categories, key terms, blocks of texts, and social science queries within various theoretical frameworks; b) searching for missing themes in the text; (c) looking for

linguistic features such as metaphors, transitions, and connectors; and (d) using physical manipulation techniques such as scanning unmarked texts, pawing, cutting and sorting. Ryan and Bernard (2003) conclude by stating the most powerful technique to theme data is to utilize multiple techniques done sequentially as "no single technique does it all" (Summary section, ¶ 2). I used a combination of pawing through text, cutting and sorting key elements of information to formulate categories, and identify themes in my data analysis.

Data display is a means of managing the data and presenting visual accounts of the information. Miles and Huberman (1994) advocate detailed displays involving complex matrices, graphs, charts, and networks; some are done manually and others are computer generated. The goal of data displays are "to assemble organized information into an immediately accessible, compact form so that the analyst can see what is happening" (p. 11). Using a simple manual system of colour-coded index cards, data piles containing single key elements of information or 'chunks', taken from all three focus group sessions were grouped together under interpretive codes.

I was able to use interpretive codes rather than basic descriptive codes as I was familiar with the organizational context that the general chunks of information pertained to (Miles & Huberman, 1994). As a way of merging the data from all three focus groups these codes were distributed under an overarching framework corresponding to the four topic headings in my literature review sections. The following headings became my major themes: (a) workplace environment, (b) organizational culture, (c) family and financial pressures, and (d) finding significance and meaning. Once the data codes were grouped under these major themes I applied Lincoln and Guba's (as cited in Miles &

Huberman, 1994) extension coding procedure on the next round of coding. I began "interrogating them in a new way, with a new theme, construct, or relationship" (p. 62) and identified a number of sub-themes as described in Table 1.

Table 1

Overarching Major Conceptual Themes and Sub-Themes

Major Themes	Sub-Themes
Workplace Environment	Physical Environment, Contractual Aspects, Peer Support, Concerns for Patient/Clients, Workplace Health and Wellness
Organizational Culture	Leadership, Learning and Development, Mentoring, Recognition
Family and Financial Pressures	Financial Considerations, Spousal Influences
Finding Significance and Meaning	Role Identification/Love of Nursing, Self Awareness and Reflection, Hobbies/Interests

This process bound my data analysis to relevant research and ensured all data addressed my research question. It also allowed me to succinctly place this information into Senge's (1990) Shifting the Burden archetype to identify leverages, draw conclusions and make my recommendations to the organization.

Conclusion drawing is transforming the data into interpretations which are the "prelude to sensitive outcomes that describe, make connections, and contribute to greater understanding" (Glesne, 2006, p. 166). Early in the data analysis process I utilized the tool suggested by Miles and Huberman (1994) of completing a contact summary form for each focus group session (see summary contact form in Appendix L). This was an

effective means of capturing salient and significant issues; identifying themes; and recording early impressions, concerns, and conclusions for each focus group session. Chapter Four focuses on making connections between the data and interpreting these into meaningful conclusions.

Polarity Management Focus Group

The data collected from this focus group proved to be unique and too different to merge well with the data collected in the Learning Circle and Appreciative Inquiry focus groups. These data were important considerations for my research sub-questions and related more to the organizational structures in place from the perspectives of two distinct levels of nursing management stakeholders. Therefore, I treated this focus group data separately in my analysis but continued to utilize the overarching concepts formed by my four major themes.

My first steps in data reduction were to summarize the series of flip charts created by the participants throughout the session. All participant names were given a numerical code and any reference to them was recorded using that corresponding number. Following Stringer's (1999) analysis process I utilized a summary document of all the flip charts and colour-coded similar key items with a coloured highlighter. I lumped these key elements into categories and created themes. I inserted the themes with the corresponding key elements listed below into each quadrant on a summary Polarity Map.

Using colour-coded index cards I documented key elements and themes for each flip chart question and for responses from the concluding thoughts handout. I also recorded significant events and captured any impressions and related questions on the

contact summary form. Notes taken by the co-facilitator during the session became part of my data for this contact summary document. All of this data on the coloured index cards was sorted into data piles under one of the four major themes.

Learning Circle Focus Group

I collected data from this focus group session by four means: (a) the contact summary sheets (b) the Learning Circle recording and transcript, (c) three flip chart questions, and (d) the concluding thoughts documents. I utilized a different means of data reduction for each area. The contact summary sheet provided data which was used in later data analysis for drawing conclusions. This summary also included information recorded in a note-book by the co-facilitator while observing the Learning Circle. Notes were taken on emotional shifts in the group, non-verbal communication through eye contact and body language, unexpected occurrences, and patterns of participation in the Learning Circle. The Learning Circle participants were each given a pseudonym which was used in the transcript to respect their confidentiality. I became familiar with the content of the digital recording by listening to it four times during the clean up process for participant verification. The transcript covered five questions addressed by the circle participants. The first check-in question did not generate data but questions two through five did. I printed the transcript and, using one color of highlighter for each question, I began the process of pawing the data by highlighting all sentences that, as Sandelowski (as cited in Ryan & Bernard, 2003) states, "make some as yet inchoate sense" (11. section, ¶ 1). I cut out each of these highlighted sections and pasted each one on an index card of the same colour. All the data were further sorted into interpretive codes. This process also accounted for the outlying data by "grouping disparate pieces into a more

inclusive and meaningful whole" (Miles & Huberman, 1994, p. 58). These themes were assigned to one of the four established major themes and sub themes. This process reduces researcher bias by: (a) not pre-judging where the initial key elements of highlighted text might go, (b) avoiding prematurely designating the categories, and (c) letting all the data appear for consideration.

From the questions I posted on the flip charts I grouped the participant-placed post-it notes into similar key items of information which created categories. Each question was given a coloured index card and I cut and pasted each key item onto separate index cards and grouped them into similar categories. I then placed these cards into data piles corresponding to my established four major theme framework and subsequently sub themed together with the transcript data.

The third grouping of data was collected from the concluding thoughts handout. The same process was applied using coloured coded index cards, sorting these into categories, and then distributing them to one of the four major themes and sub themes. The last means of collecting data was from the contact summary form which included anecdotal comments from the co-facilitator's notes.

Appreciative Inquiry Focus Group

The focus group participants in this session were split into two groups and each had created, themed and placed on flip charts their discussions around two questions during the session. Using the two summary documents created for their verification, I cut and pasted each element of each question on to a coloured index card identified with each group. All of the data from this focus group was treated the same as data from the Learning Circle by initially sorting the index cards into categories. I merged all of the

data from this AI focus group with the Learning Circle data on one template under the four major themes which allowed me to identify the sub themes.

I collected data from the concluding thoughts by taking each question's response and pasting this on a colour coded index card which I sorted into similar categories. These were placed under one of the four major themes and sub themes. There were no co-facilitator notes taken during this focus group session, therefore my contact summary form was completed solely with my observations for this session.

Ethical Issues

All ethical issues in this research were considered within the framework of the Royal Roads University's *Policy on Integrity and Misconduct in Research and Scholarship* (2000) and the *Research Ethics Policy* (2007), as well as the IH Research Ethics Board *Application for Ethical Review* (2005). All of these documents are derived from the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (1998). Applying these principles is only one piece of the researcher's ethical behavior; Glesne (2006) reminds us "ethical codes certainly guide your behavior, but the degree to which your research is ethical depends on your continual communication and interaction with research participants" (p. 146). Meyer (2000) supports this exchange between researcher and participant and emphasizes participants understand "participation is fundamental to action research...which demands that participants perceive the need to change and are willing to play an active part in the research and the change process" (p. 178).

My role as researcher was to facilitate this understanding with all participants within these ethical principles. In this research, it was the collaboration between nursing

management and front line nursing staff which produced the best strategies to address engagement and retention of Registered Nurses considering retirement. Wheatley (2005) writes about the need for leaders to give employees a sense of responsibility and an avenue to contribute their ideas. She states "we need better means to engage everyone's intelligence in solving challenges and crises as they arise" (The destructive impact of command and control section, ¶ 3). Within this framework of critically reflective action research (Morton-Cooper, 2000) I was ethically obligated to clearly state the nature of my role as researcher to both the organization and the participants at all times. My role was not one of exploiter, intervener, reformer, advocate, or friend (Glesne, 2006), but as one who respectfully inquired and collected data to enhance a "greater understanding of perceptions, attitudes, and processes" (p. 29).

I had an ethical responsibility and "scientific obligation to do research in the best way we know how...a commitment to the value of knowledge and understanding" (Palys, 2003, p. 81). Without clear ethical principles guiding this research, my conclusions may not be viewed as credible or relevant to the needs of IH. Similar to outside consultants, those of us involved in research within the organizations we work for understand that "once we begin to collect data, we have begun to change that organization" (Block, 2000, p. 42). As well, our accountability also comes from our ability "to build capacity for the client to solve the next problem on their own" (p. 49).

Ethics "is about examining, questioning, exploring, deciding and committing" (Ross, 2000, A code worth living section, ¶ 1). It is imperative that ethical principles were equally applied to the variety of research methodologies used in this qualitative research. The responsibility to approach this research ethically rested solely with me as

the researcher. As a novice researcher, ethical questions and situations were likely to arise and an established "support group to discuss worries and dilemmas" (Glesne, 2006, p. 136) was an invaluable asset in addressing these issues.

Guiding Ethical Principles

The humanistic obligations (Palys, 2003) of this research were ensured by the continued consideration of the eight ethical principles found in the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (1998). This research also received ethical approval from the Royal Roads and IH Research Ethics Review Board. Stringer (1999) states the research situation needs to be "noncompetitive and nonexploitative and enhances the lives of all those who participate" (p. 21). My research methodology and data collection processes were rigorously evaluated against the following eight ethical principles.

Respect for Human Dignity

My methodology reflected respect for participants as individuals, competent professionals, members of a collective bargaining unit, and employees of a large and complex organization. The participants were also recognized as having significant roles within systems of multiple family structures and membership in a larger social context.

Respect for Free and Informed Consent

Disclosure of all aspects of the research process and the goal of the research was communicated to participants prior to being involved in the research with an ongoing invitation for further clarification and dialogue as required. Processes were in place to secure free and informed consent to participate in the focus groups. Participation in the

research was voluntary and there was a stated provision for the withdrawal from the research at any time without impunity.

Respect for Vulnerable Persons

I did not involve any vulnerable persons as defined by the Tri-Council in the course of this research. The *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (1998) defines vulnerable persons as individuals requiring special protection due to diminished capacity or decision-making ability. I do recognize there were hierarchical and therefore power differences among the participants of the third combined focus group. I avoided pairing participants involved in direct reporting relationships in the focus group exercises. Special attention was paid to group dynamics and to encouraging and validating individual participation.

Respect for Privacy and Confidentiality

Every effort was made to apply procedural protections and care (Palys, 2003) to ensure and maintain participant confidentiality and anonymity. These efforts were communicated to each participant and agreed upon in writing in the informed consent letter. Research methodology for my research was designed to select unique participants for each focus group within considerations of each group's population size, composition and the objectives of the focus group they participated in.

Written permission was received at every phase of data collection and all participants' concerns were taken seriously and responded to in a respectful and timely manner. All data collected was limited to only information directly pertaining to the purpose of this research. All written and recorded data as well as my researcher notes are locked in a secure place and will not be held longer than necessary after the completion

of the research project before being destroyed. Access to any raw data collected is restricted to my Supervisor on a need to know basis. Ethical dilemmas were discussed in strict confidence with my Faculty Supervisor, Project Sponsor and/or my ethics advisor, and as appropriate, with the knowledge of the participants.

Respect for Justice and Inclusiveness

By using participants from two distinct target groups, front line nursing staff and nursing management groups, the ability to have a hermeneutic dialectic process occurred whereby "individuals and groups with divergent perceptions and interpretations can formulate a construction of their situation that makes sense to them all" (Stringer, 1999, p. 45).

Balancing Harms and Benefits

The design of the data collection methods considered the location, time of day, and the duration of the focus groups, in order to balance operational requirements and convenient times for the participants. Any risks to the participants and the anticipated benefits were documented on the informed consent form.

Minimizing Harm

The themes collected and interpreted from the three focus groups were verified for accuracy by participants prior to there use in successive focus groups and in the final report. Any disagreement or deviance of perspective would have been noted and explained in the research text (Zeni, 2001). Attention to the criteria of using the smallest number of participants for study validity was considered to reduce the scope of any unforeseen harm stemming from the research.

Maximizing Benefit

The known potential benefits of this research were stated in the written informed consent document and again given verbally at the beginning of each focus group session. The use of this data is intended to contribute to areas of research on: (a) factors contributing to retirement decisions, (b) strategies to delay nurse's retirement during a predicted shortage of professional Registered Nurses, and (c) engagement strategies for mid- to late-career Registered Nurses. This research has the potential to benefit various disciplines within the health care system and perhaps may also be used in a broader labour force context.

Personal Bias

Having an open and transparent research methodology, following the guidance of my Faculty Supervisor, and learning from the expertise of my ethical advisor assisted me in identifying and attempting to avoid researcher bias. Journaling my experiences, research process and personal reflections over time assisted me in discovering and addressing any personal biases that developed.

Empathy for the participants and their situations was an important value to bring to the research process. Bellman (1990) states "success in fully understanding clients depends on having had experiences like the ones they are having especially at the feeling level" (p. 97). The importance of conducting this research respectfully and with attention to detail is due to the value and importance I place on individuals' relationships to one another and the relationship to their work-life.

The ability to conduct research is both a privilege and a responsibility; Palys (2003) states "the 'truths' we unearth about the world – is only partly related to how the

world *is*, but also is related to *where* we look and *how* we choose to examine what we find there" (p. 3). I also share Miles and Huberman's (1994) description of seeing the world from a "transcendental realism" perspective where:

> Our explanations flow from an account of how differing structures produced the events we observe. We aim to account for events, rather than simply to document their sequence. We look for an individual or a social process, a mechanism, a structure at the core of events that can be captured to provide a *causal description* of the forces at work. (p. 4)

CHAPTER FOUR: ACTION RESEARCH PROJECT RESULTS AND CONCLUSIONS

Introduction

The research project results and conclusions represent findings from three focus group sessions of various stakeholders in IH (Interior Health): (a) Polarity Management and Mapping session comprised of two Program Directors and five Nurse Managers, (b) Learning Circle session that included seven female Registered Nurses between the ages 55 – 64 years who were considering retirement within five years, and (c) Appreciative Inquiry session that incorporated representatives from the first two sessions and included one Program Director, two Nurse Managers, and three front line Registered Nurses.

The data were analyzed and the findings were used to address my research question "How does Interior Health support the engagement and retention of skilled mid- to late-career Registered Nurses who are between the ages of 55 and 64 years and are considering retirement?" Related questions which also defined this research project were: "What interventions would create synergy between the personal goals of these employees and the goals of Interior Health?" and "What implications does this have on how Interior Health modifies employment practices to fully utilize mid- to late-career employees?"

In this chapter I report the research findings and conclusions in two parts. Part One deals with a discussion of the findings from the Polarity Management focus group session. This session was distinct in three major ways and the data did not merge neatly with the other two focus groups' data. The first difference involved the stakeholder composition and the focus on the systems within the organization. The Program Directors and Nurse Managers dealt with the existing organization structure and high level

management issues which were not discussed in the other two focus groups. The second difference was the skill enhancement these nursing managers gained as they learned a management tool used for identifying and addressing polarities versus problem solving issues. The third difference was apparent in session outcomes and the relationship of these outcomes to the research question and the related research sub-questions. This focus group session utilized the polarity management tool to examine the organizational paradox of retiring mid- to late-career Registered Nurses in times of labour shortages. The design of this focus group session addressed the related research question "What implications does this have on how Interior Health modifies employment practices to fully utilize mid- to late-career employees".

Part Two examines the findings from the merged data collected from the Learning Circle focus group of Registered Nurses and the mixed Appreciative Inquiry focus group sessions. These findings are reported under section heads corresponding to the four conceptual themes that emerged from the data: (a) workplace environment, (b) organizational culture, (c) family and financial pressures, and (d) finding significance and meaning.

The study conclusions section represents an integrated approach with conclusions drawn from the findings across all data sources from the Polarity Management focus group, the Learning Circle, and the Appreciative Inquiry sessions. These conclusions also include personal reflections and conversations with my Sponsor, Ethics Advisor and other colleagues across the IH organization. I extend my gratitude to all those who were an invaluable source of inspiration for this report. The final scope and limitations section of this chapter addresses considerations that have impacted or limited my research.

Results

Part One – Polarity Management Data

All data from this session were placed in a variation of the overarching concepts of three of my four conceptual themes. These variants were: (a) workplace environment, (b) organizational culture, and (c) financial considerations in IH. During the polarity management focus group session there were no discussions or data collected relating to the impact of family or financial pressures on mid- to late-career Registered Nurses, or on the issue of finding significance and meaning in midlife. The financial considerations discussed in the focus group session were at an organizational level. Data themes were created by clumping data bits generated during the creation of the polarity map by focus group participants. These themes were displayed in a polarity map summary to enable readers to observe the trends. Data findings in this report are presented in table format under each of the three conceptual themes. The format of the tables illustrate the data following the infinity loop pattern (∞) used in creating the polarity map. Using this infinity loop pattern, data from 'R-' will be listed first, followed by data from 'L+', 'L-', and then 'R+'. To successfully monitor and maintain balance between the polarities of retirement and engagement and retention, organizations need to develop strategies to ensure the results found in the L+ quadrant, the positive outcomes from focusing on retirement, and in the R+ quadrant, the positive outcomes derived from engaging and retaining mid- to late-career RN's, are maintained (see the polarity map structure in Appendix G).

Data were also collected from participants' discussions regarding the diagnosis of the critical elements of the polarity. These included determining who were the 'crusaders'

in the organization that wanted to see changes in the system; what were they most critical of, and what changes they were promoting. As well, discussions identified what communication systems were currently in place in the organization that would signal a need to begin addressing an issue; and what practices might be found in the organization if the polarity was well managed.

Polarity Management Data Findings

Workplace environment. The workplace environment theme in the Polarity Management focus group session relates to the nature of the job through work processes and staffing issues which influence the conditions determining how the work is performed. The characteristics listed in each quadrant reflect Program Manager and Nurse Manger views of what the work processes and staffing issues would be under the corresponding conditions. Table 2 is a summary of the polarity map information created by participants regarding the workplace environment.

These findings indicate that by maintaining a balance between positive retirement policies and procedures and applying appropriate engagement and retention strategies IH would achieve a sustainable, stable, and engaged nursing work force. Managers would have the ability to create optimal schedules containing a mix of skills and experience. This would facilitate the older nurse's ability to share their tacit knowledge through mentoring, as well as reduce injuries through sharing demanding physical job duties. By not maintaining this balance IH can expect to experience system stress in the form of chronic nursing staff shortages, loss of engagement of all nursing staff, possible increase in injuries in older nurses, and a low rate of retention of younger nursing staff who are looking for career advancement.

Table 2

Polarity Map Issues Relating to Workplace Environment

Polarity Map Quadrants

	R-	L+	L-	R+
Description of Quadrant	Negative outcome from focusing only on the engagement and retention of mid- to late-career RN's and neglecting their retirement	Positive outcomes from focusing on the retirement of mid- to late-career RN's	Negative outcomes from only focusing on retirement of mid- to late-career RN's and neglecting their engagement and retentions	Positive outcomes from engaging and retaining mid- to late-career RN's
Work Processes & Staffing Issues	-can not retire older RN's who have lost skill -younger staff can not advance or come on which creates shortages later -no mix of ages and experience -older RN's can not do increased workload and physical demands	-work re-design -casual pool -staff planning -selection of staff	-increased workload and no one left to work -loss of skilled expertise -decreased continuity -increase impact on system stress	-adequate staffing levels -flexible scheduling -succession planning

The Polarity Management focus group participants identified themselves as "crusaders", those who see problems with the present system and want to make things better for the future. What this group was most critical of in IH's current workplace environment was an absence of apparent: (a) retention strategies, (b) succession planning, (c) job re-design, as well as too many professional practice restrictions. They would like

to see a system overhaul particularly in job re-design; a greater influence in the negotiations of union collective agreements; and the development of competitive recruitment strategies. Participants believe that by addressing these issues IH would: (a) mitigate the risk of severe nursing shortages, (b) increase the number of older nurses in the system which would create increased staff loyalty.

Organizational culture. The organizational culture conceptual theme included factors that create a positive and productive workplace and a quality of work-life for all employees. Table 3 shows the potential impacts on the culture of the organization under each of the conditions described in the corresponding quadrant.

The 'crusaders' were critical of the following conditions they perceived to be operating in IH which negatively affect the culture of the organization: (a) no pool of funds for education, (b) reactive policies, (c) narrow focus of front line realities, and (d) no listening body in IH. What they would like see is: (a) innovative and forward thinking, (b) more creativity and risk taking, (c) positive change, and (d) attention to the individual in IH. Participants felt that if these issues were addressed the retirement occurring in IH would be manageable; more older nurses would elect to stay longer; staff loyalty would increase; the organization would be closer to becoming an organization of choice; and as one Polarity Management participant expressed it, IH would have a "thriving, productive, engaged, and empowered" staff. This polarity between retirement and engaging and retaining staff would be managed by balancing efforts between both the positives aspects of retirement and the positive outcomes from engaging and retaining staff.

Table 3

Polarity Map Issues Relating to Organizational Culture

	Polarity Map Quadrants			
	R-	L+	L-	R+
Description of Quadrant	Negative outcome from focusing only on the engagement and retention of mid- to late-career RN's and neglecting their retirement	Positive outcomes from focusing on the retirement of mid- to late-career RN's	Negative outcomes from only focusing on retirement of mid- to late-career RN's and neglecting their engagement and retentions	Positive outcomes from engaging and retaining mid- to late-career RN's
Organizational Culture Issues	-apathy to engage - reverse (negative) role modeling -resistance to change -negative morale and culture -role change out of comfort zone -no support for new RN's -new identity -increased learning curve	-younger workforce -increased morale -increase continuous quality improvements	-decreased work ethic & change of work ethic -decrease professionalism -RN's will chose what work will or will not do -negative attitudes & perspective of job	-respect & acceptance of all staff -increase retention -increase recruitment -Magnet Hospital status -increase education & organizational learning -increase quality of work-life -increase work-life balance

The participants listed the organizational practices they believe would be in place if this polarity was being well managed: (a) an education fund as a pool of dollars in corporate IH; (b) lifting of restrictions on education funds to be more inclusive; (c) the creation of a retention fund for all IH employees; (d) offering opportunities to

upgrade to all employees, as well as offering apprenticeships; (e) demonstrating the value of staff who do not belong to a union (are non-contract) by increasing benefits in order to assist in retaining managers, and attracting front line union staff to management and non-contract positions; and (f) developing active succession planning strategies at all levels in the organization.

Financial considerations in IH. Financial considerations discussed by management participants in this context were within the corporate scope of IH and did not address the finances of individual employee's salaries or pensions. The characteristics listed in each quadrant reflect the financial impacts on IH under the corresponding conditions in each quadrant. The findings suggest managers perceive a better overall financial position for IH if a balance was maintained between optimum retirement strategies and engagement and retention practices. This may require an increased short-term investment of money for longer term gains to the organization. The managers perceived that if these polarities are not well managed the financial picture would continue to degrade resulting in a critical financial picture for IH. Staffing budgets would be plagued by serious over-runs due to increased sick time, overtime, and vacation relief; as well IH would face additional costs resulting from increased liability and risk management issues. Table 4 is a summary of the polarity map information created by management participants.

Management participants felt there were systems currently in place which could act as warnings to alert IH that this polarity was not being well managed. These systems include monitoring overtime and sick time; reviewing the number of open staffing lines and rotations; and tracking the number of unfilled positions of both managers and staff.

Other systems in place that could also be utilized were statistical information on recruitment strategies and retention efforts. Participants felt that IH would benefit from continuing to administer staff surveys.

Table 4

Polarity Map Issues Relating to IH Financial Considerations

	Polarity Map Quadrants			
	R-	L+	L-	R+
Description of Quadrant	Negative outcome from focusing only on the engagement and retention of mid- to late-career RN's and neglecting their retirement	Positive outcomes from focusing on the retirement of mid- to late-career RN's	Negative outcomes from only focusing on retirement of mid- to late-career RN's and neglecting their engagement and retentions	Positive outcomes from engaging and retaining mid- to late-career RN's
IH Financial Considerations	-increase costs in vacation & sick time for older RN's	-meet budget requirements -save money	-budget over-runs -increase sick time & overtime -increase cost of orientation	-improve budget concerns

In summary, Program Managers and Nursing Managers who participated in this focus group session saw dire consequences affecting the workplace environment, the culture, and financial systems if attention was not paid to balancing positive retirement practices with engagement and retention strategies. The participants determined that each element of the paradox – retirement and the engagement and retention of staff, were interdependent of each other and neither function well independently. Both polarities were critical aspects of IH which required meaningful attention to address the health of

the organization. To be able to successfully provide healthcare to our communities, IH must attract and retain sufficient qualified and competent staff, and provide adequate financial resources to both these systems.

Part Two – Learning Circle and Appreciative Inquiry Data

To facilitate drawing conclusions, the merged data from the Learning Circle and the Appreciative Inquiry focus group sessions were displayed in a Thematic Conceptual Matrix variation which utilized the conceptual themes of: (a) workplace environment, (b) organizational culture, (c) family and financial pressures, and (d) finding significance and meaning. Miles and Huberman (1994) define a conceptually clustered matrix as one that "brings together items that 'belong together' " empirically in conceptual coherence where the "informants answering different questions are tying them together or are giving similar responses" (p. 127). This approach to displaying data further enabled the examination of participant comments within each sub-theme according to their perceived impact for these nurses. Specifically, the comments were further categorized as 'identified dissatisfiers', 'identified satisfiers', 'impact on engagement' and 'impact on retention' for mid- to late-career Registered Nurses in IH (see matrix format in Appendix M).

Miles and Huberman (1994) affirm that this data display technique supports the blending of "inferences drawn directly from the displayed data... (seeing patterns, themes; and factoring – that is, seeing a few general variables underlying many specifics), with illustrative comments drawn from elsewhere" (p. 131). I acknowledge the potential for researcher bias associated with assigning key elements in the form of direct participant quotes under these matrix categories. Miles and Huberman (1994) suggest that

entering condensed data into a matrix should be done "according to clear decision rules" (p. 141) established by the researcher. I created and referred to a list of definitions for the four conceptual themes and their corresponding sub-themes as a guide for categorizing the key elements (see definitions in Appendix N). I placed direct quotes in the matrix according to what I perceived as the "best fit". In the text of this chapter I applied the results of this matrix by referencing sub-theme sections or specific quotes as 'dissatisfiers' or 'satisfiers' according to how participants expressed them in the focus group. I also determined whether the sub-theme sections or quotes demonstrated an impact on participant engagement or impacted their retention in the organization

In order to assist in generating meanings and drawing conclusions I created a summary table for each of the four conceptual themes. Each corresponding summary table is situated in the corresponding conceptual theme section of this report and shows the frequency of any particular coded key element that was mentioned in the data. These coded data bits were organized into categories and placed under the corresponding sub-theme. This process revealed the strongest data in order to provide plausible explanations for drawing conclusions. Using a counting method in qualitative analysis is supported by Miles and Huberman (1994) who suggest "there are three good reasons to resort to numbers: to see rapidly what you have in a large batch of data; to verify a hunch or hypothesis; and to keep yourself analytically honest, protecting against bias" (p. 253).

As the researcher, I found I was more emotionally aligned with some aspects of the data over others. I acted as a participant in the Learning Circle focus group which by the nature of the methodology created an intimate environment for sharing feelings and emotions. The Appreciative Inquiry focus group also relied on people sharing meaningful

stories about their accomplishments and the high points in their working lives. Nisbett and Ross (as cited in Miles and Huberman, 1994) suggest that "people (researchers included) habitually tend to *overweight* facts they believe in or depend on, to *ignore or forget* data not going in the direction of their reasoning, and to *"see" confirming instances* far more easily than disconfirming instances" (p. 253). I believe that by counting frequencies in my data and inserting this into a summary table assisted me to address this bias which could potentially skew the findings and the conclusions.

The participant sample size for the data collected and placed in the summary tables was 10 unique individuals. These individuals were from two distinct focus group sessions and consisted of Program Directors, Nurse Managers and front line Registered Nurses. These summary tables indicate the frequency of the appearance of a key element and do not represent the intensity of the issue as portrayed by the participants. To facilitate the representation of the emotional intensity of these factors and to highlight or emphasize the significance of an issue, I have integrated participants' quotes into the text to provide rich examples. The quotes are not attributed to any one participant in the report text and some of the identifying details were neutralized in order to protect participant anonymity.

Merged Data Findings

Workplace environment. Data collected which aligned with the 'workplace environment' theme include factors involving the nature of the job and the conditions under which the work is performed including contractual agreements found in the BCNU Collective Agreement. Table 5 is a summary of the data clustered under the established sub-themes in the workplace environment. The intention of this table is to visually

demonstrate the factors in the data that have more impact on the engagement and retention of mid- to late-career Registered Nurses who are considering retirement within five years. The frequency of a key element occurring in the data indicates that this issue is likely affecting participant's workplace environment and impacting their engagement and retention.

Table 5

Factors Relating to Workplace Environment Sub-Themes

Frequency	Physical Environment	Contractual Agreements	Peer Support	Concern for Patient/Client	Health & Wellness
5 + times	Clutter Space Injury Ergonomics	-	Collegial	-	Work-life balance Coping Reduce hours Well-being
3-4 times	-	Seniority Movement	Social	-	Workload
1-2 times	-	Shift work	-	Welcoming environment Access Safety	-

Note. Dashes indicate there were no data reported.

Physical environment. Clutter, space, physical injuries, and work station ergonomics were the most frequent factors identified as 'dissatisfiers' in the physical environment and impacted negatively on participant engagement. The impact of clutter is summed up by these comments from a number of the participants:

> There is clutter everywhere and we don't realize the visual impact that clutter has; from the visual stimulation, feeling like they're on overload.
>
> I quietly redo all the bulletin boards so that they're nice and neat and tidy.
>
> In one office area where they share their office with a whole bunch of commodes, I go in and chat with them and I sit on a commode.

> It is not just the clutter, it's the noise. I really find I'm distracted very easily - and noise, it really disturbs me and I have a little trouble concentrating. I haven't brought in ear plugs yet, but I'm thinking, maybe.

A closely associated issue to clutter in the workplace is the lack of space and the problems this creates. It was perceived as important to have work space that was sufficient to do the work, was maintained, and was nicely decorated. This issue was identified in the Appreciative Inquiry focus group session as an example of what exceptional engagement practices were to the participants. This group also identified having a dedicated lounge or space for rest breaks as important. This space would "exclude work discussions" and be "refreshing, rejuvenating, and relaxing in a beautiful calm environment". The comments below from Learning Circle participants highlight other issues raised regarding space:

> The over-crowdedness is unbelievable – we've had a space issue for way too long – way too long.

> When they need more offices, they divide them in two.

> People are coming in and out – back to back, so every time we move, we hit somebody or somebody is walking behind us, you have to move, the door opens constantly and you have to move.

There was an awareness in these older nurses that the prospect of physical injuries from the physical environment was ever present and the potential for getting injured on the job would negatively impact their retention: "constraints on my nursing practice because of physical matters continue to get worse and worse"; and to protect one's self from physical injury required considering that "working less is a good thing to do now". One participant described how her aging process impacts the time it takes to safely complete her work:

> One of the things that we really have to do is to look at the physical nature of a job. In that people our age are looking out for things like their necks and their backs; their bodies just don't function quite as well as somebody that's 25 year old, so you have to be more careful. So things maybe will take a little bit longer – they should if you're going to be careful and do things properly.

For others that have experienced physical injuries, these injuries have limited the jobs they take: "my plan was to work in palliative care or medicine – that's what I liked the best but I found out that I couldn't make it through the day because my back gives out". Sometimes injuries lead to more severe consequences as this participant describes:

> I'm feeling a pain in my shoulder from my neck and that is one of the things that happen when you get old. It's aches and pains, and things come down on you, and you remember that maybe it's things like that, that might stop you from working and that kind of is concerning me these days 'cause I might have to have surgery.

Exacerbating these physical injuries are work station ergonomics. Comments from Learning Circle participants like "how awful we are when it comes to ergonomics and safety" and "has anyone seen a computer setup that is ergonomic and is friendly that does not cause repetitive strain injury?" indicate negative experiences with ergonomics in the workplace. The following illustrations draw attention to specific examples of ergonomic issues:

> We can't even get a chair. We share offices, so we've got people who are six feet tall and people who are five feet tall, so the adjustors break and you spend lots of time just trying to fix it so you can sit.

> On Acute Care, it's absolutely the worst when it comes to stations for charting, for computers, and furniture that is really frightening - you sit on it, you lean back and the thing tips.

> I can't even get a headset, we do intake over the phone for two to three hours. I have a hundred emails back and forth to try to get an ear piece for our phone.

Peer support. Collegial support versus peer advocacy was a frequent 'satisfier' in discussions around the theme of peer support which positively impacted both participant

engagement and retention. This is represented in Learning Circle comments such as "I know that nurses everywhere, whatever they do, work as part of a team"; "we'll say to each other, 'well thank you for the nice shift' and that makes you feel good"; and "you really feel as a peer with everybody there." Another aspect of this collegial relationship is one that is described by this casual employee:

> And it does help that I feel I'm helping my fellow workers too, because if I didn't do casual work, they wouldn't get time off and they'd have to work the evenings that they need off and the weekends they need off, so I feel I'm helping them in someway.

The 'concluding thoughts' summaries completed at the close of the sessions by participants collected data regarding an awareness of peer relationships these nurses appreciated as a result of participating in the Learning Circle. These reflective comments indicate the significance of these collegial relationships:

> I think I'll have more understanding of where my colleagues are coming from and be more able to communicate with them.
>
> I will look at my colleagues with different eyes and respect.
>
> More thought into my actions and words as to how I affect others around me.
>
> Show respect and compassion to my fellow nurses at all times.
>
> Accept the difficulties of life each of us may have and be forgiving if we are unable to put our all into each and every minute of our work hours.

Health and wellness. Work-life balance, coping, reducing the hours of work and general well-being were the factors most frequently mentioned regarding health and wellness in the workplace. Work-life balance was a common goal for these Learning Circle participants; if they were able to maintain a satisfactory work-life balance they were more likely to defer their retirement. Reinforcing comments which support this were: "I can have a life outside of nursing"; "I do have a personal life that is totally

separate"; "I feel like I balance my life pretty well, I'm lucky to have good health and I have a nice family and grandchildren, and there's just a lot of balance in my life".

There were many comments from the participants regarding their own, and their colleagues' stress levels and ability to cope. These indicate a 'dissatisfier' in the organization and heightened the awareness of participants' own vulnerability as well as how they act as support for others who are feeling overwhelmed. These comments speak to the awareness of how much of these nurses' energies are spent on coping which directly impacts their ability to become engaged in the work environment:

> I have a chair in the corner of my office and people will sit there and talk – they are not talking about clients issues, they're talking about how well they're coping.
>
> We've all taken on more clients. We all know that our clients are more complex, and what's happening is there is a degradation of the morale with my teammates.
>
> There are more and more complaints of workload, there are more and more complaints of 'how am I going to cope'.
>
> I go into overload – the workload piles up and I start sinking.
>
> I've had to learn a lot about boundaries in nursing for me, because I got massively burned out about three years ago.

The following poignant comments summarize the ambivalence and the lengths these nurses go to deal with stress and coping:

> I'm looking forward to the day that I won't have to deal with sick people anymore. I'm really looking forward to just dealing with health and maybe that's a selfish part of me.
>
> I was completely burned out in the department. I had blood pressure problems, I couldn't do my job to my level of satisfaction because we didn't have the staff levels; we were unsafe, we were working in unsafe conditions with patients and nurses, and I had to get out or die basically. I asked for a leave of absence, and I could get a leave of absence, but I would have to take it as stress leave, sick leave.

Some of these nurses in the Learning Circle looked forward to reducing their hours of work in order to remain longer in their nursing careers. A number of nurses have found ways to achieve this: "I work in the half-time initiative that is in the province – about working a half of the shift and sharing it with a new grad, and I think I'd like to continue that"; and "I work casual and I think I work just about as much as full time, but it's on my terms because I can say yes or no." The general consensus from the comments around reduced work hours can be summed up by this comment: "From my own personal point of view, what will keep me working is that it fits in my life and things like working less is probably a really good thing."

The final factor under health and wellness were the issues affecting the well-being of the Learning Circle participants. Issues such as driving in the winter, driving in the dark, going to people's homes and into a potentially unsafe situation, and "being protective of your physical body" were viewed as 'dissatisfiers' and did influence participant retention decisions. Attention to issues regarding well-being are seen as important and something each individual nurse is prepared to take on herself: "my hope for nurses is that we're going to take really good care of ourselves" and "if we don't take care of ourselves, who will. It has to come from us."

Key elements that were not frequently cited in the data still play a relevant part in reviewing the concepts of engagement and retention. Contractual issues were often sources of dissatisfaction in the organization, and participants realized the limited influence IH had on their ability to affect these. The following comments highlight some of these issues which impact on decisions to retire:

12 hour shifts are very hard on people.

> If I had to work a 12 hour shift, one 12 hour shift would do me in.
>
> I had to quit my job at the hospital so that I could work casual in another certification. I couldn't even go on leave from my department and work in another department for a time...they wouldn't allow me to just take a sabbatical and go somewhere else for a little while. I quit my job, I lost all my sick time, I kept all my seniority, but I lost everything else. To me that was a big slap in the face for somebody that had been there at that point for 12 years...that's my huge issue with nursing, and partly its contract rules and seniority.
>
> I will probably not work if I'm only getting called for short call.
> When an employee retires, I believe there is something in the union that says if they are not working for 30 days, they lose their seniority.

Another less frequently mentioned area was the concern for the patient/client; specifically the ability to provide a welcoming environment with good signage, easy access on frequent transit routes, and safety issues regarding over crowding in areas during high patient counts. Comments regarding these issues were categorized as 'dissatisfiers', but participants did not seem to attach any meaning as to whether these directly affected their engagement or retention in the organization.

Organizational culture. This section reports the findings associated with the conceptual theme 'organizational culture', specifically regarding the presence or absence of the influence of a people-focused leadership style and a patient-centered management philosophy. The sub-themes identified in organizational culture and summarized in Table 6 are: (a) leadership, (b) learning and development, (c) mentoring, and (d) recognition. Each of these sub-themes contains key elements that were frequently mentioned by the participants during the Learning Circle and Appreciative Inquiry focus group sessions. Many of the comments referred to in this report point to issues regarding poor, or the lack of communication. I did not specifically address communication as a sub-theme for discussion in this report as I see it as a fundamental underpinning in all aspects of

organizational culture – in leadership, learning and development, mentoring and recognition. In order for a people-orientated leadership style to be achieved and be successful, managers must develop and utilize a high level of communication skills and communication strategies.

The sub-themes are discussed here with reference to being 'dissatisfiers' or 'satisfiers', and the impact they may have on the engagement and retention of the participants. Direct quotes substantiate the findings and provide context to the importance of organizational culture in engagement and retention of these mid- to late-career nurses. Table 6 illustrates these factors under the sub-themes of leadership, learning and development, mentoring, and recognition.

Table 6

Factors Relating to Organizational Culture Sub-Themes

Frequency	Leadership	Learning & Development	Mentoring	Recognition
5 + times	Inclusion Bureaucracy Positive working relationships	Upgrade Continuous learning	Mentoring others Cycle of mentorship	Respect
3-4 times	-	-	-	Recognition Value Tacit knowledge
1-2 times	Autonomy	Conference	Advocate	Recognition by patients

Note. Dashes indicate there were no data reported.

Leadership. Inclusion in decision making, observing the bureaucracy of the system, and establishing positive working relationships with management were the most frequent factors under the sub-theme of leadership. Most examples provided by the

participants were seen as 'dissatisfiers' in the organization which negatively impacted the alignment and engagement they experienced in the organization. There were numerous remarks during the Learning Circle regarding the perceived lack of inclusion in decision making processes and the ill effects this has on the participants:

> It seems to me that management sometimes gives us lip service and then does what they want to do anyway.
>
> Tell us what you can feasibly do and what you can't and where we can meet part way, wouldn't that be kind of nice?
>
> We are in the process of talking to management, hopefully they're going to listen to us, but we don't know.
>
> It will be an after-the-fact thing, which seems to be what happens with a lot of things. Let nurses in on the planning phase and the designing phase, what's wrong with that, and how come we don't hear about it until it's too late.

Participants shared personal strategies they used to become more engaged in the organization. Some included themselves in the decision making processes by volunteering to participate in policy making sessions, or by providing feedback to their managers in efforts to establish open communication channels. These are some of the participants' efforts to establish engagement in the organization:

> So I made sure that I joined that committee, because I don't want anything to slip in under the door that I don't know about.
>
> For me, the feedback to my manager has to be twice a week; twice a week something positive, 'cause I forget how many times I just go in with issues, problems, 'please fix this and please fix that', and I think we forget, and I forget that we also need the other side of the coin, both ways and with everybody we work with.
>
> Some things you can slowly work on, but just keep working on being respected and being part of the planning, the design, and the organization.

The Learning Circle participants expressed frustration with what they described as the bureaucracy associated with the system. These 'dissatisfier' comments were without

context but elicited agreement and acknowledgement through verbal expressions or body language from other participants: " I'm very reassured to know that my paranoia is real and the 'good old boy's' network is still alive and well in health care from the top down." Examples of perceived bureaucratic decisions that were not acceptable to the participants are seen in these quotes:

> There will be musical chairs, and everyone will change and move offices at least every six months. I found out that usually the reason is because one of the head honchos wants a different view or something like that.
>
> When administration people leave, they get a golden handshake and some of those people get essentially fired - and they go away with a large cash settlement, and I'm sorry, that one does not sit well with me, because I'm not going to go away with a large cash settlement.
>
> I think the money gets spent in something like the bed utilization and Code Purple – all that paperwork - reams of stuff that has gone into that. Why? I mean those resources could have been used for more beds, more bodies to do that work that needs to be done.

The issue of developing a positive working relationship with management was a source of optimism and included a sense of shared responsibility for making this happen in the workplace. The following 'satisfiers' expressed in the Learning Circle indicate this awareness:

> You hear all this 'boss bashing' all the time - but then you have to look that you have to deal with these people, so you learn how to do that and you learn how to recognize and see them for people; and you look to what – where you could compromise, where you can meet halfway, where you can get things better and, actually that's kind of exciting.
>
> I think long term, I have bitched and complained with the best, but I also have made a conscious effort to be part of the solution, so I saw coming here today is part of that.
>
> Management has similar issues as front line people.
>
> What I see my responsibility is to create the ideal workplace is to bring some clarity; bring some calm.

Below are some examples of 'dissatisfiers', instances where participants were critical of their interactions with management which directly affected their engagement in the organization:

> Management is generally non-nursing and that has its downside because there has been a lack of understanding.
>
> Employers should treat us like they're onside with us instead of it's like a secret plan. You're in a meeting and they're telling you this is coming down the pipe, but you know there's a hidden agenda. Like 'get your agenda out on the table'.
>
> I think that communication has to increase and improve.
>
> So, in an ideal world, I would really like them to really sit down with all the players and really listen and have a frank discussion.

One group in the Appreciative Inquiry session indicated that an exceptionally engaging workplace would be an "exciting place to work with team support and where you feel you are able to make a difference." Participants viewed this workplace culture as one that would both inspire them to become engaged in the workplace and would positively influence their decision to remain in the organization.

Learning and development. Upgrading skills to maintain proficiency, acquiring new skills and working in an environment of continuous learning were the most frequently expressed desires in this section. If these key elements were implemented in the organization they would be viewed as 'satisfiers' that would positively engage and support the participants in their work. Learning Circle participants requested upgrading current skills in areas such as management concepts, basic and advanced computer information, and updated medical knowledge. They also wanted skill enhancements used in specialty practice areas such as: "medical and medication refreshers", "mediation skills", "counseling skills, specifically for palliative clients", "how to be better at

constructive criticism" and "bringing AI [appreciative inquiry] to the management group. One of the groups in the Appreciative Inquiry session indicated that "having training to provide skills such as communication, stress and technical skills" would assist in creating an engaging work environment.

One Learning Circle participant highlighted the value of continuous learning and the impact on her engagement with her comment:

> I had the opportunity to take the Gerontological Nursing Certification examination...I hadn't done anything like that for years...it was really good to review the latest research and to brush up on my physiology and interventions...helped me define again, my skill set.

Both groups in the Appreciative Inquiry session created statements supporting and valuing continuous learning after discussing the questions: "What would the VERY BEST place to work feel like?" and "How would you re-structure or add to your current work-life in order to create that feeling from now on?" The 'satisfiers' the participants posted all indicated a desire for engagement which potentially would positively affect their retention. The statements they created were as follows: (a) Learning and Teaching - personal growth and development; (b) Where learning new information would be seen as supportive and exciting; (c) Valuing and supporting educational opportunities; and (d) Enjoying and finding teaching and learning opportunities.

Mentoring. This was a sub-theme that created a large amount of 'satisfier' comments from the participants which I divided into two separate streams; (a) the act of mentoring others, particularly new nurses, and (b) acknowledging the cycle of mentorship from one generation of nurses to another. Learning Circle participants expressed they had "a responsibility to pass on knowledge", and "mentoring students and new grads [assisted in] transitioning [them] into the workforce to get their confidence and

skills going up". This mentoring relationship provided an opportunity for engagement in the organization as well as being a source of finding personal meaning for these seasoned nurses:

> The mentoring part, I like that part; I like being able to teach young people what I know. It makes you feel like what you've been doing all these years really is important.
>
> I think that's where we can mentor best - is the things that we have learned that sometimes we don't even know we know until we have somebody there; or where it's just part of us, we've just learned it over the years, and it just becomes who we are.
>
> It sort of makes you feel like, 'yah, I am doing fine, I'm dong a good job'. It's really pleasurable to be able to pass it on to somebody else and to know that they will be doing the same thing to somebody else in the future; it's kind of like a heritage or something like that.

In the Appreciative Inquiry session each of the two groups listed common themes found in the individual stories they shared about "A time when someone within the organization really engaged you or encouraged you in your work". These stories often involved a "skilled key person who was always available, brought out skills, and who re-framed mistakes into learning [which] gave them room to grow". This left a desire in the participants to "emulate the key person's skills and to use it in our organization/environment now to influence others"; this is a true demonstration of being engaged in the organization.

Again in the Appreciative Inquiry session these two groups jointly constructed major themes they felt were significant in encouraging staff and positively impacting organizational engagement. From the list of the six major themes they created, one theme supported the "self-perpetuation cycle of the [mentoring] role of mid- to late-career nurses to be ingrained at all levels". Another identified theme was promoting the "support

of synergistic relationships involving key persons and key incidents" throughout the organization. In the concluding thoughts document, these themes were supported by similar comments from the participants: "I gained insight into the role of a key person in professional life"; and a pledge to "focus on being a key person in someone else's life".

Recognition. This sub-theme dealt with aspects of recognition felt by participants in the workplace and most comments were seen as 'dissatisfiers' in the organization. Examples cited by the participants indicated they did not feel engaged or valued for their professional contributions. The issue of respect was a predominate factor in Learning Circle participant comments and included general feelings such as "nurses are not respected"; and fierce determination in "if you want respect, you had better command respect, you better go in and ask for it and you better go in and get it." Specific examples of not feeling respected were:

> So that kind of lack of respect of what we do is there; medical staff colleagues particularly, feel that the job we do is kind of like housework.
>
> What I see, is they see you as a threat if they're your manager and when you're at arm's length somehow you're more buddy-buddy. Why can't they just give us that respect anyways, because, you know we're not a threat, we're meant to be part of a team, like we're all in this together.
>
> Unfortunately, I haven't been really respectful all the time, so I suppose that's why I feel badly about it, because I would like to be respectful, but sometimes they just make me so mad.

The Learning Circle participants had the following advice for managers: "Sit and listen – don't get defensive; Treat me with respect, just hear me", and "I have a high value for respect and calmness. And you know all of that stuff doesn't cost."

The factor 'respect' also appeared on the jointly constructed list from the Appreciative Inquiry session as a critical aspect required for staff engagement. These

individual items came from each group's separate list before they produced their joint list: (a) be respectful of everyone's role and time, (b) respect a new person's opinion, and (c) everyone considered equal.

Other key elements from the sub-themes that were mentioned less frequently by the Learning Circle participants were autonomy, advocacy, feeling valued, and acknowledgment of tacit knowledge. These were deemed as 'satisfiers' in the findings and impacted positively on the participant engagement:

> The independent nature of my job – I decide who I'm going to see everyday, and I figure out how to manage my case load and that really suits me. It's a good fit.
>
> What I love about nursing is the autonomy of practice.
>
> I'm a really strong advocate for nurses and for people. I advocate the power of self, not for what I can do for you, but what you already have.
>
> I can't tell you the number of people that have said that they were so happy that I was there just to hold their hand or just to have somebody caring there.
>
> One thing about mature nurses that I noticed is that we don't know what we know. We really don't. We are sitting on years and years of experience that is – actually pretty elite.

In the Appreciative Inquiry focus group the participants listed that an engaging organizational culture would have: (a) Opportunities to do more; (b) Positive Reinforcement through positive feedback and encouragement to increase both self-esteem and job performance; and where (c) Innate qualities are recognized and built upon by everyone.

Some of the less frequently mentioned 'dissatisfiers' which lead to a decrease in engagement were found in the following comments by Learning Circle participants:

> I think that if we maybe just did one small case less in a day that it would give us the time, and the respect, to say "yes, it's going to take you a little while to do a good job".

> What recognition happens in the hospital towards the staff? If you do something wrong, everybody knows about you, but if you do something right, you don't get any pride too often, because everybody's busy, and it's hard to do that.

Family and financial pressures. This section of the report examines the internal and external pressures facing mid- to late-career Registered Nurses which include personal circumstances and family dynamics. Two sub-themes, highlighted in Table 7 were identified from the Learning Circle participant's comments: (a) financial considerations, and (b) spousal influences. There were no discussions on the impact of family dynamics such as elder care, tuition costs, supporting adult children, or caring for grandchildren as influences on decisions to retire. These issues did appear as factors in other research studies as discussed in my literature review.

Table 7

Factors Relating to Family and Financial Pressures Sub-Themes

Frequency	Financial Concerns	Spousal Influences
5 + times	-	-
3-4 times	Saving/debts	-
1-2 times	Pension Quality of income	Attitudes Plans

Note. Dashes indicate there were no data reported.

Table 7 indicates that of the all the factors mentioned, none occurred 'frequently' (5+ times) in participant discussions. As well, the factors discussed by the participants appeared more 'neutral' than identified as either a 'dissatisfier' or 'satisfier'. They did however, indicate an impact on retention; if participants had no debts, were receiving an adequate pension, had a retired spouse, and had potential plans to travel; they indicated they would likely retire sooner.

Less frequently mentioned was the issue of savings and debt load; one Learning Circle participant stated "I'm in a position where I don't have to work anymore, so I could retire next month if I wanted, because we don't have debts anymore." This is contrasted with the following statement from another participant:

> My husband hasn't worked in a number of years. He's 66 this year but he hasn't worked for a long time, so I've been the major earner in the family. I have found I'm not alone in that – there's quite a few of us nurses out there in this situation.

Financial considerations for the Learning Circle participants impacted their retention as expressed by the following comments:

> As a consideration for whether I am going to still be nursing in five year's time is things like, "what it'll do to my pension?" The financial reward for working is definitely a huge part of why I'm still here.
>
> It has to afford me to work part-time so I can have another life.
>
> I spent a lot of my early years being a hippy and going here and there, so I don't have any money.

Spousal influences were expressed in isolated comments and do influence the retention of the participants: "my husband doesn't think it's fair that I retire ahead of him" and "my husband and I are fixing up the house and looking at what we could downsize to, and whether we would like to move to the Island".

Finding significance and meaning. The conceptual theme 'finding significance and meaning' included personal introspection processes such as self-awareness, self-reflection, motivational influences, and insights into the individual journey of finding significance in midlife. Discussion also included the various and diverse interests' participants were actively pursuing in their lives. The sub-themes identified from these Learning Circle participants' comments are highlighted in Table 8 and were: (a) role identification, (b) self-awareness and reflection, and (c) hobbies and interests.

Participants described the factors in these sub-themes mainly as 'satisfiers' in their lives. The sub-theme of role identification held the most influence for engagement and retention in IH. The sub-themes 'self-awareness and reflection' and 'hobbies and interest's were described by participant's as 'satisfiers', but influenced negatively on the level of engagement and retention; these acted more as enticers to retire. Table 8 indicates that almost every key element in this theme was 'frequently' mentioned in discussions, which emphasizes the importance of this theme for this group of mid- to late-career Registered Nurses.

Table 8

Factors Relating to Finding Significance and Meaning Sub-Themes

Frequency	Role Identification	Self-Awareness	Hobbies & Interests
5 + times	Career fulfillment Personal identity Concern for profession	Self-care Self-reflection Self -awareness	Significance
3-4 times	-	-	-
1-2 times	-	-	-

Note. Dashes indicate there were no data reported.

Role identification. The factors in this section reflect career fulfillment, the pride Learning Circle participants had in being a nurse, and how this contributed in a positive manner to their retention. Also prominent in the discussions were how being a nurse was an integral part of their personal identity, and how this identity gave them meaning throughout their careers. Factors regarding the concerns participants had for the future of their profession and the perceptions they had of retirement were expressed as 'dissatisfiers'. Career fulfillment was expressed as a 'satisfier' in the following ways:

> I always thought that [nursing] was my fate - that was definitely my path in life, and I never really looked back, and I loved my training. I've always loved that I am a nurse.
>
> I enjoyed nursing – it's given me a great life; I like meeting new people, I like the hours when I can pick them, and I have been nursing now for nearly 40 years.
>
> I feel very blessed to be part of this career, part of this profession and to be able to care for people when they're at their most vulnerable is a privilege all by itself whether it be physically or mentally. Although it holds a great deal of responsibility, and I like to think that I lived up to that responsibility and continue to do so.
>
> I just feel quite proud to be part of this wonderful group of people.
>
> I still really, really love my patient contact – 95% of the time.
>
> My profession is providing me a landscape to grow. It is very joyful, actually and really challenging to make each moment the best that it can be with no matter who I'm with.

One Learning Circle participant summed up her dilemma between her feelings of being 'dissatisfied' with aspects of her employment, and the ambivalence she felt regarding leaving nursing:

> Most of my work is wound care which I really love. It's an area I feel is one of my strengths, and I think I'm good at it and I think I have a lot to offer there. So, I have mixed feelings, I am thinking right now that I probably will keep my registration and possibly do some casual. That will give me opportunity to just see where I want to be, you know, if I want to continue at all.

The following comments by a number of Learning Circle participants acknowledge the difficulties experienced with closely aligning one's personal identity with professional identity; and conversely the personal benefits this alignment creates:

> I'm a bit afraid of retiring 'cause I'm afraid that I will feel useless, and I know that's not the right way to feel, but what is the right way to feel?
>
> One of the fears that I have is that when I retire I will lose my value and I'm worried that I'll sink into that pit. Probably, that's the biggest thing that has kept me from actually taking that final step and retiring is my fear of loss of value.

> I kind of came at nursing as a way to express a part of who I am and about.
>
> I still can't fathom leaving my job or letting go of that, because it's a big part of who I am.
>
> It helps fulfill my life and I consider I'm doing something worthwhile and I have something to look forward to.

Concerns for the nursing profession were viewed as 'dissatisfiers' and were expressed in terms of future hopes for the system and for recognition of the power of nurses:

> I feel sad sometimes about where – I have mixed feelings about our profession. I feel sad for some of the things we've lost - so many good people, good mentors.
>
> I'm a little nervous about the nursing profession and everybody leaving or retiring very early.
>
> We were the squeakiest wheels, so the change is coming. We don't always reap the rewards of what we fight for, but future generations or future nurses do.

These comments were balanced by a passionately expressed plea:

> I think when we're ready to retire they should let us go without guilt. So that's sort of my feelings about it in a nutshell, like I feel like this retention business is guilting us into staying longer than maybe what we should. I have been nursing now including my training for 37 year, you know, I'm just about empty, damnit!

Self-awareness and reflection. This section included an awareness of the nurse's personal responsibility at work and work ethic; attitude and insights into their role as mid- to late-career nurses; and how the actions of these older nurses influence others and impact the system. Frequent factors appearing in this sub-theme were the areas of self-care, self-reflection, and self-awareness. Self-care issues were viewed as 'satisfiers' by the Learning Circle participants and involved areas they would like to address or improve: "living and being in the moment", "being more patient", "pursuing my personal goals", and "not sweating the small stuff." One piece of advice that sums up this focus

and speaks to a personal engagement strategy was "if you enjoy it, keep doing it and if don't enjoy it, then try something new." Another participant wanted more time outside of work for "building relationships and working on relationships and just going off and not worrying about all the 'other stuff'."

Self-reflection is a process individuals use to discover what provides meaning and purpose in their lives. If elements of these discoveries are found in their employment, the potential for engagement and retention is high. This key element captured the Learning Circle participant's inner thoughts and self-understanding which some participants developed into deep personal philosophies:

> The same respect, trust, love and passion that I have for myself – the more of that I have for myself, the more I reflect out in my daily life and that's what I'm working real hard at.
>
> It is really important to give yourself permission to try things.
>
> I have another set of skills that I try to enjoy – to aid people in however I find them. One of the things I keep into mind is that 'I'm me and they're them and I'm here with them at this time but I will try to help them with my set of skills and then I'm gone.
>
> Be aware of your influence on others or how you may affect others.
>
> I've had friends who are no longer here who were nurses, and things could change any day – so you really need to value each day.

Many of the comments regarding self-awareness came from the Learning Circle 'concluding thoughts' document. Self-awareness is related to understanding one's emotional responses and recognizing the impact of events on your emotional being. Some of these comments are introspective as a result of participating in the focus group sessions and other comments connect to the profession of nursing. All these concluding thoughts regarding participating in this session demonstrate the importance of engaging

people in discussions about their relationship to the organization and the potential effect this has on retention:

> It allowed me to vocalize and clarify my feelings about retirement or not, even made me aware of issues I didn't know I had.
>
> It was a bonding and heart warming experience to be able to speak out and listen without interruption.
>
> I'm very impressed with our depth of expertise and commitment to our profession – the collective wisdom is awesome.
>
> It has deepened my thinking, expanded it.
>
> I am putting more weight on my responsibility and desire to pass on my knowledge.
>
> More thought into my actions and words as to how I affect others around me.
>
> I'm going through the process of working on what I want to do – what's best for me (1st) and what's best for nursing (2nd).

The sub-theme of 'hobbies and interests' were seen as 'satisfiers' in the participant's lives. These relate to the personal pursuits the participants were involved in, and participants often expressed the desire to dedicate more time to these in the future. These activities tap into very personal expressions of finding meaning in their lives. The following comments relate to the commitment these Learning Circle participants have to their particular hobby or interest:

> I'm very passionate about music; you get a lot of joy out of being passionate about some things.
>
> I write a lot, and I'd like to write more. I'd like to be able to focus on writing. I'm also a wannabe artist.
>
> To maybe go on a mission and see where that takes me.
>
> All of my life is becoming much more informed and viewed by my spiritual path; and so all of my life is becoming an expression of my spiritual path. I study lots and meditate and that is becoming a stronger and stronger part of my path.

Less frequently mentioned are the significant roles that internal motivation and insight play in the engagement and retention of staff. These 'satisfier' statements were collected in the Appreciative Inquiry focus group as examples of key incidents experienced by participants in engaging situations, and express the motivational function of self-concept: (a) Self-realization of my abilities; (b) Insight of innate abilities that "I can change negative process to positive"; (c) Personal sense of wanting to do more; wanting opportunities to do and learn, to sense that potential from within; and (d) Self-realization of feelings and things I can do to positively move forward.

In summary, each conceptual theme and sub-theme organizes the findings to represent the authentic and trustworthy thoughts and feelings of a sincere and dedicated group of nurses. Each participant freely expressed what was important to them professionally and personally at this time in their careers and in their lives. Their collective responses supply ample data to consider and address my research questions on the engagement and retention of mid- to late-career Registered Nurses. I am honored to have been able to share and give voice to their perspectives and desires in this study.

Integrated Study Conclusions

Triangulation is defined by Miles and Huberman (1994) as "seeing or hearing multiple *instances* of [the findings] from different sources by using different *methods* and by squaring the finding with others it needs to be squared with" (p. 267). In order to draw valid and reliable conclusions from my data, I have triangulated and confirmed my findings in the following ways: (a) by using different data sources (stakeholders) in separate and mixed focus group sessions to collect data; (b) by using three diverse

methodologies to collect data; (c) by displaying data using a thematic conceptual matrix for qualitative data; (d) by counting the frequency of the appearance of key elements found in the data; (e) by comparing my findings to the literature for consistency and deviation; and (f) by having all participants review the findings and conclusion section for alignment and verification.

This action research project adds to the vast amount of existing data collected on nurses and their relationship to the workplace environment, the organizational culture, the impact of family and financial pressures, and finally to elements of finding significance and meaning in midlife. These findings support the hypothesis that each of these aspects of work-life operating within an organization directly affects the engagement and retention of mid- to late-career Registered Nurses. This research represents the findings of a small number of nurses from one health service area in a large and complex organization. Overall, the findings consistently mirrored those research results found in the literature on factors affecting retention within the nursing profession with only a few minor omissions. Some of the issues affecting engagement and retention found in the literature and not in my research were: (a) the influence of health and wellness programs in the workplace (Andrews et al. 2004; Bulaclac, 1996; Cyr, 2005; Reineck & Furino, 2005); (b) issues of violence and harassment (Geiger-Brown et al. 2004; Ulrich et al. 2005) (c) the use of mechanical devices to assist with heavy workload (Cyr, 2005; Geiger-Brown et al. 2004; McLennan, 2005); (d) comments regarding the alignment or misalignment of personal values and goals with organizational values and goals (Coile, 2001; Holtom & O'Neill, 2004; Izzo & Withers, 2002; Magee Gullatte & Jirasakhiran, 2005); and (e) the impacts of work-related issues on immediate or extended family

considerations (Fletcher, 2001; Hammer et al. 2005; Healy, 2001; Larkin, 2007; Timmermann, 2006). These omissions do not necessarily mean they are not issues for the nurses in my research study, only that they were not identified in my data.

Impacts on the Mid- to Late-Career RN

Participants in this study were well aware of the advantages of a healthy work-life balance at this stage in their lives and had found similar personal strategies to deal with the challenges they were facing. They would either reduce their time at work by going to casual status or they would retire from the profession. In either scenario, participants would have control over how much time they would work in consideration of: (a) their exposure to potential physical injuries from job demands and poor ergonomics; (b) the stress from coping with increased workload, space and clutter issues, and caring for complex clients; (c) the feelings of a lack of respect within the organization; (c) their financial situation and pension status; and (d) the role hobbies and interests were playing in their lives.

Another key aspect of the findings consistent with the literature was participant expressions of a powerful personal identification with being a nurse. This identification and value as a 'nurse' created the only sense of ambivalence mentioned regarding retiring from the profession. The desire to maintain working even in a reduced capacity in order to preserve identity is consistent with the literature. Stryker and Statham (as cited in Roberts & Friend, 1998) describe this relationship to work in terms of identity theory:

> Career momentum is related to overall identity and, in part to the psychological importance of work to self...a person's identity is a collection of role identities. Role identities are self-descriptions organized around social roles such as employee or spouse. (p. 197)

This personal identification as a nurse is an intrinsic asset and is not something that can be proscribed by IH as a condition of employment. This attribute can not be purchased, but it can be supported and sustained through attention to meaningful engagement strategies. Individuals can easily be de-valued and de-motivated to reduce this innate value resulting in poor work performance, disengagement, or exiting from the organization. There is an economic value in recognizing this leverage and furthering strategies for a strong culture of people-orientated leadership. The Robert Wood Johnson Foundation's report (2006) outlines the staggering costs associated with losing older nurses:

> A survey of turnover in acute care facilities found that replacement costs for nurse positions are equal to or greater than two times a regular nurse's salary.... If a hospital with 100 nurses experienced turnover at the national average of 21.3 percent in 2000, annual expenditures associated with the turnover of medical-surgical nurses alone amounted to as much as $1,969,015. (p. 8)

Impacts on the Organization

Having full time older nurses go to casual status does offer benefits to both the organization and the older nurse. As the polarity map illustrated, the organization would have an adequate casual pool to utilize for vacation relief, sick coverage, overtime and staffing shortages. Younger nurses would take much of the full time work with all its heavy physical demands, and succession planning would be achieved as newer nurses could actively advance their careers. As well, IH would benefit financially from a large casual pool as this situation would create: (a) reduced staffing and benefit costs for less expensive newer and casual nurses; (b) reduced costs associated with aggressive recruitment tactics including finder fees and signing bonuses; (c) a reduction in the

substantive costs involved in all aspects of replacing staff; and (d) lower costs associated with long term disability and worker compensation premiums.

A benefit to both the organization and the individual nurse was identified in the polarity management session as being able to have a balance of experienced and newer nurses on shift together. The findings support the sense of recognition and importance older nurses receive from passing on tacit knowledge, offering peer support, and mentoring new nurses. Nursing management also agreed the organization culture would benefit from a staff mix of ages and experience as there would be positive role modeling of work ethics, increased staff morale, and the formation of respectful collegial relationships.

This mutually beneficial arrangement between the older nurse and IH will only exist if the concerns raised by these participants in this report are addressed. In order for older nurses to consider casual employment they must: (a) feel respected and valued; (b) feel they have a voice in their work environment; and as the literature suggests, (c) be aligned with and actively engaged in fulfilling the purpose and goals of the organization. If the 'dissatisfiers' identified by the participants in the findings section are not fully addressed, the older nurse will not maintain her registration, will not participate in the casual work pool, will not pass on tacit knowledge through mentoring, and will not assist IH in addressing severe financial overruns in staffing budgets.

It is significant to note that having retired nurses retain casual status does not mitigate the fact of looming nursing shortages. IH still needs to attract, engage, and retain those nurses who are not in a position to retire, as well as the thousands of staff working in other areas of the organization. Baumruk's (as cited by Gibbons, 2006) research states:

> Companies experience a 'honey-moon' in which new employees' engagement remains high for the first two years of employment, dips, then rebounds after five years of service.... [This] is explained by the novelty of a new job and the learning opportunities it presents. As these wear off, the engagement level drops, and turnover begins to take its toll, leaving a higher proportion of highly engaged employees among those in the high-tenure ranks. (p. 9)

The concerns expressed by participants regarding the workplace environment and organizational culture are not unique to the nursing sector in healthcare. All IH employees are affected by: (a) diminished space and increased clutter; (b) a lack of positive working relationships with management; (c) not feeling valued, recognized, or respected; (d) not having access to continuous learning opportunities; and (e) a lack of ongoing strategies addressing their well-being in the workplace. Lowe's (2006) research describes various healthcare organizations which subscribe to a people-orientated leadership where people matter as such as efficiencies, and affirms that:

> Achieving significant breakthrough in quality of work life and health service quality requires a systemic strategy that builds a people-centred culture. One of the hallmarks of heath-care organizations that have embarked on sweeping cultural change is a relentless pursuit of improvement through measurement, accountability and follow-up actions. Everyone understands that excellence in health service delivery is achieved by enabling and supporting employees to be physically, mentally, emotionally and socially healthy and well. (p. 22)

In completing the polarity map Program Directors and Nurse Mangers were also acutely aware of the impact on organization stress if mid- to late-career nurses were not engaged and retained. Comments from the Polarity Management concluding thoughts documents stated they recognized that to address this issue would require "thinking outside the box" to "positively move us towards a better place to work". By attending to the needs of the individual older nurse and creating a positive workplace environment, IH would also be "promoting the nursing profession" by attracting people to the nursing profession, as well as being competitive and successful in recruiting younger nurses.

These management participants also predicted that if issues in work processes, the organizational culture, and attention to financial support for front line concerns were not met, IH may face "severe staff shortages", including shortages at the managerial level. IH would also face an increased duty to accommodate acutely ill constituents; significantly increase risk and liability issues; and perhaps having to resort to "closing hospitals and facilities".

Summary of the Results

Figure 6 illustrates how the Shifting the Burden archetype (Senge, 1990) can be applied to reveal potential outcomes from decisions to either address or ignore the concerns expressed by participants during this research. The issues discussed in the themes - 'workplace environment', 'organizational culture', 'family and financial considerations', and in the individual's ability to 'find significance and meaning in midlife', all significantly impact IH and need to be carefully considered. The two balancing loops in the diagram are both attempting to resolve issues found in the themes. In the top symptomatic loop decisions to ignore, utilize old problem solving paradigms, or only superficially deal with participant concerns, will produce consequences that will maintain a cycle of scarcity in both human and financial resources in IH.

Senge (1990) describes what could occur in the organization at this juncture are "'eroding goals'. Whenever there is a gap between our goals and our current situation there are two sets of pressures: to improve the situation and to lower our goals....we all can become 'addicted' to lowering our goals" (p. 108).

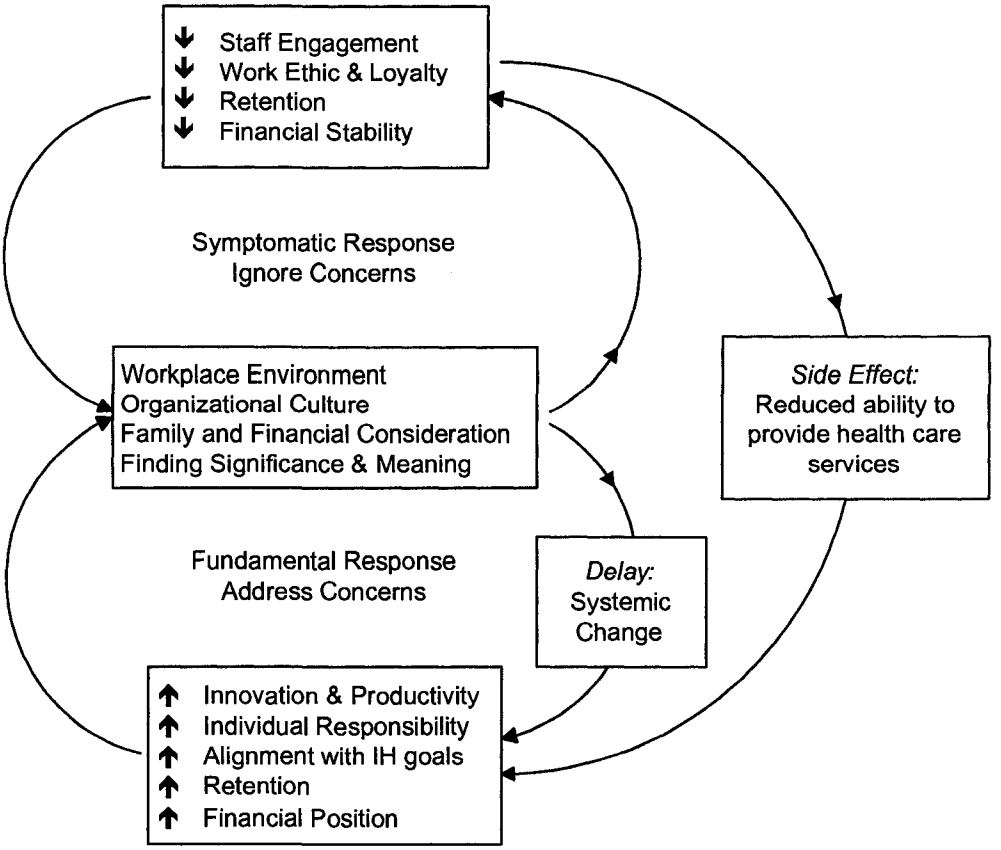

Figure 6: Shifting the burden archetype illustrating ramifications from the four themes

An amplified side effect of this symptomatic response will be the debilitating side effect of a reduced ability to provide health care services. Possible ramifications of this situation could be: (a) a reduction in the range and scope of healthcare services; (b) increased risk and liability issues; (c) increased waitlists for diagnostic and surgical procedures; (d) increased financial demands across the system; (e) possible closures of programs and facilities; and (f) erosion of the health and well-being of the community.

If a fundamental response is applied to address participant concerns discussed in these conceptual themes, the organization will thrive in an environment of engaging work practices; enjoy the retention of competent, qualified, and committed staff; and maintain

financial stability. To implement strategies required for a fundamental response, IH leadership at all levels must inspire a shared vision; model the values of the organization; and empower and respect staff throughout the organization.

In conclusion, I believe my research findings support the underling premise to my research question; that IH can develop strategies that will enhance the level of engagement and retention of mid- to late-career Registered Nurses. Innovations can be implemented to create synergy between the goals of the individual employee and the organization; and employment practices in IH can be improved to utilize the strengths mid- to late-career Registered Nurses bring to the organization. These can be accomplished by attending to issues in the workplace environment, transforming the organizational culture, understanding the financial and family pressures of older nurses, and supporting the individual's ability to finding significance and meaning through aspects of their work in midlife.

Scope and Limitations of Research

The data collected in this research were consistent with other research studies that focused on issues and concerns of older nurses but should not be used to generalize conditions of older nurses beyond this study and organizational setting. The research findings and conclusions also support calls in the literature for increased strategies for the engagement and retention of mid- to late-career Registered Nurses. However, there are limitations to the validity and wide applicability of this research. The data sampling was restricted to participants from one Health Service Area in a large and complex organization. The total number of stakeholders in this study was 14 unique individuals; three categories of participants were represented in the research and the following

percentages indicate the number participants involved from the total sample size in the North Okanagan: (a) 67% of the Program Directors; (b) 38% of the Nurse Managers; and (c) 6% of eligible mid- to late-career Registered Nurses from two of the three areas of practice.

Other factors that may have influenced the research findings were gender and ethnicity. In this study all participants were Caucasian females. There was not an intentional exclusion of males in this study as there were males in both the Nurse Manager and Registered Nurse groups who could have elected to participate, however none did. The North Okanagan does have a multi-ethnic population mix in the Registered Nurse group, but none of these individuals volunteered to participate in the research study. The inclusion of males and/or representatives from other ethnicities in the research study may have resulted in different data being collected, particularly in the 'financial and family considerations' and 'finding significance and meaning' conceptual themes. These differences might have altered the findings and ultimately the conclusions of this report.

The methods of data collection may also have been a limiting factor in this study. The polarity management tool applied to this research was done in a narrow and incomplete approach. Without a wider and more diverse group of participants, a broader discussion and deeper revelations of all the issues could not be discovered. Also inherent in the interview style of data collection methodologies I used is the issue Silverman (1993) describes as "the situated nature of people's accounts" (p. 199). Mishler (as cited by Silverman, 1993) suggests researchers "fail to recognize the problematic analytical status of interview data which are never simply raw but are both situated and textual" (p.

199). Miles and Huberman (1994) also support this stance and advise that "informants will often craft their responses to be amenable to the researcher and to protect their self-interests" (p. 265).

Another limitation in the research is the position I have in the organization; I am a manager in the North Okanagan, but not in the nursing field. As well, I am not privy to the leadership discussions or strategic planning done at higher levels in IH. Therefore, I am not aware of the myriad of strategies addressing engagement and retention issues currently being implemented or considered by experienced and competent corporate staff.

It is prudent to acknowledge once again that the findings and conclusions in this research stem directly from participant comments and concerns; at no time did I attempt to extrapolate other issues or concerns, or interpret data to make a new set of assumptions. The research was designed to explore with various stakeholders their day to day experiences working in IH. Fundamentally, this research is interested in organizations and leadership – not the physiological aspects of aging or financial strategies in retaining and recruiting employees, and as such the data was analyzed within an organizational culture and leadership context.

I will give Silverman (1993) the last word on drawing conclusions. He suggests that researchers should aim "to stay at one level of analysis and to see what you can say about the data at that level, without seeking to resolve philosophical, or occasionally participants', questions about the 'essential' character of 'reality' (p. 198).

CHAPTER FIVE: RESEARCH IMPLICATIONS

Introduction

This section provides recommendations to Interior Health derived from an action research project addressing the research question "How does Interior Health support the engagement and retention of skilled mid- to late-career Registered Nurses who are between the ages of 55 and 64 years and are considering retirement?" The following sub-questions for the project are addressed: "What interventions would create synergy between the personal goals of these employees and the goals of Interior Health?" and "What implications does this have on how Interior Health modifies employment practices to fully utilize mid- to late-career employees?" The research adds to a relatively large body of literature addressing the retention of nurses during current and future shortages of nursing professionals. As the research was conducted in one Health Service Area (the North Okanagan) within Interior Health, further research within IH needs to be done to assure generalizability of the results. IH may extrapolate the basic concepts reflected in the findings, conclusions, and recommendations as applicable to areas outside of nursing within the organization. The literature review contained in this report also provides examples of recent research validating the findings and recommendations made in the report.

Through a hermeneutic dialectic process, research participants consistently identified issues that were organized into four conceptual themes: (a) workplace environment, (b) organizational culture, (c) family and financial considerations, and (d) finding significance and meaning in midlife. Issues discussed in each of these themes directly impacted the engagement of older nurse participants in their work-life and

contributed to their decisions on when they would retire from IH. Retirement decisions also included considerations of whether to return as casual staff or to cancel their registration to practice nursing. The findings and conclusions in Chapter Four were derived from data analyzed through the lens of my research question on engagement and retention of mid- to late-career Registered Nurses. These were subsequently reviewed and validated by the research participants through a feedback loop in the participatory action research process.

This section provides an opportunity to consider mechanisms for addressing: (a) the issues and concerns of mid- to late-career Registered Nurses which impede their engagement and retention; and (b) the apprehensions of the nursing management group regarding nursing shortages. Recommendations to the organization discussed in this section address those issues raised through participant experiences and therefore it can be assumed that the recommendations represent the views of the participants. Recommendations to IH are discussed as fundamental responses to create leverage in changing the organizational culture to produce sustainable organizational systems. This will be followed by a discussion on the organizational implications of these recommendations. A final section in this chapter discusses future research projects that may complement and augment the results of the research project.

Study Recommendations

Using a systems thinking approach to address the research findings offers recommendations that focus on the "structures that underlie complex situations...discerning high from low leverage change...shift[ing] the mind from seeing parts to seeing wholes" (Senge, 1990, p. 69). The conceptual framework of the research

project utilizes Senge's (1990) Shifting the Burden archetype. This lens encourages us to look for leverages where "actions and changes in structure can lead to significant, enduring improvements" (p. 114). This archetype allows for a holistic analysis of issues affecting complex organizations. For instance, to address an organizational issue focused solely on financial parameters is viewed by systems analyst, Donella Meadows (1997) as the least likely area to affect leverage in a complex system. She asserts:

> Numbers are last on my list of leverage points...probably ninety-five percent of our attention goes to numbers, but there's not a lot of power in them....Not that parameters aren't important—they can be, especially in the short term and to the individual who's standing directly in the flow. But they RARELY CHANGE BEHAVIOR. If the system is chronically stagnant, parameter changes rarely kick-start it. If it's wildly variable, they don't usually stabilize it. If it's growing out of control, they don't break it. (9. Numbers section, ¶ 5)

Meadows (1997) suggests leverage points in a complex organization vary in effectiveness; her article lists these leverage points from the least effective to the most effective: (a) numbers; (b) material stocks and flows; (c) regulating negative feedback loops; (d) driving positive feedback loops; (e) information flows; (f) the rules of the system (incentive, punishments, constraints); (g) the power of self-organization; (h) the goals of the system; and (i) the mindset or paradigm out of which the goals, rules, feedback structure arise. Meadows views the organizational mindset or paradigm as the most significant place to affect leverage in the following way:

> There is nothing physical or expensive or even slow about paradigm change. In a single individual it can happen in a millisecond. All it takes is a click of the mind, a new way of seeing....you keep pointing at the anomalies and failures in the old paradigm, you come yourself, loudly, with assurance, from the new one, you insert people with the new paradigm in places of public visibility and power. You don't waste time with reactionaries; rather you work with active change agents and with the vast middle ground of people who are open-minded. (1. The mindset or paradigm out of which the system arises section, ¶ 6)

Figure 7 depicts the Shifting the Burden archetype (Senge, 1990) reflecting the dynamics created around a national shortage of Registered Nurses. It demonstrates how financially-based recruitment programs tend to be symptomatic solutions rather than addressing underlying issues through fundamental solutions applied in an organizational culture of engagement and retention. Nursing positions in IH are currently deemed as "hard to fill" positions and the recently created financially-based incentives and recruitment programs offer immediate short-term strategies or symptomatic responses to this issue.

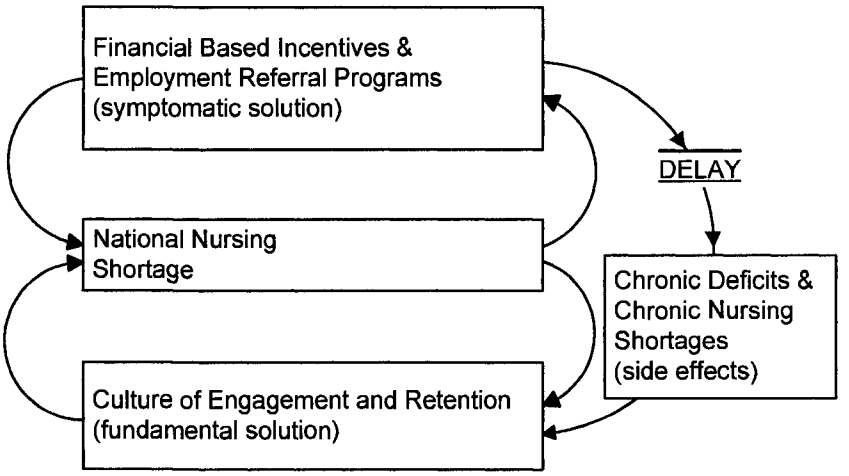

Figure 7: Illustrates the Shifting the Burden archetype during a national nursing shortage.

Within IH symptomatic responses include current incentive programs such as the Employment Referral Program, enhanced relocation allowances, and the discretionary ability of managers to offer increased vacation time for non-contact nursing positions. Relying on these financially based programs over time undermines IH's ability to make the deeper organizational changes required to support a culture of engagement and

retention affecting all staff. The side effects created by applying these symptomatic responses are increasingly larger portions of departmental budgets being allocated to staffing budget overruns. These overruns are created by increased relief, over time, and sick time while waiting for new staff to be hired. Funds to hire, orientate and retain nursing staff will be substantially diminished resulting in a chronic shortage of nursing staff within IH. Continued reliance on purely financially-based approaches to attract new nursing staff has the potential to create increasingly expensive incentive programs. These increased recruitment expenditures may eventually reduce the ability of IH to invest in long-term fundamental responses impacting the organizational culture which would assist in the retention of mid- to late-career Registered Nurses.

Focusing on long-term solutions (fundamental responses) requires a sense of shared vision throughout the organization. By fundamentally addressing issues underlying older nurses' disengagement and retirement, new patterns of sustainability will be created throughout the organization. These new patterns will begin to address a myriad of organizational culture issues and will impact positively on financial stability within IH.

The recommendations provided to IH in this chapter will assist in creating a competitive advantage through long-term 'fundamental responses' to the issues of mid- to late-career nurses; rather than 'symptomatic' or reactive "quick fix" responses producing 'just in time' hiring of new nurses. These recommendations are contained in two broad categories of fundamental responses: (a) Recommendations for an Optimal Workplace Environment; and (b) Recommendations for Organizational Leadership. The

five recommendations put forth in this report address issues research participants deemed as immediate to their engagement and retention as Registered Nurses.

Recommendations for an Optimal Workplace Environment

Recommendation One

It is recommended that the Facilities Management department review existing pressures on identified stressed physical environments in IH. It is proposed that this analysis review current space allocation criteria and current time frames established to address severe space issues affecting front line employees with the goal of attending to deficiencies as soon as possible. Research participants identified inadequate space as a dominate theme affecting their dissatisfaction and disengagement in their work. Lack of space impacted directly on their ability to work safely; as well they dealt with increasing amounts of clutter produced by storage space being converted to work space. It is counter-intuitive to double utilization by halving the physical space currently used for an activity. With mid- to late-career nurses poised to retire, the risk is losing these nurses to retirement while IH prolongs addressing the immediate concerns of over-crowding and clutter due to lack of storage space.

Participants felt the abrupt shift from individual offices to over-crowded open work stations was done without adequate rationale communicated to front line employees who carry out the work. From participants' perspectives, what was gained in accommodation was lost in productivity, efficiency, and in some cases, safety – all factors that directly impact job satisfaction, engagement, and retention.

Recommendation Two

It is recommended that the excellent work of the Workplace Health and Safety department expand to provide ergonomics education sessions at all shared work stations with the special needs of the older worker in mind. Existing education sessions require pre-registration, may only repeated once, and have class size limitations. Increasing ergonomic education opportunities for front line nurses at their work stations is critical to achieve their attendance as staff finds it increasingly difficult to leave their work area. Hands on demonstrations and immediate application of the ergonomic information are an optimal vehicle for learning as a variety of individuals and their immediate concerns would be present. A "Train the Trainer" workshop would assist in providing facilitators for front line training. The benefit of this would be an efficient use of Workplace Health and Safety staff's time and would create a pool of on-site expertise. It is also recommended that provision for telephone support aids such as headsets be investigated for all front line staff communicating with clients for extended periods. This may reduce the potential for muscular strain and injury particularly for older or injured staff, and address expressed concerns for client confidentiality in using speaker phones.

Recommendation Three

It is recommended that Human Resources review current nursing duties and create provisions for mid- to late-career nurses to continue to practice as casuals or in alternate supportive roles in the organization. An important source of information for addressing the debilitating effects of poor job design for older nurses is abundantly found in the research literature. Investigating mechanisms for flexible work options or job sharing tasks that reduce the likelihood of injury or undo stress for the older nurse may

alleviate the option of early retirement in some older nurses. Current labour trends indicate future workforce planning and scheduling processes may need to incorporate strategies for attracting, retaining, and engaging older nurses as well as other employees in many areas of IH.

Recommendations for Organizational Leadership

Throughout the research, participants have expressed concerns and issues directly related to the quality and effectiveness of the leadership they have experienced. In a recent article, Tangri (2007) states:

> Seventy per cent of corporate culture is shaped by leadership, and this is generally modeled by senior leadership...because of the crisis mentality of the past few decades, management had focused more on results and tasks, and less on people skills. This focus created unhealthy workplaces and increased stress. (p. 25)

Attention to leadership issues recommended in this report is predicated on the assumption that IH desires a change in culture. The starting place for this organizational change is a willing to address leadership issues at all levels of the organization. Support for the recommendation to examine the nature of leadership in IH comes from different sources. The first source is the successive survey results provided by Watson Wyatt for 2002, 2003 and 2005 (Watson Wyatt Worldwide 2002; 2003; & 2006) in IH's pursuit to become an 'Organization of Choice'. Findings from each of these surveys indicate there is room for improvement in the alignment and engagement of employee goals with the goals of IH. The second source supporting strategic attention to leadership issues are from research participants in the findings and conclusion section of this research.

Within IH there are examples of outstanding leadership and there are examples, as expressed by research participants, where organizational leadership requires attention.

Senge (1990) supports the premise that "organizations learn only through individuals who learn. Individual learning does not guarantee organizational learning. But without it no organizational learning occurs" (p. 139). The Organizational Learning and Development department has excellent strategies in place to address many of the continuous learning opportunities the research participants identified as contributing to their engagement and retention, but lacks adequate resources to deliver these in a comprehensive and effective way.

Recommendation Four

It is recommended that the Organization Learning and Development department expand education and development programs to the enhance skills for all nurses in a leadership capacity in the organization. Currently, a pilot session for the *Next Generation Nursing Leadership* program includes funding for 19 individuals in the Central Okanagan (Kelowna). This well designed nursing leadership process is a highly effective tool to provide a basis for a people- focused leadership model. To be effective this program requires adequate Organizational Learning and Development staff and resources to reach a critical mass of nursing leaders who would effect organizational change at the front line. This education process supports the current role the research participants have as mentors and coaches for other nurses. Formalizing these leadership skills will facilitate and promote what the participants identified as a desired future culture – one which includes a "self-perpetuation cycle" (participant comment) of mentoring in the organization. The research findings substantiate participant's recognition of the importance of this education from their experiences of having had a mentor in their professional life or feeling fulfilled through their mentoring of other nurses. This

initiative would support participant's desires for "synergistic relationships" (participant comment) to be established throughout the organization.

Recommendation Five

It is recommended that the Senior Executive Team make creating a culture of leadership a high priority in the organization through funding processes for leadership assessments and education across the organization. To do so it is proposed that Human Resources conduct a leadership survey for all leaders at all levels of the organization to assess the following components: (a) their current level of engagement; (b) an evaluation of the time spent on core and non-core job duties; (c) current leadership and personal mastery development organizational leaders feel they require; and (d) methods of measurement and accountability for leadership activities. The results of this survey would be used by the Organizational Learning and Development department to design interventions and education to address gaps and realign trends that appear in the results. This fundamental response needs to be adequately resourced given the size of the organization and the level of penetration required to effect change and shift to a leadership orientated culture.

Research participants expressed throughout the three focus group sessions, their frustrations found in working for IH and their desires for a preferred organizational culture. Participants' comments in this research did not include examples of their alignment with the vision of IH; instead comments often demonstrated a gap between personal and organizational alignment. From this finding I posit the purpose and vision held within the leadership areas of IH are not being embraced by older nurses. Participant comments in this research conveyed minimum enrollment or commitment to a shared

organizational vision, and indicated a resignation to be merely compliant with organizational policies and procedures.

The long-term benefits from investing in enhancing individual leadership capacity will provide IH leverage in attracting staff during shortages, retaining valuable mid- to late-career professionals through a sense of organizational loyalty and work ethic, and provide financial stability in times of possible funding crises. It is only through good leadership that IH will achieve its vision "To set new standards of excellence in the delivery of health services in the Province of British Columbia" (Interior Health, Vision and Mission, 2005).

Organization Implications

Implications of Recommendations One and Two

In the Interior Health 2007/08 – 2009/10 Service Plan (Aiton, 2007), Goal #4 is titled "Engage our Staff, Physicians and Volunteers" (p. 18) and reflects the organization's commitment to all of its associated human resources. IH has created a Healthy Workplace Model demonstrating the integrated aspects of the physical environment, individual health practices, and the work environment in relation to activities used to attract, retain, and engage individuals. Recommendations One and Two – addressing space and clutter and attending to poor workplace ergonomic practices, are directly inline with the IH objective of: "the implementation of strategies for addressing the supply, distribution , education, training, skills, patterns of practice and work environment will be paramount" (Aiton, 2007, p. 18). By following through with Recommendations One and Two, IH will demonstrate its commitment to this goal to

front line staff. This implementation will immediately create a safer environment for older nurses, show value and respect their concerns, and enhance their professional practice. Other expected benefits to IH may be a reduction in injuries, sick time, long term disability, and worker compensation claims. The Workplace Health and Safety department currently addresses these issues to the best of its ability, but it is prudent to note that some participants felt the important work IH departments are currently developing to create a better workplace were not fully reaching them in any meaningful way.

Implications of Recommendation Three

By implementing Recommendation Three – reviewing duties for older nurses and exploring opportunities for alternate roles, IH will create a safe environment for older nurses to utilize their expertise, share tacit knowledge, and remain in the workplace longer. Shifting the culture to respond to the needs of older nurses is predicated on IH having the desire to retain older workers as productive members of their workforce. This requires a re-alignment of intellectual resources and attitudinal shifts in the organization. This requires IH understanding the limitations of any 'symptomatic responses' that focus solely on attracting new younger staff as a strategy to enhance organizational growth and development. Inclusion of the older nurse in IH's vision of an excellent workplace aligns organizational goals with individual goals for finding significance and meaning through continuing to work.

Modifying current nursing job duties and creating alternate roles for the older nurse may require advocating within the collective agreement process. At the 14th Annual General Meeting and Conference of the Health Employers Association of British

Columbia, a presentation on *"Healthy Outcomes" under Industry Collective Agreements* (Sartison, 2007) encourages health care employers to "consider how older workers with age-related disabilities will be accommodated in a flexible, individualized way. Consider modified duties, hours, job requirements or equipment" (p. 7). While collective agreement bargaining processes are a long-term strategy, advocating for these opportunities provides a fundamental response to changing the organizational culture. Work redesign will assist older nurses to remain active in direct patient care by attending to their unique health and wellness needs.

Participants felt the focus for managers appears to have shifted to a business model with the primary goal being saving money and reducing budget deficits rather than supporting exceptional patient care through its professional staff. Alternative roles for older nurses on a full time or part-time basis would address concerns nursing management participants expressed regarding staff shortages, sharing knowledge and creating optimal staff mixes on a shift.

Implications of Recommendation Four

Current literature suggests an effective nursing manager's role is primarily one of people-focused leadership, empowerment, and recognition (Magee Gullatte & Jirasakhiran, 2005; Manion, 2004; Robert Wood Johnson Foundation, 2007; Snow, 2002). Recommendation Four suggests the current resources allocated to the Organizational Learning and Development department are insufficient to affect wide spread organizational change through educational processes. The *New Generation Nursing Leadership* pilot program in IH is an excellent beginning to achieve a culture of people-focused leadership. To build strong leadership and affect engagement and

retention across IH, the number of individuals receiving this education needs to expand exponentially. A quantitative study by Sellgren, Ekvall, and Tomson (2007) regarding the effect of leadership on nursing staff turnover, found:

> In order to decrease staff turnover the goal for the nurse manager must be to develop her leadership behaviour towards a 'super' leadership style. This will help in creating a climate that makes the staff feel engaged in their work, find it stimulating to contribute to the success of the unit and find the work as stimulating and meaningful. In such a climate the staff will feel satisfied and be more likely to stay. (p. 180)

Gibbons' (2006) study of employee engagement in industry found that "employee engagement may be a factor in driving length of services...and drivers that influence engagement may shift as the employee ages" (p. 9). There is no distinct separation between the engagement and retention of older nurses and the engagement and retention of all staff in IH. Engaged staff are staff the organization will retain; developing good leaders is integral to any retention strategy.

The Organizational Learning and Development department must be sufficiently resourced to provide education that impacts the front line staff across IH. Currently there is well designed management educational opportunities through the *Pathways to Leadership* series of workshops aimed at personal and professional growth. Anecdotal feedback from managers regarding these sessions support the value of this education; but also expresses their frustrations at the logistics of attending due to travel, full or cancelled courses, and costs to their budgets. The size and complexity of IH necessitates that a proportional budget and staff compliment within Human Resources is required to develop solid leadership reaching right to the front line nursing staff who are delivering patient care.

Implications of Recommendation Five

Recommendation Five suggests the Senior Executive Team invest heavily in leadership development at many levels in the organization. Extensive research by Welbourne (2007) indicates issues in employee engagement begin with leaders themselves being engaged. Her research found leaders are often working in suboptimal environments which require more personal energy than the leaders have; "the work environment in most organizations is becoming more stressful...and leaders themselves are becoming burned out, confused, and disengaged" (Leader energy and engagement section, ¶ 2). Engagement and long-term performance requires all employees to be involved in both their core job duties and the non-core aspects of their jobs. These non-core activities include: (a) being innovative, (b) participating in teams, (c) improving personal skills and knowledge, and (d) acting as a supportive organizational member. When leaders are unable to be fully engaged in their work Welbourne (2007) suggests a situation results where:

> Leaders are creating or are in an environment where employee engagement will be very difficult to achieve. When leaders are working at an energy level that is suboptimal, and when they have a difficult time merely getting their own jobs done, they will not value nor be interested in anyone engaging in the non-core job roles. (The leader and employee engagement challenge section, ¶ 1)

Blanchard (2007) affirms that "a compelling vision creates a strong culture in which the energy of everyone in the organization is aligned...culture not only underlies all that an organization does but also determines its readiness for change" (p. 23). Without attention to the leadership culture in IH, making specific changes to enable staff to complete only their core job duties will not produce the desired effect of aligning and engaging employees. Senge, Scharmer, Jaworski and Flowers (2004) echo what many

leadership gurus' passionately advocate: "when people in leadership positions begin to serve a vision infused with a larger purpose, their work shifts naturally from producing results to encouraging the growth of people who produce results" (p. 141). Attaining personal alignment of staff at all levels in the organization with IH's vision is a fundamental response that will resonate throughout the organization and result in the ability to attract and retain staff during expected shortages.

To implement many of the recommendations proposed in this research requires a leadership style that is predominately people-focused which ultimately begins with the personal introspection of each individual leader. Senge et al. (2004) believe that:

> When the 'theys' go away and the 'we' shows up, people's awareness and capabilities change....when people who are actually creating a system start to see themselves as the source of their problems, they invariably discover a new capacity to create results they truly desire. (p. 45)

As Quinn (2004) affirms "we have observed that leadership development, like organizational transformation, begins with personal change" (p. 229). This basic truth that individuals are the key to change is postulated in leading edge leadership literature (Blanchard, 2007; Boyatzis & McKee, 2005; Kouzes & Posner, 2002; Schein, 1992; Senge, 1990; Senge et al. 2004; Quinn, 2004; Vaill, 1996; Yukl, 2006). This is reinforced by Anderson and Ackerman Anderson (2001) who state "like it or not, most of the significant changes in organizations today require leaders to attend to culture, behavior, and mindset, including their own" (p. 30). Goleman et al. (2002) also state "leaders can and do make significant, in some cases life-altering, changes in their styles that ripple into their teams and trigger important changes throughout the entire organization" (p. 96).

Continuous leadership development is an activity requiring expertise, commitment, and time. This investment in leadership development within IH will pay

dividends if it is strategic, collaborative, and comprehensive. Senge et al. (2004) discuss the concept of "deeper levels of learning" which are differentiated from routine "reactive learning" (p. 11). In reactive learning "thinking is governed by established mental models and doing is governed by established habits of action" (p. 10). In this model of reactive learning, "executives seek to 'change their organization', as if it were an entity separate from themselves. They then find themselves frustrated when others resist the planned changes, again externalizing the difficulty" (p. 92). By utilizing deeper levels of learning, what is generated is an "increasing awareness of the larger whole – both as it is and as it is evolving – and actions that increasingly become part of creating alternative futures" (p. 11). By applying a 'system thinking' process to the discussion of leadership, the leverages for change in IH will stem from the new possibilities created by reflection, innovation, and a larger sense of intention. This can be summed up by Senge et al. (2004):

> The seeds for this transformation lie in seeing our reality more clearly, without preconceptions and judgments. When we learn to see our part in creating things that we don't like but that are likely to continue, we can begin to develop a different relationship with our "problems"... we become open to what might be possible, and we're inevitably led to the question "So what do we want to create?" But the "we" in this statement is a larger "we". (p. 131)

Summary

The five recommendations in the report will all result in enhanced engagement and retention strategies accommodating mid – to late-career nurses in IH. Most of the recommendations have a substantial investment in leadership development. Shifting the culture of a large and complex organization like Interior Health requires a new approach to leadership which Quinn (2004) refers to as "deep change". Quinn asserts that in a normal state of leadership "the management role tends to be a role of reactive problem

solving, of preserving the hierarchical status quo and minimizing personal risk" (p. 16), and to effect deep change requires developing leaders who will enter a "Fundamental State of Leadership". It is in this state that Quinn suggests "we become more purpose-centered, internally driven, other-focused, and externally open" (p. 21).

To make the types of organizational changes that will (a) motivate and align all staff to IH's vision, purpose and goals, and (b) enable IH to become a competitive employer during times of nursing shortages, will require strong desire and individual commitment at all levels of the organization to shift to this position. Senge et al. (2004) affirm this:

> By reinforcing the separation of people from their problems, problem solving often functions as a way of maintaining the status quo rather than enabling fundamental change. The problem-solving mind-set can be adequate for technical problems. But it can be woefully inadequate for complex human systems, where problems often arise from unquestioned assumptions and deeply habitual ways of acting. Until people start to see their own handprint on such problems, fundamental change rarely occurs. (p. 51)

Long-term financing of initiatives which fundamentally change the nature of the organization will provide the leverages IH needs to survive in a competitive environment. Short-term expenditures aimed at attracting a diminished workforce supply is not a competitive leverage. Investing in people-focused leadership strategies, communication development, continuous learning opportunities, and redesigning work to accommodate the older worker are the leverage points IH can attain. The pursuit of attributes making IH an "organization of choice" is a crucial 'fundamental response' and represents a commitment towards a culture of outstanding leadership.

Implications for Future Research

Organizational culture is reinforced through continuous organizational learning. It would be prudent for IH to understand organizational learning across various disciplines in IH. Crossan, Lane, and White (1999) have developed a framework to explore the relationship of four processes of learning within the structure of three distinct levels of learning in organizations. The interaction of processes such as intuiting, interpreting, integrating, and institutionalizing are linked to the individual, group, and organizational levels used to affect organizational learning.

Crossan, Lane and White (1999) demonstrate how "organizational learning can be conceived as a principal means of achieving the strategic renewal of an enterprise" (p. 522) to enhance competitive advantage. Their research reveals how strategic renewal can be accomplished through organizational learning, but caution:

> Continued investment in individual and even in group learning may be counterproductive if the organization does not have the capacity to absorb or utilize it. If this is the case, future research in organizational learning needs to move from the reasonably well-developed understanding of individual – and group-level learning to understanding the flows of learning between the levels. (p. 535)

It may be relevant to investigate how the four processes - intuiting, interpreting, integrating, and institutionalizing, currently flow through individual, group, and organizational levels in IH. Measuring the success of current organizational learning and development strategies may determine directions for future learning and resources in many sub-cultures within the organization such as older workers, Generation X'ers, and multi-ethnic staff.

Due to the predicted acute shortage of nursing and other professional staff it is not inconceivable that many of our health care workers will come from other countries.

Diversity workshops are currently offered in some areas and it may be prudent that various aspects of diversity continue to be studied and communicated across the organization. IH may find it advantageous to research the impact of multi-cultures within an organizational culture. Specific strategies may be required to attract, engage, and retain multi-ethnic health care workers including job embeddedness, integration into local communities, accommodation of diverse cultural norms and values in the workplace, and clarification of role expectations. In his conclusions on employee engagement, Gibbons (2006) supports this investigation by stating "research clearly reflects widely-varying levels of employee engagement between different countries of the world" (p. 14). This strategy will enable IH to embrace staff diversity within the organization without serious disruption to its culture.

The role of finding significance and meaning in midlife as a factor in engagement and retention is not a phenomena that is well studied in the literature. IH may want to gain an understanding of how these intrinsic individual values may be used to assist in broadly defining strategies to retain older workers. Internal surveys targeting specific demographics may assist IH to proactively develop initiatives that engage older workers. Further research is also needed to investigate leadership characteristics and working conditions to accommodate the needs of older nurses who are naturally tending to self-reflection and evaluation in midlife.

Conclusion

The ideas in this final report are intended to stimulate dialogue, spark creativity, challenge existing paradigms, and most importantly, carry forward the sincere experiences and wishes of a sample of nursing management and older nurses in the North

Okanagan. I believe my research provides numerous ideas to assist IH to engage and retain mid- to late-career Registered Nurses. I indicated some areas research participants felt could create synergy between their personal goals and the goals of IH through attending to specific elements of organizational culture. I have put forth ideas which are supported in the literature for mechanisms to modify the workplace environment to better utilize older nurses. The action research design of this research process "engages people and organizations in discovering what gives life to human systems when they are most effective and constructive and using knowledge to envision and create the preferred future" (Kerka, 2003, ¶ 1).

CHAPTER SIX - LESSONS LEARNED

Embarking on a Masters of Arts in Leadership at this age and stage has been one set of "white water" rapids on my river of life. This journey bears all the hallmarks Vaill (1996) describes in *Learning as a Way of Being*; a "complex, turbulent, changing environment" (p. 4), effective learning through a "high degree of self-direction" (p. 45), and drawing on old and new skills to tap into "creative leaderly learning" (p. 135). My journey has been transformative, enriching my life on many levels. It has taught me how to think critically and apply academic rigor to my writing. Each day moving towards project completion has increased my self-confidence, revealed more of the art of practicing gratitude, and given me the gift of personal fulfillment. Professionally, this journey has channeled my energies to truly lead from behind; trusting that the greatest successes result from the empowerment of others. I can attest that "personal transformation is the greatest challenge of all and demands the deepest commitment...this process of waking ourselves up to more of what is possible is our direct path to leading transformation successfully" (Anderson & Ackerman Anderson, 2001, p. 204). Pursuing my Masters has pushed me into unfamiliar territory and made me stronger for it. What has remained constant throughout this process is the joy and satisfaction I have for developing capacity in others; it is in this arena that I will do my best work.

I have developed an understanding of the differences between leadership and management. I see leadership as an intricate and complex set of concepts that reflect personal values, personal mastery, and personal commitment. Management I believe is utilizing technical expertise in navigating a myriad of changing conditions in the

environment. Choosing to lead or to manage in situations is often a product of our "mental models"; these are the "deeply ingrained assumptions, generalizations, or even pictures or images that influence how we understand the world and how we take action" (Senge, 1990, p. 8). The challenge in leading and managing is confronting old models and embracing new paradigms. There is a role for both leading and managing; and skillful leaders will use both effectively. Throughout this Masters program I have reveled in theories of leadership – going deeper into systems thinking with Senge; delighting in synchronicity with Jaworski; and the appreciating the power of the 'U' Movement with Scharmer (Senge et al. 2004).

Lessons for Conducting Action Research

Action research starts where ever you are and connects you to your subject matter and participants in many ways. The challenge for researchers is to be accepted in your chosen project area by earning the trust of the participants. This research project does not involve my professional peers in the organization, but it represents a group that I am bound to by long organizational tenure and efforts to find significance in my own mid-life. I was sensitive to the fact that my credibility as a researcher in the area of nursing may be an issue and I used this awareness as a guide for designing and conducting my research.

Researchers such as Glesne (2006), Kirby and McKenna (1989), and Stringer (1999) counsel that the goal of action research is to improve conditions for the participants in their situations. As a researcher I became part of the study through my interactions in the focus groups and by regularly reflecting on my own assumptions, biases, and values. I was intrigued how simple the needs of mid- to late-career nurses

were in the organization, yet how complex they would be to meet. The sincerity of participant's experiences and desires impacted me – compelling me to give them a credible voice towards designing a preferred future in the organization. It is my sincere hope I have contributed to improving the situation in Interior Health for mid- to late-career Registered Nurses by collecting their experiences and writing persuasively as a call for action.

Providing the opportunity for all participants to review the findings and conclusions in Chapter Four was vital to the action research process. Participants had the opportunity to confirm that I had accurately captured their words, meanings, and desires. The pitfalls of not doing so were to risk distorting participant's voices to reflect my biases and position. Stringer's (1999) hermeneutic dialectic process resonated with me early in my research project. Using this as a guiding principle in my research consolidated my early learning's from my degree in Social Anthropology. I proudly wear the label of social constructionist, understanding that "our world is shaped by the many dialogues and discourse that we have with one another – conversations in which we both selectively make sense of our past and present experience and history and create shared images of what we anticipate in the future" (Magruder Watkins & Mohr, 2001, p. 28).

The value of involving others through the action research cycle is not to be underestimated; the more involvement participants, advisors and organization members have in the research project, the more authentic and valid the study. Throughout the project my Ethics Advisor provided me with thoughtful questions regarding my methodologies and data analysis to ensure I stayed true to the principles of action

research: by having participants "collectively investigate their own situation, [they] build a consensual vision of their life-world" (Stringer, 1999, p. 11).

I would recommend to novice researchers that the literature review be done prior to conducting data collection and writing the findings and conclusions section of the report. By having an understanding of what other researchers studied and the challenges they faced facilitates your research design, stimulates different sets of questions, and considers information from a new perspective. From my literature review I developed a thread of four strong conceptual themes that provided continuity throughout my writing; these were: (a) workplace environment, (b) organizational culture, (c) family and finances, and (d) finding significance in midlife. Using these themes I had a solid framework that connected my research to the literature and allowed me to organize and meaningfully display my data to draw unbiased conclusions and verify them with participants.

Lessons on the Process of Leading Positive Organizational Change

Leaders are responsible for the cultural preparations necessary for successful change initiatives in organizations. These cultural preparations cannot just be managed; they must be a part of a larger leadership strategy to expose old paradigms and prepare people to positively respond to change. Leadership entails not only creating the concrete steps required to change; it requires understanding, empathy, and modeling your core values. Organizations create the conditions under which the alignment and engagement of all staff either flourishes or fades. Leaders understand the organizational perils that exist in the gaps between disseminating information, implementing strategies, and getting buy-in.

Using Senge's (1990) shifting the burden archetype as a conceptual framework through out the research paper was an important anchor in grounding my thoughts and writing for organizational change. This archetype modeled the various organizational conditions presented in this research to illustrate the consequences of 'quick fixes' or symptomatic responses and contrasted these with the stability created through long-term fundamental responses. Organizational leverages were identified through these models to create recommendations that addressed broader underlying organizational issues. My research is a vehicle for mid- to late-career nurses in Interior Health to respond to the leadership they are receiving; arguably this may be different from what the organization perceives it is providing. My recommendations expose gaps in the system and provide reflection points for the organization to create long term fundamental responses to the engagement and retention of older nurses. The threat of nursing shortages is real; the need to retain the older nurse is critical; the means to do this exist within the actions and culture of the organization.

I spent long hours contemplating my recommendations; determining how to convey the sense of urgency I feel the organization must have regarding the engagement and retention of mid- to late-career nurses. If implemented, I believe my recommendations will assist in changing the culture in Interior Health; they will create a better work-life for all staff, and provide value-added leverage during nursing shortages by retaining experienced nurses.

Using Action Research Productively

Setting up a research project requires attention to detail. Care must be taken in crafting invitations as there is only one opportunity to interest and engage potential

participants. Understanding sampling techniques and the ethics involved in selecting participants is critical to the authenticity of the results of the research. A dilemma I faced was not getting participants from one nursing area of practice that I had targeted in my sample frame. The temptation was to re-send invitations to all targeted nurses from this area of practice. Doing this would have contradicted the random nature of my sample, implied a break in participant confidentiality, and may have appeared coercive. I had to respect the decision of those nurses who 'withdrew' from the research by not accepting the invitation to participate and carry on with nurses who had committed to participate in the research.

An area where I was caught off guard was mailing out the invitations to front line Registered Nurses. To ensure the confidentiality of participants, my Sponsor was responsible for sending out the invitations to the sample of Registered Nurse's targeted for my research. Not being in control of this aspect of my research left me feeling unclear regarding how many invitations were actually mailed; whether they were sent to home or work addresses; and whether all qualified nurses in the sample received an invitation. I discovered the invitations were sent to work addresses which potentially damaged the confidentially around receiving an invitation. All mail for each unit is delivered to a common location; therefore everyone knew who had received an invitation. My advice to novice researchers would be to gather as much information as you can from your Sponsor regarding inviting participants and do not make assumptions on how invitations were issued and to whom.

An area I would do differently would be to pilot all of my questions contained in the focus group sessions. For example, I asked participants in the Learning Circle focus

group to list the personal skills they would like to acquire. The responses I received were a list of the hobbies they were interested in. What I actually had sought were areas of personal competence that participants wanted to develop. The rational for asking for this information was to identify any competencies the organization could provide training for as part of engaging mid – to late-career nurses.

I would also caution researchers to have experience as a participant or facilitator with the methodologies you choose for focus groups. I did not have enough experience with Appreciative Inquiry to understand how long each element would take. I had designed the focus group to review a summary of the two other sessions and have participants complete the Discovery, Dream, Design and Delivery phases all within three hours. This was unattainable within this timeframe and would have resulted in inadequate data collection and a chaotic experience for the participants. Fortunately, early advice from my Sponsor allowed me to revamp the focus group session without compromising the hermeneutic dialectic process and the data I was anticipating collecting.

As I was approaching writing Chapter Four I realized I did not have a solid grounding in qualitative data analysis. I did not have any knowledge of the variety of matrixes that would organize and display my data to assist in writing an accurate and unbiased version of the data. I concur with Miles and Huberman (1994) that "better displays are a major avenue to valid qualitative analysis" (p. 11). Valuable time was spent reading, understanding, and applying information found in the indispensable resource *Qualitative Data Analysis* (Miles & Huberman, 1994). As Miles and Huberman (1994) suggest, early knowledge in these areas would have assisted me in the following areas: (a) designing appropriate instrumentation, (b) influencing my sampling decisions; (c)

clarifying concepts required to write the research; (d) setting priorities for data collection, and (e) displaying data to draw valid conclusions. I suggest this text is a 'must read' in the Master's program to ensure each student receives the same opportunities to enhance their research project.

I feel my research is just the "tip of the ice berg" and I am convinced that a determining factor in the future stability of staffing services in health care will come from retaining one of our greatest assets, the mid- to late-career nurse.

References

Aiton, S. (2007, March). *2007/08 – 2009/10 Service Plan.* Interior Health Authority. Kelowna, B.C.: Author.

Anderson, D., & Ackerman Anderson, L. S. (2001). *Beyond change management: Advanced strategies for today's transformational leaders.* San Francisco, CA: Pfeiffer.

Andrews, J., Manthorpe, J., & Watson, R. (2004). Employment transitions for older nurses: A qualitative study. *Journal of Advanced Nursing, 51*(3), 298 – 306. Retrieved November 8, 2006, from the EBSCO database.

Annis Hammond, S. (1996). *The thin book of appreciative inquiry.* (2nd ed.). Bend, OR: Thin Book.

Baldwin, C., & Linnea, A. (2001). Basic guidelines for calling a circle. Retrieved March 15, 2007, from http:/www.peerspirit.com/

Baldwin, C., & Linnea, A. (2006). *A guide to peerspirit circling.* Langley, WA: PeerSpirit.

Bellman, G. M. (1990). *The consultant's calling: Bringing who you are to what you do.* San Francisco: Jossey-Bass.

Berg, B. L. (2004). *Qualitative research methods for the social sciences* (5th ed.). Boston: Pearson Education.

Berman Brown, R., & Adebayo, S. (2004). Perceptions of work-time and leisure-time among managers and field staff in a UK primary health care trust. *Journal of Nursing Management, 12*(5), 368 – 374. Retrieved November 16, 2006, from the EBSCO database.

Blanchard, K. (Ed.). (2007). *Leading at a higher level.* Upper Saddle River, NJ: Prentice Hall.

Block, P. (2000). *Flawless consulting: A guide to getting your expertise used* (2nd ed.). San Francisco: Jossey-Bass.

Bolman, L., & Deal, T. (2003). *Reframing organizations* (3rd ed.). Toronto, ON: Wiley.

Bonner Curriculum. (n.d.). *Learning circles: An introduction.* Retrieved March 3, 2007, from http://www.bonner.org/resources/modules/modules_pdf/ BonCurFacilLearnCircles.pdf

Boyatzis, R., & McKee, A. (2005). *Resonant leadership.* Boston: Harvard Business School Press.

Buford, B. (1994). *Half time: Changing your game plan from success to significance.* Grand Rapids, MI: Zondervan.

Buford, B. (2007, Winter). Finishing well: How pathfinders transform success to significance. *Leader to Leader, 43.* Retrieved May 23, 2007, from www.leadertoleader.org/knowledgecenter/L2L/winter2007/buford.html

Bulaclac, M. (1996). A work site wellness program. *Nursing Management, 27*(12), 19 – 21. Retrieved November 10, 2006, from the ProQuest database.

Bushe, G. R. (1998). Appreciative inquiry with teams. *The Organization Development Journal, 16*(3), 41-50. Retrieved April 22, 2007, from http://www.gervasebushe.ca/aiteams.htm

CBC News. (2007, April 2). *$4M to retrain older B.C. nurses.* Retrieved April 5, 2007, from http://www.cbc.ca/health/story/2007/04/02/bc-nurses.html

Canadian Council on Health Services Accreditation. (2005). *Accreditation survey report: Interior Health Authority.* Author.

Canadian Institute for Health Information. (2006). *Workforce trends of registered nurses in Canada, 2005.* Author.

Cohen, J. (2006). The aging nursing workforce: How to retain experienced nurses. *Journal of Healthcare Management, 51*(4), 233 – 245. Retrieved November 10, 2006, from the ProQuest database.

Coile, R. (2001). Magnet hospitals use culture, not wages, to solve nursing shortage. *Journal of Healthcare Management, 46*(4), 224 – 227. Retrieved November 10, 2006, from the ProQuest database.

Cooperrider, D., & Whitney, D. (1999). *Appreciative inquiry: Collaborating for change.* San Francisco, CA: Berrett-Koehler Communications.

Crossan, M., Lane, H.W., & White, R.E. (1999). An organization learning framework: From intuition to institution. *The Academy of Management Review, 24*(3), 522-537. Retrieved May 8, 2006, from the JSTOR database.

Cyr, J. (2005). Retaining older hospital nurses and delaying their retirement. *Journal of Nursing Administration, 35*(12), 563 – 567. Retrieved November 17, 2006, from the CINAHL database.

Deluga, R. (1988). The politics of leadership: The relationship between task-people leadership and subordinate influence. *Journal of Organizational Behavior, 9*(4), 359 – 366. Retrieved May 7, 2006, from the JSTOR database.

Demo, D. (1992). The self-concept over time: Research issues and directions. *Annual Review of Sociology, 18*, 303-326. Retrieved May 26, 2007, from the JSTOR database.

Detert, J., Schroeder, R., & Mauriel, J. (2000). A framework for linking culture and improvement initiatives in organizations. *The Academy of Management Review, 25*(4), 850 – 863. Retrieved May 8, 2006, from the JSTOR database.

Dychtwald, K., Erickson, T., & Morison, R. (2006). *Workforce crisis: How to beat the coming shortage of skills and talent.* Boston, MA: Harvard Business School Press.

Eggleston, M., Interior Health Authority Human Resource Strategic Services. (n.d.) *The genesis project: Our quest to become an organization of choice.* Retrieved September 18, 2006, from http://inside.interiorhealth.ca/Employee+Info/Human+Resources

Fletcher, L. (2001). Elder care a concern of aging workforce. *Business Insurance, 35*(10), 3 – 8. Retrieved August 11, 2006, from the EBSCO database.

Geiger-Brown, J., Trinkoff, A., Nielsen, K., Lirtmunlikaporn, S., Brady, B., & Vasquez, E. (2004). Nurses' perception of their work environment, health, and well-being. *AAOHN Journal, 52*(1), 16 – 22. Retrieved November 16, 2006, from the EBSCO database.

Gibbons, J. (2006).*Employee engagement: A review of current research and its implications* (The Conference Board). Retrieved June 25, 2007, from www.conference-board.org

Gifford, B., Zammuto, R., & Goodman, E. (2002). The relationship between hospital unit culture and nurses' quality of work life. *Journal for Healthcare Management, 47*(1), 13 – 26. Retrieved November 10, 2006, from the ProQuest database.

Glesne, C. (2006). *Becoming qualitative researchers: An introduction* (3rd ed.). New York: Longman.

Goleman, D., Boyatzis, R., & McKee, A. (2002). *Primal leadership: Realizing the power of emotional intelligence.* Boston: Harvard Business School Press.

Grossman, S., & Valiga, T. (2005). *The new leadership challenge: Creating the future of nursing.* Philadelphia: F.A. Davis Company

Hammer, L., Neal, M., Newsom, J., Brockwood, K., & Colton, C. (2005). A longitudinal study of the effects of dual-earner couples' utilization of family-friendly workplace supports on work and family outcomes. *Journal of Applied Psychology, 90*(4), 799-810. Retrieved November 8, 2006, from the EBSCO database.

Health Employers Association of British Columbia. Retrieved October 12, 2006, from http://www.heabc.bc.ca

Healy, M. (2001). Management strategies for an aging work force. *AAOHN Journal, 49*(11), 523 – 531. Retrieved December 4, 2006, from the EBSCO database.

Herzberg, F. (2003, January). One more time: How do you motivate employees? *Harvard Business Review, 81*(1). Retrieved May 5, 2006, from the EBSCO database.

Holahan, C. K., Holahan, C. J., & Wonacott, N. (1999). Self-appraisal, life satisfaction, and retrospective life choices across one and three decades. *Psychology and Aging, 14*(2), 238-244. Retrieved May 26, 2007, from the EBSCO database.

Holter, I., & Schwartz-Barcott, D. (1993). Action Research: What is it? How has it been used and how can it be used in nursing? *Journal of Advanced Nursing, 18*(2), 298 – 304. Retrieved December 4, 2006, from the EBSCO database.

Holtom, B., & O'Neill, B. (2004). Job embeddedness: A theoretical foundation for developing a comprehensive nurse retention plan. *Journal of Nursing Administration, 34*(5), 216 – 227. Retrieved November 17, 2006, from the CINAHL database.

Interior Health, Accreditation Office. (2006). Retrieved October 11, 2006, from http://www.interiorhealth.ca/Information

Interior Health, Human Resource Strategic Services. (2006). *People management plan. Draft.*

Interior Health, Okanagan Health Service Area Profile. (2006). Retrieved April 1, 2007, from http:/www.interiorhealth.ca/Information/Reports/Local+Health+Profiles/

Interior Health, Research Ethics Board, (2005).*Application for ethical review.* Retrieved March 28, 2007, from http://www.interiorhealth.ca/Information/Research/Ethics/Apply/Forms+and+Requirement

Interior Health, Retention, (2007). Retrieved February 16, 2007, from http://inside.interiorhealth.ca/Employee+Info/Human+Resources/Retention

Interior Health, Vision and Mission. (2005). Retrieved September 22, 2006, from www.interiorhealth.ca/Information

Interior Health, 2005/06 Key Priorities. (2006). Retrieved September 22, 2006, from http://inside.interiorhealth.ca/News+and+Info/About+Interior+Health/Key+Priorities+and+Projects/Home.htm

Izzo, J., & Withers, P. (2002). Winning employee-retention strategies for today's healthcare organizations. *Healthcare Financial Management, 56*(6), 52 – 57. Retrieved November 16, 2006, from the EBSCO database.

Johnson, B. (1992). *Polarity Management.* Amherst, MA: HRD Press.

Kerka, S. (2003). Appreciative Inquiry. *Educational Resources Information Center, 41.*

Kirby, S., & McKenna, K. (1989). *Experience, research, social change: Methods from the margins.* Toronto, ON: Garamond Press.

Kouzes, J. & Posner, B. (2002) *The leadership challenge* (3rd ed.). San Francisco: Jossey-Bass.

Larkin, M. (2007). Shortage strategies. *Journal of Nursing Administration, 37*(4), 162 – 163. Retrieved May 8, 2007, from the EBSCO database.

Letvak, S. (2002). Retaining the older nurse. *Journal of Nursing Administration, 32*(7/8), 387 – 392. Retrieved November 17, 2006, from the CINAHL database.

Lowe, G. (2006, March). *Making a measurable difference: Evaluation quality of work life interventions.* Retrieved November 16, 2006, from www.cna.aiic.ca

MacKeracher, D. (2004). *Making sense of adult learning* (2nd ed.). Toronto, ON: University of Toronto Press.

Magee Gullatte, M., & Jirasakhiran, E. (2005). Retention and recruitment: Reversing the order. *Clinical Journal of Oncology Nursing, 9*(5), 597 – 604. Retrieved November 8, 2006, from the EBSCO database.

Magruder Watkins, J. & Mohr, B. (2001). *Appreciative inquiry: Change at the speed of imagination.* San Francisco, CA: Jossey-Bass/Pfeiffer.

Manion, J. (2004). Nurture a culture of retention. *Nursing Management, 35*(4), 29 – 39. Retrieved November 10, 2006, from the ProQuest database.

Market, J. (2005). *The need to work: Social and financial considerations effecting the retirement decision.* Paper presented at the meeting of the American Sociological Association, Philadelphia.

Maurer, T. (2001) Career-relevant learning and development, worker age, and beliefs about self-efficacy for development. *Journal of Management, 27*(2), 123 – 140. Retrieved November 13, 2006, from the EBSCO database.

McKenzie, C. (2003). Learning Circles. Retrieved March 15, 2007, from http://www.learningbyheart.com/circles.html

McLennan, M. (2005). Nurses' views on work enabling factors. *Journal of Nursing Administration, 35*(6), 311 – 318. Retrieved November 17, 2006, from the CINAHL database.

Meadows, D. (1997, Winter). Places to intervene in a system. *Whole Earth, 91*, 78 – 84. Retrieved February 13, 2006, from the EBSCO database.

Merriam, S. B., & Caffarella, R. S. (1999). Self-directed learning. In *Learning in adulthood: A comprehensive guide* (2nd ed.). (pp. 288-317). San Francisco: Jossey-Bass.

Meyer, J. (2000). Qualitative research in health care: Using qualitative methods in health care related action research. *BJM,* 320, 178 – 181. Retrieved August 9, 2006, from http://bmj.bmjjournals.con/cgi/reprint/320/7228/178

Miles, M. B. & Huberman, A. M. (1994). *Qualitative data analysis* (2nd ed.). Thousand Oaks, CA: Sage.

Morgan, D. (1997). *Focus groups as qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

Morison, R., Erickson, T., & Dychtwald, K. (2006, March). Managing middlescence. *Harvard Business Review.* 79 – 86.

Morton-Cooper, A. (2000). *Action research in health care.* London: Blackwell Science.

Naumanen, P. (2006). The health promotion of aging workers from the perspective of occupational health professionals. *Public Health Nursing, 23*(1), 37 – 45. Retrieved May 8, 2007, from the EBSCO database.

Newman, K., Maylor, U., & Chansarkar, B. (2002). "The nurse satisfaction, service quality and nurse retention chain": Implications for management of recruitment and retention. *Journal of Management in Medicine, 16*(4), 271 – 291. Retrieved November 10, 2006, from the ProQuest database.

Nogueras, D., (2006). Occupational commitment, education, and experience as a predictor of intent to leave the nursing profession. *Nursing Economic$, 24*(2), 86 – 93. Retrieved November 16, 2006, from the EBSCO database.

O'Connor, D. & Wolfe, D. (1991). From crisis to growth at midlife: Changes in personal paradigm. *Journal of Organizational Behavior, 12*(4), 323-340. Retrieved May 26, 2007, from the JSTOR database.

Osterloh, M., & Frey, B. (2000). Motivation, knowledge transfer, and organizational forms. *Organization Science, 11*(5), 538 – 550. Retrieved May 8, 2006, from the JSTOR database.

Palys, T. (2003). *Research decisions: Quantitative and qualitative perspectives* (3rd ed.). Toronto, ON: Nelson.

Quinn, J. (1978). Job characteristics and early retirement. *Industrial Relations, 17*(3), 315 – 323. Retrieved November 8, 2006, from the EBSCO database.

Quinn, R. (2004). *Building the bridge as you walk on it: A guide for leading change.* San Francisco: Wiley & Sons.

Reineck, C., & Furino, A. (2005). Nursing career fulfillment statistics and statements from registered nurses. *Nursing Economic$, 23*(1), 25 – 30. Retrieved November 16, 2006, from the EBSCO database.

Robert Wood Johnson Foundation. (2006, June). *Wisdom at work: The importance of the older and experienced nurse in the workplace.* Princeton: NJ: Author. Retrieved May 27, 2007, from http://www.rwjf.org/files/publications/other/wisdomatwork.pdf

Roberts, B.W. & Friend, W. (1998). Career momentum in midlife women: Life context, identity, and personality correlates. *Journal of Occupational Health Psychology, 3*(3), 195-208. Retrieved May 26, 2007, from the EBSCO database.

Rosaura Consulting Ltd. (2005). *A staff communications survey – Final report.* Retrieved October 11, 2006, from www.interiorhealth.ca

Ross, S. (2000). What is the value of ethics? [Electronic version]. *API Journal* Retrieved May 8, 2006, from http://www.ethics.org.au/things_to_read/articles_to_read/general_issues/article_0164.shtm

Royal Roads University. (2000). *Policy on Integrity and Misconduct in Research and Scholarship.* Retrieved September 2, 2006, from http://www.royalroads.ca/research/ethical-reviews/integrity-misconduct-policy.htm

Royal Roads University. (2007). *Research Ethics Policy.* Retrieved January 25, 2007, from http://www.royalroads.ca/admissions/code-conduct/research-ethics.htm

Rowan, J. (2000). Research ethics. *International Journal of Psychotherapy, 5*(2), 103 – 111. Retrieved March 31, 2007, from the EBSCO database.

Ryan, G.W., & Bernard, H. R. (2003). *Techniques to identify themes in qualitative data.* Retrieved November 21, 2006, from http://www.analytictech.com/mb870/readings/ryan-bernard_techniques_to_identify_themes_in.htm

Salter, T. (2004). Retirement age: Economic outcome or social choice? Pension flexibility and retirement choice. *Pension, 9*(3), 256 – 274. Retrieved November 8, 2006, from the EBSCO database.

Sartison, D. (2007, June). *Healthy outcomes under industry collective agreements.* Paper presented at HEABC's 14th Annual Meeting and Conference, Vancouver, Canada.

Schein, E. (1992). *Organizational culture and leadership* (2nd. ed.). San Francisco, CA: Jossey-Bass.

Sellgren, S., Ekvall, G., & Tomson, G. (2007). Nursing staff turnover: Does leadership matter? *Leadership in Health Services, 20*(3), 169-183. Retrieved June 2, 2007, from www.emeraldinsight.com/1751-1879htm

Senge, P. M. (1990). *The fifth discipline: The art and practice of the learning organization*. Toronto, ON: Currency.

Senge, P., Scharmer, O., Jaworski, J., & Flowers, B. (2004). *Presence.* New York: Currency.

Shaw, G. (2006, September 16). Employers offer flexible work hours, work-life balance to attract employees. *The Vancouver Sun,* p. G1.

Silverman, D. (1993). *Interpreting qualitative data: Methods for analyzing talk, text and interaction.* Thousand Oaks, CA: Sage.

Sleyster, S. & Waldeck, P. (2006). It's time to redefine the retirement planning paradigm. *Institutional Investor, 40*(1), 8 – 9. Retrieved November 9, 2006, from the EBSCO database.

Snow, J. (2002). Enhancing work climate to improve performance and retain valued employees. *Journal of Nursing Administration, 32*(7/8), 393 – 397. Retrieved November 17, 2006, from the CINAHL database.

Stewart, A., & Ostrove, J. (1998). Women's personality in middle age: Gender, history, and midcourse corrections. *American Psychologist, 53*(11), 1185-1194. Retrieved May 26, 2007, from the EBSCO database.

Stroh, P., & Miller, W.W. (1994). Learning to thrive on paradox. *Training & Development, 48*(9), 28 – 39. Retrieved January 31, 2007, from the ProQuest database.

Stringer, E.T. (1999). *Action research (*2nd ed.). Thousand Oaks, CA: Sage Publications.

Tangri, R. (2007, September). Putting a price on stress. *Canadian Healthcare Manager, 14*(5), 24-25.

Timmermann, S. (2006). Boomers, their aging parents, and their employers: What's changed? *Journal of Financial Service Professionals, 60*(5), 25 – 27. Retrieved September 11, 2006, from the EBSCO database.

Tobin, G. A., & Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing, 48*(4), 388 – 396. Retrieved March 31, 2007, from the EBSCO database.

Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans. 1998 (with 2000, 2002, and 2005 amendments). Retrieved September 2, 2006, from http://www.pre.ethics.gc.ca/english/policystatement/policystatement.cfm

Uhrynuk, B. (2000). *How nurses find meaning in their work.* Unpublished master's thesis, Royal Roads University, Victoria, British Columbia, Canada.

Ulrich, B., Buerhaus, P., Donelan, K., Norman, L., & Dittus, R. (2005). How RNs view the work environment: Results of a national survey of registered nurses. *Journal of Nursing Administration, 35*(9), 389 – 396. Retrieved November 17, 2006, from the CINAHL database.

Vaill, P. B. (1996). *Learning as a way of being: Strategies for survival in a world of permanent white water.* San Francisco: Jossey-Bass.

Watson Wyatt Worldwide. (2002). The best companies to work for in B.C.*: Survey report for Interior Health Authority.* Retrieved November 17, 2007, from http://insidenet.interiorhealth.ca/Employee+Info/Human+Resources/Resources+and+Info/Reports+Data+Survey+Results.htm

Watson Wyatt Worldwide. (2003). IH overall: *Organization of choice 2003.* Retrieved November 17, 2007, from http://insidenet.interiorhealth.ca/Employee+Info/Human+Resources/Resources+and+Info/Reports+Data+Survey+Results.htm

Watson Wyatt Worldwide. (2006, January). *2005 organizational survey: Executive summary of findings.* Retrieved November 17, 2007, from http://insidenet.interiorhealth.ca/Employee+Info/Human+Resources/Resources+and+Info/Reports+Data+Survey+Results.htm

Welbourne, T. (2007). Employee engagement: Beyond the fad and into the executive suite. *Leader to Leader. 44*(Spring), 45 – 51. Retrieved July 3, 2007, from http://leadertoleader.org/leaderbooks/L2L/spring2007/welbourne.html.

Wheatley, M. (2002). When change is out of our control [Electronic version]. *Human Resources for the 21st Century.* Retrieved June 19, 2006, from http://www.margaretwheatley.com/articles/whenchangeisoutofcontrol.html

Wheatley, M. (2005). How is your leadership changing? [Electronic version]. Retrieved June 19, 2006, from http://www.margaretwheatley.com/articles/howisyourleadership.html

Wheatley, M., & Kellner-Rogers, M. (1998). The promise and paradox of community. [Electronic version]. Retrieved February 13, 2006, from http://www.margaretwhealey.com/articles/paradox.html

Wolcott, H. (1990). *Writing up qualitative research.* Newbury Park, CA: Sage.

Yukl, G. (2006). *Leadership in organizations* (RRU Custom Edition, 6th ed.). Upper Saddle River, NJ: Prentice-Hall.

Zeni, J. (2001). A guide to ethical decision making for insider research (epilogue) [Electric version]. Retrieved August 9, 2006, from http://www.writingproject.org/cs/nwpp/print/nwpr/309

Appendix A: Polarity Management Invitation

Invitation to the North Okanagan Program Directors and Nurse Managers
Re: Focus Group Participants

My name is Candis Eikerman. I am enrolled in a Master of Arts in Leadership at Royal Roads University in Victoria B.C. I am currently in the process of conducting a research study on "How does IH, North Okanagan region, support the engagement and retention of skilled mid to late career Registered Nurses who are between the ages of 55 and 64 years and are considering retirement". My research project is being sponsored by Interior Health under the direction of Christine Bonney, Leader, Organizational Learning and Development.

As a Program Director or Nurse Manager in the North Okanagan you have been selected as a potential focus group participant. I am writing to request your participation in one 3-hour focus group. I will investigate the expectations, needs and considerations of mid-career Registered Nurses who are considering early retirement and are between the ages of 55 and 64 years. Using action research methods, my goal is for all stakeholders to co-formulate meaningful practices to address existing roadblocks and create innovative approaches to capture employee engagement and increase retention.

Your participation in this research is completely voluntary and you will have the right to withdraw at any time. In order to assist you in making an informed decision about whether or not you would like to participate in the focus group, it may be helpful to provide you with additional information about the research study and motivation for pursing this research topic.

Currently in IH, an ever increasing amount of operational funding is spent on staffing and overtime budgets; and the role of external recruitment consultants focuses on more creative means to recruit staff in a competitive global market. The goal of my research is to identify leverage points for IH to broadly address current and looming shortages of professional nursing staff. The challenge for IH will be to simultaneously continue to support the financial costs related to existing critical staffing issues in the short-term and investing appropriate resources to identified leverage points for the long-term.

It will be the successful recruitment of scarce professional and skilled human resources that will define the level of health care IH can provide to our communities. Through my research, I hope to assist IH in understanding, engaging and retaining nursing staff from this valuable sector of mid to late career employees.

Related questions which I would ask you to consider in preparation for this focus group are: (a) How does IH engage mid to late career Registered Nurses who have held the same position for the term of their employment? (b) What organizational determinants reinforce these Registered Nurses to remain in their same position over an extended period? (c) What interventions would create synergy between the personal goals of a mid to late career Registered Nurse and the goals of IH? and (d) What implications does this

have on how Interior Health modifies employment practices to fully utilize mid to late career employees?

During this focus group we will discuss the paradox of encouraging the retirement of older nurses in the face of looming shortages of professional nurses. The information created by this discussion will be themed to gain an understanding of what actions could be taken to address this situation within a both/and framework. A summary of this focus group will be will be given to you to verify for accuracy before a final report is written.

I would like to have a total of 8 participants at this focus group session. Should you elect to participate in this focus group, I will confirm by email with you the details of the date, time and location; and I would ask you to review the letter of free and informed consent and confidentiality agreement that you will be asked to sign and bring with you to the focus group.

Prior to commencing the focus group, I will confirm your willingness to participate by asking you to sign and date a consent form. I have enclosed a copy of the consent for you to keep and review. As you review the consent form, please note it addresses the purpose, intended uses, and protection of confidentiality of the data. Please be assured that participation is completely voluntary and if you choose to participate, you do have the right to with draw at any time. Your name will not appear in the data or final report.

This is one of three focus groups involved in this research study. At the end of this focus group I will ask for 4 volunteers to participate in a final focus group session along with 4 representatives from a focus group of front line Registered Nurses who are between the ages of 55 and 64 years who are considering retirement.

The information gathered from this third and final focus group will be used in combination with other data gathered from the two other focus groups to produce a final report. The knowledge gleaned from this research project will be provided to Interior Health with some suggestions for enhancing the retention and engagement of mid to late career Registered Nurses. I will also facilitate this focus group with the assistance of another facilitator.

Only I as the researcher will have access to any of the individual responses from any of the focus groups in order to analyze data and prepare a final report. Dr. Nancy Greer is my Faculty Supervisor and she can provide further details on this research or process, if you wish. You may contact her at xxxxxxx. When the study is complete, if you wish information on the findings, I will gladly make them available to you.

This focus group will be held Monday, June 18, 2007. In order to maintain a level of confidentiality for the focus group participants, I will provide you with the location of this focus group when you confirm your participation with me. I will have a light continental breakfast ready for 8:30 am, and we will start the focus group session at 9:00 am and finish up at 12:00. Carole Falkner will be assisting me as co-facilitator for this focus group.

If you have any questions or concerns associated with any aspect of the research process you are welcome to call me in advance by telephone or email me at the address below.

Please call or email me by within 3 days of receiving this invitation to register your participation in this focus group.

Candis Eikerman
xxxxxxx
xxxxxxxxx@xxxxxx

In closing, I would like to genuinely thank you for taking the time out of your busy workday to read this correspondence and I look forward to hearing from you at your earliest convenience.

Yours truly,

Candis Eikerman
Researcher

Appendix B: Polarity Management Consent

Consent Form for Program Director/Nurse Manager
Focus Group Participants

Research Proposal:
"How does IH, North Okanagan region, support the engagement and retention of skilled mid to late career Registered Nurses who are between the ages of 55 and 64 years and are considering retirement?"

Researcher:
Candis Eikerman, MA Leadership candidate, Royal Roads University.

Facility Supervisor:
Dr. Nancy Greer, Royal Roads University

Project Sponsor:
Christine Bonney, Leader, Organizational Learning and Development, Interior Health

This project is designed to investigate the expectations, needs and considerations of mid to late career Registered Nurses in Interior Health, North Okanagan region, who are considering retirement and are between the ages of 55 and 64 years. This is one of three focus groups involved in this research study. At the end of this focus group I will ask for 4 volunteers to participate in a third and final joint focus group session along with 4 representatives from the focus group of front line Registered Nurses between the ages of 55 and 64 year who are considering retirement. Using qualitative action research methods my goal is for all stakeholders to co-formulate meaningful practices to address existing roadblocks and create innovative approaches to capture employee engagement and increase retention.

The information gathered from this focus group will be used in combination with other data gathered from the two other focus groups to produce a final report. The knowledge gleaned from this research project will be provided to Interior Health with some suggestions for enhancing the retention and engagement of mid to late career Registered Nurses. I will facilitate this focus group with the assistance of another facilitator.

Please read the following information carefully and sign it if you give your consent to participate in the study.

You will participate in a three hour focus group with seven other members of the Program Director/Nurse Manager team in the North Okanagan. The focus group will be conducted in a room that is private and quiet and will be facilitated by me and another facilitator. Your participation is completely voluntary and you will have the right to withdraw at any time.

During this focus group we will discuss the paradox of encouraging the retirement of older nurses in the face of looming shortages of professional nurses. The information created by this discussion will be themed to gain an understanding of what actions are could be taken to address this situation within a both/and framework. A summary of this focus group will be will be given to you to verify for accuracy before a final report is written.

Related questions which I would ask you to consider in preparation for this focus group are: (a) How does IH engage mid to late career Registered Nurses who have held the same position for the term of their employment? (b) What organizational determinants reinforce these Registered Nurses to remain in their same position over an extended period? (c) What interventions would create synergy between the personal goals of a mid to late career Registered Nurse and the goals of IH? and (d) What implications does this have on how Interior Health modifies employment practices to fully utilize mid to late career employees?

Loss of anonymity will occur for all participants of this focus group, however, all participants, the researcher and facilitator will keep all focus group data and conversations entirely confidential. Your identity will not be used in the data or final report.

All notes and analysis of the data will be kept under lock and key and destroyed after the final report is published. These will be kept strictly confidential. Only the researcher will have access to the individual responses to analyze data and prepare a final report. Dr. Nancy Greer is my Faculty Supervisor you are welcome to contact her regarding this study. Her email address is provided below.

This study is a scholarly inquiry, for the purpose of contributing to knowledge about engagement and retention of mid to late career nurses. The findings will be presented in a scholarly report and presentations. In addition, a summary of the study will be made available to all participants at the end of the project. The final copy of the project report will be housed at Royal Roads University and will be available on-line.

Please feel free to contact me at any time if you have further questions concerning matters relating to this research.

Candis Eikerman, M.A. Leadership Candidate
Royal Roads University, Victoria B.C.

E-Mail : xxxxxxx@xxxxxxx
Telephone: xxxxxxx

Your signature indicates that you understand to your satisfaction the nature of your participation in this research study, and that you agree to participate.

I hereby affirm that I will not communicate or in any manner disclose publicly information discussed during the course of this focus group. I agree not to talk about material relating to this study or this focus group with anyone outside of my fellow focus group members, the facilitator, or the researcher.

_____ _____

Participant Date

_____ _____

Researcher Date

This study has been designed to comply with the Royal Roads University Research Ethics Policy. If you have any questions related to the ethical procedures governing this research, you may contact Dr. Nancy Greer at xxxxxxxx.

If you have any concerns about your treatment or rights as a research subject, please contact the Chair of the Research Ethics Board of Interior Health through the Office of Research Services at xxxxxxxxx

A copy of this consent form has been given to you to keep for your records and reference.

Appendix C: Letter of Invitation to Participate in a Learning Circle

You are invited, on a purely voluntary basis, to participate in a research study that is looking at issues of "How does IH, North Okanagan region, support the engagement and retention of skilled mid to late career Registered Nurses who are between the ages of 55 and 64 years and are considering retirement?" Candis Eikerman is conducting this study in partial fulfillment of her requirements for a MA in Leadership degree from Royal Roads University. This research project is being sponsored by Interior Health under the direction of me, Christine Bonney, Leader, Organizational Learning and Development.

This focus group will be in the design of a Learning Circle where participants will share thoughts and feelings about the profession of nursing and how Interior Health could support you as a skilled professional to remain engaged in the workforce. The entire research study also includes two other focus groups; one involving Program Directors and Nurse Managers, and a final group involving representatives taken from each of the previous two focus groups.

The Learning Circle will be 3 hours long and will be held at a quiet location during which time participants will have the opportunity to share thoughts, experiences and ideas related to these issues:

- your feelings about the nursing profession
- envisioning what your role would look like if you prolonged your career
- what professional development you would need to fulfill this new role
- what personal skills would you like to enhance

Your personal experiences are important for this study. We are asking your assistance to make a positive difference in the working lives of Registered Nurses by giving your dreams a voice. We hope you will feel a sense of contributing to your profession from using your experiences to help other RN's who will come after you. As well, your participation will provide meaningful input towards organizational change. During the Learning Circle you will join your peers in discussing practices that will address existing roadblocks and explore innovative approaches to capture employee engagement and increase retention.

Your participation is completely voluntary and on the day of the Learning Circle you may speak or not as you choose in the Learning Circle. You will have the right to withdraw at any time. The Learning Circle session will be tape recorded by a co-facilitator to maintain accuracy and produce verifiable data for the research. A transcription of the session will be sent to you to verify your portion for accuracy before a final report is written; this will likely take one more hour of your time at your own convenience.

In the transcription of the tape recording you will be given a pseudonym and your name will not appear in the transcription or in any other material used in the research. All responses will be kept completely anonymous within the final project report and are strictly confidential. Once the study is complete, Candis will provide you with an opportunity to view the results of the study.

Only Candis as the researcher will have access to any of the individual responses from any of the focus groups to analyze data and prepare a final report. Dr. Nancy Greer is the Faculty Supervisor for this research study and she can provide further details on this research or process if you wish. You may contact her at xxxxxxxx.

It is hard to keep a sense of anonymity in a group setting such as this Learning Circle, however, it is imperative that the participants, researcher and co-facilitator will keep all focus group information and conversations entirely confidential. The information gathered from this Learning Circle will be used in combination with other data gathered from the two other focus groups to identify any patterns of roles changes, personal and professional development opportunities, and the organizational support required.

Candis would like to have 9 volunteers for the Learning Circle. If you are considering retiring before the age of 64 years and are willing to participate in this study, please contact Candis Eikerman by phone or email at the address below within 3 days of receiving this invitation. Please understand there will be no remuneration offered or provided to you for your participation in this research.

This Learning Circle will be held Wednesday, July 4, 2007. There will be a light continental breakfast ready for 8:30 am and Candis will start the Learning Circle at 9:00 and finish up at 12:00. In order to maintain a level of confidentiality for this focus group, Candis will provide you with the location of the session when you confirm your participation with her. Should you elect to participate in this Learning Circle and respond to this invitation, Candis will email or mail you the location of the Learning Circle focus group, a few reflection questions, and a letter of free and informed consent that you will be asked to review. You will sign a copy of this informed consent form at the Learning Circle session. Enclosed is some information on Learning Circles.

If you have any questions, please feel free to contact me via email or phone:

Please call or email Candis within 3 days of receiving this invitation to register your participation in this Learning Circle focus group.

Candis Eikerman
xxxxxx
xxxxxxx@xxxxxxx

Yours very truly,
Christine Bonney, Project Sponsor
Leader, Organizational Learning and Development
Interior Health
xxxxxxxx
xxxxxxxx@xxxxxxx

encl. Learning Circle handout

Appendix D: Learning Circle Consent

Free and Informed Consent Form for the Learning Circle

Investigator: Candis Eikerman

Faculty Supervisor: Dr. Nancy Greer

Dear Participant,

Thank you for volunteering to participate in this Learning Circle for my major research project.

The purpose of this study is to look at the issues of "How does IH, North Okanagan region, support the engagement and retention of skilled mid-career Registered Nurses who are between the ages of 55 and 64 years and are considering retirement". I am conducting this study in partial fulfillment of the requirements for a MA in Leadership degree from Royal Roads University.

On Wednesday, July 4, 2007 from 9:00 - 1200 a Learning Circle will be held at the Noric House Board Room during which you will have the opportunity to share your thoughts and ideas related to these issues:

- your feelings about the nursing profession
- envisioning what your role would look like if you prolonged your career
- what professional development you would need to fulfill this new role
- what personal skills would you like to enhance

The information gathered from this Learning Circle will be used in combination with other data gathered from two other focus groups to identify any patterns of roles changes, personal and professional development, and the organizational support required. The knowledge gleaned from this research project will be provided to Interior Health with some suggestions for enhancing the retention and engagement of mid to late career Registered Nurses.

Your participation is completely voluntary and on the day of the Learning Circle you may speak or not as you choose. You will have the right to withdraw at any time. The Learning Circle will take approximately three hours. The Learning Circle session will be tape recorded by a facilitator to maintain accuracy and produce verifiable data. If you elect to withdraw during the course of the circle, your responses will be kept out of the transcriptions and not included in the study in any way. A transcription of the session will be given to you to verify for accuracy before a final report is written.

Although anonymity is lost during the actual circle experience, each participant will be asked to keep confidential the content of the circle by signing this informed consent and agreement of confidentiality letter. For the purpose of the transcription of the tape recording you will be given a pseudonym and your name will not appear in the transcription or in any other material used in the research. All responses will be kept completely anonymous within the final project report and are strictly confidential. You

will have an opportunity to review a draft of the final report to validate that your anonymity has been protected.

The tape recordings and all notes and analysis of the data will be kept under lock and key and will be destroyed after the final report is published. These will be kept strictly confidential. Only I as the researcher will have access to your individual responses to analyze data and prepare a final report. Dr. Nancy Greer is my Faculty Supervisor and I can provide details, if you wish to contact her regarding this study at xxxxxxxxx. The final copy of the project report will be housed at Royal Roads University and will be published on-line.

By signing this letter, it is understood that you agree to having read the above information and are freely consenting to participate in the study and commit to maintain the confidentiality of the other participants in the group. If you have any questions please contact me at xxxxx or email me at the following address: xxxxxxxxxx. Enclosed is some information on the structure and intent of a Learning Circle.

Please sign this letter of free and informed consent and bring it with you to the circle on

---

I hereby affirm that I will not communicate or in any manner disclose publicly information discussed during the course of this Learning Circle focus group. I agree not to talk about material relating to this study or this focus group with anyone outside of my fellow focus group members, the facilitator, or the researcher.

Name:

Signature:

Date:

Researcher Signature: *Date:*

If you have any concerns about your treatment or rights as a research subject, please contact the Chair of the Interior Health Research Ethics Board through the Office of Research Services at xxxxxxxx

A copy of this consent from will been given to you to keep for your records and reference

Appendix E: Concluding Thoughts Template

This document was modified for each focus group session as listed below:

Focus Group Polarity Management: "Understanding the paradox of retiring mid to late career RN's in times of projected nurse shortages."

1. Has this morning's session changed your thinking? How?
2. Has this session enhanced your understanding of mid - to late-career RN within Interior Health?
3. How will you use this morning's conversation to further your profession?

Focus Group Learning Circle:

1. Has this morning's session changed your thinking? How?
2. Has this session enhanced your understanding of mid- to late-career RN's within Interior Health?
3. How will you use this morning's conversation to further your profession?

Focus Group Appreciative Inquiry:

1. Has this morning's session changed your thinking? How?
2. Has this session enhanced your understanding of mid- to late-career RN's within Interior Health?
3. How will you use this morning's conversation to further your profession?

Appendix F: Consent Form for Appreciative Inquiry Focus Group Participants

Research Proposal:
"How does IH, North Okanagan region, support the engagement and retention of skilled mid-career Registered Nurses who are between the ages of 55 and 64 years and are considering early retirement?"

Researcher:
Candis Eikerman, MA Leadership candidate, Royal Roads University.

Facility Supervisor:
Dr. Nancy Greer, Royal Roads University

Project Sponsor:
Christine Bonney, Leader, Organizational Learning and Development, Interior Health

This is the third and final focus group involved in this research study. This focus group consists of representatives who volunteered from the first two focus group sessions in my research. Using qualitative action research methods my goal is for all stakeholders to co-formulate meaningful practices to address existing roadblocks and create innovative approaches to capture employee engagement and increase retention. The information gathered from this third focus group will be used in combination with other data gathered from the two other focus groups to produce a final report. The knowledge gleaned from this research project will be provided to Interior Health with some suggestions for enhancing the retention and engagement of mid-career Registered Nurses.

Please read this section carefully and sign it if you give your consent to participate in the study.

You will participate in a 3-hour focus group consisting of three representatives of the Program Director/Nurse Manager group and three representatives who volunteered from the first focus group of front line Registered Nurses between the ages of 55 and 64 years who are considering early retirement. All members of this group work for Interior Health, North Okanagan region. The focus group will be conducted in a room that is private and quiet and will be facilitated by me and another facilitator. Your participation is completely voluntary and you will have the right to withdraw at any time.

This focus group will hear summaries of the first two focus groups and will start their conversations from this point. The focus group will be facilitated in an Appreciative Inquiry framework and we will work through the Discover and Dream stages of the process (Cooperrider and Whitney, 1999). The Discovery stage is about appreciating the best of the current situation; and the Dream stage takes us through envisioning all the possibilities of what could be. The facilitator will lead the focus group through these two stages designed to identify commonalities and differences between all points of view and question the current reality of mid-career nurse engagement and retention. Together the

participants will craft challenging questions which will used to build towards create positive change for IH.

Loss of anonymity will occur for all participants within this focus group; however, all participants, the researcher and the facilitator will keep all focus group data and conversations entirely confidential. Your identity will not be used in the data or final report. You will also be asked to sign a group confidentiality agreement at the time of the focus group.

All notes and analysis of the data will be kept under lock and key and destroyed after the final report is published. These will be kept strictly confidential. Only the researcher will have access to the individual responses to analyze data and prepare a final report. Dr. Nancy Greer is my Faculty Supervisor and you are welcome to contact her regarding this study.

This study is a scholarly inquiry, for the purpose of contributing to knowledge about *engagement and retention of mid-career nurses*. The findings will be presented in a scholarly report and presentations. In addition, a summary of the study will be made available to all participants at the end of the project.

Your signature below indicates that you understand to your satisfaction the nature of your participation in this research study, and that you agree to participate.

I hereby affirm that I will not communicate or in any manner disclose publicly information discussed during the course of this focus group. I agree not to talk about material relating to this study or this focus group with anyone outside of my fellow focus group members, the facilitator, or the researcher.

_____ _____

Participant Date

_____ _____

Researcher Date

Please feel free to contact the researcher at any time if you have further questions concerning matters relating to this research.

Candis Eikerman M.A. Leadership candidate
Royal Roads University, Victoria B.C.
E-Mail : xxxxxxxxxx
Telephone: xxxxxxxx

This study has been designed to comply with the Royal Roads University Research Ethics Policy. If you have any questions related to the ethical procedures governing this research, you may contact Dr. Nancy Greer at xxxxxxxx

If you have any concerns about your treatment or rights as a research subject, please contact the Chair of the Research Ethic Board in Interior Health through the Office of Research Services at xxxxxxx

A copy of this consent from has been given to you to keep for your records and reference

Appendix G: Polarity Map - Nursing Management Focus Group

"What are the positive aspects of having mid - to late-career RN's on the unit?"

L+	R+
Positive outcomes from focusing on the retirement of mid- to late-career RN's	Positive outcomes from engaging and retaining mid - to late-career RN's
Retirement	Engagement and Retention
L-	R-
Negative outcomes from only focusing on retirement of mid - to late-career RN's and neglecting their engagement and retention	Negative outcome from focusing only on the engagement and retention of mid - to late-career RN's and neglecting their retirement

Appendix H: Questions for the Polarity Management Focus Group

DIAGNOSIS and PRESCRIPTION (Flip Chart Question)

- In which quadrant is Interior Health located in now?
- Who is "crusading"? (Names/groups) Wanting to move from the downside to the opposite pole. What are they critical of? (in one lower quadrant) What are they promoting? (in corresponding diagonal upper quadrant)
- Who is "tradition-bearing"? (Names/groups) Wanting to preserve what is good about the present, staying in the upside of the present pole. What are they afraid of losing? (other upper quadrant) What are they afraid the crusade will lead to? (in the other lower quadrant)
- What is the fallout if the Crusaders prevail? What is the fallout if the Tradition-Bearers prevail?
- What communication systems need to be in place to alert IH when we are sliding into one downside?
- What practices in IH would be in place if this polarity was being well managed? (moving between the upper 2 quadrants). What could move us to these now?

Appendix I: Focus Group Questions

Focus Group – Program Directors and Nurse Managers

In the invitation I will ask these participants to consider the following related questions: (a) How does IH engage mid – to late-career Registered Nurses who have held the same position for the term of their employment? (b) What organizational determinants reinforce these Registered Nurses to remain in their same position over an extended period? (c) What interventions would create synergy between the personal goals of a mid-career Registered Nurse and the goals of IH? and (d) What implications does this have on how Interior Health modifies employment practices to fully utilize mid-career employees?

This session will have the following questions posed to the participants:

1. What do you feel mid – to late-career nurses would like to do with their remaining years in the profession?
2. How do we reconcile the paradox of encouraging the retirement of older nurses in the face of looming shortages of professional nurses?
3. What actions need to be taken by Interior Health to address this situation?

Focus Group – Learning Circle

The Learning Circle invitations will include the following questions for them to think about in preparation for the Learning Circle experience: (a) their feelings about the nursing profession, (b) envisioning their role if they prolonged their nursing career, (c) what professional development they would need to fulfill this new role, and (d) what personal skills would they like to enhance.
At the Learning Circle, I will start off the circle with a general statement and as the circle proceeds the conversation evolves from what has been said by others.

These are the three questions I will insert into the conversation::

1. "What I love best about my job is……..".
2. "I think I could use my skills to benefit my profession in a way that would…."
3. "What help from the organization I would need to do this would be……."

Focus Group –Registered Nurses and Program Directors/Nurse Manager Representatives

The final focus group will consider the question: "How can IH support the retention and engagement of Registered Nurses considering early retirement?"

This session will have the following questions posed to the participants:

1. What currently works well in supporting the retention and engagement of registered nurses between the ages of 55 and 64 years?
2. What are the most important contributions that mid – to late-career RN's bring to the workplace?
3. What are the role possibilities for mid – to late-career RN's in order to engage and retain them and at the same time would bring positive changes for IH?

Appendix J: Basic Guidelines for Calling a Circle

This handout is a gift from PeerSpirit, Inc. an educational company devoted to building communities of reflection, adventure and purpose. Founded in 1994, PeerSpirit has taught circle process in the US, Canada, Europe and Africa. It is a consortium consisting of Christina Baldwin, Ann Linnea and teaching colleagues with areas of expertise in health care administration, religious/church administration and congregational health, education, nonprofit boards, environmental and community revisioning. See:www.peerspirit.com

The circle, or council, is an ancient form of meeting that has gathered human beings into respectful conversation for thousands of years. The circle has served as the foundation for many cultures.

What transforms a meeting into a circle is the willingness of people to shift from informal socializing or opinionated discussion into a receptive attitude of thoughtful speaking and deep listening and to embody and practice the structures outlined here.

THE COMPONENTS OF THE CIRCLE

- Intention
- Welcome Start-point
- Center and Check-in/Greeting
- Agreements
- Three Principles and Three Practices
- Guardian of process
- Check-out and Farewell

INTENTION

Intention shapes the circle and determines who will come, how long the circle will meet, and what kinds of outcomes are to be expected. The caller of the circle spends time articulating intention and invitation.

WELCOME OR START-POINT

Once people have gathered, it is helpful for the host, or a volunteer participant, to begin the circle with a gesture that shifts people's attention from social space to council space. This gesture of welcome may be a moment of silence, reading a
poem, or listening to a song--whatever invites centering.

ESTABLISHING THE CENTER

The center of a circle is like the hub of a wheel: all energies pass through it, and it holds the rim together. To help people remember how the hub helps the group, the center of a circle usually holds objects that represent the intention of the circle. Any symbol that fits this purpose or adds beauty will serve: flowers, a bowl or basket, a candle

CHECK-IN/GREETING
Check-in helps people into a frame of mind for council and reminds everyone of their commitment to the expressed intention. It insures that people are truly present. Verbal sharing, especially a brief story, weaves the interpersonal net.

Check-in usually starts with a volunteer and proceeds around the circle. If an individual is not ready to speak, the turn is passed and another opportunity is offered after others have spoken. Sometimes people place individual objects in the center as a way of signifying their presence and relationship to the intention.

SETTING CIRCLE AGREEMENTS:
The use of agreements allows all members to have a free and profound exchange, to respect a diversity of views, and to share responsibility for the well being and direction of the group. Agreements often used include:

- We will hold stories or personal material in confidentiality.
- We listen to each other with compassion and curiosity.
- We ask for what we need and offer what we can.
- We agree to employ a group guardian to watch our need, timing, and energy.
- We agree to pause at a signal, and to call for that signal when we feel the need to pause.

THREE PRINCIPLES:
The circle is an all leader group.

1. **Leadership rotates** among all circle members.
2. **Responsibility is shared** for the quality of experience.
3. People **place ultimate reliance on inspiration** (or spirit), rather than on any personal agenda.

THREE PRACTICES:
1. To speak with intention: noting what has relevance to the conversation in the moment.
2. To listen with attention: respectful of the learning process for all members of the group.
3. To tend the well being of the circle: remaining **aware of the impact** of our contributions.

FORMS OF COUNCIL:
The circle commonly uses three forms of council: talking piece, conversation and reflection. *Talking piece council* is often used as part of check-in, check-out, and whenever there is a desire to slow down the conversation, collect all voices and contributions, and be able to speak without interruption. *Conversation council* is often used to when reaction,

interaction, and an interjection of new ideas, thoughts and opinions are needed. *Reflection, or Silent council* gives each member time and space to reflect on what is occurring, or needs to occur, in the course of a meeting.

Silence may be called so that each person can consider the role or impact they are having on the group, or to help the group realign with their intention, or to sit with a question until there is clarity.

GUARDIAN

The single most important tool for aiding self-governance and bringing the circle back to intention is the role of the guardian. To provide a guardian, one circle member at a time volunteers to watch and safeguard group energy and observe the circle's process. The guardian usually employs a gentle noisemaker, such as a chime, bell, or rattle, that signals everyone to stop action, take a breath, rest in a space of silence. Then the guardian makes this signal again and speaks to why he/she called the pause. Any member may call for a pause.

CHECKOUT AND FAREWELL

At the close of a circle meeting, it is important to allow a few minutes for each person to comment on what they learned, or what stays in their heart and mind as they leave. Closing the circle by checking out provides a formal end to the meeting, a chance for members to reflect on what has transpired, and to pick up objects if they have placed something in the center. As people shift from council space to social space or private time, they release each other from the intensity of attention being in circle requires. Often after check-out, the host, guardian, or a volunteer will offer a few inspirational words of farewell, or signal a few seconds of silence before the circle is released.

May your circles be great teachers and places to rest on the journey.

Appendix K: Researcher Notes Appreciative Inquiry Focus Group

Act as facilitators pulling more info out – help them focus on deeper levels of feelings

9:45 – 10:00 Discover Stage:
Break into three dyads of: Autumn & Celeste; Spring & Winter; Fall & Summer
Set at separate tables with flip chart paper and pens on table

1. One person shares peak experience and the other listens and writes down significant items of information.
2. Share your story with feelings of: "Describe the time you felt you contributed your best quality work or practices – something you were proud of or really made a difference at work." (Flip Chart 13)
3. Switch at 7 mins each

10:00 – 10:25 Discover Stage:
Mix group into two Trio's of: Autumn, Winter & Celeste; Spring, Summer & Fall
Set at separate table with flip chart paper and pens on table
One speaker, one recorder, and one interviewer prompting for deeper expressions of how this made that person feel. (key concept)

1. Share your story of: "A time when someone within the organization really engaged you or encouraged you in your work?" (Flip Chart 14)
2. Recorder: Write down main categories/significant items as the story unfolds
3. Switch at 8 mins each.

10:25 – 10:40 BREAK

10:40 – 11:00 Discover Stage:
1. Come back together in trio's and together theme all of the flip charts onto one – 5 mins
2. Have a representative of each trio present their flip chart of themes giving some background
   Presentation 1 – 5 mins
   Presentation 2 – 5 mins
3. Pull both into one document of 4 – 5 Major Themes – 5 mins

11:00 – 11:50 Dream Stage – Possibility Conversations: (Flip Chart 15 - 16)
Back to the two trios: Using the major themes the group has selected,
1. Develop provocative propositions for the future – Answer these questions:
   - What would the very best place to work feel like? AND-
   - How will you structure/add to your work-life to create that feeling from now on?
2. Any TECHNIQUE to capture your dream: write a story or a series of statements OR draw picture (metaphor) and write a story or statements (35 mins)
3. Start each story or statement with Exceptional Engagement Is…..
4. Share these statements with the group (7 mins each)

Appendix L: Contact Summary Form

Focus Group Session:
Participants:
Date:

SALIENT POINTS/ MAIN ISSUES	THEMES

CONCERNS and CONCLUSIONS:

Appendix M: Thematic Conceptual Matrix

Impact of Conditions on the Engagement and Retention of Mid- to Late-Career RN's

1.0 Conceptual Theme: Workplace Environment

Sub Theme	Dissatisfiers	Satisfiers	Impact on Engagement	Impact on Retention
Physical Environment				
Contractual Aspects				
Peer Support				
Concerns for Patient/Client				
Health and Wellness				

2.0 Conceptual Theme: Organizational Culture

Sub Theme	Dissatisfiers	Satisfiers	Impact on Engagement	Impact on Retention
Leadership				
Learning and Development				
Mentoring				
Recognition				

3.0 Conceptual Theme: Family and Financial Pressures

Sub Theme	Dissatisfiers	Satisfiers	Impact on Engagement	Impact on Retention
Financial Considerations				
Spousal Influences				

4.0 Conceptual Theme: Finding Significance and Meaning

Sub Theme	Dissatisfiers	Satisfiers	Impact on Engagement	Impact on Retention
Role Identification / Love of Nursing				
Self-Awareness and Reflection				
Hobbies and Interests				

Appendix N: Definitions of Conceptual Themes and Sub Themes

1.0 Workplace Environment

Defines the context of employment, the nature of the job, and the conditions under which the work is performed.

1.1 Physical Environment: Defines the physical space where the work is carried out; this includes equipment used to assist in completing tasks ranging from office equipment to work aids. This includes aspects of the organization of the physical space and the space availability.

1.2 Contractual Aspects: Defines aspects involving legislated processes in the BCNU Collective Agreement. These include scheduling options, movement restrictions between different union certification sites in IH, and the loss of seniority upon retirement when applying for casual work.

1.3 Workplace Health and Wellness: Defines concerns regarding the impacts of work directly on the employee's health and safety. These include workload issues, coping abilities, wellbeing, reducing work from full time, and work-life balance.

1.4 Concern for Patients/Client: Defines the concern RN's have for patients/client's safety, comfort and convenience when interacting with IH.

1.5 Peer Support: Defines the relationship RN's have with their peers and colleagues and the importance of social aspects of these relationships.

2.0 Organizational Culture

Defines the relationship between organizational culture and the retention of nursing staff through the influences of people focused leadership and patient-centered care philosophies.

2.1 Leadership: Defines issues of autonomy and independence; being included in decision making processes; relationship to management in terms of treatment, attitude, accommodation, communication, and problem-solving. Also includes points of view regarding the bureaucracy of the organization.

2.2 Learning and Development: Includes issues of the value of learning, continuous learning, skill development and upgrading of skills for proficiency of current knowledge. It includes areas in computer skills, new skills, job enhancement, medical knowledge and increasing ones skill set.

2.3 Mentoring: This includes the importance of mentoring new/young RN's and role modeling while on the job. It is seen as a self perpetuation cycle to pass on knowledge. It also includes discussions of advocacy for nurses of all ages in the system.

2.4 Recognition: From an organizational perspective it defines aspects of feeling valued and cared for, getting positive reinforcement, being respected and validated as persons. Respect for the nursing profession, associated nursing duties, and valuing tacit knowledge, as well as recognition of innate abilities and being given stretch opportunities. Includes feedback from patients/clients and feeling useful as a nurse;

3.0 Family and Financial Pressures

Defines the variety of internal and external pressures facing mid- to late-career RN's, ranging from personal circumstances, family dynamics, and financial pressures.

3.1 Financial Influences: These include discussions on financial savings, debt load, and pension status.

3.2 Spousal Influences: These include attitude of spouse on partners retirement, pressures to travel, renovate, or to re-locate.

4. Finding Significance and Meaning

Defines personal introspection processes such as: self-reflection, motivational influences, and insight from finding meaning and significance in midlife. It includes the individual's selection of activities and leisure pursuits.

4.1 Role Identification / Love of Nursing: This includes concerns for the nursing profession and working for changes they won't realize during their work time. Discussions on the love the profession, pride in being a nurse, and the sense of self, and finding personal meaning through their career. Discusses what retirement means to them.

4.2 Self-Awareness and Reflection: This includes sense of personal responsibility and work ethic in the organization and towards the job; having positive attitudes, being a positive part of change. Includes insights into their current role as mid- to late-career nurses; how their actions influence others, and impacts the system. Includes openness to opportunities for continuous learning, insights into their abilities, and how self-improvements will impact quality of work-life.

4.3 Hobbies and Interests: This includes personal pursuits they are starting to participate in now and want to dedicate more time to in the future to pursue a sense of meaning and fulfillment in their lives.

Holly Lyons

From: Eikerman, Candis [Candis.Eikerman@interiorhealth.ca]
Sent: Wednesday, June 11, 2008 3:38 PM
To: Thesishelp
Subject: FW: MAL: Permission for use of IHA documents

Hi Holly, here is my original permission from IH. Let me know if it is satisfactory. Thanks Candis

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From: Doyle, Pat
Sent: Monday, October 02, 2006 11:03 AM
To: Eikerman, Candis
Cc: Bonney, Christine
Subject: RE: MAL: Permission for use of IHA documents

Candis:
Please regard this correspondence as approval to use IH documentation contained in your report.
Patrick Doyle
Chief Human Resources Officer,
Interior Health Authority

From: Eikerman, Candis
Sent: Monday, October 02, 2006 10:07 AM
To: Doyle, Pat
Cc: Bonney, Christine
Subject: MAL: Permission for use of IHA documents

Hi Pat, further to our discussion regarding obtaining written permission for the use of any internal organizational documents for information in developing concept proposals for my major project. This would include use of vision, mission and values statements; organizational charts, and annual reports. Internal documents which are not marked confidential such as memoranda, e-mail, minutes of meetings and internal news bulletins. I will ask persons responsible for these materials directly if I use them in an assignment.

I understand that I will be requesting an ethics review of my major project from IHA in the future.

Christine Bonney has consented to be my Sponsor for my project. I have attached the first draft of my general idea – which needs a much narrower focus!

Thanks for the loan of the WW 2005 Executive Summary, may I photo copy this for future reference? I will return it to you shortly.

Candis Eikerman
Manager Volunteer Services
North Okanagan
Phone: (250) 558 - 1266
Fax: (250) 558 - 1239

Holly Lyons

From: Eikerman, Candis [Candis.Eikerman@interiorhealth.ca]
Sent: Thursday, June 26, 2008 3:43 PM
To: Thesishelp
Subject: FW: Use of "Basic Guidelines for Calling a Circle" for Thesis

Hi Holly, I can now say "I'm finished"! Thanks for your help and patience with this process...Cheers Candis

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From: Christina Baldwin [mailto:cbaldwin@peerspirit.com]
Sent: Thursday, June 26, 2008 3:24 PM
To: Eikerman, Candis
Subject: Re: Use of "Basic Guidelines for Calling a Circle" for Thesis

Dear Candis,
I have looked at the pages you cited for me. Thank you. This is a fine piece of work! I know some others who are doing similar research, and if it would be useful, I can put you in touch. Thank you for tending to this permission: you have my permission to cite and quote as illustrated in your finished thesis.

Congratulations!
Christina Baldwin
6/27/08
Christina Baldwin & Ann Linnea www.peerspirit.com
PeerSpirit, Inc.
Building Communities of Reflection, Adventure & Purpose
PO Box 550, Langley, WA 98260 USA
360-331-3580

On Jun 26, 2008, at 10:34 AM, Eikerman, Candis wrote:

Hi Christina – yes the thesis is long and I was totally engaged in writing every single word!

I would like you at PeerSpirit to know how important the "Basic Guidelines for Calling a Circle" was to my project. I used the Circle as a focus group technique with a group of participants representing "older" front line Registered Nurses who had strong and sometimes conflicting emotions about their life's work; this respectful and deep way of communicating resonated with them and allowed for significant issues to be brought forward. I was specifically looking at how we can engage and retain our "older" nurses and found that changing working conditions to be safer was, of course, number one, but that finding significance and meaning in their work was also a significant driver to postponing retirement. Without the structured safety of the Circle I doubt I would have been able to bring these desires, emotions and thoughts fully to the surface.

You can find how I proposed to use the Learning Circle from pages 73 – 76; I also sent out the handout of "Basic Guidelines for Calling a Circle" in the invitation to the front line nurses in Appendix C on page 193, and Appendix J on page 204 are the Guidelines I sent out; on page 112 – 137 you will find how I used the data from the Learning Circle to draw conclusions – I use direct quotes from the Registered Nurses in this section.

I hope this information is adequate and look forward to hearing from you soon. Thank you for consideration.

Candis

From: Christina Baldwin [mailto:cbaldwin@peerspirit.com]
Sent: Wednesday, June 25, 2008 5:20 PM
To: Eikerman, Candis
Subject: Re: Use of "Basic Guidelines for Calling a Circle" for Thesis

Dear Candis,
i would like to grant you permission, and I would like to see the context in which you used the basic guidelines. since your paper is hundreds of pages long, would you please send me the page reference and I'll take a look. I do not anticipate a problem. thank you,
christina B.

Christina Baldwin & Ann Linnea www.peerspirit.com
PeerSpirit, Inc.
Building Communities of Reflection, Adventure & Purpose
PO Box 550, Langley, WA 98260 USA
360-331-3580

On Jun 11, 2008, at 4:34 PM, Eikerman, Candis wrote:

Hello PeerSpirit, I have recently submitted my thesis to be published through Royal Roads University, Victoria, B.C. Canada, as partial fulfillment of the requirement to graduate in a Master of Arts in Leadership program. I used your "Basic Guidelines for Calling a Circle" as a foundation for holding a Learning Circle with a group of participants in my research. I was remiss in not getting your permission prior to using these guidelines as I did not understand that once I publish my thesis, it technically becomes commercial work. I have attached my thesis for your perusal and ask that you grant permission for my use of the "Basic Guidelines for Calling a Circle" in this work.

Respectfully,

Candis Eikerman, B.A., MA Leadership
Manager Volunteer Services
North Okanagan
Interior Health Authority
Phone: (250) 558 - 1266
Fax: (250) 558 – 1239
candis.eikerman@interiorhealth.ca
<Eikerman Candis Final Thesis.pdf>