ATHABASCA UNIVERSITY

# WORKPLACE ENVIRONMENT AND RETENTION OF REGISTERED PSYCHIATRIC NURSES: A MIXED-METHOD STUDY

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**WORKPLACE ENVIRONMENT AND RETENTION OF REGISTERED PSYCHIATRIC NURSES: A MIXED-METHOD STUDY**

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In partial fulfillment of the requirements for the degree of

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## Dedication

I dedicate this work to my husband and two boys. I am grateful for their constant and endless support. This work is also dedicated to the psychiatric nurses of B.C., whose dedication and compassion inspire me every day and to all nurses who feel dissatisfied, experience burnout, or are contemplating leaving their role or the profession altogether.

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## Abstract

*Background:* There are projections of a significant nursing shortage in Canada, which could have negative implications for clients, nurses, and organizations. British Columbia employs 49% of Canada's psychiatric nurses—a specialized subgroup that provides holistic care to clients, families, and communities, yet remains understudied.

*Purpose:* The purpose was to assess psychiatric nurse intent to leave, identify their direction if leaving and understand their perspective on retention.

*Method:* A mixed-method convergent parallel study invited psychiatric nurses in British Columbia to complete a survey. Analysis included descriptive statistics and qualitative content analysis. Findings were merged for integration and reporting.

*Results:* The survey yielded a 20% response rate (n = 302). Over half of participants desire to leave their organization within a decade, and 22% often consider leaving the profession. Priority retention strategies include supportive work environments, increased compensation and better psychological benefits.

*Implications:* Organizations and unions can use the findings to develop retention, training, and recruitment interventions.


*Keywords:* registered psychiatric nurse, mental health, psychosocial, intent to leave, turnover intention, work environment, Canada, retention strategies, nursing shortage, British Columbia

## Preface

My nursing journey began in the emergency department, where I found joy in mentoring new nurses. Drawn to education, I transitioned into a role as a nursing instructor in a psychiatric nursing program. This experience deepened my appreciation for psychiatric nurses and the vital contributions they make to the Canadian healthcare system. Witnessing widespread burnout among emergency nurses during and after the pandemic, I became concerned about how registered psychiatric nurses were coping and whether they might be considering leaving the specialty or profession.

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## List of Abbreviations

B.C. – British Columbia

BCCNM – British Columbia College of Registered Nurses and Midwives

BCNU – British Columbia Nurses Union

CIHI – Canadian Institute of Health Information

CMHA – Canadian Mental Health Association

COPSOQ – Copenhagen Psychosocial Questionnaire

Gen X – Generation X

Gen Y – Generation Y

Gen Z – Generation Z

ICN – International Council of Nurses

ID – Identification

IP – Internet Protocol

MHN – Mental Health Nurse

MMR – Mixed Method Research

NEXT – Nurses Early Exit

NPR – Nurse patient ratio

PN – Practical Nurse

QUAN – Quantitative

qual – Qualitative

QCA - Qualitative Content Analysis

REDCap – Research Electronic Data Capture

RN – Registered Nurse

RPN – Registered Psychiatric Nurse

RPNAS – Registered Psychiatric Nurses Association of Saskatchewan

RPNRC – Registered Psychiatric Nurse Regulators of Canada

SRS – Simple Random Sampling

TIS – Turnover Intention Scale

USD – United States Dollar

# Chapter 1. Introduction

## Introduction

Psychiatric nurses are a specialized group of nurses who collaborate in care of clients, families and communities with a holistic focus of care in a variety of settings (Registered Psychiatric Nurse Regulators of Canada [RPNRC], 2023; Tomblin Murphy et al., 2022). With a population of nearly 7000 in Canada, registered psychiatric nurses (RPNs) are recognized as a distinct group of nurses in four provinces and three territories – British Columbia (B.C.), Alberta, Manitoba, Saskatchewan, the Northwest Territories, Nunavut, and Yukon (RPNRC, 2023). RPNs work in complex environments while enduring high levels of occupational stress that can lead to burnout and intention to leave the profession or current job. Occupational stressors can include high rates of sexual harassment (Havaei et al., 2020), high workload demands, and lack of support (Adams et al., 2021; Kunzler et al., 2020), these stressors compound the adversity RPNs endure daily. Additionally, RPNs are exposed to frequent critical incidents and workplace violence – which can lead to posttraumatic stress disorder, burnout and a compromised wellbeing (Bui et al., 2023; Havaei et al., 2020). These occupational stressors in combination with frequent critical events can lead to RPNs choosing to leave their organization and/or profession.

Nurses working in a psychiatric/mental health setting are at an increased risk for leaving their job compared to the general nursing population due to additional challenges they face (Stewart et al., 2022). Challenges include actual and potential workplace violence, moral distress, emotional and physical exhaustion, limited autonomy in practice, limited professional development opportunities, feelings of not being valued

and stigma related to mental health services and patients (Stewart et al., 2022). The use of evidence-informed strategies to support RPNs response to these stressors is critical to addressing workplace issues that continue to have negative ramifications for patients, organizations, and RPN stress, emotional exhaustion and burnout (López-López et al., 2019; Tomblin Murphy et al., 2022), potentially intensifying the nursing shortage in Canada. These strategies are critical to the recruitment and retention of this at-risk profession.

Over one million B.C. residents will experience a mental illness or substance use disorder in their lifetime (Canadian Mental Health Association [CMHA], 2024). In B.C., there are 30,000 mental health act apprehensions each year and 37% of B.C. residents report a decline in their mental health since the pandemic (CMHA, 2024). Home insecurity is a risk factor for mental illness and B.C. reports a 31% increase in homelessness in 2023 (CMHA, 2024). B.C. also has the highest rates of toxic drug deaths in Canada (CMHA, 2024). There is a lack of research focusing on RPNs, a specialized group of essential nurses caring for B.C. residents struggling with mental health and addictions. The characteristics of employment and intent to leave for B.C. RPNs are not known. While some research has identified important factors for the retention of mental health nurses (MHN), the generalizability to RPNs is limited. The term MHN is associated with any nurse (RPN, registered nurse [RN] or practice nurse [PN]) that works in a mental health setting; RNs and PNs can specialize in mental health after completing their educational program (College of Nurses of Ontario, 2023; Smith & Khanlou, 2013). The educational curricula differ among the three nursing professions, and it is important to consult and assess RPNs if B.C. aims to address retention in this

group and prevent exacerbation of the nursing shortage. The next section describes the gaps in literature and establishes an understanding of the current state of nursing and RPN employment globally, nationally, and provincially in B.C.

## Background

### *The Nursing Shortage: A Global Crisis*

The nursing shortage is a longstanding global issue that has negative consequences for nurses, patients and organizations (Buchan et al., 2022). Pre-pandemic there was a global deficit of 5.9 million nurses, impacting all countries, this deficit has been amplified by COVID-19 (Buchan et al., 2022; Tomblin Murphy et al., 2022). With a global loss of 4% of nurses, Buchan et al. (2022) estimate the nurse deficit could reach 7 million, while the International Council of Nurses (ICN, 2021) estimate the shortage could be upwards of 13 million. Stewart et al. (2022) estimate MHNs as 1% of the global nursing workforce, with >95% located in upper middle to high income countries. Workforce planning for this population of nurses is challenging given less than half of the countries with MHNs have a defined process for tracking workforce data, resulting in an unclear estimation of the shortage in this population (Stewart et al., 2022) .

The nursing shortage has been further compounded by increased rates of burnout and stress and the nursing workforce is aging. One in 6 nurses are expected to retire in the next 10 years globally (Buchan et al. 2022), compared to 1 in 4 in B.C. (Statistics Canada, 2022). Workforce issues are contributing to additional exit of nurses from the profession. If workplace concerns reported by nurses are not addressed by employers, it is feared those intending to leave will leave (Buchan et al., 2022). Buchan et al. (2022) synthesized global data and recommended strategies aimed to sustain and retain nurses.

Similar strategies were recommended in a Canadian report on the sustainability of nursing in Canada by Tomblin Murphy et al. (2022). Examples of strategies include supporting safe staffing levels, conducting regular nurse impact assessments, expanding educational offerings, assessing retention, and developing pandemic related policies (Buchan et al., 2022; Tomblin Murphy et al., 2022). In addition, Buchan et al. (2022) highlight the importance of regular assessments of the nursing workforce to gain individual and organizational perspectives and highlights an absence of data in this area. Understanding the retention of RPNs in B.C. Canada is an important starting point to sustaining this profession within Canada.

### *Nursing Shortage in Canada*

The nursing shortage in Canada has been an issue since the early 2000s with many recommendations for retention and recruitment ignored (Bourgeault & Ahmed, 2022). The number of nursing vacancies in Canada doubled between 2020 to 2021 (Buchan et al., 2022), mostly due to the Covid Pandemic (Bourgeault & Ahmed, 2022: Tomblin, Murphy et al. 2022). RN/RPN vacancies in Canada were the highest of all occupations in the first quarter of 2023 (28,335) – increasing 24% from the previous year (Statistics Canada, 2023). This trend is expected to continue with projections placing Canada at 155,400 vacancies by 2031, with only 143,700 new workers expected to fill vacancies, leaving a remaining 11,700 nurse (RN/RPN) deficit (Government of Canada, 2023). The experiences of health care workers during the pandemic were examined in 2021 and key findings include nine in 10 participants reporting more stress with 1/4 intending to leave their job or profession (Statistics Canada, 2022). Job stress and burnout account for the largest factor (>60%) impacting the decision to leave (Statistics Canada, 2022). Canada's

primary response to this crisis has been focused on recruitment of international nurses, incentives, expansion of educational opportunities, and developing mentorship programs (Tomblin Murphy et al., 2022). These actions have failed to achieve substantial results in recruiting and retaining nurses, particularly through a pandemic. Experts emphasize that employment and workplace related strategies need to focus on organizational environments, nurses' wellbeing and consider how newer generations differ in priorities and respond less to incentives (Tomblin Murphy et al., 2022).

In 2023, there were over 5000 nurse vacancies in B.C. and a projected 27,000 more are required to care for the growing population by 2031 (British Columbia Nurses Union [BCNU], 2023). BCNU (2023) emphasize the poor planning from the provincial government in the 2000s as a contributing factor to the continued nursing shortage in B.C. In their recommendations, Bourgeault and Ahmed (2022) suggest data needs to be collected and used to address the shortage of nurses. López-López et al. (2019) and Stewart et al. (2022) report different nursing specialties have different needs. With even more variation within the mental health field, nurses practice in a variety of clinical environments – potentially each with their own set of factors that impact retention and intent to leave (Adams et al., 2021). A study of RPNs in B.C. will identify the unique generational and organizational supports that could be most effective in retaining and sustaining this important nursing specialty population. The following sections provides more detail about RPN demographics and scope of practice in Canada.

## RPNs in Canada: Demographics and Scope of Practice

### *Demographics*

The Canadian Institute of Health Information (CIHI, 2022) profiled a select group of mental health care providers in Canada in 2021 and reported that 82% of RPNs were female, 39% were younger than 40 years, 11% were older than 60 years, and the largest population of RPNs reside in BC. Although RPNs represent a small portion of nurses in Canada, (1.36% of nursing population in 2020), they represent approximately 6% of nurses in B.C. (BCNU, 2022; Buchan et al., 2022; RPNRC, 2023). As of 2023, there were 3383 practicing RPNs in B.C. (British Columbia College of Nurses and Midwives, 2024), 1498 in Alberta (College of Registered Psychiatric Nurses of Alberta, 2024), 811 in Saskatchewan. (Registered Psychiatric Nurses Association of Saskatchewan, 2024a), 1189 (including temporary) in Manitoba (College of Registered Psychiatric Nurses of Manitoba, 2024), 31 in the Yukon (Government of Yukon, 2024) and 32 in the Northwest Territories and Nunavut (The College and Association of Nurses of the Northwest Territories and Nunavut, 2024).

### *RPN Scope of Practice*

RPNs care for diverse, vulnerable and stigmatized individuals, groups, families and communities (College of Registered Psychiatric Nurses of Alberta, n.d.). Guided by legislative and regulatory bodies, RPNs provide comprehensive care (emotional, physical, spiritual and cultural) with a focus on mental and developmental health, addictions and mental illness (Registered Psychiatric Nurse Regulators of Canada, 2014). Therapeutic relationships are paramount, and RPNs must have excellent communication and interpersonal skills (RPNRC, 2014). Workplace settings vary greatly for RPNs with

sub-specialties including community mental health, acute psychiatry, geriatric psychiatry, child and youth, forensics, addictions and street nursing (College of Registered Psychiatric Nurses of Alberta, n.d.)

Assessing RPN intent to leave and the factors that influence that choice is an important first step in understanding this nursing specialty. This knowledge will be important to avoiding the crisis that Saskatchewan is currently experiencing. In 2021, Saskatchewan declared a staffing emergency stating 50% of their RPNs were expected to retire in the next five years (Registered Psychiatric Nurses Association of Saskatchewan [RPNAS], 2023). This data was collected through a needs assessment (RPNAS, 2023) and was a critical step for the province in addressing the vacancies within this profession and the projected nursing shortage. BCNU (2022) assessed intent to leave in a sample of 3479 B.C. nurses (RNs/LPNS/RPNs) in 2021 and found 35% reported intent to leave, but only 4% of participants were RPNs. Considering 49% of Canada's RPNs are in B.C. (CIHI, 2022), it is essential the province have a greater understanding of this nursing specialty to secure its future.

### *Future of Psychiatric Nursing*

The growth of RPNs in Canada was limited to 3.3% in 2023, slightly increased from the previous year (Canadian Institute for Health Information, 2024). There are only three accredited psychiatric nurse programs in B.C. (British Columbia College of Nurses and Midwives [BCCNM], 2023) and maximum of 380 graduates per year (A. Holland, personal communication, October 20, 2024; C. McInerney, personal communication, October 17, 2024). B.C. has recently invested in nursing education programs, with 40

new seats designated for psychiatric nursing that began September 2023 (Government of British Columbia, 2022). This is a small step in addressing the nursing shortage.

In May 2023, a feasibility study was conducted in three eastern provinces related to the interest in expanding the psychiatric nursing profession to support mental health services in their regions (Nova Scotia Health et al., 2023). The intention is to introduce RPNs in the eastern provinces to support the mental health and wellbeing of Canadians (Nova Scotia Health et al., 2023). With the increasing demand for mental health services world-wide (Stewart et al., 2022), there is ample room in the health systems to expand the number of nurses practicing as RPNS.

## Problem Statement

The existing literature describes the global crisis of a nursing shortage, with disturbing projections in Canada. The importance of focused efforts on the retention and recruitment of nurses are highlighted consistently in published literature and global (Buchan et al., 2022), national (Bourgeault & Ahmed, 2022; Tomblin Murphy et al., 2022), and provincial reports (BCNU, 2021). However, without an in-depth understanding of the problem in one of Canada's distinct nursing professions (RPNs), targeted efforts for retention may be inadequate. B.C. has the largest population of RPNs in Canada, yet the rates of those intending to leave are unknown. Mixed-method research (MMR) offers a unique perspective that lends to a comprehensive understanding of the problem through merging and comparing of quantitative and qualitative data (Creswell & Plano Clark, 2018; Irvine et al., 2020). RPNs as a sub-group of nursing is under-researched, and this MMR study aims to begin to fill the research gap in this important area.

## Study Purpose

Assessing the potential for B.C. RPN departures from the profession is essential for two reasons. First, this data will identify the potential of an RPN shortage. Second, knowledge from this study will provide important information about the organizational factors contributing to retention. The purpose of this MMR study was to examine B.C. RPN's perceptions of their workplace environments, their intent to leave and strategies they report as valuable for retention. A convergent parallel mixed methods design was used to collect qualitative and quantitative data in parallel, then analyzed separately, and finally merged to report the findings (Creswell & Plano Clark, 2018).

### *Research Question and Study Objectives*

The study analyzed data to answer one research question: Is British Columbia at risk for a psychiatric nursing shortage? The primary objective was to determine the percentage of RPNs in B.C. intending to leave. The secondary objectives of the study were to (a) identify workplace factors relevant to RPN's decision to leave or stay and (b) identify strategies that RPNs report as important to retention in the workplace.

## Definition of Terms

The term MHN is associated with any nurse (RPN, registered nurse [RN] or practice nurse [PN]) that works in a mental health setting; RNs and PNs can specialize in mental health after completing their educational program (College of Nurses of Ontario, 2023; Smith & Khanlou, 2013). The educational curricula differ among the three nursing professions. Intent to leave, burnout and retention are interrelated concepts relevant to this study. Retention can be defined as strategizing to keep nurses already in position and being motivated by factors impacting their decision to stay or leave (Adams et al., 2021). The literature lacks a clear and consistent definition of intention to leave. For this study, intent to leave will be defined as those with the desire to leave their current job, or the profession (Hasselhorn et al., 2003; Simon et al., 2010). Those intending to leave the profession can be further classified into two groups: those that intend to leave related to individual and/or workplace factors versus retirement (Simon et al., 2010). Burnout is a result of several work-related factors and defined by three elements: emotional exhaustion, depersonalization or cynicism, and reduced personal accomplishment (Gómez-Urquiza et al., 2017; Hetzel-Riggin et al., 2020). Burnout is displayed through physical, emotional, behavioural, interpersonal and attitudinal symptoms (Hetzel-Riggin

et al., 2020), and can manifest as fatigue, loss of energy, feelings of incompetence and cynicism (López-López et al., 2019). In assessment of their work environment, participants were asked about their experiences with discrimination. Discrimination was defined as an offensive behaviour participants are exposed to or a witness of (Burr et al., 2019). Infringing on human rights, discrimination is unfair and/or includes negative treatment of individuals (ZareKhafri et al., 2022).

# Chapter 2. Review of the Literature

Considering the lack of research on psychiatric nurses in Canada, the literature reviewed to inform the development of this study focused on MHN intent to leave and factors impacting intent to leave.

## Intent to Leave

Knowledge around the rates of intent to leave in MHNs and RPNs is limited. Globally, psychiatric nurses' intent to leave has been studied in China, with 20% (n = 7933) intending to leave their job due to challenging work experiences (Jiang et al., 2019). This pre-pandemic rate may have risen, and estimates could be significantly higher given the trend post-covid in other nursing specialities. In a study of psychiatric nurses in Jordan and Israel, Alsaraireh et al. (2014) and Baum and Kagan (2015) report a strong inverse relationship between job satisfaction and turnover but did not study rates of intent to leave.

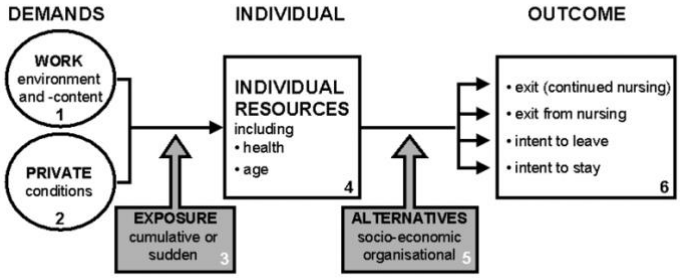
## Nurses Early Exit: Model of Departure from Health Care Work

Early in the review of the literature, the Nurses Early Exit (NEXT): Model of Departure from Health Care Work was found and subsequently used to frame the findings of the literature review. Hasselhorn et al. (2003) developed the NEXT Model of Departure from Health Care Work as an initial step in their study addressing nursing sustainability concerns in Europe (see Figure 1). The purpose of the NEXT Model was to identify relevant factors influencing a nurses' departure from health care (Hasselhorn et al., 2003). The model identified and defined positive and negative factors influencing intent to leave, and findings supported differentiation between attractive and unattractive healthcare institutions (Hasselhorn et al., 2003). There are six elements of the NEXT

model including three categories (demands, individual, and outcome) and two pathways (exposure and alternatives) (Hasselhorn et al., 2003). The model is describing the influence of push and pull factors on a nurse's decision to leave and the direction they exit (Hasselhorn et al., 2003). Push factors are internal factors that push the nurse to leave, and pull factors are external factors outside of their job pulling them to a new job (Hasselhorn et al., 2003). Hasselhorn et al. (2003) conceptually defined several measures to examine nurse's intent to leave, in their longitudinal study of nurses in Europe (Hasselhorn et al., 2003). Making this model an appropriate choice to guide the development and analysis for this study.

**Figure 1**

*The Nurses Early Exit (NEXT) Model of Departure from Health Care Work*




*Note*: This figure was created by Hasselhorn et al. (2003) for their research studying the factors impacting intent to leave for nurses in Europe.

## Factors Impacting Intent to Leave

A myriad of factors impact MHNs intent to leave, these factors can be categorized as individual and demands (Hasselhorn et al., 2003). Individual factors include age (Adams et al., 2021) and gender (Alsaraireh et al., 2014). Demands include work environment and work content, and private conditions (Hasselhorn et al., 2003). Work

environment and work content are interchangeable with the term workplace factors in the context of this paper. Workplace factors can be further grouped into six themes: nurses wellbeing, nurse/client interaction, nurse commitment, training and development, work conditions and support. These factors tend do not exist in isolation and tend to influence each other (Buchan et al., 2022; Hasselhorn et al., 2003; ICN, 2021) creating complex challenges that lead to exacerbation of the nursing shortage. Private conditions include relationship status, level of education, and experience (Alsaraireh et al., 2014) and support network outside of work (Oates et al., 2020). Individual and demand factors are discussed in detail in the following summary.

### *Individual Factors*

Individual factors are inclusive of an individual's resources such as age (Hasselhorn et al., 2003). Several individual factors have been found to impact intent to leave for MHNs including age and gender. Younger MHNs are a professional group at high risk of leaving (Adams et al., 2021). In a study of an MHN residency program, Pelletier et al., (2019) found 11.7% of new nurses left within the first year. In another study, Alsaraireh et al. (2014) found turnover negatively correlated with age and experience. This may be related to younger nurses reporting lower levels of resilience (Zheng et al., 2017). In B.C., younger nurses are at the greatest risk of leaving; 42% of those age 20-29 reported they are somewhat likely or extremely likely to leave the nursing profession and of the same age group 91% reported a decline in their mental health since the pandemic (BCNU, 2021). Considering resilience fosters over time, younger nurses are less likely to have the coping skills required to bounce back from

adversity experienced in the workplace (Cooper et al., 2020), leaving them at risk for burnout (Cooper et al., 2021; Heath et al., 2020).

Gender has been identified an individual factor impacting intent to leave (Adams et al., 2021; Oates et al., 2020; Zhang et al., 2022). For example, male psychiatric nurses in China were more likely to leave (Jiang et al., 2019), report lower job satisfaction (Alsaraireh et al., 2014), and experience burnout, compared to females. Zhang et al. (2022) suggest male nurses may lack coping mechanisms, feel a need to protect female peers and are less likely to feel a sense of belonging among the female dominated profession. Males account for 10% of RPNs in B.C. (Government of Canada, 2023), and it is relevant to consider how gender may impact those wanting to leave.

### *Demand Factors*

Demand factors include the work environment, work content and private conditions (Hasselhorn et al., 2003). The workplace factors identified in the literature as relevant to intent to leave for MHNs was categorized into six themes and private conditions include level of experience, level of education, and support outside of work.

**Workplace Factors.** Workplace factors have been identified as similar for all nurses (Stewart et al., 2022). However, Stewart et al. (2022) has identified and described distinct differences for MHNs. For example, MHNs experience additional barriers related to providing care and seeking services for patients with mental illness and the effect of associated stigma places undue strain on the work of MHNs (Stewart et al., 2022). Six themes were identified pertaining to specific workplace factors impacting MHNs retention and intent to leave: training and development, work conditions, support, nurse commitment, nurse/client interaction and nurse wellbeing.

***Training and development.*** Training for MHNs includes a variety of topics, with one of the most important being orientation of new nurses to their workplace (Joseph et al., 2022; Oates et al., 2020). The first six months of employment are vital to the establishment of confidence in the workplace for new nurses (Joseph et al., 2022). A comprehensive orientation with support from colleagues is essential for early retention (Oates et al., 2020), with new nurses naming shortened orientation as a reason for leaving an employer (Pelletier et al., 2019). Joseph et al. (2022) report that a consistent level of support needs to be provided during the first year of MHN employment to prevent newer, younger nurses from leaving.

In addition to orientation, ongoing and specialized education and training is seen as important to both new and senior nurses. For example, in one study, a group of forensic nurses reported that training on coping strategies was an important factor for retention (Oates et al., 2020). In this same study, the lack of opportunities for ongoing training and development was reported as feelings of being left behind by senior nurses and as a reason for newer nurses to question their future (Oates et al., 2020). Barriers such as staffing issues often took precedence in this same study as the reason for not offering ongoing training and development (Oates et al., 2020).

***Work conditions.*** Day to day work conditions impact MHNs intent to leave. Working more than 40 hours per week was associated with intent to leave for psychiatric nurses in China (Jiang et al., 2019). While shift hours and working weekends (23%) were collectively reported as the most important factor, along with staffing concerns (23%), impacting new nurses' dissatisfaction with their job (Pelletier et al., 2019). Working short-staffed and with an increased workload (Adams et al., 2021; Redknap et al., 2015),

and overcrowding of patients (Alsarahrieh et al., 2014), are common sources of MHN dissatisfaction leading to increased intent to leave. These working conditions influence the ability of new nurses to manage expectations in their new role (Pelletier et al., 2019). The adjustment to meeting patient and employer expectations, combined with challenging work conditions leads to increased stress and overwhelm for new nurses (Pelletier et al., 2019).

***Support.*** In their review, inclusive of quantitative, mixed-method and qualitative studies, Redknap et al. (2015) found positive nurse/physician relationships are important. These relationships contribute to MHNs levels of confidence and feelings of being respected and valued. This relationship extends into the team dynamic and cohesion of health care providers in the workplace (Redknap et al., 2015). In their study of the longevity of MHNs in the United States, Alexander et al. (2015) identified positive team dynamics as a factor that increases the confidence of MHNs and fosters a sense of belonging. Positive team dynamics also foster supportive work relationships (Adams et al., 2021) and facilitate trust within teams in high-security settings (Oates et al., 2020). Nurses that left their job reported negative experiences with team dynamics and feelings of exclusion (Adams et al., 2021).

Level of supervisory support is also related to MHNs satisfaction with their current job and impacts intent to leave (Adams et al., 2021; Yanchus et al., 2017). Yanchus et al. (2017) report supervisory support has a negative relationship with turnover. Highlighting the need for positive supervisory support to create psychologically safe workplace environments. The level and duration of supervisory support for new nurses is particularly important (Joseph et al., 2022). Supervisory support through mentorship is

essential for new nurses to successfully transition and develop confidence in clinical practice (Joseph et al., 2022). Lack of supervisory support led to nurses leaving (Joseph et al., 2022).

***Nurse commitment.*** Level of nurse commitment to and relationship with an organization impacts MHN intent to leave. Nurses need to feel recognized and valued in their place of employment (Alexander et al., 2015; Joseph et al., 2022; Redknap et al., 2015), feel ownership of the nursing values within an organization (Redknap et al., 2015), and believe that they are making a difference in the lives of others (Alexander et al., 2015). MHNs want to engage in leadership activities (Adams et al., 2021; Redknap et al., 2015), participate in hospital affairs (Redknap et al., 2015) and have some level of control over their work (Alsararieh et al., 2014). When their role is devalued, and appropriate value is not attributed to their contributions they are more likely to leave or intend to leave the organization where they are employed (ICN, 2021). Feeling valued and respected for their knowledge and role is reflected in their satisfaction with their salary (Alsararieh et al., 2014). MHN satisfaction with their salary has a negative association with turnover intention, or intent to leave (Alsaraireh et al., 2014), nurses who are satisfied with their salary are less like to leave their place of employment.

***Nurse/client interaction.*** Negative nurse-client interactions also impact intent to leave. In a nationwide survey of psychiatric nurses in China, one third of participants experienced patient-initiated violence; this interaction was related to a greater intent to leave compared to colleagues that did not experience this type of violence (Jiang et al., 2019). MHNs worldwide, experience the second highest rates workplace violence, (55% physical, 73% non-physical), and the highest rates of sexual harassment (30%) among

nursing specialties (Havaei et al., 2020). MHNs care for distressed populations and endure emotionally hard labour (Oates et al., 2020). Without adequate coping skills, exposure to trauma and risk of violence contributes to emotional difficulties experienced by MHNs (Oates et al., 2020). This level of emotionally hard labour varies in workplace settings. Oates et al. (2020) discuss the challenges forensic nurses experience in establishing a therapeutic relationship with their clients. They also report exposure to trauma as a factor contributing to stress, which impact a nurse's intent to leave (Oates et al., 2020).

***Nurse wellbeing.*** The individual and workplace factors described in the literature in isolation and in combination create stressful environments for nurses (Oates et al., 2020) and contribute to MHNs feelings of wellbeing, this is expressed as burnout (Adams et al., 2021). Statistics Canada (2022) reported that job stress and burnout were two major contributing factors impacting nurses' intent to leave during the pandemic. Forensic nurses report increased stress related to working in high security settings (Oates et al., 2020), and new MHNs report high stress related to job expectations and the level of support provided in the practice setting (Pelletier et al., 2019). High stress also contributes a nurse's feelings of wellbeing. In one study of mental health professionals, it was reported that job satisfaction can affect wellbeing, leading to turnover and emotional exhaustion (Yanchus et al., 2017). In one study, over 20% of MHNs reported high levels of emotional exhaustion (Azevedo et al. (2019). In a systematic review on the same topic, it was reported that over a ¼ of MHNs studied reported high levels of emotional exhaustion (López-López et al., 2019).

**Private Conditions.** Private conditions include marital or relationship status, level of experience, higher education, and level of support outside of work. Marital status impacts intent to leave, with single MHNs reporting greater rates of intent to leave (Alsaraireh et al., 2024). Level of experience impacts MHNs intent to leave (Alsaraireh et al., 2024). In their scoping review on retention of MHNs transitioning into practice, Joseph et al. (2022) emphasized the need for ongoing support of new nurses to prevent intent to leave. In general, Canadian nurses working less than five years have the greatest intent to leave (Statistics Canada, 2022). Those with a higher level of education also report higher rates of intention of leave (Alsaraireh et al., 2014). This higher rate may be related to career advancement (Alsaraireh et al., 2014). Finally, support outside the workplace, has also been reported as a factor impacting intent to leave. In an integrative review of forensic nurses' experiences, support outside of work was identified as a factor important to retention (Oates et al., 2020).

**Risk for Burnout**

Given the multiple factors impacting intent to leave in the MHN subspecialty and forensic nursing population and the potential for burnout to develop in response to these same factors, it was deemed prudent to examine the literature on the risk for burnout. There is a correlational relationship between burnout and intent to leave (Christianson et al., 2022). Burnout is well-researched in the nursing population and has been a topic of discussion for decades. The incidence of burnout experienced by nurses is steadily increasing on a global scale. A recent study conducted during the pandemic, reported that MHNs in the U.S. experience moderate levels of burnout (Kameg et al., 2021). Burnout has significant consequences and nurses experience negative outcomes in response to

burnout (Gómez-Urquiza et al., 2017). Understanding burnout as a response to the recent pandemic and ongoing health system crisis left behind is an important addition to the literature (ICN, 2021). Given that burnout is related to intent to leave, it is a priority to assess levels of the same in B.C. (BCNU, 2021). This study will assess RPNs experience of burnout.

### *High Risk Groups*

MHNs are at high risk for burnout related to high rates of emotional exhaustion (Adams et al., 2021), the highest rates of sexual harassment (Havaei et al., 2020), and exposure to violence (Havaei et al., 2020; Jang et al., 2022). Single male nurses, working greater than 40 hours a week are even higher risk for burnout (Zhang et al., 2019). Entry into practice as a new psychiatric nurse involves stress inducing change (Joseph et al., 2022), and these nurses have been identified at high risk for burnout due to their novice status, age and level of experience (Adams et al., 2021; Alsaraireh et al., 2014). This stress inducing change is related to the new nurse's need to adapt to new work environments, professional relationships, workload and the responsibility of being a practicing psychiatric nurse (Joseph et al., 2022). The younger the nurse the higher the risk for burnout (López-López et al., 2019) and intent to leave (Adams et al., 2021). The age factor is especially important for the RPN population in Canada, with almost ½ being less than 40 years old (CIHI, 2023).

## Implications for RPNs, Patient Care and Organizations

The implications of burnout, intention to leave and the nursing shortage are multifaceted and complex. In Canada, recruitment has been the major focus, with limited focus on retention. This strategy contributes to a cycle of bringing new nurses into the

profession without adequately addressing workplace issues, resulting in nurses enduring high levels of job stress and burnout, leading to intent to leave or turnover, further worsening the nursing shortage (Foster et al., 2019). This cycle has negative implications for nurses, patients, and organizations. For nurses, much of the literature focuses on the nurse's inability to cope with adversity instead of addressing organizational problems and workplace issues that have contributed to this phenomenon for decades (Buchan et al., 2022; Kunzler et al., 2020). Nurses have been experiencing physical and mental health challenges including burnout due to workplace stress, workplace aggression (López-López et al., 2019), lack of supportive workplace relationships (Adams et al., 2021), exposure to trauma, emotional hard labour (Oates et al., 2020), and heavy workloads (O'Connor et al., 2018). The pandemic further exacerbated the problem. In 2021, MHNs in Canada reported a decline in mental health (Statistics Canada, 2022). It is unclear how this mental decline impacted RPNs in B.C., but this is not an MHN-centered problem. Considering the work environment directly impacts MHNs wellbeing, organizations are obligated to create systemic change (Jun et al., 2021; Kunzler et al., 2020; López-López et al., 2019; Tomblin Murphy et al., 2022).

It is well documented in the literature that nurses' mental health matters, and it directly and indirectly influences patient outcomes (Foster et al., 2021; López-López et al., 2019). Workplace settings functioning short-staffed report reduced quality of care, higher risk of error (Adams et al., 2021), and decreased patient satisfaction (Jun et al., 2021; López-López et al., 2019). High rates of emotional exhaustion have negative implications for patients (López-López et al., 2019). With depleted emotional reserves,

MHNs face challenges meeting clients and families with objective responses (López-López et al., 2019).

Organizations are impacted by nurse's intent to leave and departure from the workplace. These negative implications include financial cost (Adams et al., 2021; Jun et al., 2021), employee wellbeing (Jun et al., 2021), and patient perception of care (Foster et al., 2021). The cost of replacing nurses is high (Adams et al., 2021; Jun et al., 2021); and directly related to sick leave, absenteeism (López-López et al., 2019), hiring agency nurses, and recruiting, training and orientating new nurses (Adams et al., 2021). Jun et al. (2021) estimates the cost to organizations as high as $37-$58,000 USD per nurse replacement.

After implementing a nurse residency program (for RNs) aimed at improving retention – one organization reported a cost savings of four million dollars over four years – an estimated savings of $50,000 USD per nurse (Hillman & Foster, 2011). It is fiscally and morally essential for health care organizations to implement strategies that address and improve workplace conditions for nurses and in turn, patient care (Adams et al., 2021; Jun et al., 2021; López-López et al., 2019; Tomblin Murphy et al., 2022). Adams et al. (2021) found young age was the most significant factor impacting retention of MHNs, this supports the need for organizations to invest in the orientation, training and support of new nurses. All workplace factors have a degree of modifiability and are important for organizations to attend to. Directly related to the factors impacting intent to leave, organizations can focus on facilitating support in the workplace (López-López et al., 2019; Oates et al., 2020), clarifying roles, supporting autonomy (O'Connor, 2018),

and providing access to clinical supervision (López-López et al., 2019; Oates et al., 2020; O'Connor et al., 2018).

**Strengths and Limitations**

The review of the literature identified gaps in the body of knowledge for psychiatric nurses, particularly identifying a lack of research for RPNs in Canada. In the review of literature, the NEXT Model of Departure from Health Care Work was discovered and provided theoretical foundation for this study (Hasselhorn et al., 2003). The articles reviewed provided evidence substantiating the nursing shortage in B.C. (Statistics Canada, 2022) and assisted in identifying areas requiring further research. For example, Adams et al. (2021) identified age as the most significant factor impacting retention. The author suggests future research explore how to best support younger, new nurses in the first two years of practice and a greater understanding of this population is needed. Joseph et al. (2022) supported this and the continued exploration of factors impacting the transition of new MHNs into practice due to lack of evidence in the literature. Lastly, the findings of the review aided in development of the survey and the decision to use MMR methodology to gain an understanding of the RPN perspective.

The literature reviewed included quantitative (Kameg et al., 2021), qualitative (Oates et al., 2021) and two mixed-method studies (Agyapong et al., 2015; Gunn, 2015) that were included in the systematic review by Adams et al. (2021). There is a need for further mixed method studies focused on geographic and/or practice setting (e.g., addictions, community) groups of MHNs and RPNs. MMR contributes to a rich understanding of concepts through the insight that emerges from integration of quantitative and qualitative data (Creswell & Plano Clark, 2018). The review of literature

for this study was not an exhaustive search and was limited by scholarly publications and the researcher's skill.

Strengths of the studies included in this review include a global perspective, and the aspiration to fill existing research gaps (Adams et al., 2021; Joseph et al., 2022; Oates et al., 2020). Limitations of the current literature include the publication of only one Canadian study included in the review by Adams et al. (2021). This gap is significant considering the lack of research inclusive of RPNs in Canada as a major MHN workforce and their differing educational preparation. RPNs experiences may differ from MHNs globally. Limitations of the current literature also includes studies completed over several decades with no attention to shifting contexts, small samples, poor response rates, cross-sectional design (Adams et al., 2021), pre-pandemic studies (Joseph et al., 2022), and inclusion of studies limited to highly secure hospitals (a forensic sub-specialty setting) (Oates et al., 2020). These limitations impact the generalizability and application of findings to all MHNs. This study aims to address some of the gaps in the literature by determining the extent of the intent to leave in B.C. RPNs, and identifying factors related to intent to leave in different mental health settings and strategies for retention. The goal is to contribute to the knowledge necessary to sustain the RPN profession in B.C.

# Chapter 3. Theoretical Framework

## Use of Models in Mixed-Method Research

This study used a descriptive, MMR design including a cross-sectional survey with quantitative and qualitative questions to capture the views, experiences and thoughts from RPNs in B.C. at a single point in time. While the focus of this study was quantitative driven, open-ended questions in the survey ensured a qualitative arm to substantiate the MMR design and add richness to the data. MMR is considered an emergent methodology, and clear guidelines to support junior researchers with the integration of theoretical models into MMR are still developing (Haynes-Brown, 2023).

Haynes-Brown (2023) used an exemplar to highlight the ways a theoretical model can be used in MMR. During study design, theoretical models can be used to create diagrams that map models to concepts, aiding researchers in visualizing the relationships between different components of their study (Haynes-Brown, 2023). Models can assist in the development of research instruments by providing a structured framework for item selection or guiding selection of validated instruments (Haynes-Brown, 2023). These also help frame a study by offering a systematic approach to conceptualizing research questions and hypotheses within the context of existing theories (Haynes-Brown, 2023). During data collection and analysis, a model guides researchers in organizing and interpreting both quantitative and qualitative data, ensuring coherence and consistency in findings and integration of results (Haynes-Brown, 2023). There is a recognized need for further guidelines to support researchers in effectively incorporating models into MMR, ensuring their optimal utilization and enhancing the overall quality of research outcomes

(Haynes-Brown, 2023). This study used the NEXT Model of Departure from Health Care Work to frame the literature review findings, develop a survey and integrate data.

**Use of the NEXT Model in the Research Study**

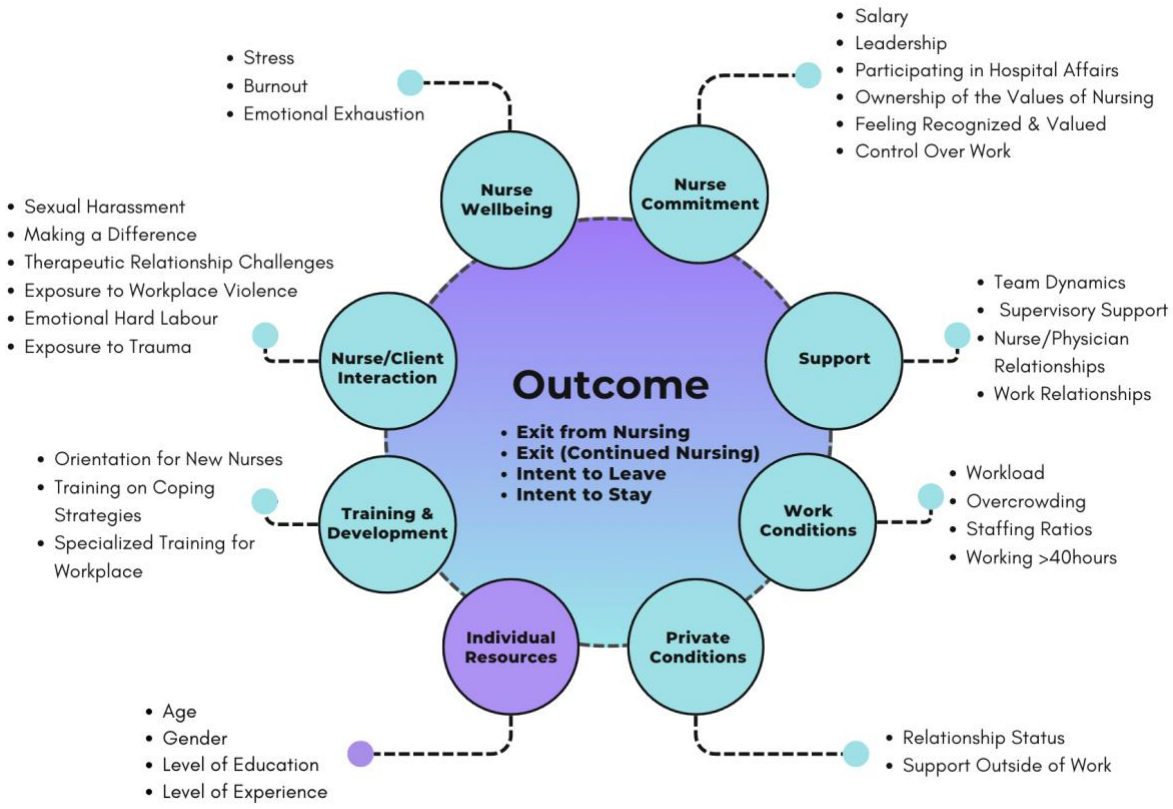
The NEXT Model (Hasselhorn et al., 2003) was used as a template for recognizing and understanding how individual factors, workplace factors and private conditions contribute to RPNs' intent to leave in a greater context. For example, the NEXT model describes the relationship between a nurses' private life, the speed to which factors occur (sudden or cumulative), and outside factors such as job opportunity influence a nurse's decision to leave (Hasselhorn et al., 2003). As applied to RPNs – the individual category includes demographics such as age and gender. The demands category includes work environment and work content, and their private conditions (Hasselhorn et al., 2003). Work environment and work content include several factors that are categorized as six main concepts: training and development, work conditions, support, nurse/client interaction, nurse wellbeing, nurse commitment. Private conditions include external factors such as level of experience and education, relationship status, and support outside of work. The model explains the interplay between individual, workplace, and private life factors on a nurses' intent to leave or stay. The model also explains how the decision to leave may be influenced by variables organizations are unable to control such as job opportunity, premature retirement, and socioeconomic factors (Hasselhorn et al., 2003). The model can be used to identify targeted interventions that can foster retention in RPNs in B.C.

In this research study, the NEXT model was used to frame the key findings of the literature review (see Figure 2), inform the development of the items used in the survey

and assist with the integration of the quantitative and qualitative results. For example, the survey was developed to address the research objectives using a combination of previously validated tools and structured questions to assess the individual, workplace and private conditions identified in the literature. The survey also addressed suggestions for research and identified gaps, such as exploring the significance of workplace setting and presence of a support network outside of work (Adams et al., 2021; Oates et al., 2020), in relation to intent to leave. The study was designed for the qualitative and quantitative analysis to be performed independently, and their findings integrated using the NEXT model as a tool for comparing and merging of data.

**Figure 2**

*Factors Impacting MHN/RPN Intent to Leave Based on Literature Review Findings*




*Note:* Figure 2 displays the literature review findings of potential factors impacting intent to leave for MHN/RPNs in a preliminary model. The preliminary model depicts the interconnectedness of factors imbedded in the *NEXT* Model framework (individual, demands and outcomes). The purple circle represents individual, and the blue circles represent demands.

The next chapter begins with a description of mixed-method methodology and its place in mental health nursing. Study procedures are then discussed.

# Chapter 4. Methodology

## Research Design

The study aimed to answer one research question: Is B.C. at risk of a psychiatric nursing shortage? The primary objective was to determine the percentage of RPNs in B.C. intending to leave. The two secondary objectives are 1) identify workplace factors potentially important to RPNs decision to stay or leave, and 2) identify retention strategies RPN report as important. To best answer the research question and address the objectives, a mixed-method approach was used.

### *MMR in Nursing*

MMR presents multiple benefits as a methodology for nursing research. Irvine et al. (2020) describes the integration of quantitative and qualitative data as a good fit for nursing considering the different ways of knowing that are fundamental to nursing. MMR facilitates evidence-based nursing and provides a comprehensive perspective of nursing issues (Thompson & Ivankova, 2022). In their review, Beck and Harrison (2016) found most nursing MMR studies focused on nursing education and nurses' relationship with other nurses or their environment. MMR has also been used globally in nursing education to understand simulation (Harder, 2023), community nursing (Berthelsen et al., 2023), mental health nursing (Kettles et al., 2011), long-term care and general nursing (Irvine et al., 2020). Despite the benefits of MMR in nursing, Harder (2023) cautions it is not suitable in all contexts – it needs to fit appropriately to address research objectives and requires significant planning.

While there has been an upward trend of improving research methods (Irvine et al., 2020), MMR is still a work in progress in the field of nursing research (Younas et al.,

2019). Beck and Harrison (2016) conducted the second published review of MMR in nursing; the first review focused solely on mental health and only included five studies. They described a significant increase in the number of MMR studies (n = 294) between 1998-2014 (Beck & Harrison, 2016). Younas et al. published a review in 2019, reporting a five-year prevalence (2014-2018) of MMR in nursing (n = 134) at 1.89%. While both studies report challenges with conducting and reporting of MMR, Younas et al. (2019) described a shift in nursing with noted improvements in quality since the previous review from Beck and Harrison (2016).

**Strategies Moving Forward.** In their review of MMR in nursing, Younas et al. (2019) found narrative integration was the most prevalent design with few studies using advanced integration procedures such as joint displays, data transformation or triangulation. Irvine et al. (2020) reported limited evidence of integration, and a general lack of methodological rigour in the studies they reviewed. Several strategies have been identified to improve the process of integration in nursing MMR, including use of advanced data integration techniques (Irvine et al., 2020; Younas et al., 2019), clearly reporting/identifying the study design (Irvine et al. 2020), and including integration in all phases of research (Fetter et al., 2013). Researchers need to ensure integration seeks to answer the research question (Younas et al., 2019).

Beyond integration, strategies nursing researchers can utilize when engaging in MMR include providing adequate rationale for mixed-methods, (Creswell & Plano Clark, 2018; Kettles et al., 2011; Younas et al., 2019), correctly labeling the study design, describing the research paradigm (Younas et al., 2019), and adhering to a specific criteria while describing the sequence, reporting clear inferences, acknowledging limitations

(Harder, 2023; Irvine et al., 2020), and simply identifying the design in the title (Creswell & Plano Clark, 2018). Despite challenges with reporting of MMR in nursing research, the above-mentioned recommendations provide an opportunity for nursing researchers to improve its application. This study addressed the limitations when conducting this study to increase rigor (Younas et al., 2019) and reproducibility (Irvine et al., 2020).

### *Mixed-Method Convergent Parallel Design Used in This Study*

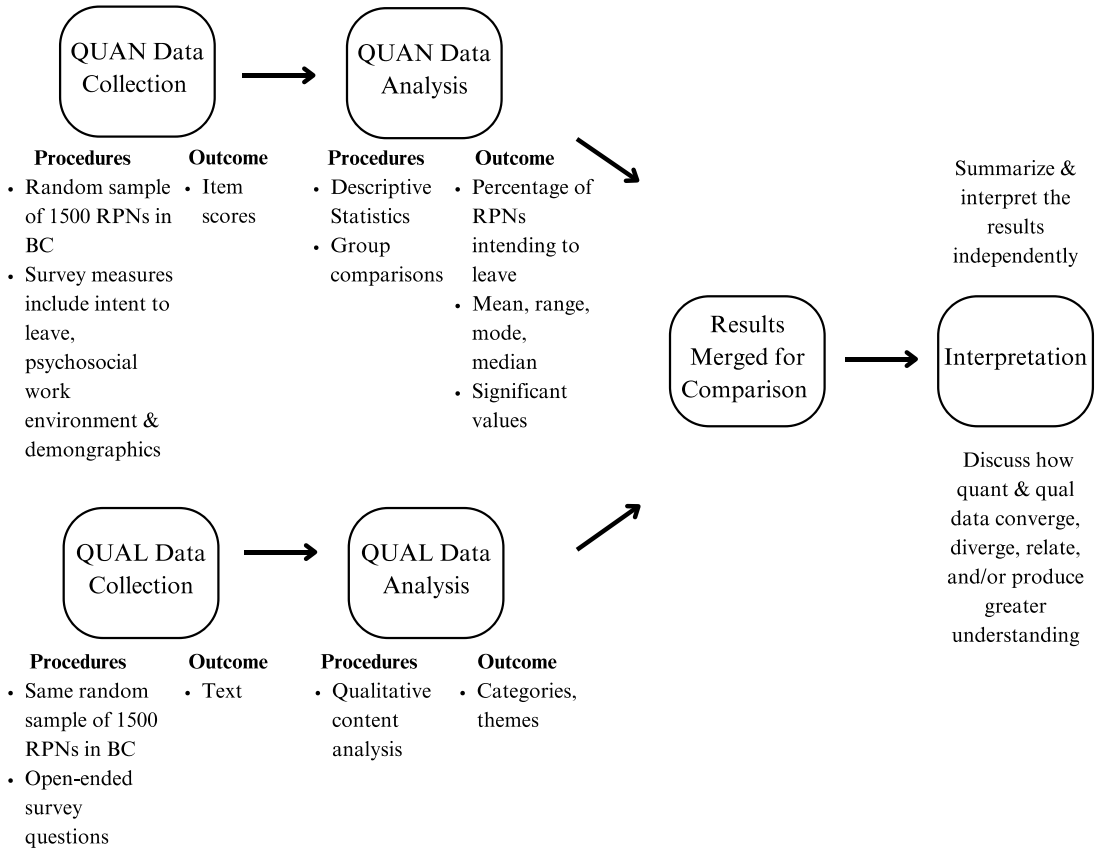
The main feature of MMR is integration, the extent to which two types of data come together (Fetters et al., 2013). MMR takes advantage of the strength of both qualitative and quantitative methods. Integration is achieved through three of the study processes: 1) design, 2) methods and 3) interpretation and reporting (Fetters et al., 2013). Creswell and Plano Clark (2018) clearly define the ways MMR uses integration, but it is up to the researcher to decide on the mixed-method approach most appropriate to answer the research question. This study used a quantitatively driven (QUAN/qual) MMR design, highlighting the need to define and describe a population while understanding how qual data contributes to richness and greater understanding of results (Kansteiner & König, 2020).

One of the core MMR designs, convergent parallel design (Creswell & Plano Clark, 2018), was used in this study (see Figure 3). Parallel indicating both methods are executed concurrently, and the data is then converged (Kettles et al., 2011). A convergent parallel design includes four major steps: data collection, data analysis, merging, and interpretation (Creswell & Plano Clark, 2018). In the first two steps, QUAN/qual data are collected synchronously, and analyzed independently with pre-determined procedures (Creswell & Plano Clark, 2018). The results converge in the last two steps, merging and

interpretation (Creswell & Plano Clark, 2018). Merging can include various methods of bringing the results together and may include joint display, comparison of two types of data in a table, or transformation of one type of data to the other for further analysis (Creswell & Plano Clark, 2018). Interpretation includes deciding and discussing how the results converge, expand or diverge (Creswell & Plano Clark, 2018; Fetters et al., 2013).

**Figure 3**

*The Mixed Method Convergent Parallel Design Used in this Study*




*Note*: The figure outlines the convergent parallel design used in this study, detailing the procedures and/or outcomes in each step of the design.

Both QUAN/qual data were required in this study to gain a comprehensive understanding of the factors influencing RPN intent to leave. The convergent parallel design facilitated the results from a large sample to be effectively analyzed. Descriptive statistics calculations were applied to the QUAN data as a means of describing and defining the population. Qualitative content analysis (QCA) was used to analyze the qual data for complementarity, expansion, and triangulation (Kansteiner & König, 2020). Triangulation is achieved through the convergence of results from two data sets, expansion increases the extent of understanding with QUAN/qual and complementarity elaborates on the QUAN findings with the qual (Kansteiner & König, 2020).

**Cross-Sectional Survey.** This study used a descriptive cross-sectional survey to collect QUAN/qual data and analyze each individually from a single point or short period of time (Wang & Cheng, 2020). Observational studies of this type are useful in characterizing a population and determining prevalence of a phenomenon, such as intent to leave (Setia, 2016; Wang & Cheng, 2020). Cross-sectional design allowed data collection in a relatively short period of time, was inexpensive compared to other designs (e.g., interventions), and allowed the researcher to reach a larger sample (Wang & Cheng, 2020). Since cross-sectional designs are used to describe a population, findings can be used to generate hypotheses, inform and direct future longitudinal research such as cohort studies (Wang & Cheng, 2020). This study used a survey to determine the prevalence of intent to leave in RPNs and descriptive statistics were used to characterize the population characteristics identified from the literature, including individual, and demand factors.

## Sampling Procedures

### *Participants*

RPNs working in B.C. were recruited to participate in this study. Eligible participants were practicing RPNs with current registration in B.C. and able to communicate in English. RPNs with temporary or non-practicing registration in B.C., employed student nurses and those out of province were excluded from the study. An application to partner with BCCNM for dissemination of the survey to participants was submitted once research materials were finalized and ethics approval was obtained, as their review and approval of the study project was required. BCCNM is the only regulatory body for nurses (RPNs, RNs, PNs and Nurse Practitioners) and midwives in B.C. (BCCNM, 2022). The decision to pursue this partnership was based on accessibility to the population of interest. All participants were required to review the information letter and provide consent prior to starting the survey.

### *Sampling*

Careful planning of the sampling strategy is imperative for cross-sectional studies, due to the diverse nature of populations (Wang & Cheng, 2020). A common limitation of MMR is the use of different samples for QUAN and qual streams (Creswell & Plano Clark, 2018). This study mitigated this limitation by using the same large sample for both methods of data collection. A non-probability sampling strategy, purposive sampling was used to recruit participants for the study, with the intent to collect data representative of the population of study (Campbell et al., 2020). Inclusion and exclusion criteria were developed based on the participant having an in-depth understanding of the phenomenon being studied (Campbell et al., 2020). In this study,

clear inclusion and exclusion criteria were outlined along with a rationale to increase trustworthiness (Campbell et al., 2020).

BCCNM used random survey dissemination to 1500 participants meeting the inclusion and exclusion criteria. Considering statistical comparison was not used in the data analysis for this study, given its descriptive nature, sample size did not rely on statistical power (Eng, 2003; Wang & Cheng, 2020), but the preciseness of the means and proportions (Eng, 2003). An estimated sample size of 351 was determined using a 95% confidence interval, with a +/- 5% margin of error, 50/50 split (Dillman et al., 2014), and sampling frame of 3305 (BCCNM, 2022). Oversampling was used in attempt to achieve the estimated sample size.

### *Ethical considerations*

Ethics approval (Ethics file number 25626) was obtained through the Athabasca Research Ethics Board prior to the study (see Appendix A). The study had low to very-low risk to participants. One risk to participants was being uncomfortable or experiencing moral distress when completing the survey. This risk was mitigated by promoting the value associated with participation in sharing their experiences, and RPNs could stop their participation in the survey at any point. B.C. mental health resources were shared at the end of the survey, if additional support was required.

## Data Collection

Data collection occurred simultaneously for QUAN/qual data. The researcher coordinated with BCCNM for research materials – initial email with invitation to participate (see Appendix B), survey, letter of information and informed consent (see Appendix C), and email reminder – to be distributed to the appropriate RPN population.

The initial email notified participants of the study and included an invitation to participate, this email contained the survey link. One reminder email was sent two weeks later. Please refer to the recruitment emails for details (see Appendix D). An assessment of the response rate occurred after each email. After approximately one month, it was decided the response rate was sufficient (20%) and no further participants needed to be recruited. Please refer to the study timeline for target dates (see Appendix E).

Data was collected using the online survey platform Research Electronic Data Capture (REDCap), software supported by the Athabasca University Research Office. REDCap is a secure application designed for the conception and use of online surveys for research studies. The survey was reviewed by practicing RPNs and feedback incorporated. The survey was piloted with two RPNs to ensure it was free of spelling errors or technological issues. Personal information or identifiers such as name, address, city, or IP address identifiers were not collected in the study. Participants consented to the anonymous online survey prior to beginning the survey. Responses were saved on the REDCap database for analysis. Once data collection was complete, the original data was transferred and stored on the Athabasca University secure website as backup. All data was transferred from REDCap and exported as files – on a password protected laptop with password protected files. The original data set third and fourth backup will be stored on flash drive in a locked cabinet in the primary researcher's home office for five years.

### *Measures*

The survey used in this study includes 93 questions and takes approximately 10-20 minutes to complete. It is a combination of two validated instruments, the TIS-6 (Bothma & Roodt, 2013) and the Canadian version of The Copenhagen Psychosocial

Questionnaire (COPSOQ) called StressAssess (Occupational Health Clinics for Ontario Workers [OHCOW], 2024) (total 72 items), demographic questions (13 items), additional open-ended questions (2 items), and additional questions to meet the needs of the study (6 items). All measures and questions were chosen based on the literature review findings that identified individual and demands factors relevant to intent to leave. Please refer to the survey for all items (see Appendix F).

**Demographics** Participant information was collected to determine characteristics of the population. Most of which were included in the literature as individual or demand factors impacting intent to leave in MHNs. Demographics, and data about individual and demand factors included age, gender, relationship status, level of education, years of experience, whether their primary place of work involves direct patient care, geographical location, and primary workplace setting.

**Intention to Leave.** Intent to leave data was collected using the six-item Turnover Intention Scale (TIS-6) adapted by Bothma & Roodt (2013) from the original 15-item TIS by Roodt (2004) to prevent survey fatigue and increase response rate (as cited in Bothma & Roodt, 2013). The scale contains six questions assessing intent to leave that include thoughts of leaving, achieving work related goals, and looking forward to work. Participants were asked to answer each question using the scale provided. There are four different response options used in the scale, and one example is never; rarely; sometimes; often; and always. The TIS-6 scores can range from 6 to 30 and a score 18 or greater reflects the desire to leave the organization, while a score less than 18 indicates a desire to stay (Bothma & Roodt, 2013). In addition to these six questions, an additional three questions were created to assess direction of departure related to retirement plans, plans

to leave the profession and barriers preventing them from leaving their current job. These items were meant to inform the development of appropriate retention strategies (Simon et al., 2010). Permission was received to use the TIS-6 in this study and use of the tool is subject to copyright restrictions.

**Factors Relevant to RPNs and Intent to Leave.** The COPSOQ, now in its third rendition (COPSOQ III) was designed with the intent to be used in research on work and health (Burr et al., 2019). It has been widely used in international research and their tool administration guidelines state each country is responsible for coordinating to ensure consistent use of a validated version (COPSOQ International Network, 2020). The Canadian version of the COPSOQ (StressAssess) is a combination of various tools to assess the workplace environment (OHCOW, 2024). This study used the COPSOQ III questions used in StressAssess, with an additional COPSOQ question about salary.

A total of 48 items were used to assess seven domains: demands at work, work organization and job contents, interpersonal relations and leadership, work-individual interface, social capital, conflict and offensive behaviours, and health and wellbeing (Burr et al., 2019). Each domain was comprised of two to seven scales. Table 1 describes the domains, associated scales, number of items and scoring information (Burr et al., 2019). The COPSOQ III questions used in the StressAssess tool were selected for this survey because the combination of scales assesses the psychosocial aspects of the MHN workplace environment, including individual and demand factors, that impact intent to leave, as identified in the literature review.

**Table 1**

Domains, Scales and Scoring of the Canadian Version of the COPSOQ III (StressAssess)

| Domain | Dimension/ Scale | No. of Items (Item Name and Label) | High Level Good (Yes/No) | Scale Range (Min-Max) |
|---|---|---|---|---|
| Demands at work | Quantitative Demands | 3 (QD2 Complete task; QD3 Get behind; QD4 Enough time) | No | 0-300 |
| | Emotional Demands | 3 (ED1 Emotional disturbing; EDX2 Deal with other people's problems; ED3 Emotionally demanding) | No | 0-300 |
| | Work Pace | 2 (WP1 Work fast; WP2 High pace) | No | 0-200 |
| Work organization and Job Contents | Influence at work | 2 (INX1 Influence decisions on work; IN3 Amount of work) | Yes | 0-200 |
| | Possibilities for development | 3 (PD1 Take initiative; PD2 Learning new things; PD3 Use skills) | Yes | 0-300 |
| | Meaning of Work | 2 (MW1 Work meaningful; MW2 Work important) | Yes | 0-200 |
| Interpersonal Relations and Leadership | Predictability | 2 (PR1 Informed about changes; PR2 Information to work well) | Yes | 0-200 |
| | Recognition | 2 (RE1 Recognized by management; RE3 Treated fairly) | Yes | 0-200 |
| | Role Clarity | 2 (CL1 Clear objectives; CL3 Expectation) | Yes | 0-200 |
| | Role Conflicts | 3 (CO2 Contradictory demands; CO3 Do things wrongly; IT1 Unnecessary tasks) | No | 0-300 |
| | *Illegitimate Tasks* [a] | | | |
| | Quality of Leadership | 3 (QL2 Prioritize job satisfaction; QL3 Work planning; QL4 Solving conflicts) | Yes | 0-300 |
| | Social Support from Colleagues | 3 (SCX1 Support colleagues; SW1 Atmosphere) | Yes | 0-300 |
| | *Sense of Community at Work* [a] | | | |

| Domain | Dimension/ Scale | No. of Items (Item Name and Label) | High Level Good (Yes/No) | Scale Range (Min-Max) |
|---|---|---|---|---|
| | Social Support from Supervisor | 2 (SSX1 Supervisor listens to problems; SSX2 Support supervisor) | Yes | 0-200 |
| Work-Individual Interface | Commitment to the Workplace | 2 (CW2 Workplace great importance; CWX3 Recommend to other people) | Yes | 0-200 |
| | Job insecurity | 3 (JI1 Unemployed; JI3 Finding new job; IW1 Transferred another job) | No | 0-300 |
| | *Insecurity over Working Conditions* [a] | | | |
| | Job Satisfaction | 2 (JS4 Job in general; JS5 Salary) | Yes | 0-200 |
| | Work Life Conflict | 3 (WFX1 Being in both places; WF2 Energy conflict; WF3 Time conflict) | No | 0-300 |
| Social Capital | Vertical Trust | 2 (TM1 Management trust employees; TMX2 Employees trust information) | Yes | 0-200 |
| | Organizational Justice | 2 (JU1 Conflicts resolved fairly; JU4 Work distributed fairly) | Yes | 0-200 |
| Health and Wellbeing | Self-rated Health | 1 (GH1 General health) | Yes | 0-100 |
| | Sleeping Troubles | 2 (SL2 Hard to sleep; SL4 Woken up several times) | No | 0-200 |
| | Burnout | 4 (BO1 Worn out; BO2 Physically exhausted; BO3 Emotionally exhausted; BO4 Tired) | No | 0-400 |
| | Somatic Stress | 2 (SO1 Stomach-ache; SO2 Headache) | No | 0-200 |
| | Cognitive Stress | 2 (CS2 Difficult thinking clearly; CS4 Difficult remembering) | No | 0-200 |

*Note*. This table provides information on the domains, scales and scoring of the COPSOQ III items (Burr et al., 2019) used in the survey.

[a] Italicized dimensions were single scales combined with similar scales, as outlined in the StressAssess tool

Of the 24 scales used, 10 favour a low score, meaning a low score is good for the participant (Burr et al., 2019). Results with a high score demonstrate participants reported a high level of that dimension (Burr et al., 2019). For example, a high score for the Burnout scale translates to high levels of burnout, but a low score would be desirable for the participant, demonstrating a low level of burnout. For consistency in describing the mean for each scale, a five-point Likert type scale was created and based on the number of items per scale. For example, a one item scale used the following: low (0-20); low-moderate (20-40); moderate (40-60); moderate-high (60-80); and high (80-100). Each item provides a variety of responses to choose from. Two example response options include always; often; sometimes; seldom; never/hardly ever and to a very large extent; to a large extent; somewhat; to a small extent; to a very small.

As a part of the Canadian version of the COPSOQ III, StressAssess created additional questions, following the same format, to assess offensive behaviours workers are exposed to: bullying, threats of violence, physical violence, discrimination and undesired sexual attention (OHCOW, 2024). If participants reported they had been exposed to discrimination in the last 12 months at work, they were additionally asked what type of discrimination they experienced.

The inclusion of open-ended questions to collect qual data was purposeful, with the aim to uncover potential factors relevant to RPNs that may differ from those described in the MHN literature. Open-ended responses also shift the dynamic from the researcher's agenda to the participant, giving a voice to participants. For example, one open-ended questions asked RPNs, "what work-related factors are important to you that may not have been covered in this survey?".

**Strategies Important to the Retention of RPNs.** The second open-ended question offered RPNs a voice, by eliciting suggestions for strategies they feel are important to the retention of RPNs in the workplace. Ideas and comments from participants have the potential to contribute to theoretical and research development (Decorte et al., 2019). One question was provided to assess RPNs thoughts and ideas for retention strategies, "what strategies do you think are important for the retention of registered psychiatric nurses?".

## Data Analysis

### *Preparation*

All variables were coded in Redcap prior to data collection. Each participant data set was assigned a unique record identification (ID) number to track and locate data easier. Prior to finalizing the descriptive statistics or performing analysis of the data set, data was cleaned and checked for missing data, errors and outliers (Costanzo, 2023; Field, 2018). All decisions made were tracked and provided with rationale in a data analysis log. Data was analyzed using descriptive statistics (Field, 2018). Text responses were reviewed manually for comprehension. Prior to forming a decision, data was checked to the original source for comparison (Field, 2018).

Numerical variables were reviewed independently in a scatterplot, this visual analysis was helpful for detection of outliers (Field, 2018). Outliers were confirmed by using data points residing +/- 2.5 the standard deviation as the threshold for exclusion (citation). Non-error outliers were kept considering they represent a natural variation of the population (Dash et al., 2023; Frost, 2019).

No outliers were identified, as all responses were either feasible and/or resided within the numerical variable parameters. REDCap identified missing data points. All records with less than 5% missing data (n = 90; 30%) were kept and deemed acceptable to leave unchanged (Montelpare et al., 2020). The decision to leave the numerical missing data was guided by the descriptive design of the study, which relies on preciseness of means and proportions, not statistical power (Eng, 2003). Records with greater than 5% missing data (n = 7; 2%), were removed from the data set (Kang, 2013; Montelpare et al., 2020).

QCA relied on a manual process, thus cleaning of the qual data relied on the researcher's comprehension of text responses. In the preparation phase, the researcher aimed to make sense of the data (Elo & Kyngäs, 2008), and text responses were reviewed for clarity, understanding and accuracy (Creswell & Plano Clark, 2018). This process included edits for spelling, acronyms, clarity, and punctuation (Costanzo, 2023; Zoss, 2017). All edits and decisions were reviewed by two research supervisors. In preparation for qual data analysis, the text responses were then organized by case ID (Creswell & Plano Clark, 2018) and saved as an excel spreadsheet. All methods aimed to improve the integrity and trustworthiness of the data (Costanzo, 2023; Creswell & Plano Clark, 2018; Montelpare et al., 2020).

### *Quantitative Analysis of Survey Data*

QUAN data was analyzed using Excel and RedCap. Objective one was to discover the percentage of RPNs in BC intending to leave and their direction of departure. This objective was met by specifying the percentage of RPNs intending to leave and their direction of departure (retirement, leaving profession, leaving current

job). Objective two was to determine individual and demand factors impacting RPNs' intent to leave. This objective was met through the exploration of the data using descriptive statistics. Descriptive statistics including frequency distributions, measurements of central tendency (mean, median, mode) and dispersion (standard deviation, range, variance) were used to explore the factors reported by the participants (Field, 2018), identify patterns and trends, and describe characteristics of the population (Reichenheim & Coutinho, 2010; Wang & Cheng, 2020).

### *Qualitative Analysis of Survey Data*

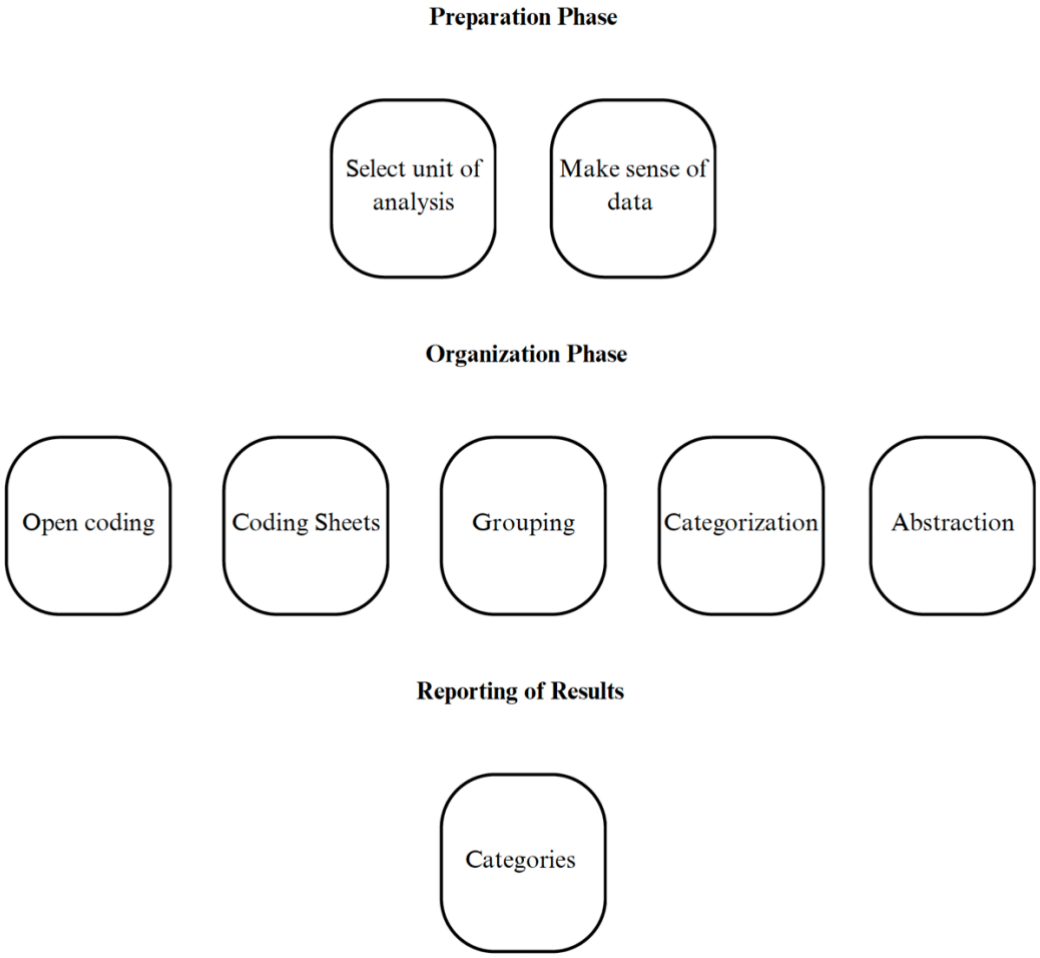
QCA with an inductive approach was used to analyze data meant to complete objectives two and three – determining factors relevant to RPNs in the workplace and strategies RPNs report as important to retention. Inductive QCA is a systematic method of inquiry that analyzes text to generate categories describing a phenomenon and uncovering new insights (Elo & Kyngäs, 2008). QCA is the most used in psychiatry/psychology and is often used to build models or theoretical framework (Elo & Kyngäs, 2008). MMR popularity is likely due to its systematic process and replicability (Kansteiner & König, 2020).

Considering there is not enough knowledge on the career intentions and work environment of RPNs in B.C., the researcher used an inductive approach (specific participant text to general categories or themes) to guide the QCA process (Elo & Kyngäs, 2008). The benefit of this approach is in its neutrality. Based on the data collection method, the decision was made to perform manifest analysis – a basic analysis of the text – compared to latent, a more in-depth approach that considers non-verbal communication of the participant (Bengtsson, 2016; Graneheim & Lundman, 2004). Elos

and Kyngäs (2008) describe the process of QCA in three phases: preparation, organization and reporting of results (see Figure 4).

**Figure 4**

*The Qualitative Content Analysis Process*




*Note.* The QCA process used in this study utilized an inductive approach and is based on the procedures outlined by Elo and Kyngäs (2008).

In the preparation phase, the researcher selected a unit of analysis, suitable data was collected and the researcher attempted to make sense of data (Elo & Kyngäs, 2008). Making sense of the data requires the researcher to read and re-read the text, become

familiar with it, and gain a general sense of it (Elo & Kyngäs, 2008). Organization included open coding, creation of coding sheets, grouping, creation of categories, and abstraction (Elo & Kyngäs, 2008). During this phase, initial exploration of the data included reading through the data, tracking initial thoughts through memos, and writing headings on the printed text (Elo & Kyngäs, 2008). Headings were transferred to coding sheets to allow grouping and categorization (Elo & Kyngäs, 2008). Abstraction is the process of creating categories and sub-categories, ensuring data fit only in one category and not another; this required constant comparison and revisiting to the data (Elo & Kyngäs, 2008). Reporting of results is how the researcher chooses to describe the content of categories, utilizing a selected data visualization approach (Elo & Kyngäs, 2008; Rouder et al., 2021). Data visualization is vital in conveying results and included tables, word clouds, and other creative images (Rouder et al., 2021).

### *Procedures for Drawing Inferences*

Integration in MMR is the essence of the design. The convergent parallel design of the study outlines the first two steps (QUAN/qual data collection and analysis) of integration as occurring simultaneously but independently (Fetter et al., 2013). The design dictates further analysis once the two data sets merge (Fetters et al., 2013). Integration through methods relates to the third step in the convergent parallel design – simultaneous merging of the independently analyzed QUAN/qual data sets, brought together for comparison (Fetters et al., 2013). The purpose is to create integrated and comprehensive results that lend to a greater understanding of the concepts being explored (Creswell & Plano Clark, 2018; Fetters et al., 2013). Integration of data during interpretation and reporting includes joint displays and data transformation to allow

comparison of the common QUAN/qual concepts (Creswell & Plano Clark, 2018). Joint display is a side-by-side visual representation of QUAN/qual results (Fetters et al., 2013), whereas data transformation converts one type of data to the other for further analysis (Onwuegbuzie & Teedlie, 2003). To develop a plan for this study, the researcher utilized the decision tree for integration (Younas & Durante, 2023), the decision was made to compare the QUAN/qual results with tables and graphs and assess how the data converge, diverge, or expand using side-by-side comparison (Creswell & Plano Clark, 2018).

**Factors Relevant to RPNs.** Participants were provided with the opportunity through an open text response to share factors important to RPNs not covered in the survey. Categories/themes emerging from the QCA process and data transformation (QUAN→qual) were used to compare the relevant workplace factors identified through the closed-ended items to the open-ended response themes. Data visualization techniques, such as a word cloud, and joint displays were used to portray the results.

**Retention.** Categories or themes emerged from the data when using QCA – generating a list of retention strategies important to RPNs. Data transformation (qual→QUAN) was used to create a new variable (retention) and the strategies coded based on the categories/themes, which were then compared to different age groups. Transforming the qual→QUAN data allows for the frequency of the themes/categories to be converted to percentages and counts (Fetters et al., 2013). Joint displays were then utilized to summarize the results (Creswell & Plano Clark, 2018; Fetters et al., 2013). Understanding the different needs of generations is important (Buchan et al., 2022; Tomblin Murphy et al., 2022). This process assisted in determining which retention

strategies originate from each generation. Knowledge created from this process will support organizations in employing appropriate strategies based on the demographics of their employees.

**Discrimination.** In the survey, there are three questions assessing the RPN experience of discrimination in the workplace. If participants indicated *yes* to having experienced discrimination, a follow up question asked *from whom,* and a second follow-up question assessed what type of discrimination they experienced with an open text response. QCA was used to identify categories/themes from the types of discrimination reported in open text responses. Joint display compared the QUAN/qual results for the concept of discrimination from the three questions. Data transformation (qual→QUAN) converted the categories/themes to counts and percentages.

**Quantitative Rigor**

Validity and reliability are two concepts used to detail and describe how well a study demonstrates rigor and trust in the study and confidence in results (Heale & Twycross, 2015; Sürücü & Maslakci, 2020)**.** Validity refers to the extent a concept measures what it says it will measure (Heale & Twycross, 2015; Sürücü & Maslakci, 2020). Two previously valid tools, TIS-6 (Bothma & Roodt, 2013) and the Canadian version of COPSOQ called StressAssess (OHCOW, 2024) were integrated into the larger survey for this study. The validity of the initial COPSOQ focused on correlations between scales and found most scales demonstrated low to moderate correlation and generally measured what was intended, and those with moderate correlation measuring different aspects of the same construct (Montelpare et al., 2020). Burr et al. (2019) reports the COPSPQ III factor structure was verified among Canadian workers. TIS-6

confirmed criterion-predictive validity and differential validity, by differing between those intending to leave or stay with statistically significant differences between the two groups (Bothma & Roodt, 2013).

Reliability is concerned with consistency of measuring the concept (Heale & Twycross, 2015). The Cronbach alpha score greater than 0.70 demonstrates internal consistency (Heale & Twycross, 2015). The COPSOQ items have a mean Cronbach alpha of 0.80 (Burr et al., 2019). PSOQ is now in its third version based on studies testing validity and reliability. The test-retest of the COPSOQ II demonstrated good reliability; the data is yet to come for the COPSOQ III test-retest (Burr et al., 2019). TIS-6 demonstrated good reliability with a mean Cronbach alpha 0.80 and factor analysis confirming a one-dimensional construct of turnover intention (Bothma & Roodt, 2013).

**Qualitative Rigor**

Reliability, validity and generalizability collectively are methods used to demonstrate trustworthiness; these principles focus on replicability, use of data processes, and to what extent the results can be applied to a population (Leung, 2015). Trustworthiness refers to the extent a study is based on participants thoughts and experiences and not researcher bias – this translates to confidence in the study throughout all phases of research (Elo et al., 2014). Trustworthiness is the researcher's responsibility, and it is essential to outline the strategies used to strive for trustworthiness *a priori* (Elo et al., 2014). Elo et al. (2014) state trustworthiness is defined by credibility, transferability, dependability, confirmability and authenticity. Credibility relates to how clearly participants are identified and defined (Elo et al., 2014). The stability of data in different settings and over time describes dependability, while confirmability is

concerned with the objectivity of the data and a neutral presentation of results (Elo et al., 2014). Transferability refers to the degree to which the study results can be applied in other settings or with other groups (Elo et al., 2014). Authenticity refers to the researcher's ability to demonstrate different views of the data and relies on the researcher's skill in performing QCA (Elo et al., 2014). This study strived for trustworthiness through actions (see Figure 5) based on the principles described by Elo et al. (2014).

**Figure 5**

*Procedures for Trustworthiness*

| | Preparation | Organization | Reporting of Results |
|---|---|---|---|
| **Credibility** | • Self-awareness as a researcher<br>• Unstructured data collection as much as possible<br>• Pre-testing with RPNs<br>• Clear description of participants (inclusion & exclusion criteria)<br>• Appropriate unit of analysis | • Explain how categories & codes formed<br>• How well do codes/categories cover data<br>• Check for representativeness as a whole<br>• Seek agreement between researchers<br>• Continuous reflection | • Continuous reflection<br>• Detailed description of analysis process<br>• Use of figures/tables to explain categorization process |
| **Confirmability** | • Rationale provided for inclusion & exclusion criteria | • One researcher analyzes<br>• Other researchers carefully follow up on entire analysis process and categorization<br>• Discussion of differing opinions on categorization | • Data presented objectively<br>• Demonstrate neutrality<br>• Demonstrate evidence of how categories were developed<br>• Include examples of participants responses |
| **Dependability** | • Clearly outlined eligibility criteria<br>• Data cleaning reviewed by research supervisors | • Track coding decisions<br>• Use memos to track changes during coding/re-coding/re-labeling | • Describe the analysis process in detail |
| **Transferability** | • Data cleaning reviewed by research supervisors<br>• Clear inclusion & exclusion criteria | • Rich description of the data sets & process | • Data, participants, & sampling method clearly described |
| **Authenticity** | • Develop detailed analysis plan<br>• Analysis plan reviewed by research supervisors | • Research supervisors maintain close overview of analysis process | • Clearly describe how results converge, diverge or expand<br>• Provide enough data to allow for alternate views to be explored |

*Note:* Figure 5 details the methods used to strive for trustworthiness in this study during the three phases of qualitative content analysis (preparation, organization and reporting of results) as outlined by Elo et al. (2014).

# Chapter 5. Results

## Introduction

The internet-based survey was distributed to a sample of 1500 practicing RPNs in B.C. A total of 399 surveys were recorded, and 97 surveys were identified as incomplete as they were not submitted and consent not provided. Completed surveys totaled 302, representing a response rate of 20% (302 completed of 1500 surveys). One TIS-6 had a missing response and was excluded from analysis of turnover intention, 7 records with greater than 5% missing data were removed from analysis to improve integrity of results (Montelpare et al., 2020), 56 records had less than 5% missing data and were coded as missing and missing items were excluded from analysis, as this was unlikely to bias results (Montelpare et al., 2020).

Numeric variables (*age,* and *years of work as a RPN*) were free of errors and error outliers – all data had good probable fit within variable parameters. There was non-error outliers present in *age,* but these were important to include as a variance in data presents a clear description of the population (Dash et al., 2023). All text responses were reviewed to confirm understanding and facilitate familiarity with responses. Minor edits were completed for clarity and anonymity (acronyms, removal of identifying text, spelling, punctuation, and unclear responses). Two records were removed after discovering identical text responses to open-ended questions.

The main objectives of this study were to determine the prevalence of RPNs intending to leave and their direction of departure, factors relevant to their intent to leave (individual, and demand), and strategies RPNs report as important to retention. This

chapter describes the QUAN and qual results from each objective independently, then merges findings in a combined comparison for true mixed methods interpretation.

**Demographic Profile**

Table 2 summarizes the demographic profile of the participants from this study. Of the participants, 83.2% (n = 243) were female, 14.4% were male (n = 42), 1.7% (n = 5) preferred not to say and 0.7% (n = 2) were non-binary. The mean age was 46.54 (*SD* 12.13) with 98.3% (n = 288) of participants having worked as an RPN for at least one year. Only 1.7% (n = 5) were new graduate nurses having worked less than one year. The mean years worked as an RPN was 15.8 (*SD* 11.57). Most of the participants worked in urban settings (85.2%, n = 248) in direct patient care roles (87.7%, n = 256), with the primary workplace setting of community (38.9%, n = 114), and acute care (27%, n = 79). The highest qualification in nursing for participants was a diploma in psychiatric nursing (48.6%, n = 142), followed by degree in psychiatric nursing (34.3%, n = 100), then a masters in either psychiatric nursing or another field (16%, n = 47). Of participants, 65.4% (n = 191) were employed regular full-time and 23.2% (n = 68) work overtime a moderate amount, 23.9% (n = 70) occasionally, 25.3% (n = 74) rarely, or 18.4% (n = 54) never. Participants reported having a support system outside of work (95.5%, n = 276), while relationship status was dispersed between single (16.5%, n = 48), common law (18.6%, n = 54), legally married (51.5%, n = 150), divorced (6.5%, n = 19), separated (4.5%, n = 13), and widowed (2.4%, n = 7).

**Table 2**

*Demographic Characteristics of Participants (n = 293)*

| Sample Characteristics | n (%) | M (*SD*) |
|---|---|---|
| Years worked as an RPN *[a] | 277 | 15.80 (*11.57*) |
| Age *[b] | 282 | 46.54 *(12.13)* |
| 24-27 (Generation Z) | 13 (4.6) | |
| 28-43 (Millennial or Generation Y) | 108 (38.3) | |
| 44-59 (Generation X) | 116 (41.1) | |
| 60-78 (Boomer Generation) | 45 (16) | |
| Gender * | | |
| Female | 243 (83.2) | |
| Male | 42 (14.4) | |
| Non-binary | 2 (0.7) | |
| Prefer not to say | 5 (1.7) | |
| Highest qualification in nursing * | | |
| RPN diploma | 142 (48.6) | |
| Bachelor of psychiatric nursing | 37 (12.7) | |
| Bachelor of science in psychiatric nursing | 63 (21.6) | |
| Masters - psychiatric nursing | 20 (6.8) | |
| Masters - other than nursing | 27 (9.2) | |
| PhD | 3 (1) | |
| Job status * | | |
| Regular full-time | 191 (65.4) | |
| Regular part-time | 70 (24) | |
| Casual | 31 (10.6) | |
| Geographical location * | | |
| Urban | 248 (85.2) | |
| Rural | 37 (12.7) | |
| Remote | 6 (2.1) | |
| Primary workplace setting | | |
| Community | 115 (39.2) | |

| Sample Characteristics | n (%) | M (*SD*) |
|---|---|---|
| Acute care | 81 (27.6) | |
| Other [c] | 33 (11.3) | |
| Addictions | 20 (6.8) | |
| Emergency | 17 (5.8) | |
| Forensics | 11 (3.8) | |
| Education | 10 (3.4) | |
| Outpatient Clinic | 6 (2) | |
| Relationship status [*] | | |
| Legally married | 150 (51.5) | |
| Common-law | 54 (18.6) | |
| Single | 48 (16.5) | |
| Divorced | 19 (6.5) | |
| Separated | 13 (4.5) | |
| Widowed | 7 (2.4) | |

[*] Missing data: Years worked as an RPN (n = 11); Age (n = 11); Gender (n = 1); Highest qualification in nursing (n = 1); Job status (n = 1); Geographical location (n = 2); Relationship status (n = 2).

[a] Only those having worked >1 year were asked this question.

[b] The minimum age was 24 and maximum 76.

[c] Other primary workplace settings reported: Long term care (n = 9); Tertiary (n = 6); Corrections (n = 5); Semi-acute (n = 1); Administration (n = 1); Private practice (n = 1), Foot care (n = 1); Housing (n = 1); Youth custody (n = 1); Adolescent (n = 1; Pediatrics (n = 1), Intellectually delayed with mental health/psychiatric diagnosis (n = 1); Informatics (n = 1); Home based nursing consultant (n = 1); and Complex care (n = 1).

## Objective One: Intent to Leave and Direction of Departure

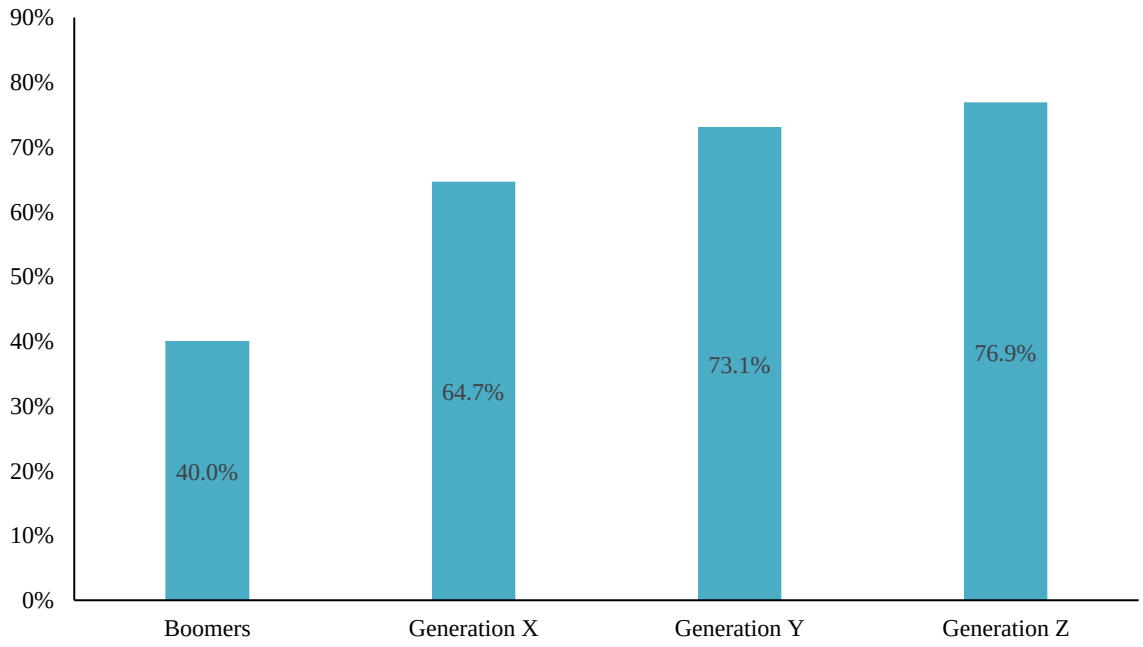
The NEXT Model of Early Departure from Health Care Work lists four potential outcomes: exit (continued nursing), exit from nursing, intent to leave and intent to stay (Hasselhorn et al., 2003). Exit from nursing reflects leaving the profession or retirement. This study assessed all four possible outcomes.

### *Quantitative Findings*

Of the initial sample of 293, one participant did not complete the TIS-6 and was excluded from analysis. With 292 participants completing the TIS-6, 64.4% (n = 188) displayed a desire to leave and 35.6% (n = 104) a desire to stay. The mean TIS-6 score was 19.86 (*SD* 5.28). The desire to leave increased with each generation as displayed in Figure 6.

**Figure 6**

*Desire to Leave by Generations*




*Note*: Figure 6 displays the percentage of those with the desire to leave their organization within each generation of practicing RPNs in British Columbia (n = 282). Ten participants did not report their age, and their results were excluded from this analysis.

Of participants, 51.7% plan to retire in the next 10 years – 21.5% (n = 63) in the next 5 years and 30.2% (n = 85) in 5-10 years. Responses were evenly distributed between 4 of 5 options regarding how often they considered leaving the profession –

never (24.3%, n = 71), rarely (24.0%, n = 70), sometimes (23.6%, n = 69), often (21.9%, n = 64), always (n = 18, 6.2%). Participants were asked about barriers to leaving their job or organization, and results demonstrated 38.3% (n = 72) of those that desire to leave their organization experience barriers to acting on this desire to a very large extent (16.5%, n = 31), to a large extent (21.8%, n = 41), somewhat (31.4%, n = 59), to a small extent (13.3%, n = 25), and to a very small extent (16.5%, n = 31). Direction of departure was summarized in Table 3.

**Table 3**

*Intent to Leave and Direction of Departure[*] (n=292)[a]*

| Outcome | n | % |
|---|---|---|
| Desire to Leave[b] | 188 | 64.4 |
| Desire to Stay | 104 | 35.6 |
| Retire 0-5 years | 64 | 21.5 |
| Retire 0-10 years | 85 | 30.2 |
| Often Consider Leaving the Profession | 64 | 21.9 |

[*] Direction of departure defined by 1) retirement, 2) remain in job 3) leaving profession, and 4) leaving current job.

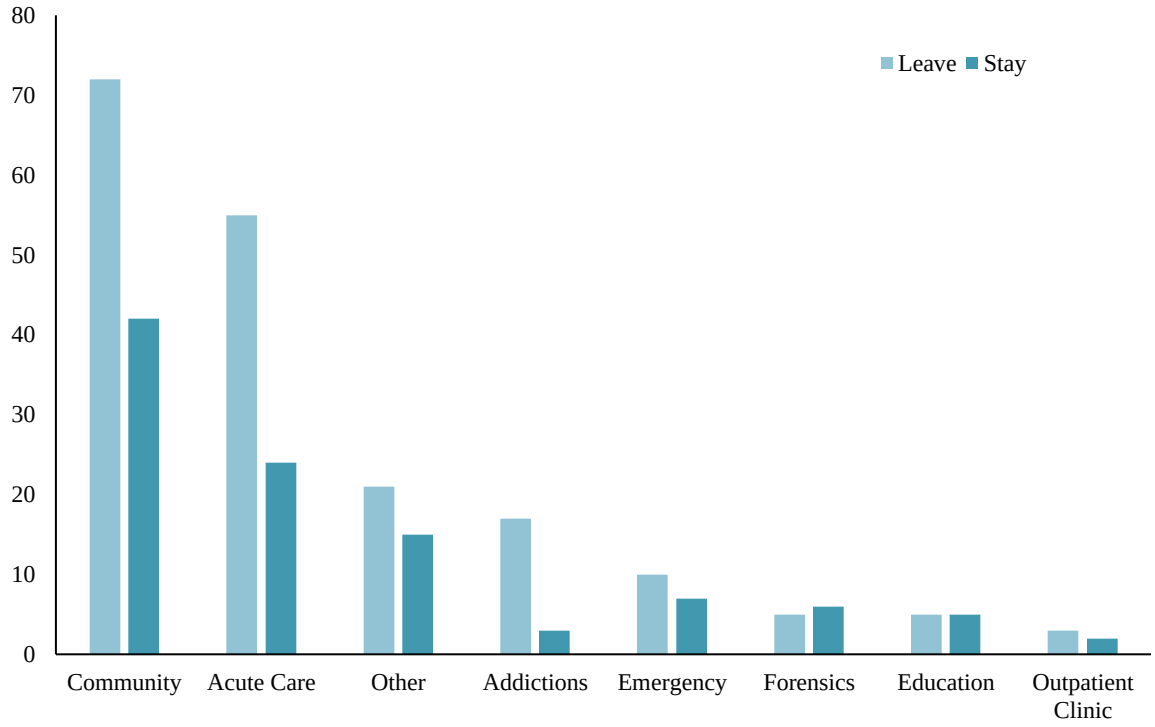
[a] One respondent did not complete the TIS-6 scale and was excluded from analysis.

[b] Of those with a desire to leave, 18.1% (n = 34) plan to retire in 0-5years, and 29.3% (n = 55) plan to retire in 5-10 years.

When comparing workplace settings, those working in addictions (n = 17, 85%), acute care (n = 55, 69.6%) and community (n = 72, 63.2%) had a greater desire to leave that those working in forensics, education, emergency or outpatient clinics. Other workplace settings were more evenly split in the desire to leave or stay (see Figure 7).

**Figure 7**

*Desire to Leave or Stay Compared to Workplace Setting*




*Note*. Figure 7 displays the difference between RPNs that desire to leave or stay based on their workplace setting. . Other primary workplace settings include: Long term care (n = 9); Tertiary (n = 6); Corrections (n = 5); Semi-acute (n = 1); Administration (n = 1); Private practice (n = 1), Foot care (n = 1); Housing (n = 1); Youth custody (n = 1); Adolescent (n = 1; Pediatrics (n = 1), Intellectually delayed with mental health/psychiatric diagnosis (n = 1); Informatics (n = 1); Home based nursing consultant (n = 1); and Complex care (n = 1).

## Objective Two: Factors Relevant to B.C. RPNs in the Workplace

The NEXT Model of Early Departure from Health Care Work considers individual (individual resources such as age and gender) and demand (workplace and private conditions) factors that impact the decision to leave or stay (Hasselhorn et al.,

2003). Results highlighted additional factors potentially important to the RPNs decision to stay or leave that was not found in the literature review.

### *Quantitative Findings*

Of the initial sample of 293, some participants did not complete at least 50% of the items in a scale and were excluded from analysis: n = 6 (<1%) Self-rated Health scale, n = 1 (<1%) Vertical Trust scale, and n = 1 (<1%) Organizational Justice scale. For the COPSOQ III questions scored, each item was scored in a dimension/scale ranged from 0-100. For each dimension scored, mean scale scores, standard deviation and missing values were calculated (see Table 4 ). A higher score is good in most dimensions (COPSOQ International Network, 2021), with exceptions, listed in Table 4.

**Table 4**

*Psychosocial Factors Relevant to RPNs in the Workplace (n = 293)**

| Domain | Dimension/ Scale | No. of Items (Item Name and Label) | High Level Good (Yes/No) | Scale Range (Min-Max) | Scale Mean *(SD)* | Missing Scores [a] | Missing Items [b] |
|---|---|---|---|---|---|---|---|
| Demands at work | Quantitative Demands | 3 (QD2 Complete task; QD3 Get behind; QD4 Enough time) | No | 0-300 | 149.06 (66.06) | 0 | 2 |
| | Emotional Demands | 3 (ED1 Emotional disturbing; EDX2 Deal with other people's problems; ED3 Emotionally demanding) | No | 0-300 | 219.28 (56.84) | 0 | 4 |
| | Work Pace | 2 (WP1 Work fast; WP2 High pace) | No | 0-200 | 133.28 (40.04) | 0 | 1 |
| Work organization and Job Contents | Influence at work | 2 (INX1 Influence decisions on work; IN3 Amount of work) | Yes | 0-200 | 90.10 (42.71) | 0 | 3 |
| | Possibilities for development | 3 (PD1 Take initiative; PD2 Learning new things; PD3 Use skills) | Yes | 0-300 | 223.12 (46.41) | 0 | 1 |
| | Meaning of Work | 2 (MW1 Work meaningful; MW2 Work important) | Yes | 0-200 | 156.57 (41.55) | 0 | 2 |
| Interpersonal Relations and Leadership | Predictability | 2 (PR1 Informed about changes; PR2 Information to work well) | Yes | 0-200 | 100 (46.91) | 0 | 2 |
| | Recognition | 2 (RE1 Recognized by management; RE3 Treated fairly) | Yes | 0-200 | 107.85 (54.33) | 0 | 1 |
| | Role Clarity | 2 (CL1 Clear objectives; CL3 Expectation) | Yes | 0-200 | 125.85 (47.71) | 0 | 2 |
| | Role Conflicts *Illegitimate Tasks* [c] | 3 (CO2 Contradictory demands; CO3 Do things wrongly; IT1 Unnecessary tasks) | No | 0-300 | 160.07 (72.51) | 0 | 6 |
| | Quality of Leadership | 3 (QL2 Prioritize job satisfaction; QL3 Work planning; QL4 Solving conflicts) | Yes | 0-300 | 145.65 (85.16) | 0 | 3 |

| Domain | Dimension/ Scale | No. of Items (Item Name and Label) | High Level Good (Yes/No) | Scale Range (Min-Max) | Scale Mean *(SD)* | Missing Scores [a] | Missing Items [b] |
|---|---|---|---|---|---|---|---|
| | Social Support from Colleagues *Sense of Community at Work* [c] | 3 (SCX1 Support colleagues; SW1 Atmosphere) | Yes | 0-300 | 147.01 (39.06) | 0 | 5 |
| | Social Support from Supervisor | 2 (SSX1 Supervisor listens to problems; SSX2 Support supervisor) | Yes | 0-200 | 122.61 (57.18) | 0 | 4 |
| Work-Individual Interface | Commitment to the Workplace | 2 (CW2 Workplace great importance; CWX3 Recommend to other people) | Yes | 0-200 | 122.18 (49.73) | 0 | 6 |
| | Job insecurity *Insecurity over Working Conditions* [c] | 3 (JI1 Unemployed; JI3 Finding new job; IW1 Transferred another job) | No | 0-300 | 55.12 (68.77) | 0 | 5 |
| | Job Satisfaction | 2 (JS4 Job in general; JS5 Salary) | Yes | 0-200 | 117.41 (45.52) | 0 | 2 |
| | Work Life Conflict | 3 (WFX1 Being in both places; WF2 Energy conflict; WF3 Time conflict) | No | 0-300 | 159.47 (80.84) | 0 | 1 |
| Social Capital | Vertical Trust | 2 (TM1 Management trust employees; TMX2 Employees trust information) | Yes | 0-200 | 109.85 (46.84) | 1 | 4 |
| | Organizational Justice | 2 (JU1 Conflicts resolved fairly; JU4 Work distributed fairly) | Yes | 0-200 | 99.57 (47.28) | 1 | 4 |
| Health and Wellbeing | Self-rated Health | 1 (GH1 General health) | Yes | 0-100 | 52.61 (23.51) | 6 | 6 |

| Domain | Dimension/ Scale | No. of Items (Item Name and Label) | High Level Good (Yes/No) | Scale Range (Min-Max) | Scale Mean *(SD)* | Missing Scores [a] | Missing Items [b] |
|---|---|---|---|---|---|---|---|
| | Sleeping Troubles | 2 (SL2 Hard to sleep; SL4 Woken up several times) | No | 0-200 | 109.73 (57.96) | 0 | 1 |
| | Burnout | 4 (BO1 Worn out; BO2 Physically exhausted; BO3 Emotionally exhausted; BO4 Tired) | No | 0-400 | 249.32 (92.39) | 0 | 1 |
| | Somatic Stress | 2 (SO1 Stomach-ache; SO2 Headache) | No | 0-200 | 73.72 (51.65) | 0 | 1 |
| | Cognitive Stress | 2 (CS2 Difficult thinking clearly; CS4 Difficult remembering) | No | 0-200 | 87.12 (54.88) | 0 | 2 |

[*] n = 293 minus the missing scores for each dimension/scale.

[a] A score is considered missing and not included in calculations if greater than 50 percent of the scale items were missing.

[b] Missing items refers to total number of missing responses in the dimension/scale for the sample.

[c] Italicized dimensions were single scales combined with similar scales, as outlined in the StressAssess tool.

RPNs mean scale score demonstrated moderate to moderate-high levels for seven of nine scales where a low score favours the participant: moderate Quantitative Demands (*M* 149.06), moderate-high Emotional Demands (*M* 219.28), moderate-high Work Pace (*M* 133.28), moderate Role Conflicts (*M* 160.07), moderate Work Life Conflict (*M* 159.47), moderate Sleeping Troubles (*M* 109.73), moderate-high Burnout (*M* 249.32) and moderate Cognitive Stress (*M* 87.12). The exceptions were low Job Insecurity (*M* 55.12) and low-moderate Somatic Stress (*M* 73.72). Fourteen scales favoured high levels, where high levels benefit the participant. RPNs mean scale score was moderate to moderate-high for the following: moderate Influence at work (M 90.10), moderate-high Possibilities for development (*M* 223.12), moderate-high Meaning of Work (*M* 156.57), moderate Predictability (*M* 100), moderate Recognition (*M* 107.85), moderate-high Role Clarity (*M* 125.85), moderate Quality of Leadership (*M* 145.65), moderate Social Support from Colleagues (*M* 147.01), moderate-high Social Support from Supervisor (*M* 122.61), moderate-high Commitment to the Workplace (*M* 122.18), moderate Job Satisfaction (*M* 117.41), moderate Vertical Trust (M 109.85), moderate organizational Justice (M 99.57), and moderate Self-rated Health (*M* 52.61).

RPNs were asked if they had been exposed to or witnessed offensive behaviours during the last 12 months and were able to select more than one option when asked *from whom*/*at whom*. Of the participants, 67.3% (n = 196) were exposed to Threats of Violence, 55.7% (n = 162) Physical Violence, 29.1% (n = 85) Undesired Sexual Attention, and 26.3% (n = 77) Discrimination. Of those that responded yes to being exposed to an offensive behaviour, 100% reported Threats of Violence (n = 196) and Physical Violence (n = 162) from clients/patients, and 94.1% reported Undesired Sexual

Attention from client/patients. Bullying was prevalent at 45.5% (n = 133), with 69.2% (n = 92) reported it from colleagues. Participants reported discrimination from colleagues (n = 41; 53.2%), managers/supervisors (n = 33; 42.9%), and clients/patients (n = 31; 40.3%). Of the 293 participants, 69% (n = 202) reported witnessing offensive behaviours aimed at others than self, during the last 12 months. Of the participants, 68.2% (n = 137) reported the offensive behaviour was aimed at colleagues and 66.2% (n = 133) reported Bullying as the offensive behaviour witnessed followed by Threats of Violence (n = 121; 60.2%), Discrimination (n = 95; 47.3%), Physical Violence (n = 87; 43.3%), and Undesired Sexual Attention (n = 71; 35.3%). Table 5 summarizes the results of offensive behaviours in the workplace.

**Table 5**

*Prevalence of Offensive Behaviours in the Workplace**

| Type of Offensive Behaviour | Exposed to Offensive Behaviour n (%) | | | | | From Whom [a] n (%) | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Yes Daily | Yes Weekly | Yes Monthly | Yes A Few Times | No | Colleagues | Manager/ Supervisor | Subordinates | Client/ Patient |
| Undesired Sexual Attention | 6 (2.1) | 16 (5.5) | 11 (3.8) | 52 (17.8) | 207 (70.9) | 15 (17.6) | 4 (4.7) | 1 (1.2) | 80 (94.1) |
| Threats of Violence | 36 (12.4) | 58 (19.9) | 28 (9.6) | 74 (25.4) | 95 (32.6) | 7 (3.6) | 7 (3.6) | 1 (0.5) | 196 (100) |
| Physical Violence | 19 (6.5) | 35 (12) | 32 (11) | 76 (26.1) | 129 (44.3) | 2 (1.2) | 1 (0.6) | 0 (0) | 162 (100) |
| Bullying | 21 (7.2) | 23 (7.9) | 14 (4.8) | 75 (25.7) | 159 (54.5) | 92 (69.2) | 49 (36.8) | 19 (14.3) | 32 (24.1) |
| Discrimination | 14 (4.8) | 8 (2.7) | 10 (3.4) | 45 (15.4) | 216 (73.7) | 41 (53.2) | 33 (42.9) | 7 (9.1) | 31 (40.3) |
| | Witnessed Offensive Behaviour Aimed at Others n (%) | | | | | At Whom [b] n (%) | | | |
| Witnessed Offensive Behaviour [c] | 29 (9.9) | 50 (17.10 | 29 (9.9) | 94 (32.1) | 91 (31.1) | 137 (68.2) | 27 (13.4) | 29 (14.4) | 103 (51.2) |

[*] Undesired sexual attention (n = 292); Threats of Violence (n = 291); Physical Violence (n = 291); Bullying (n = 292); and Discrimination (n = 293).

[a] Undesired sexual attention (n = 85); Threats of Violence (n = 196); Physical Violence (n = 162); Bullying (n = 133); and Discrimination (n = 77).

[b] The frequency of witnessed offensive behaviours: Undesired sexual attention (n = 71; 35.3%); Threats of Violence (n = 121; 60.2%); Physical Violence (n = 87; 43.3%); Bullying (n = 133; 66.2%); and Discrimination (n = 95; 47.3%).

RPNs reported working fully staffed always (n = 16; 5.5%), often (n = 97; 33.3%), sometimes (n = 91; 31.3%), seldom (n = 63; 21.6%) and never/hardly ever (n = 24; 8.2%). Leadership opportunities were present in the workplace: 10.2% (n = 30) to a very large extent, 21.8% (n = 64) to a large extent, 33.1% (n = 97) somewhat, 21.8% (n = 64) to a small extent, and 13% (n = 38) to a very small extent. RPNs experience with adequate orientation as a new graduate ranged, with 12.7% (n = 37) of participants reporting adequate orientation to a very large extent, 26.7% (n = 78) to a large extent, 26% (n = 76) somewhat, 17.1% (n = 50) to a small extent, and 17.5% (n= 51) to a very small extent. Participants reported a good working relationship between physicians and staff always (n = 61; 21.2%), often (n = 122; 42.4%), sometimes (n = 79; 27.4%), seldom (n = 16; 5.6%), and never/hardly ever (n = 10; 3.5%).

### *Qualitative Findings*

Workplace factors important to RPNs were also assessed using two open-ended questions – one asking what workplace factors were important to them that may not have been covered in the survey and another asking the type of discrimination they were exposed to.

**Workplace Factors.** Based on the analysis of responses (n = 193) of qual data for workplace factors important to RPNs, five main themes emerged: 1) Union, 2) Valuing the Profession, 3) Clinical Operations, 4) Physical and Psychological Safety, and 5) Social Context.

***Union.*** RPNs value their union in supporting a safe work environment and ensuring their work is valued. It was defined by the occurrence of responses discussing

union involvement or union related responsibilities. Four sub-themes emerged from the qual data: Adequacy of Pay, Workplace Benefits, Union Support and High-Quality Mental Health Support.

Two RPNs articulated the need for increased pay related to the high risk of harm in their work environment, one stated, “danger pay for working in unsafe community settings”. Participants also described the inadequacy of pay related to minimum raises only due to inflation instead of performance. One respondent explained the importance of demonstrating ability in relation to wage increase, “being able to successfully work into a higher up position and increase wages – not wages negotiated between the union and employer, as most of the time it is just wages to account for inflation”. Participants clearly described how Workplace Benefits including “vacation time” and “earned days off” were important to them. One response, “effects of cumulative trauma and PTSD” more indirectly led to the sub-theme High Quality Mental Health Support. This theme was defined by responses that portrayed a need for greater support of RPNs mental health in direct relation to what they are exposed to in their workplace environment. Three nurses voiced lack of support from the union in general, one participant wrote “we were not asked if we felt supported by our union - we don't feel supported at all”, and five participants responses related specifically to client care, “nurse-patient ratios”.

***Valuing the Profession.*** Participants voiced the importance of seeking value for the profession. They described the need for recognition and the necessity to be treated as a valued stakeholder at their workplace. The sub-themes were Inclusion, Autonomy, Recognition. RPNs voiced the need to be included as contributors to organizational and policy related issues and how they are invested in their role. One respondent described

the need for leadership/decision makers at the organizational level to consult RPNs related to issues impacting them, "being listened to and having your thoughts/feelings considered when making decisions related to the role of RPN". Other participants used more powerful words such as "transparency" and "trust" to articulate the collaborative workplace they envision for RPNs. Autonomy emerged quickly, as participants voiced their desire to engage in primary decision-making at the clinical care level as well. One respondent described her inability to engage in decision making as "Micromanagement from [the] team lead" and another as limited "level of autonomy over workload". Recognition described the participants as the level of respect and understanding of the RPN role. Participants mentioned that they under-recognized as nurses, for example, one respondent wrote, "RPNs [are] not being given the same value as RNs, [we are] overlooked for training [opportunities]" and "[I'm] not respected [or] my psychiatric nursing specialty, people [don't] realize what I can do".

***Clinical Operations.*** Participants discussed the importance of the day-to-day aspects of managing the work of being in a clinical environment and the staff within that environment. The sub-themes that emerged were Support for Professional Development, Work Environment, Scheduling and Mismanagement. Responses revealed that RPNs want to expand their skillset but lack the time or opportunity to complete professional development – thus the theme Support for Professional Development emerged. One respondent suggested, "[we need] protected time to take education", while many others referred to the lack of opportunity. "[We need] access to what is needed to do [the] job such as appropriate training and education". One respondent acknowledged the importance of continuing education in complex work environments, "working with very

complex patients with no access to psychology or additional training [is difficult]" and "[we have] limited education opportunities for mental health and addiction services".

The participants described the importance of Physical Space where their work is done. For example, participants mentioned the appeal and functionality of the physical environment. One participant recommended that RPNs be provided with "better work areas aesthetically and ergonomically". Another important aspect of the physical space was proximity of the workplace, as it related to "commute distances". Scheduling emerged as a sub-theme and participants discussed work-life balance, and the number of staff working with them when on shift. One respondent shared their experience of trying to manage her workload and she was interested in greater flexibility, "[We need the] opportunity to work permanent part time rather than full time. There are not enough opportunities. It would provide a better work life balance rather than having to go casual".

Mismanagement was described by participants as a disconnect between management and realities of RPN practice. Participants voiced a strong desire for managers with strong leadership skills and a will to advocate for workplaces where RPNs are better able to meet standards of care. One respondent described the disconnect between RPNs and management at their workplace, "there is a large divide between management and floor staff. It often feels as though they place several expectations on us without having any idea of the reality of direct patient care". Another RPN response described the outcome of a negative experience, "When I got my master's degree 10 years ago, I left a great job because the manager harassed me. So, I took a lower paying job with less opportunities". Another respondent described how a decision made by

management impacts the wellbeing and satisfaction of RPNs, "[my] time off requests [is] being denied", potentially influencing their intent to leave.

***Physical and Psychological Safety.*** Participants described work environments as being riddled with physical and psychological safety concerns for clients and RPNs. Moral Distress and RPN Safety emerged as sub-themes. First and foremost, client care was reported as an important workplace factor for RPNs. Participants revealed their dedication to client care and wellbeing, as well as a disdain for the gaps in the system that present physical and psychological safety concerns for clients. One respondent described the physician shortage and lack of community support as a safety concern "[there are] not enough psychiatrists. Doctors are rarely available to discuss clients, and the clients are only seen once every 5-6months. [The] housing crisis has [also] severely affected our clients". RPNs also described feeling helpless in meeting the needs of the client caused moral distress – a psychological and emotional internal battle. RPN Safety was described as concerns with their own psychological and physical safety. One respondent did not feel supported by her workplace and shared that "client abusive behaviour and nurse exposure to substances [are tolerated by] the employer". Other participants were concerned for their safety while working in the community setting, stating they were expected to "drive youth alone" and "work alone".

***Social Context.*** Participants described the many ways Social Context is important to them with the sub-themes of Team Cohesion, Professional Satisfaction, and Mentoring and Clinical Supervision. Team Cohesion was described as the bond and positive relationships between RPNs and others health care professionals. Team Cohesion includes "collaboration", "community", "conflict resolution" and "to work as a

team. The team was not limited to care staff, it included other professionals involved with clients as well, such as Behavioralists and Activity Workers". Professional Satisfaction was mentioned by RPNs as those experiences driving their satisfaction in the workplace. Two participants spoke positively about these factors, such as "value of staying in nursing" and "morale building". Two participants focused on the negative, "interpersonal drama among colleagues and its effect on job satisfaction (I love my job, but I hate the "politics")", and "less bureaucracy would be nice. There are some tasks that are expected of us that I don't see the purpose of. At the end of the day I shouldn't care, except that it takes up time that could be spent with my client or solving a problem".

The third sub-theme, Mentoring and Clinical Supervision was described by participants as a need for more support in the beginning of their career. One respondent identified the need for experienced staff to be available to mentor new RPNs and wrote about "the need for more mentors to support a novice workforce". Another alluded to the significant impact an experienced nurse can have on a new graduate nurse, by writing "the impact of senior nurses on new grads and newer nurses to the field".

**Discrimination.** Discrimination was defined as an offensive behaviour participants are exposed to or a witness of (Burr et al., 2019). Infringing on human rights, discrimination is unfair and/or includes negative treatment of individuals (ZareKhafri et al., 2022). Based on the analysis of responses (n = 63) of qual data for types of discrimination, the following five themes emerged: 1) racism, 2) ageism, 3) ableism, 4) sexual orientation and gender identity, and 5) incivility. Some participants reported experiencing more than one type of discrimination and lack of detail in responses suggest all the discrimination sub-themes lacked depth.

***Racism.*** Racism is defined as beliefs or actions that discriminate against someone based on race, skin colour, national or ethnic origin or culture (citation). Four sub-themes were identified from the responses based on the types of racism reported by RPNs – race, skin colour, national or ethnic origin, and culture. The responses were brief but offer awareness to the racism experienced by RPNs in the workplace. Twenty-one participants wrote "racist", "racial microaggressions", "racism", "racist remarks". Two participants referred to "skin colour", and four referred to national or ethnic origin, "ethnicity", "foreigner", and "culture".

***Ageism.*** Ageism was defined by the participant perspective of discriminatory beliefs or actions based on age. Seven participants reported experiencing "ageism" and "age discrimination", or "age" although it is difficult to understand the context of discrimination they were exposed to. Two responses were clearer and more described their personal experience: "elder" and "I am older so [I am] not considered knowledgeable". In a few words, these nurses describe how they feel perceived by others in the workplace based on their age.

***Ableism.*** This theme was defined by the participants perspective of beliefs or actions that discriminate against someone based on their abilities. Individuals with different levels of ability may experience challenges and require support or accommodation – but often instead are confronted with discrimination(Dhanani et al., 2022). Like the previous discrimination themes, RPNs generally described being discriminated against due to a disability while others were more specific. Two participants wrote "autism", and "being neurodiverse". Three other participants referred to their "disability" or "about having experienced previous health issues".

***Sexual Orientation and Gender Identity*.** This main theme was defined by participants perspective of discrimination in any form related to their Sexual Orientation and Gender Identity. The two sub-themes were anti-2SLGBTQIA+ and Sexism. For the sub-theme anti-2SLGBTQIA+, participants did not describe the details of discrimination. For example, one respondent stated, "homophobia", and another "anti-LGBT". Sexism emerged as a sub-theme based on responses describing discrimination related to their sex assigned at birth, or their gender identity. One respondent reported discrimination, "for being a female in leadership", while another specified "gender discrimination".

***Incivility*.** The responses that informed this theme were the most descriptive and three sub-themes were identified: exclusion, personality conflicts, and physical appearance. Exclusion was defined by the participants as a discriminatory action or belief based on a person's physical, social/emotional exclusion, including rejection, omission, or isolation. One RPN described her experience of being excluded from stepping in to a leadership position: "I was not considered for the leadership position until the previous leader stepped down and no one applied for the position". Two participants felt excluded based on their physical appearance and reported a "weight bias". While others reported discrimination based on personality conflicts that disrupted their workplace: "I was being targeted for things I never did" and "[I was] not being allowed to do my work due to personality conflicts".

### *Combined Comparison*

Combined comparison involves integration of the two types of data to validate one another or contribute to a greater understanding of the concept being studied. Combined comparison strategies used for objective two include data transformation, a

word cloud, and joint displays. To determine relevant workplace factors important to RPNs from the qual data, sub-themes were transformed (qual→QUAN) to enable counts and percentages. A word cloud was created to illustrate the factors most important to RPNs (see Figure 8). Words were used from the subthemes with the most responses: Scheduling (n = 25), Professional Satisfaction (n = 21) and Employee Safety (n = 20). The larger the word, the more frequently the word was used by participants. This resulted in findings that produced a greater understanding of workplace factors important to RPNs.

**Figure 8**

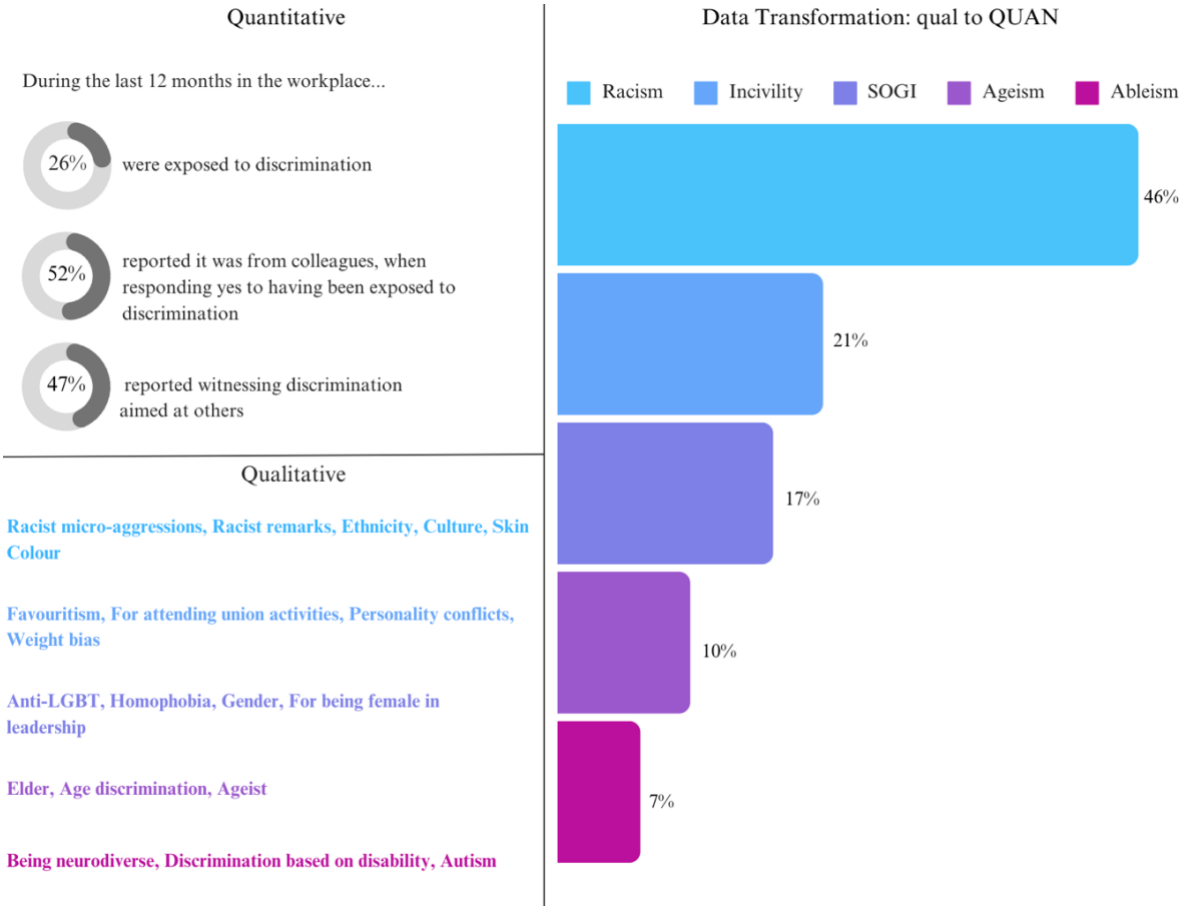
*Word Cloud of Workplace Factors Important to RPNs*


Note: Figure 8 was created using the words from the top three sub-themes of workplace factors important to RPNs.

The categories that emerged from the discrimination qual findings were compared and merged with the QUAN results for discrimination in a joint display – this resulted in confirmed findings that produced a greater understanding of RPNs experiences of discrimination in the workplace (see Figure 9).

**Figure 9**

*Combined Comparison of Discrimination Experienced by RPNs in the Workplace*




*Note:* SOGI = Sexual Orientation and Gender Identity. The qual data above are responses to the type of discrimination RPNs were exposed to. The five themes and their responses were transformed to QUAN data – the percentage reflects the frequency of responses for the theme compared to the total number of responses (n = 77). Frequency for the main themes: Racism (n = 35); Incivility (n = 16); SOGI (n = 13); Ageism (n = 8); Ableism (n = 5).

The qual themes and sub-themes for workplace factors important to RPNs were merged and compared to the corresponding QUAN psychosocial dimensions; this combined comparison outlined how the different dimensions/themes converged, diverged, related and/or produced a greater understanding (see Figure 10). The dimensions that converged with the qual data include Quantitative Demands, Emotional Demands, Work Pace, Working Fully Staffed, Influence at Work, Leadership Opportunities, Meaning of Work, Role Conflict, Adequate New Graduate Orientation, Social Support from Colleagues, Commitment to the Workplace, Working Relationship Between Staff and Physicians, Vertical Trust, Burnout, Physical Violence, Threats of Violence, Bullying, Discrimination and Vicarious Trauma. The dimensions that diverged with the qual data include Quality of Leadership, Role Clarity, Possibilities for Development, Predictability, Recognition, Social Support from Supervisor, and Job Satisfaction. Results that relate include cognitive and somatic stress, sexual harassment, organizational trust, sleeping troubles and self-rated health. Overall, this combined comparison resulted in findings that produced a greater understanding of the psychosocial work environment for RPNs.

**Figure 10**

*Combined Comparison of Psychosocial Workplace Factors Relevant to RPNs*

| **Quantitative**<br><br>Dimension, Score Mean or n (%), Overall Finding | **Qualitative**<br><br>Themes: Sub-themes<br>• Participants responses | **Combined Comparison**<br><br>Converge, Diverge, Relate or Produce Greater Understanding |
|---|---|---|
| Quantitative Demands<br>*M* 149.06<br>Moderate quantitative demands | Clinical Operations – Scheduling<br>• Short staffed<br>• Overuse of sick time<br>Clinical Operations – Mismanagement<br>• In summary...the time to do the job to the standard of care I should and want to meet<br>Union – Union Support<br>• Nurse-patient ratios<br>Incivility – Personality Conflicts<br>• Not being allowed to do my work due to personality conflicts | Converge: Working short staffed, or with high patient-nurse ratios decreases the time for RPNs to perform their skills and care for clients. |
| Emotional Demands<br>*M* 219.28<br>Moderate-high emotional demands | Union – High Quality Mental Health Support for Staff<br>• Compassion fatigue for addictions<br>Physical and Psychological Safety – Moral Distress<br>• Not enough psychiatrists. Doctors are rarely available to discuss clients, and the clients are only seen once every 5-6months. The housing crisis has severely affected our clients<br>Incivility – Personality Conflicts<br>• Being targeted for things I never did, reporting false things | Converge: RPNs need for mental health support is evidence their role impacts them psychologically and emotionally. |
| Work Pace<br>*M* 133.28<br>Moderate-high work pace | Clinical Operations – Scheduling<br>• Short staffed<br>• Overuse of sick time<br>Union – Union Support<br>• Staff to patient ratio | Converge: Like quantitative demands, the lack of time, increased workload, and working short-staffed impacts the pace of work. |
| *Work Fully Staffed*<br>Always (n = 16, 5.5%), often (n = 97, 33.3%), sometimes (n = 91, 31.3%), seldom (n = 63, 21.6%), never/hardly ever (n = 24, 8.2%) | Clinical Operations – Scheduling<br>• Short staffed<br>Incivility – Personality Conflicts<br>• PCC cancelled shifts, did not respond to emails and blocked me from picking up on another unit | Converge: Staffing is a major concern for RPNs – 64% of participants report working short-staffed *often* or *sometimes.* |

| **Quantitative**<br><br>Dimension, Score Mean or n (%), Overall Finding | **Qualitative**<br><br>Themes: Sub-themes<br>• Participants responses | **Combined Comparison**<br><br>Converge, Diverge, Relate or Produce Greater Understanding |
|---|---|---|
| Influence at work<br>*M* 90.10<br>Moderate influence at work | Valuing the Profession - Autonomy<br>• Level of autonomy over workload<br>Valuing the Profession - Inclusion<br>• Being listened to and having your thoughts/feelings considered when making decisions related to the role of RPN | Converge: There is room for growth with RPNs level of influence at work, they seek autonomy and a voice. |
| Possibilities for development<br>*M* 223.12<br>Moderate-high possibilities for development | Clinical Operations - Support for professional development<br>• Opportunities for professional development<br>• Limited opportunities for advancement or education<br>Valuing the Profession – Inclusion<br>• RPNs not being given the same value as RNs, being overlooked for training | Diverge: RPNs acknowledge the possibilities for development are relatively high – this is a mismatch as they often reported needed more support for professional development. |
| *Leadership Opportunities*<br>To a very large extent (n = 30, 10.2%), to a large extent (n = 64, 21.8%), somewhat (n = 97, 33.1%), to a small extent (n = 64, 21.8%), to a very small extent (n = 38, 13.0%) | Clinical Operations - Support for professional development<br>• Limited opportunities for advancement or education<br>Valuing the Profession - Autonomy<br>• Level of autonomy over workload<br>Valuing the Profession - Recognition<br>• RPNs not being given the same value as RNs, being overlooked for training<br>Incivility – Exclusion<br>• I was not considered for the leadership position until the previous leader step down and no one applied for the position | Converge: Majority of participants report leadership opportunities are largely available. There is room for growth and RPNs display a strong need for more work opportunities and leadership. |
| Meaning of Work<br>*M* 156.57<br>Moderate-high meaning of work | Physical and psychological safety – Moral Distress<br>• Inadequate services for clients with complex mental health challenges<br>Social Context – Professional Satisfaction<br>• Mental engagement - the work needs to be stimulating | Converge: RPNs demonstrate unease and evidence of moral distress in their responses, acknowledging their work and the care they provide is important to them. |
| Predictability<br>*M* 100<br>Moderate predictability | Valuing the Profession – Inclusions<br>• Transparency<br>• Management listening to our perspective | Diverge: RPNs seek increased inclusion and a desire to be involved in decision-making. |

| **Quantitative**<br><br>Dimension, Score Mean or n (%), Overall Finding | **Qualitative**<br><br>Themes: Sub-themes<br>• Participants responses | **Combined Comparison**<br><br>Converge, Diverge, Relate or Produce Greater Understanding |
|---|---|---|
| **Recognition**<br>*M* 107.85<br>Moderate recognition | Valuing the Profession – Recognition<br>• Acknowledging staff strengths<br>Valuing the Profession – Inclusion<br>• Not being respected regarding my psychiatric nursing specialty people not realizing what I can do | Diverge: Moderate levels of recognition diverge from the need multiple qual responses for an increase in recognition from employers, managers and physicians. |
| **Role Clarity**<br>*M* 125.85<br>Moderate-high role clarity | Clinical Operations – Mismanagement<br>• There is a large divide between management and floor staff. It often feels as though they place several expectations on us without having any idea of the reality of direct patient care | Diverge: RPNs report a divide between management and staff despite reporting moderate-high role clarity – evidence of an understanding of their work expectations. |
| **Role Conflicts**<br>*M* 160.07<br>Moderate role conflict | Social Context – Team Cohesion<br>• Communication<br>• Team Collaboration<br>Social Context – Professional Satisfaction<br>• Less bureaucracy would be nice. There are some tasks that are expected of us that I don't see the purpose of. At the end of the day I shouldn't care, except that it takes up time that could be spent with my client or solving a problem<br>Clinical Operations – Mismanagement<br>• There is a large divide between management and floor staff. It often feels as though they place several expectations on us without having any idea of the reality of direct patient care | Converge: There is some qual evidence RPNs needs improved communication between management and staff regarding expectations. This converges with the moderate role conflict and room for improvement for clarification of work demands. |
| ***Adequate New Graduate Orientation***<br>To a very large extent (n = 37, 12.7%), to a large extent (n = 78, 26.7%), somewhat (n = 76, 26.0%), to a small extent (n = 50, 17.1%), to a very small extent (n = 51, 17.5%) | Social Context – Mentoring and Clinical Supervision<br>• The need for more mentors to support a novice workforce<br>• The impact of senior nurses on new grads and newer nurses to the field<br>• Clinical supervision and support | Converge: Only 39.4% of RPNs reported adequate orientation *to a very large extent* or *to a large extent*. This converges with the qual data responses that outline the need for more mentorship and support for new graduate nurses. |

| **Quantitative**<br><br>Dimension, Score Mean or n (%), Overall Finding | **Qualitative**<br><br>Themes: Sub-themes<br>• Participants responses | **Combined Comparison**<br><br>Converge, Diverge, Relate or Produce Greater Understanding |
|---|---|---|
| **Quality of Leadership**<br>*M* 145.65<br>Moderate quality of leadership | Clinical Operations – Mismanagement<br>• Manager should have education and understanding of the field they are managing<br>• Management/ supervisors that are more involved in direct patient care<br>• Improved leadership - the leaders now are punitive, ill informed, poorly trained<br>Valuing the Profession<br>• Micromanagement from team lead<br>Clinical Operations – Support for Professional Development<br>• Protected time to take education<br>Clinical Operations – Scheduling<br>• Short staffed | Diverge: The qual data diverges from the moderate levels of Quality of Leadership describing a divide and challenge with supervisors and management. |
| **Social Support from Colleagues**<br>*M* 147.01<br>Moderate social support from colleagues | Social Context – Team Cohesion<br>• To work as a team. This does not just mean primary care staff, but other professionals involved with the clients such as Behavioralists or Activity workers<br>• Lack of meaningful reflective practice within teams<br>Social Context – Professional Satisfaction<br>• Interpersonal drama among colleagues and its effect on job satisfaction (I love my job, but I hate the "politics") | Converge: The qual data suggests teamwork could improve, reflecting the moderate social support from colleagues. |
| **Social Support from Supervisor**<br>*M* 122.61<br>Moderate-high social support from supervisor | Social Context – Team Cohesion<br>• How supported we are<br>Social Context – Mismanagement<br>• Improved leadership - the leaders now are punitive, ill informed, poorly trained | Diverge: Despite the qual data describing a need for improved leadership, RPNs report moderate-high social support. This is evidence majority of RPNs have positive relationships with supervisors. |
| ***Working Relationship Between Staff and Physicians***<br>always (n = 61, 21.2%), often (n = 122, 42.4%), sometimes (n = 79, 27,.%), seldom (n = 16, 5.6%), never/hardly ever (n = 10, 3.5%) | Valuing the Profession – Recognition<br>• Not being respected regarding my psychiatric nursing specialty, people not realizing what I can do<br><br>Valuing the Profession – Inclusion<br>• Trust<br>• Not being respected regarding my psychiatric nursing specialty people not realizing what I can do | Converge/Relate: 63.6% report a good working relationship *often* or *always.* While majority of RPNs have a positive experience, and qual data does not mention the specific relationship between staff and physicians in a positive or negative way. |

| **Quantitative**<br><br>Dimension, Score Mean or n (%), Overall Finding | **Qualitative**<br><br>Themes: Sub-themes<br>• Participants responses | **Combined Comparison**<br><br>Converge, Diverge, Relate or Produce Greater Understanding |
|---|---|---|
| **Commitment to the Workplace**<br>*M* 122.18<br>Moderate-high commitment to workplace | Physical and psychological safety – Moral Distress<br>• Not enough psychiatrists. Doctors are rarely available to discuss clients, and the clients are only seen once every 5-6months. The housing crisis has severely affected our clients<br><br>Social Context – Professional Satisfaction<br>• You asked about personal satisfaction at work. It's not personal, it's professional. Professional satisfaction drives me at work | Converge/Relate: QUAN data demonstrates RPNs are committed to their work with clients, this is supported by the responses discussing client care as important to them. |
| **Job Insecurity**<br>*M* 55.12<br>Low job insecurity | Social Context – Professional Satisfaction<br>• Job uncertainty | Diverge/Relate. There is only one mention of job uncertainty. Not enough data to support convergence. |
| **Job Satisfaction**<br>*M* 117.41<br>Moderate job satisfaction | Union – Adequacy of pay<br>• Danger pay for working in unsafe community settings<br>• Adequate compensation - getting paid for overtime and premiums<br>Valuing the Profession – Recognition<br>• Not being respected regarding my psychiatric nursing specialty, people not realizing what I can do<br>Social Context – Professional Satisfaction<br>• You asked about personal satisfaction at work. It's not personal, it's professional. Professional satisfaction drives me at work<br>Union - Workplace Benefits<br>• Vacation time<br>Clinical Operation – Mismanagement<br>• Level of shared (or differing values) between colleagues and supervisors regarding client care<br>Physical and Psychological – Employee Safety<br>• What are workplaces doing for employee safety | Converge. RPNs qual responses indicate a lower job satisfaction that what is reported through QUAN results. |
| **Work Life Conflict**<br>*M* 159.47<br>Moderate work-life conflict | Clinical Operations – Scheduling<br>• Shift work and impacts to families<br>• Work life balance<br>Incivility – Exclusion<br>• Discrimination/judgement for family role/obligations | Converge. Data supports RPNs struggle with the balance between work and life. |

| **Quantitative**<br>Dimension, Score Mean or n (%), Overall Finding | **Qualitative**<br>Themes: Sub-themes<br>• Participants responses | **Combined Comparison**<br>Converge, Diverge, Relate or Produce Greater Understanding |
|---|---|---|
| **Vertical Trust**<br>*M* 109.85<br>Moderate vertical trust | Valuing the Profession – Inclusion<br>• Being listened to and having your thoughts/feelings considered when making decisions related to the role of RPN<br>Clinical Operations – Mismanagement<br>• There is a large divide between management and floor staff. It often feels as though they place several expectations on us without having any idea of the reality of direct patient care | Converge/Relate. RPNs do not feel heard, and this can appear as lack of trust. |
| **Organizational Justice**<br>*M* 99.57<br>Moderate organizational justice | Social Context – Professional Satisfaction<br>• Fairness/justice<br>Social Context – Team Cohesion<br>• Conflict resolution<br>• | Relate. There is mention of fairness/justice and conflict resolution in qual data, but more data is needed to support fairness in the workplace. |
| **Self-rated Health**<br>*M* 52.61<br>Moderate self-rated health | Union – High Quality Mental Health Support for Staff<br>• Compassion fatigue for addictions<br>• Effects of cumulative trauma and PTSD<br>Clinical Operations – Scheduling<br>• Work life balance | Relate. There is a need for increased support of RPNs mental health from the qual data. |
| **Sleeping Troubles**<br>*M* 109.73<br>Moderate sleeping troubles | Union – High Quality Mental Health Support for Staff<br>• Compassion fatigue for addictions<br>• Effects of cumulative trauma and PTSD<br>Clinical Operations – Scheduling<br>• Work-life balance | Relate. The qual data surrounding the impacts of their work relate to the moderate sleeping troubles. |
| **Burnout**<br>*M* 249.32<br>Moderate-high burnout | Union – High quality mental health support for staff<br>• Compassion fatigue for addictions<br>• Effects of cumulative trauma and PTSD<br>Physical and Psychological Safety – Moral Distress<br>• Not enough psychiatrists. Doctors are rarely available to discuss clients, and the clients are only seen once every 5-6months. The housing crisis has severely affected our clients”<br>• Lack of allied health for patients<br>Incivility – Personality Conflicts<br>• Not being allowed to do my work due to personality conflicts<br>Clinical Operations – Scheduling<br>• Work life balance | Converge. The many factors impacting levels of burnout are included in RPNs qual responses. |

| **Quantitative**<br>Dimension, Score Mean or n (%), Overall Finding | **Qualitative**<br>Themes: Sub-themes<br>• Participants responses | **Combined Comparison**<br>Converge, Diverge, Relate or Produce Greater Understanding |
|---|---|---|
| **Somatic Stress**<br>*M* 73.72<br>Low-moderate somatic stress | Union - High quality mental health support for staff<br>• Effects of cumulative trauma and PTSD<br>Physical and Psychological Safety – Moral Distress<br>• Not enough psychiatrists. Doctors are rarely available to discuss clients, and the clients are only seen once every 5-6months. The housing crisis<br>Incivility – Personality Conflicts<br>• Not being allowed to do my work due to personality conflicts | Relate. The many factors included in RPNs qual responses relate to causes of stress. |
| **Cognitive Stress**<br>*M* 87.12<br>Moderate cognitive stress | Union - High Quality Mental Health Support for Staff<br>• Effects of cumulative trauma and PTSD<br>Physical and Psychological Safety – Moral Distress<br>• Not enough psychiatrists. Doctors are rarely available to discuss clients, and the clients are only seen once every 5-6months. The housing crisis<br>Incivility<br>• Not being allowed to do my work due to personality conflicts | Relate. The many factors included in RPNs qual responses relate to causes of stress. |
| **Sexual Harassment**<br>Exposed to undesired sexual attention: 29.1% (n = 85)<br>From whom: 94.1% (n = 81) client/patient; 17.6% (n = 15) colleagues | Union - High Quality Mental Health Support for Staff<br>• Effects of cumulative trauma and PTSD<br>Physical and Psychological Safety – Employee Safety<br>• Client abusive behaviour, nurse exposure to substances the employer expects us to tolerate | Relate. The qual data does not specifically mention sexual harassment. More exploration is needed. |
| **Threat of Violence**<br>Exposed to threats of violence: 67.3% (n = 196)<br>From whom: 100% (n = 196) client/patient; 3.6% (n = 7) colleagues; 3.6% (n = 7) manager/supervisor | Union - High Quality Mental Health Support for Staff<br>• Effects of cumulative trauma and PTSD<br>Physical and Psychological Safety – Employee Safety<br>• Client abusive behaviour, nurse exposure to substances the employer expects us to tolerate<br>• What are workplaces doing for employee safety | Converge. The QUAN data is overwhelming, in that 67% of participants experience threats of violence. This is supported with the qual data for the prioritization of employee safety. |
| **Physical Violence**<br>Exposed to physical violence: 55.6% (n = 162)<br>From whom: 100% (n = 162) client/patient; 1.2% (n = 2) colleagues | Union - High Quality Mental Health Support for Staff<br>• Effects of cumulative trauma and PTSD<br>Physical and Psychological Safety – Employee Safety<br>• Violence precautions | Converge. The data provide evidence physical violence is common for RPNs and they need more protections physically and mentally. |

| **Quantitative**<br>Dimension, Score Mean or n (%), Overall Finding | **Qualitative**<br>Themes: Sub-themes<br>• Participants responses | **Combined Comparison**<br>Converge, Diverge, Relate or Produce Greater Understanding |
|---|---|---|
| **Bullying**<br>Exposed to bullying: 45.6% (n = 133)<br>From whom: 69.2% (n = 92) colleagues; 36.8% (n = 49) manager/supervisor; 24.1 (n = 32); 14.3% (n = 19) subordinates | Union - High Quality Mental Health Support for Staff<br>• At worst, daily bullying in past<br>Physical and Psychological Safety – Employee Safety<br>• What outcomes are in place for colleagues who mistreated each other<br>Incivility – Personality Conflicts<br>• Not being allowed to do my work due to personality conflicts | Converge. RPNs describe bullying from colleagues the most. This is an ongoing issue that is supported with qual data. |
| **Discrimination**<br>Exposed to discrimination: 26% (n = 77)<br>From whom: 53.2% (n = 41) colleagues; 42.9% (n = 33) manager/supervisor; 40.3% (n = 31) client/patient | Racism – Race<br>• Racist microaggressions<br>Ageism<br>• Age discrimination<br>Incivility – Exclusion<br>• For attending union activities<br>Ableism<br>• Discrimination based on disability<br>Sexual Orientation and Gender Identity<br>• Anti-LGBT<br>Physical and Psychological Safety – Employee Safety<br>• What outcomes are in place for colleagues who mistreated each other | Converge and produce a greater understanding. The qual data provides information to the type of discrimination experienced by RPNs. The qual data provides an understanding to where the discrimination originates. |
| **Vicarious Offensive Behaviours**<br>Witnessed offensive behaviour: 69% (n = 202); At whom: 68.2% (n = 137) colleagues, 51.2% (n = 103) client/patient. Type of offensive behaviour: 66.2% (n = 133) bullying, 60.2% (n = 121) threats of violence, 47.3% (n = 95) discrimination, 43.3% (n = 87) physical violence, 35.3% (n = 71) undesired sexual attention | Union - High Quality Mental Health Support for Staff<br>• Effects of cumulative trauma and PTSD<br>Physical and Psychological Safety – Employee Safety<br>• Client abusive behaviour, nurse exposure to substances the employer expects us to tolerate<br>• What outcomes are in place for colleagues who mistreated each other<br>Physical and Psychological Safety – Moral Distress<br>• Mixture of demographics causing conflict for patients/clients and staff | Converge, relate and produce a greater understanding. The qual data provide detail to the experiences of RPNs in the workplace and the QUAN exemplifies the significance of the vicarious trauma in the workplace. |

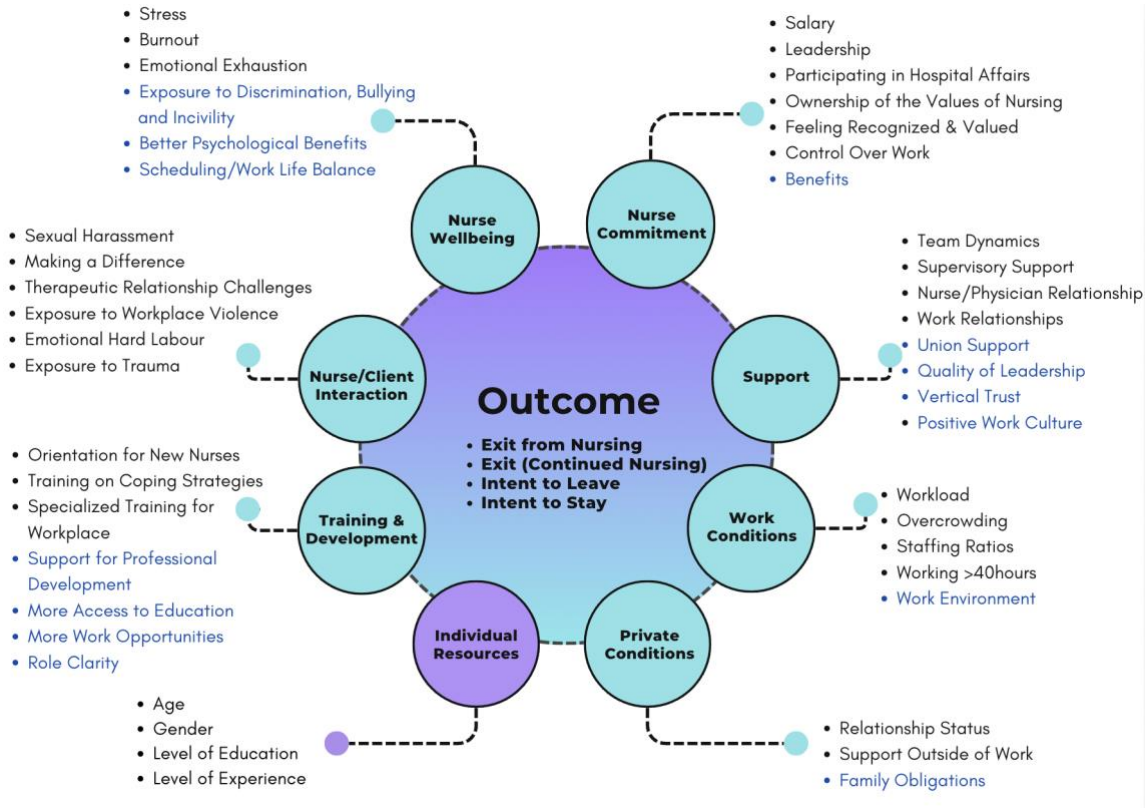
*Note*: This figure compares the themes that emerged from the qual data to a related dimension and reported how they converged, diverged, relate and/or produced a greater understanding. Italicized dimensions were items created for this survey. A scale was created and used to analyze the mean scores for each scale: 1) one-item scale low (0-20); low-moderate (20-40); moderate (40-60); moderate-high (60-80); and high (80-100), 2) two-item scale: low (0-40); low-moderate (40-80); moderate (80-120); moderate-high (120-

160); and high (160-200), 3) three-item scale: low (0-60); low-moderate (60-120); moderate (120-180); moderate-high (180-240); and high (240-300, 4) four-item scale: low (0-80); low-moderate (80-120); moderate (120-240); moderate-high (240-320); and high (320-400).

Figure 11 builds on the preliminary model of workplace factors impacting MHNs intent to leave developed from literature review findings. The model evolved to now include QUAN and qual findings from this study (individual and demand factors) that may potentially impact RPNs intent to leave.

**Figure 11**

*Potential Factors Impacting MHN and RPNs Decision to Leave or Stay*




Note. This framework builds on the preliminary framework (Figure 2) developed from the literature review using the *NEXT* Model of Departure from Health Care Work categories and principles. Building on the literature review findings, this model includes additional factors based on the findings from this study. Black writing represent the factors impacting MHNs intent to leave, assembled from the literature review. Blue writing indicates the additional factors important to RPNs intent to leave.

## Objective Three: Strategies Important to the Retention of RPNs

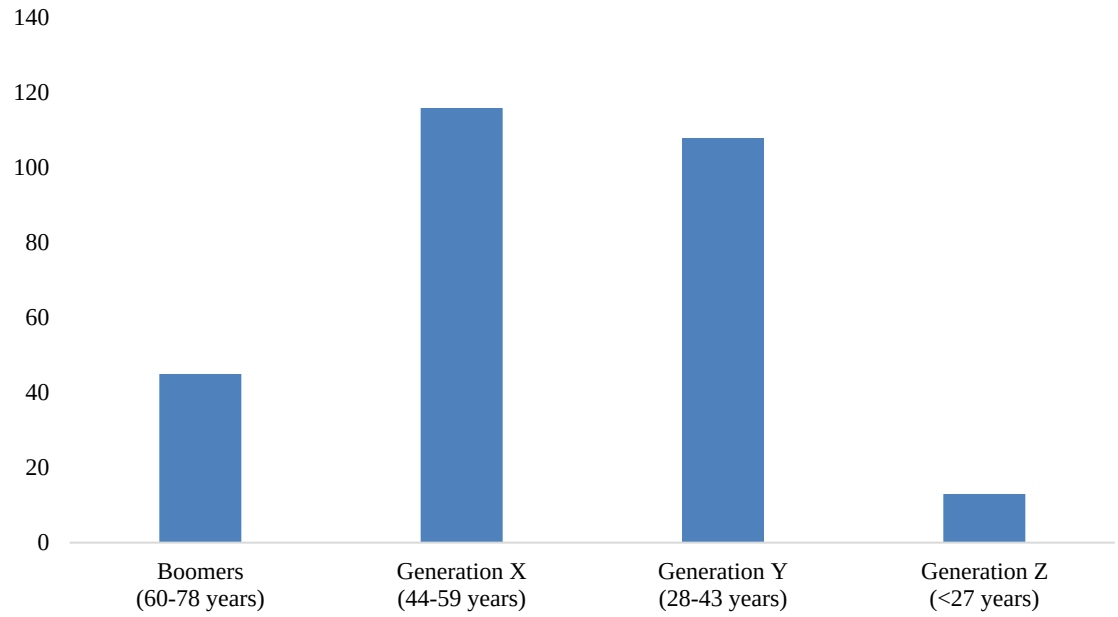
The third objective used The NEXT Model of Early Departure from Health Care Work to frame how strategies can positively or negatively influence the decision to leave or stay (Hasselhorn et al., 2003). The results highlight the significance of listening to the voice of the population (RPNs) and tailoring retention strategies to each nursing sub-group.

### *Quantitative Findings*

Each respondent's age was grouped into a matching generation based on the following year ranges: Boomers (1946-1964); Gen X (1965-1980); Gen Y, (otherwise known as Millennials) (1981-1996); and Gen Z (1997-2012) (Brunjes, 2019). Of the participants, 41.1% (n = 116) were Gen X, 38.3% (n = 108) Gen Y, 16% (n = 45) Boomers, and 4.6% (n = 13) Gen Z.

**Figure 12**

*Participants by Generation*




*Note*: Boomers (1946-1964); Generation X (1965-1980); Generation Y (1981-1996); Generation Z (1997-2012).

Frequency for generations: Boomers (n = 45); Gen X (n = 116); Gen Y (n = 108); Gen Z (n = 13).

### *Qualitative Findings*

Based on the analysis of responses (n = 218) of qualitative data, five main themes emerged: 1) Compensation and Benefits, 2) Opportunity for Advancement, 3) Feeling Valued, 4) Supportive Work Environments, and 5) Safer Work Environments.

**Compensation and Benefits.** This theme captured workplace strategies and offerings related to the benefits and compensation that RPNs desire. The responses heavily focused on wage and incentives, ways to maintain their mental health, and the need for greater support from the union for a variety of reasons. Three main themes emerged from the RPNs responses – Money, Better Psychological Benefits and Empowering Unions. For the main theme Money, many RPNs described the need for

better compensation, “fair wage”, “increase pay to match inflation”, while others focused on the risks they face in the workplace, “[we need] stricter, less vague language regarding working short and appropriate compensation for same”. One RPN highlighted how different workplace settings impact pay:

> All RPN's need to be under British Columbia Nurses Union, [and the] Nurses Bargaining Association contract to receive proper wage and classification. We lost a lot working for Crown corporation and their low paying Collective Agreement with Community Living British Columbia and Jail Nurses.

RPNs also suggested various monetary incentives as strategies important to the retention of RPNs such as, “annual retention bonuses”, “incentives for redeployment”, and “more paid vacation”.

Empowering Unions was a main theme that emerged from RPNs responses that conveyed a passionate voice regarding an increased need of support from their union on a personal and professional level. One concerned RPN stated, “British Columbia Nurses Union does little more than collude with employers to hide patient abuses and staff abuse. Nurses need better protections than what BCNU offers”. Others suggested strategies describing the need for greater support from the union regarding language in their contract, as one RPN explained, “clearer language in the nurse's bargaining association, [so there is] less room for interpretations by the employer”. RPNs repeatedly suggested they need union support to provide safe patient care, “[there needs to be] review of patient loads to give more time for one-on-one time with clients”, “[we need]

safer patient ratios", "[we need a] reduced workload to enable meeting practice standards". Other RPNs suggested union support is needed for "longer breaks" and "fair job delegation".

Better Psychological Benefits emerged as a theme for RPN desire for strategies that support mental health and reflect the hazardous nature of their profession. In only a few words, many RPNs described the impact their role plays and the need for self-care, "[we need] increased time off due to emotional trauma", and "support for mental health days". Others focused retention suggestions on mental health specific benefits, "[there needs to be] post-traumatic stress disorder screening and attention to front line mental health and family wellness" and "[we need] counselling that is fully covered, we basically have free massages all year but only 6 counseling appointments".

**Opportunity for Advancement.** This main theme emerged from RPNs responses and revealed a determination and desire to expand the profession provincially and nationally. Four sub-themes were identified: More Access to Education, More Work Opportunities and Advances, Honouring Competencies, and Better Training. For the sub-theme More Access to Education, RPNs described strategies to increase their knowledge and credentials, impacting their opportunity for advancement "[we need] education opportunities to increase skill set", "[educational opportunities and master's programs", and "cross training to RN functions, [and] opportunities in work in acute care settings". Regarding More Work Opportunities and Advances, RPNs seek more work opportunity with their scope and suggest expansion of their profession, stating "[we need] more work options. RPNs are never included in policy, and [psychiatric nursing] appears not recognized even though it is a specialty", "[RPNs need to] expand to other provinces",

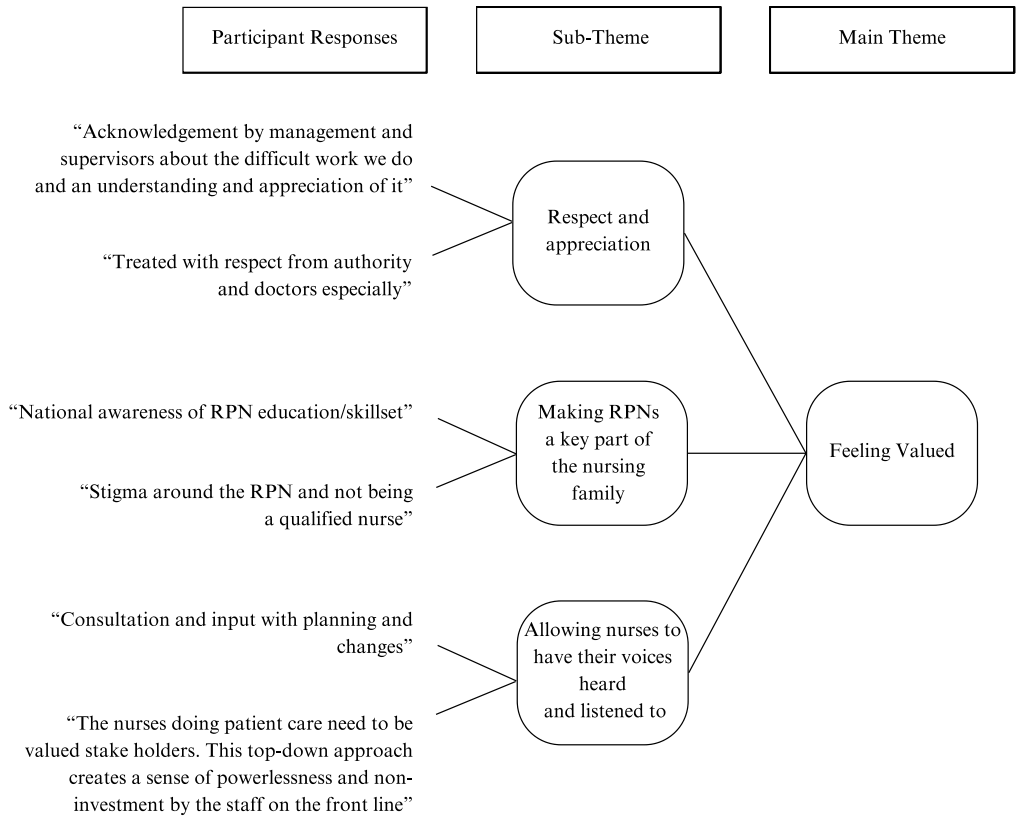
and “[they need to] open more job opportunities”. Honouring Competencies was a sub-theme linked to advancement. RPNs suggested “role clarity” and “increased awareness of scope of practice and opportunities to work in medical fields” is needed. One RPN stated “[we need to] reduce the double-standard of RPNs not being a specialty for mental health positions as well as being excluded from entry-level positions outside of mental health or long-term care positions”. The responses conveyed RPNs feel they are not utilized to their full scope and want more opportunities to work in medical settings.

Better Training was a key theme that emphasized the importance of RPN education, orientation, mentorship and professional development. Some described the need to better prepare RPNs for the workforce, “[it is challenging] not having primary care when your expected to get out of your specialty and do things such as public health”, and “[there should be] increased learning for psychotherapy skills as many employers expect RPNs to have counselling skills which is not realistic”. Other RPNs focused on the integration into the workforce by suggesting, “longer orientation”, “more mentorship of younger nurses”, and “proper orientation and supporting of new graduates”.

**Feeling Valued.** Many nurses expressed their desire to be heard, respected, appreciated and recognized for the value they offer in providing specialized mental health care. RPNs seek to be valued by physicians, organizations, their union and RNs. Three sub-themes surfaced as illustrated in Figure 13: Respect/Being Appreciated, Allowing Nurses to have Their Voices Heard and Listened To, and Making RPNs a Key Part of the Nursing Family.

**Figure 13**

*Sample Abstraction Process: Feeling Valued*




*Note:* This figure depicts the process of abstraction for one of the main and sub-themes for workplace factors important to RPNs.

The first sub-theme, Respect and Appreciation, was clearly articulated by RPNs, "[I want to be] treated like a person (not a number) by health authorities", "[we deserve to be] treated with respect from authority and doctors especially", and "[ we need] acknowledgement by management and supervisors about the difficult work we do and an understanding and appreciation of it". One RPN referred to stigma as a barrier to respect, describing how their knowledge and skill are not always valued, "[there needs to be] more work to reduce stigma, so doctors take you seriously when there are medical

concerns present". Allowing Nurses to have Their Voices Heard and Listened To, was a sub-theme that represented RPNs wanting a seat at the table. They want to not only contribute but have their voices heard to create a sense of belonging and personal job satisfaction, as one RPNs described, "the nurses doing patient care need to be valued stake holders. This top-down approach creates a sense of powerlessness and non-investment by the staff on the front line". Other RPNs explicitly stated how they want to be included in decision making, "[I want to be] listened to by management", "management/directors need to talk to front line staff before making changes", and "[RPNs need] consultation and input with planning and changes".

Making RPNs a Key Part of the Nursing Family was the third sub-theme to emerge, highlighting the work to be done to ensure RPNs are recognized for their specialized skillset among nurses as a group. Their responses also reflect how RPNs are specialized nurses, yet the general population (including other nurses), do not have knowledge of their unique role in the health care system. The need for recognition was described by one RPN, "[there needs to be] increased recognition of [the] differences between RPNs and RNs. Often RNs don't understand our training and look down at our skills despite working on the same team. [We need] increased acknowledgement of the need for RPNs in leadership". Another RPN described how they feel stigma impacts the recognition of RPNs in the nursing family, "[there is] stigma around the RPN [and] not being a qualified nurse 99% of the time. RPNs do not get any sort of recognition from anyone, either management or other healthcare professionals". RPNs also described how being recognized impacts future generations and the sustainability of the profession, "[we need] more visibility of RPNs in the workforce. Specifically for newer nurses to see and

feel a sense of pride in their job. I find that we don't see much about RPN work and its value", and "[we] need national awareness of [the] RPN education/skillset".

**Supportive Work Environments.** This main theme described the work environment of RPNs as one needing more support from managers and improved teamwork with colleagues. RPNs often described the need to create work-life balance and made statements that reflect their job satisfaction. The four sub-themes that emerged were Competent Supervisors/Leadership, Positive Work Culture, Job Satisfaction and Scheduling. Competent Supervisors/Leadership encompassed responses referring to the relationship between RPNs and someone in a leadership role or their ability to carry out their role (e.g. supervisor or manager). Differing from an authoritarian approach, some RPNs described transformational leadership, "[RPNs need] transparency by management, leadership and clear direction", and "supportive action when a nurse needs constructive support". Other RPNs responses had a negative tone and described their challenges with leadership in the workplace, "[there needs to be] management support, [such as] education in staff support and how to address issues rather than bully" and "the challenge of micromanaging and accountability of leadership or management".

RPNs seek "more support" and "emotional support" from colleagues and leadership with suggested strategies focused on collaboration and relationship building. Positive Work Culture was described by RPNs, "team building or bonding", "team morale building days away from office with fun activities", "[we need] better staff and leadership relationships", and "managers and supervisors working together with staff to build safer and more positive work environments". The theme of Job Satisfaction emerged from the responses describing their content, "[it is important] to enjoy what you

are doing and finding it satisfying, and not to treat it as just a job", and "getting back to 'art' of psychiatry and less task-focused robotic care that seems to be trending out of schools". Other RPNs acknowledged the need for local change, "better working conditions", "office space", and systemic change, "w[e need] actual solutions to address health care crisis we are facing" and "better long-term staff retention".

The need for flexibility, adequate staffing and work life balance recurred – and the theme Scheduling emerged. Some RPNs generally described "better work life balance", while others described concrete strategies to achieve the balance they seek, "[we need] flexible work schedules [and] time for self-care such as exercise", "flexible, work options, such as part-time or shared lines", and "more perks for casual staff. More options of jobs share or increase in part-time lines - creating more opportunities for work/life balance".

**Safer Work Environment.** Physical and Psychological Safety in the Workplace, Care for Nurses and Patients, and Organizational Support of Safety were the three sub-themes for Safer Work Environments that emerged from RPNs responses. RPNs highlight the importance of feeling safe and supported in the workplace. Physically and Psychological Safety emerged from the general responses highlighting the need for "safer working conditions" and "psychological safety". This included "[there should be] stricter consequences for violence against nurses in the workplace" and "more safeguards against violence and substance use exposure". In contrast, Care for Nurses and Patients emerged from RPNs responses detailing their experiences that demonstrated moral distress, "[they need to be] funding recovery services rather than just managing the

emergencies all the time", "it is all drugs now, not psychiatry. This is not what I signed up for". One RPN described lack of services for clients and the impact it has on RPNs:

> Implementation of strategic plans to deal with challenges such as waitlists or not having adequate services. For example, some very complex and violent individuals in the community that teams are expected to support sometimes at the expense of staff safety. The patient isn't getting the level of care required and staff are being exposed to many risks.

Other RPNs described the psychological effects they experienced combined with the lack of recognition and support, "[they needs to be] tending to staff day to day post covid that are now burnout", "[there is a] lack of compassion/empathy or [it is] vicarious trauma and its lasting impacts", and "[they should] not [be] treating nurses and all staff like we are replaceable". This sub-theme amplifies the need of organizations to provide psychological care to RPNs.

Organizational Support of Safety emerged from RPNs suggested strategies to improve physical and psychological safety in the workplace. RPNs described ways organizations can increase safety, "[we need] acknowledgement the work is high risk and being adequately supported by management emotionally (e.g., increased debriefs, [and] communication skills workshops)", and "[there should be] opportunities for timely debriefing". Other RPNs highlighted how workplace setting impacts the resources for safety, "staff need access to more personal protection, [such as] de-escalation and Non-Violent Crisis Intervention outside of hospitals", and "[we] need [a] better relationship

with the police". This sub-theme also included organizational support in reporting of incidences, "[we need] support in follow up around incidences of violence and bullying and harassment", and "less challenges when accessing mental health claims".

***Combined Comparison***

The themes that emerged from the qual findings for retention strategies were compared and merged with the QUAN results for age. This was done by transforming the main themes of retention strategies to QUAN data (counts and percentages) (see Table 6) and comparing the new variables (themes) to different age groups (generations). This resulted in findings that produced a greater understanding of the needs of RPNs and emphasized how the different generations diverge in retention strategies important to them.

**Table 6**

*Strategies for Retention: Main and Sub-themes (n = 424)*[*]

| Theme | n (theme or sub-theme) | % (theme or sub-theme) |
|---|---|---|
| Compensation and Benefits | 129 | 30.4% |
| Money | 56 | 43.4% |
| Better Psychological Benefits | 18 | 32.1% |
| Empowering Unions | 54 | 41.9% |
| Opportunities for Advancement | 86 | 20.3% |
| More Access to Education | 25 | 29.1% |
| Better Training | 20 | 23.3% |
| Honouring Competencies | 11 | 12.8% |
| More Work Opportunities and Advances | 29 | 33.7% |
| Feeling Valued | 58 | 13.7% |
| Respect and Appreciation | 32 | 55.2% |
| Allowing Nurses to have their Voices Heard and Listened to | 8 | 13.8% |
| Making RPNs a Key Part of the Nursing Family | 16 | 27.6% |
| Supportive work environment | 101 | 23.8% |
| Competent Supervisors/Leadership | 25 | 24.8% |

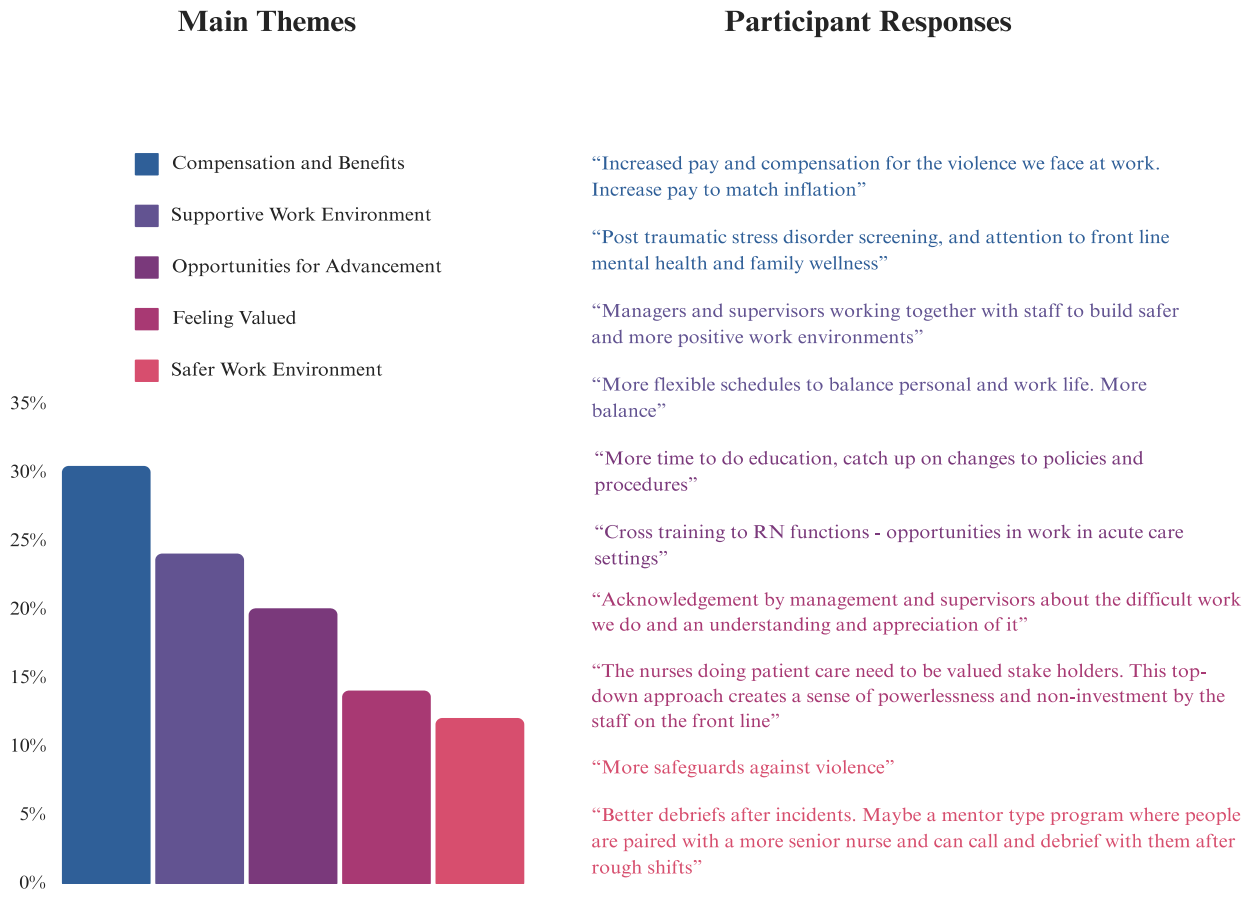
| Theme | n (theme or sub-theme) | % (theme or sub-theme) |
|---|---|---|
| Positive Work Culture | 16 | 15.8% |
| Job Satisfaction | 27 | 26.7% |
| Scheduling | 32 | 31.7% |
| Safer work environments | 50 | 11.8% |
| Physical and Psychological Safety in the Workplace | 24 | 48.0% |
| Organizational Support of Safety | 13 | 26.0% |
| Care for Nurses and Patients | 12 | 24.0% |

[*] The total number of strategies (n = 424) exceeded the number of participants (n = 218) as many participants reported more than one strategy. Six responses were used to title main themes: Compensation/Benefits (n = 1); Feeling Valued (n = 2); Supportive Work Environment (n = 1); Safer Work Environments (n = 1); and Opportunities for Advancement (n = 1). The percentage of each main theme is calculated based on the total number of suggested strategies (n = 424). The percentage of each sub-theme is calculated based on the total of its main theme.

The top theme of suggested strategies by RPNs was Compensation and Benefits. Figure 14 is a joint display of QUAN and qual data of suggested retention strategies. This was done by transforming the main themes of retention strategies to QUAN data (counts and percentages) and placing them in a joint display next to the QUAL data. RPNs responses reflect that while better remuneration such as higher pay and hazard pay is a priority, there is a need for greater union support to ensure safe nurse-client ratios and improved psychological benefits to allow RPNs to tend to their mental health.

**Figure 14**

*Combined Comparison Strategies for Retention: Main themes and Participant Responses*

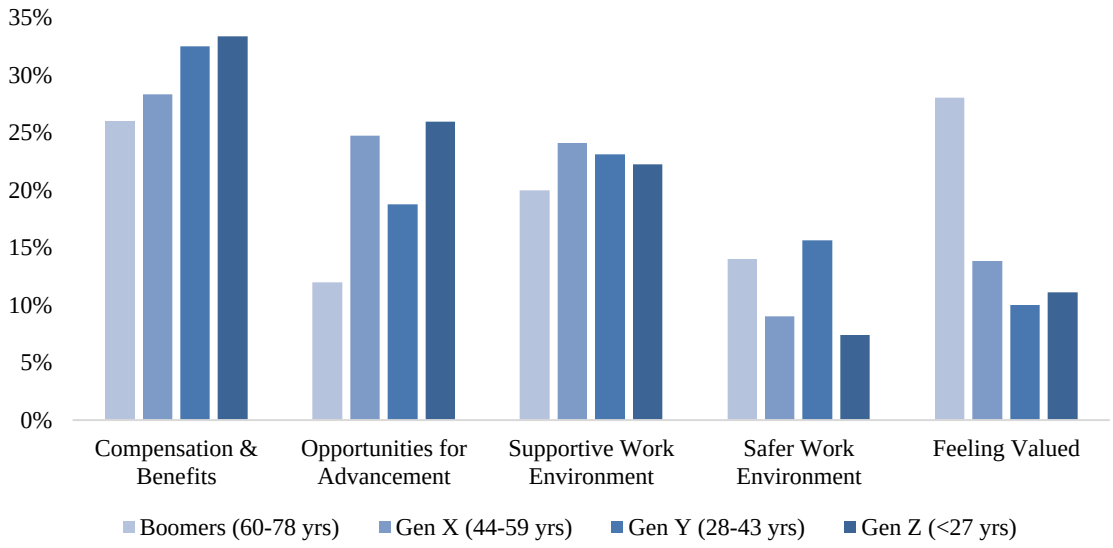



*Note:* This figure displays the main themes that emerged from QCA on the strategies important to the retention of RPNs as reported by RPNs, along with sample participant responses from each main theme. The percentage represents the frequency of main theme compared to the total number of responses.

Compensation and Benefits was the top main theme for all generations except Boomers. Feeling Valued (n = 14) was the main theme with the most suggest strategies for retention for Boomers, closely followed by Compensation and Benefits (n = 13). Supportive Work Environments was the theme with the second most suggested strategies from Gen Y (n = 37). Opportunity for Advancement was second for Gen X (n = 41) and Gen Z (n = 7). Figure 15 summarizes the main themes by generation, while Figure 16 displays participants' most suggested strategies for retention for each generation.

**Figure 15**

*Strategies for Retention by Main Theme for Each Generation*




*Note*: This figure displays the main themes of retention strategies important to RPNs and the percentage of each theme reported by the different generations. The total number of strategies suggested (n = 424) exceeded the number of participants (n = 218) as many participants reported more than one strategy. There were 11 missing values for age and their responses were excluded from this analysis.

**Figure 16**

*Combined Comparison: The Most Suggested Strategies for Retention by Generation*

| QUAN/qual<br><br>Frequency (n) of the main and sub-theme | qual<br><br>Participant responses of suggested strategies important to the retention of RPNs |
|---|---|
| Boomers | |
| 1. Feeling Valued (n = 14)<br>• Respect and Appreciation (n = 6) | • Acknowledgement of work that is performed well with lots of positive feedback and support<br>• Staff appreciation<br>• Respect |
| 2. Compensation and Benefits (n = 13)<br>• Empowering Unions (n = 7) | • More vacation<br>• Safer staff ratios |
| 3. Supportive Work Environment (n = 10)<br>• Job Satisfaction (n = 5) | • To enjoy what you are doing and finding it satisfying and not to treat it as just a job<br>• I have stayed working because I was able to secure a self-managed and controlled work environment |
| 4. Safer Work Environment (n = 7)<br>• Physical and Psychological Safety in the Workplace (n = 3)<br>• Organization Support of Safety (n = 3) | • Support to report harassment<br>• Support in follow up around incidences of violence and bullying and harassment |
| 5. Opportunities for Advancement (n = 6)<br>• Honouring Competencies (n = 2)<br>• More Work Opportunities and Advances (n = 2) | • Opening different nursing fields to hire RPN. (e.g. in primary care setting)<br>• Better career options<br>• Transparent goals with opportunity for advancement |
| Generation X | |
| 1. Compensation and Benefits (n = 47)<br>• Empowering Unions (n = 24) | • Actual and appropriate mandated minimum staffing levels and patient ratios<br>• Reduced workload, to enable meeting practice standards |
| 2. Opportunity for Advancement (n = 41)<br>• More Education (n = 16) | • Explore ways to allow RPNs to become nurse practitioners<br>• More province wide resources aimed at psychiatric nursing practice<br>• Education opportunities to increase skill set |
| 3. Supportive Work Environments (n = 40)<br>• Competent Supervisors/Leadership (n = 13) | • Support from management<br>• Good management/leadership that are transparent and authentic<br>• Supportive action when a nurse needs constructive support |
| 4. Feeling Valued (n = 23)<br>• Respect and Appreciation (n = 14) | • Well planned celebration for nursing week – it doesn't happen with community nurses<br>• Treated with respect from authority and doctors especially |
| 5. Safer Work Environment (n = 15) | • Psychological safety |

| | |
|---|---|
| • Physical and Psychological Safety in the Workplace (n = 10) | • Better debriefs after incidents. Maybe a mentor type program where people are paired with a more senior nurse and can call and debrief with them after rough shifts |
| Generation Y | |
| 1. Compensation and Benefits (n = 52)<br>• Money (n = 24) | • Hazard pay<br>• Fair wages<br>• Transit subsidy |
| 2. Supportive Work Environment (n = 37)<br>• Scheduling (n = 15) | • Better work-life balance<br>• There is limited flexibility for scheduling and vacation time off puts nurses against each other to fight for highly desired time<br>• Support for requested time off |
| 3. Opportunities for Advancement (n = 30)<br>• More Work Opportunities and Advances (n = 12) | • Access to work in Eastern provinces even as temp and return to explore and have more flexibility. RPNs work in some of the most expensive provinces |
| 4. Safer Work Environment (n = 25)<br>• Physical and Psychological Safety in the Workplace (n = 11) | • Adequate safety measures<br>• Prioritizing safe workplace |
| 5. Feeling Valued (n = 16)<br>• Respect and Appreciation (n = 10) | • More work to reduce stigma, so doctor take you seriously when there are medical concerns present |
| Generation Z | |
| 1. Compensation and Benefits (n = 9)<br>• Money (n = 5) | • Increase pay to match inflation<br>• Inclusion of higher pay/danger pay in units with high safety concerns |
| 2. Opportunities for Advancement (n = 7)<br>• Better Training (n = 2)<br>• More Work Opportunities and Advances (n = 2)<br>• More Education (n = 2) | • Increased learning for psychotherapy skills as many employers expect RPN's to have counselling skills which is not realistic<br>• More opportunities to work in different fields such as Forensic Nurse Examiner, Sexual Assault Nurse Examiner, Long-term Care/dementia wards<br>• Free university education to complete degrees or masters |
| 3. Supportive Work Environment (n = 6)<br>• Positive Work Culture (n = 3) | • More support in the workplace<br>• Managers and supervisors working together with staff to build safer and more positive work environments |
| 4. Feeling Valued (n = 3)<br>• Respect and Appreciation (n = 2) | • Acknowledgement by management and supervisors about the difficult work we do and an understanding and appreciation of it<br>• Acknowledgement the work is high risk and being adequately supported by management |
| 5. Safer Work Environment (n =2)<br>• Organizational Support of Safety (n = 2) | • Being adequately supported emotionally (e.g., increased debriefs, communication skills workshops)<br>• More available resources for RPN's to access when they are off site |

*Note*: The left column ranks the main theme for each generation with the bullet representing the most suggested sub-theme. The corresponding suggested strategies are in the right column.

**Results Summary**

The merging and integration of QUAN and qual data provided an in-depth understanding of B.C.'s RPNs career intentions and work environment. A total of 64.4% (n = 188) of RPNs in B.C. desire to leave their job. Nearly half (46.8%; n = 89) of those participants also plan to retire in the next ten years. The desire to leave increases with each generation and Gen Z was found to have the highest rate. Psychological safety and attending to mental health are significant priorities emanating from the qual data and relates to the QUAN finding indicating that RPNs are exposed to offensive behaviors at high rates and that moderate-high emotional demands persist, contributing to moderate-high burnout. Suggested strategies for retention vary between generations, highlighting the need for stakeholders to complete an assessment of the population in their workplace and employ strategies across the RPN career path.

# Chapter 6. Discussion

## Discussion: Objective One

This study focuses on the reality of a significant psychiatric nursing shortage in B.C. RPNs desire to leave their organization is at critical levels (64%), with 31% often or always considering leaving the profession. There is an overlap with nearly half of those with a desire to leave also planning to retire within ten years, a failure to address workplace issues or integrate focused retention strategies may result in these RPNs retiring early. The desire to leave is higher than what was reported for nursing professionals (RPN/LPN/RN) in B.C. in 2021 (BCNU, 2021). BCNU (2021) reported 51% of emergency and intensive care nurses and 35% of all nurses were more likely to leave within two years because of the pandemic. In 2023, Barrowclough et al. studied intent to leave in B.C.'s nurses (RN/LPN/RPN) and reported 23.9% are seriously considering leaving and 10.2% are planning to leave in the next two years (Barrowclough et al., 2023). While these studies have included RPNs in their research, this specialized sub-group of nurses have specific needs and work environments distinctive from RNs and this needs to be considered when evaluating the data.

The percentage of RPNs intending to leave increases with each generation. The sustainability of RPNs is bleak without the retention of new graduate and/or Gen Z RPNs. In their study of new graduate nurse's pandemic experiences in Ontario, Canada, McMillan (2023) report this group is determined not to follow the *nurse martyr* path and remain in a toxic work environment. Where their workplace needs were not met, this group of new graduate nurses found it easy to move on (McMillan et al., 2023).

Each generation adds value to their profession and contributes to the experiences, development and career paths of others. The potential early retirement of RPNs is also a concern impacting new graduates, as this depletes the workforce of mentorship and an expert skillset with years of experiential learning. Saskatchewan declared an urgent staffing issue with a needs assessment report in 2021 stating 50% of RPNs were eligible for retirement within two years (RPNAS, 2024b). They are now facing a public health crisis with a consistent decline in practicing RPNs, greater than 50% of practicing RPNs eligible for retirement, and not enough seats for applicants (RPNAS, 2024b). Interventions need to be in place to prevent B.C. from a similar crisis.

After over a decade of inaction (Bourgeault & Ahmed, 2022), the pandemic forced the federal government to prioritize the health of Canadians. The government of B.C. has begun to advocate for nurses and safe work environments related to staffing and workload, though the mandates are decades late. Safe workplace environments, recruitment and retention, and accessible career pathways are priorities highlighted in the Health Human Resource strategy for B.C. that started with the 2023 budget (Government of British Columbia, 2023). Despite movements forward such as minimum nurse to patient ratio (NPR) (Government of British Columbia, 2023, 2024) – the reality of a nursing shortage will make it difficult for organizations to achieve the NPR. Advancements for RPNs remain stagnant and there is no mention of minimum NPR for psychiatric/mental health workplace settings. Although RPNs represent a small portion of nursing in B.C., their impact is significant and crucial for future initiatives that support the mental health of B.C.'s residents.

**Discussion: Objective Two**

The mixed-method nature of the study uncovered workplace factors important to RPNs and learned if and how they may differ from MHNs and RNs. The inclusion of qual data identified unique factors not found in the literature review, that are relevant to RPNs desire to leave or stay. The factors include support for professional development, more access to education and work opportunities, role clarity, benefits, union support, quality of leadership, vertical trust, positive work culture, work environment, family obligations, better psychological benefits, scheduling/work life balance, and exposure to discrimination, bullying and incivility.

This study found RPNs are experiencing discrimination from colleagues the most and reported experiences of incivility. Incivility is defined as disrespectful or negative behaviour towards others (Atashzadeh Shoorideh et al., 2021). This can include verbal or non-verbal, action or inaction and includes passive aggressiveness (Atashzadeh Shoorideh et al., 2021), belittling comments, bullying, gossip, exclusion (Alsadaan et al., 2024), abusive behaviour, discrimination, harassment and rude and dismissive communication (Lewis, 2023). Incivility is not a new problem for nurses and has prevalence rates ranging from 32% and up to 90% in new graduate nurses (MacDonald et al., 2022). Recent studies have linked incivility to having a negative impact on nurse's wellbeing leading to job dissatisfaction, stress and burnout (Alsadaan et al., 2024). Incivility can come from patients, families, colleagues or superiors (Alsadaan et al., 2024). In a study of incivility in psychiatric and general nursing students in Manitoba, the clinical environment was the key setting and RN clinical instructors and staff nurses were the main perpetrators (Chachula et al., 2022). Discrimination is a form of incivility,

placing the prevalence of incivility for B.C.'s RPNs at 26%. This would increase if other acts of violence were included.

Along with a compromise to psychiatric nurse's wellbeing, incivility compromises teamwork, performance, professional communication and patient safety (Lewis, 2023). In their qualitative study, Evans (2020) reported that emotional support from a trusted colleague, life experience and education, professional boundaries, reflective practice, and self-care impact the psychiatric nurse wellbeing and ability to build resilience. Strategies to build resilience are only part of the solution. The work environment of the dominantly female demographic of RPNs exposed to multiple traumas needs to be addressed.

**Discussion: Objective Three**

The qual data provided key information to assist stakeholders to better understand the needs of RPNs. When exploring the strategies for the retention of RPNs, two key findings emerged. First, there is a variance between generations and their workplace priorities. While this is not a new discovery and some argue focusing on differing generations feeds stereotypes, understanding the identity of each generation can assist organizations in creating ideal workplace environments and retention plans (Tussing et al., 2024). Price (2015) briefly discusses the differences in priorities between the generations but instead of focusing on characterization by age or date of birth they discuss early- (first five years of practice), and mid- and late-career nurses (beyond five years of practice). One of four key strategies to retain and support Canadian nurses is to, "implement targeted retention initiatives across the career course" (Bourgeault and Ahmed, 2022, p. 29). This shaped the analysis of this study, and the results outlined key

retention strategies for each generation allowing stakeholders essential information when planning and developing interventions for RPNs.

Comparing the retention strategies suggested by RPNs, there is a vast difference between those already utilized and the needs of RPNs. While there are similar themes, RPNs priorities differ from other nursing sub-groups. Barrowclough et al. (2023) reported the top three themes important to retention of B.C.'s nurses as Compensation, Safe Staffing and Work Life Balance. Three key differences were evident in this study. RPNs prioritization of Opportunities for Advancement was higher, there was an additional theme of Feeling Valued, and the theme Compensation and Benefits was inclusive of union concerns and the need for better psychological benefits expanding beyond the idea of mental health days. Perhaps RNs prioritize work opportunity and advancement less due to ample existing opportunities. RPNs need to be a part of the conversation. In their discussion of the theme of Advancement, there was no mention of pathways to growth psychiatric nursing such as LPN to RPN, RPN to NP or of RPN expanding their scope (Barrowclough et al., 2023). Tomblin-Murphy et a. (2022) suggest strengthening the voice of nurses in policy. To build on this recommendation, all nursing sub-groups need to be represented at government levels.

To retain and support nursing in Canada, Bourgeault and Ahmed (2022) suggest four key recommendations: workload reduction, implementation of retention strategies across career course, prioritize safe work environments, and embed mental health supports, but they do not address RPNs specifically in their report. Their recommended actions that align with data from this study on retention strategies include minimum NPR, a minimum care standard, foster workplaces free of bullying and violence, build

caring work environments, dedicate mental health days, embed wellness programs, provide accessible internet based cognitive behavioural therapy, offer nurse residency programs, facilitate access to continued education, leadership and management for nurses programs, and flexible scheduling (Bourgeault & Ahmed, 2022). To value and grow the profession of psychiatric nursing and maintain the mental health of residents in B.C. and beyond, leaders need to examine these actions and see how they apply to meet the specific needs of RPNs.

## Recommendations

This MMR study provides depth of understanding and new insights into B.C.'s RPNs and provides direction for future research. The addition of future mixed methods studies to the literature would continue this trajectory. In addition to the recommendations by Bourgeault and Ahmed (2022), this study generated psychiatric nursing specific interventions for education, organizations and research.

### *Education*

Educators have a crucial role for students in the early stages of their psychiatric nursing careers. Their action or inaction set the foundation for their experiences and educators have the difficult task of ensuring new graduates have the tools to foster the resilience required to remain in the profession. Five recommendations for education include: 1) educate student psychiatric nurses about the workplace environments and the potential impact of this on their health and wellbeing, 2) strive to foster safe clinical practice environments free of incivility, 3) explore advanced practice options and career pathways (e.g., RPN to NP, degree completion, LPN to RPN, 4) educate, model and

practice the use of resilience strategies, and 5) inclusion of RPNs in decision-making roles and conversations with stakeholders.

***Organizations***

The results of this study will be shared with relevant stakeholders, including levels of government, professional organizations, unions, and employers of RPNs in B.C. They are encouraged to target and employ retention, training, and recruitment strategies important to the different generations and specific to the needs of RPNs. RPNs are encouraged to continue to work with these stakeholders to advocate for interventions that fit their needs. Seven recommendations for the organizations include: 1) prioritize RPNs for leadership positions in mental health workplace settings, 2) support professional development with allocated time off and mental health specific workshops, 3) re-evaluate compensation based on risk and cost of living, and 4) facilitate relationship building between the union and RPNs, 5) inclusion of RPNs in conversations with decision-makers, 6) utilize the scope of RPNs to expand work environments and job opportunities, and 7) initiate a pilot project utilizing retention strategies suggested by RPNs.

***Research***

There are opportunities to expand on the findings of this study in future research. This could involve the establishment of a government funded pilot of one or two key strategies that would likely improve retention and prevent burnout among the study population. Another could be a replication in three years to assess if the situation has improved as we move farther away from the pandemic. Four recommendations for future research related to this study and population include, 1) inclusion of age in data collection, 2) inclusion of ethnicity and nationality in data collection, 3) targeted research

to Gen Z and new graduate nurses, and 4) targeted studies solely on RPNs in B.C. Age is an important demographic to include to ensure results can be stratified by generation. Ethnicity should also be collected when exploring offensive behaviors in the workplace to provide a greater understanding of who is experiencing discrimination, bullying, or incivility in the workplace. Research with new graduate nurses and/or the Gen Z population should be prioritized. These groups need to be understood and valued to ensure they continue to join and remain in the profession – they are the key generation to target for sustaining the profession of psychiatric nursing in B.C. Future research can also generate hypotheses based on the findings from this study to further explore RPNs intent to leave in relation to specific factors such as workplace environment. The most salient point is for research of RPNs be distinct from other sub-groups of nurses to ensure they are represented in the literature.

## Limitations

### *MMR Inquiry*

MMR has a definitive place in nursing research, but challenges still exist. In this study, the researcher made efforts to mitigate these challenges. Creswell & Plano Clark (2018) emphasize the challenges that exist in each step of MMR research, that if not addressed lend to limitations to the study design. In the planning stage, differing sample sizes can be a challenge (Creswell & Plano Clark, 2018). This can arise when qualitative methods such as interviews or focus groups use significantly smaller sample sizes compared to quantitative methods (Creswell & Plano Clark, 2018). This limitation was mitigated by using a large sample size and the same sample size for both methods (Creswell & Plano Clark, 2018). One strategy to improve merging of results is to

measure the same concept with both methods (Creswell & Plano Clark, 2018). During interpretation, there is a need to assess for divergence and outline a plan if this occurs, such as reanalyzing (Creswell & Plano Clark, 2018). There are three variants of the convergent design – data transformative, questionnaire and parallel (Creswell & Plano Clark, 2018). The limitation of parallel is that data only come together during interpretation (Creswell & Plano Clark, 2018). Further limitations include interpretation and personal bias in relation to QCA (Elo et al., 2014).

### *Cross-Sectional Design*

While a descriptive cross-sectional design is beneficial for describing a population and informing future studies through identification of patterns and generation of hypotheses, assessing the population at a single point in time prevents the capacity to measure incidence (Reichenheim & Coutinho, 2010). These studies also lack the ability to analyze associations and result in limited causal inferences (Reichenheim & Coutinho, 2010; Wang & Cheng, 2020). A cross-sectional design often uses surveys to reach large populations, this method increases non-response bias, where those that choose not to respond are different from those that complete it (Reichenheim & Coutinho, 2010). Recall bias is also a concern if participants are not able to accurately recall information (Wang & Cheng, 2020). Dillman et al. (2014) reports web-based surveys result in a low-medium response rate. This can be mitigated by following best practices in questionnaire development and survey distribution regarding sequencing and layout (Dillman et al., 2014), and use of random sampling (Wang & Cheng, 2020). Use of validated tools may decrease measurement error and increase confidence in the results (Dowrick et al., 2015).

### *Sampling Strategy*

A limitation of non-probability sampling is the limited generalizability of results (Campbell et al., 2020). The generalizability is limited to RPNs in B.C. Due to privacy legislation, the researcher did not have access to the sampling frame; third-party consent issues meant that approximately 1500 participants were not able to be contacted. BCCNM identified all units of the sampling frame using the inclusion and exclusion criteria. Another disadvantage is potential cost incurred, access to the sampling frame relies on a partnership with BCCNM, and there is a cost for their services.

# Chapter 7. Conclusion

This study generated key recommendations for policymakers, educational programs and employers. The results of this study indicate a call for action that focuses on workplace change. Policymakers, organizations, educational programs and employers all need to contribute to the improvement of working conditions and wellbeing of RPNs and accessible mental health care for patients. Working towards these outcomes will benefit organizations from the perspective of physical, emotional and psychological wellbeing of RPNs, cost-savings, and patient safety. Lack of action will continue to negatively impact the patient care, wellbeing of RPNs and the sustainability of the profession.

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# Appendix A: Certification of Ethics Approval

**CERTIFICATION OF ETHICAL APPROVAL**

The Athabasca University Research Ethics Board (REB) has reviewed and approved the research project noted below. The REB is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2) and Athabasca University Policy and Procedures.

**Ethics File No**.: **25626**

**Principal Investigator**:
Sarah Borsa, Graduate Student
Faculty of Health Disciplines\Master of Nursing

**Supervisor/Project Team**:
Dr. Tammy O'Rourke (Supervisor)
Dr. Jennifer-Lynn Fournier (Co-Supervisor)

**Project Title**:
Registered Psychiatric Nurses in British Columbia: Career Intentions and Workplace Environment

**Effective Date:** March 18, 2024 **Expiry Date**: March 17, 2025

**Restrictions:**

Any modification/amendment to the approved research must be submitted to the AUREB for approval prior to proceeding. Any adverse event or incidental findings must be reported to the AUREB as soon as possible, for review.

Ethical approval is valid *for a period of one year*. An annual request for renewal must be submitted and approved by the above expiry date if a project is ongoing beyond one year.

An Ethics Final Report must be submitted when the research is complete *(i.e. all participant contact and data collection is concluded, no follow-up with participants is anticipated and findings have been made available/provided to participants (if applicable))* or the research is terminated.

**Approved by:** **Date: March 18, 2024**

Paul Jerry, Chair
Faculty of Health Disciplines, Departmental Ethics Review Committee

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Athabasca University Research Ethics Board
University Research Services Office
1 University Drive, Athabasca AB Canada T9S 3A3
E-mail rebsec@athabascau.ca
Telephone: 780.213.2033

# Appendix B: Invitation to Participate

**INVITATION TO PARTICIPATE**

## Registered Psychiatric Nurses of British Columbia

My name is Sarah Borsa, and I am a Master of Nursing thesis student at Athabasca University. I am conducting a research project about the career intentions and work environment of RPNs in British Columbia. This research is being supervised by Dr. Tammy O'Rourke, BS/MS, PhD, NP.

You have been identified as a potential participant because you are an RPN practicing in British Columbia. Your thoughts and experiences in the workplace are important. The purpose of this study is to identify the presence/extent of a psychiatric nursing shortage in British Columbia, understand the current workplace environment for RPNs, and identify strategies important to the retention of RPNs.

No identifying information will collected during the study and participation involves completion of an anonymous online survey. Your participation in this study involves taking 10-20 minutes to complete the survey on your own schedule, on your phone, tablet or computer.

The information you provide will help us understand RPN career intentions and their work environment in British Columbia. The results of this study may offer some direction for organizations to support the retention of psychiatric nurses. Sharing your experiences will also help us to plan future studies. I do not anticipate you will face any risks because of participating in this research other than feeling uncomfortable with what you share or potential moral distress when answering questions. You may choose not to answer a question, and you may end the survey at any time without being asked why.

Thank you for considering this invitation. If you have any questions or would like more information, please contact Sarah Borsa (the principal investigator) or Dr. Tammy O'Rourke (thesis supervisor) using the contact information below.

Thank you,
*Sarah Borsa*

**Principal Investigator (Researcher):**
Sarah Borsa
Master of Nursing Student
Athabasca University
Sborsa1@learn.athabascau.ca

**Supervisor:**
Dr. Tammy O'Rourke
Thesis Supervisor
Athabasca University
tammyorourke@athabascau.ca

This project has been reviewed by the Athabasca University Research Ethics Board. Should you have any comments or concerns regarding your treatment as a participant in this project, please contact the Research Ethics Officer by e-mail at rebsec@athabascau.ca or by telephone at 780.213.2033.

## Appendix C: Letter of Information and Informed Consent

Registered Psychiatric Nurses in British Columbia: Career Intentions and Work Environment

**ONLINE PARTICIPANT CONSENT FORM**

**Principal Researcher:**
Sarah Borsa
Master of Nursing Student
Athabasca University
Sborsa1@learn.athabascau.ca

**Supervisor:**
Dr. Tammy O'Rourke
Thesis Supervisor
Athabasca University
tammyorourke@athabascau.ca

You have been invited to participate in a research study about registered psychiatric nurses in British Columbia and their career intentions. As part of this research, we are interested in identifying workplace factors relevant to career intentions and strategies for retention. This study is being as a requirement to complete my Master of Nursing at Athabasca University.

As a participant, you are being asked to complete an anonymous online survey about your career intentions and workplace experiences. Participation will take approximately 10-20 minutes.

There are probably no immediate direct benefits for your participation in this study. However, you will have a chance to share your career intentions, your experience in the workplace and strategies you feel are important for the retention of psychiatric nurses. What we learn from you will help us begin to understand registered psychiatric nurses' experiences in British Columbia and may provide some direction for organizations to support the retention of psychiatric nurses. Sharing your experiences will also help us to plan future studies. One risk is you being uncomfortable with what you tell us. For example, you may feel some moral distress when answering questions about your workplace experience. You may choose not to answer a question, and you may end the survey at any time without being asked why.

Involvement in this study is entirely voluntary and you may refuse to answer any questions or to share information that you are not comfortable with. You will not be asked to provide any personal or identifiable information or data. REDCap is the online platform used for this survey and is hosted within the Athabasca University's secure cloud environment with strict controls and permissions.

You may withdraw from the study at any time by simply closing out of your browser. Once you submit your completed survey, however, data cannot be withdrawn as the survey is completely anonymous. Please retain a copy of this consent form for your records.

Any hard copy data will be kept in locked cabinets in my home office. All electronic data will be encrypted and kept in a password protected computer at my home office. Data will be retained from this study for potential re-use in similar studies in the future. Further

research ethics board approval would have to be sought if a later project is designed for secondary use of the data. All information and records will be destroyed by confidential shredding; electronic records will be deleted in five years, approximately by May 2029.

The final report may contain your actual responses, but nothing will identify you. Results of this study may be published in a Canadian nursing journal. Findings may be shared in the form of a report with stakeholders such as British Columbia College of Nurses and Midwives, Nurses and Nurse Practitioners of British Columbia, and the British Columbia Nurses Union. The results of the study may be shared in a presentation at Douglas College. The existence of the research will be listed in an abstract posted online at the Athabasca University Library's Digital Thesis and Project Room and the final research paper will be publicly available.

If you have any questions about this study or require further information, please contact Sarah Borsa or Dr. Tammy O'Rourke using the contact information above.

This study has been reviewed by the Athabasca University Research Ethics Board. Should you have any comments or concerns about your treatment as a participant, the research, or ethical review processes, please contact the Research Ethics Officer at 780.213.2033 or by e-mail to rebsec@athabascau.ca.

Thank you for your assistance in this project.

**CONSENT:**
**The completion of the survey and its submission is viewed as your consent to participate.**

BEGIN THE SURVEY

## Appendix D: Recruitment Emails

### First Contact (sent with invitation to participate) – April 15

*Name of Study in email headline:* Registered Psychiatric Nurses of British Columbia Survey

Dear Registered Psychiatric Nurse,

You have been identified as a practicing RPN in British Columbia. You are receiving this email as an invitation to participate in an anonymous online survey. We are interested in learning more about your experiences as a RPN and how those experiences influence your career intentions.

For the purpose of anonymity, no identifying information will be collected during the study and your participation will only require 10-20 minutes. Your participation is voluntary, and if you come to any question that you prefer not to answer please skip it and go on to the next. Should you have any questions or comments please refer to the invitation letter for contact information.

Simply click on this link to be automatically logged into the survey:
https://idea-redcap.research.athabascau.cloud/surveys/?s=893NMTJEDMTK9KCK

Your participation is very important, and I appreciate you considering this request.

Sincerely,
Sarah Borsa

**Master of Nursing Student**
**Faculty of Health Disciplines**
**Athabasca University**
sborsa1@learn.athabascau.ca

**Second Contact – April 29**

*Name of Study in email headline:* Final Reminder to complete Registered Psychiatric Nurses of British Columbia Survey
Dear Registered Psychiatric Nurse,

Two weeks ago you received an email about your participation in the **Registered Psychiatric Nurses of British Columbia Survey**. The survey is anonymous and no identifying information is collected during the study, therefore I am unable to determine who has completed the survey. Thank you again if you have already completed the survey.

Many have already provided us with valuable information, we expect the results to be very useful to the province of British Columbia. You are being contacted a second and final time because your opinion is important, and only by obtaining many responses can we ensure the survey results are a valid reflection of British Columbia's RPNs.

To complete the survey, simply click on this link:
https://idea-redcap.research.athabascau.cloud/surveys/?s=893NMTJEDMTK9KCK

Your response is completely voluntary, but highly encouraged. I appreciate your considering my request.

Sincerely,
Sarah Borsa

**Master of Nursing Student**
**Faculty of Health Disciplines**
**Athabasca University**
sborsa1@learn.athabascau.ca

# Appendix E: Project Timeline

| Primary Researcher (R), Thesis Supervisor (TS), Partner (P) | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Thesis Proposal & Timeline: Registered Psychiatric Nurses in British Columbia** | | | | | | | | | | | | | | |
| **Phase** | **Task** | **Person** | **2024** | | | | | | | | | | | |
| | | | **Dec** | **Jan** | **Feb** | **29-Mar** | **31-Mar** | **07-Apr** | **21-Apr** | **28-Apr** | **May** | **June** | **July** | **Sept-Dec** |
| **Pre-study** | REB Submission | R | | | | | | | | | | | | |
| | Build Survey in Word, then transfer to RedCap | R/TS | | | | | | | | | | | | |
| | Pre-test Survey | R | | | | | | | | | | | | |
| | Adjust Items | R | | | | | | | | | | | | |
| | Apply BCCNM | R | | | | | | | | | | | | |
| **Recruitment + Data Collection** | Initial Email | P | | | | | | | | | | | | |
| | Distrubute e-survey | P | | | | | | | | | | | | |
| | 1st reminder email | P | | | | | | | | | | | | |
| | 2nd reminder email | P | | | | | | | | | | | | |
| | Final reminder email | P | | | | | | | | | | | | |
| | Assess reponse rate | R | | | | | | | | | | | | |
| **Data Management** | Code variables in SPSS | R | | | | | | | | | | | | |
| | Create back up x 3 | R | | | | | | | | | | | | |
| | Enter data - SPSS | R | | | | | | | | | | | | |
| **Data Analysis** | Clean Data | R | | | | | | | | | | | | |
| | Analysis in SPSS | R | | | | | | | | | | | | |
| | Content Analysis | R | | | | | | | | | | | | |
| **Compilation** | Write Report | R | | | | | | | | | | | | |

## Appendix F: Survey



# Registered Psychiatric Nurses of British Columbia Survey

Thank you for completing this questionnaire. This study will help better understand the career intentions and work environment of psychiatric nurses in British Columbia. The nursing shortage is projected to continue, and it is important we learn about psychiatric nurses and their work environment to plan for retention strategies.

Your participation is voluntary, and your responses will be kept confidential. No personally identifiable information will be collected at any time. If you have questions, please contact Sarah Borsa, primary researcher (sborsa1@learn.athabascau.ca) or Dr. Tammy O'Rourke, thesis supervisor (tammyorourke@athabascau.ca).

START HERE

This section has 7 questions. These questions are about where you work. If you work in more than one workplace setting, please answer each question for your primary workplace (the job you work at the most).

1) Have you worked as a registered psychiatric nurse for at least one year?

◯ Yes
◯ No

How many years have you worked as a registered psychiatric nurse?

_____

2) What type of geographical setting do you currently practice in?

◯ Urban (geographical area such as a town or city)
◯ Rural (geographic area that is located outside towns and cities, low population density)
◯ Remote (geographic area situated far from the main centres of a population)

3) What is your primary workplace setting?

◯ Acute Care
◯ Community
◯ Outpatient Clinic
◯ Forensics
◯ Addictions
◯ Emergency
◯ Education
◯ Other

Please specify your primary workplace setting:

_____

4) Does your job involve direct client care?

◯ Yes
◯ No

5) What is your current job status?

◯ Casual
◯ Regular Part-time
◯ Regular Full-time

6) Do you plan to retire in the next 0-5 years?

◯ Yes
◯ No

7) Do you plan to retire in the next 5-10 years?

◯ Yes
◯ No

**This section has 7 questions. The first set of questions asks about your career intentions in the next 9 months. Please read each question and indicate your response using the scale provided for each question.**

**During the past 9 months...**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1) | How often have you considered leaving your job? | never ○ | rarely ○ | sometimes ○ | often ○ | always ○ |
| 2) | How satisfying is your job in fulfilling your personal needs? | very satisfying ○ | satisfied ○ | neither ○ | dissatisfied ○ | totally dissatisfying ○ |
| 3) | How often are you frustrated when not given the opportunity at work to achieve your personal work-related goals? | never ○ | rarely ○ | sometimes ○ | often ○ | always ○ |
| 4) | How often do you dream about getting another job that will better suit your personal needs? | never ○ | rarely ○ | sometimes ○ | often ○ | always ○ |
| 5) | How likely are you to accept another job at the same compensation level should it be offered to you? | highly unlikely ○ | unlikely ○ | neutral ○ | likely ○ | highly likely ○ |
| 6) | How often do you look forward to another day at work? | always ○ | often ○ | sometimes ○ | rarely ○ | never ○ |
| 7) | How often have you considered leaving the profession of psychiatric nursing? | never ○ | rarely ○ | sometimes ○ | often ○ | always ○ |

**The TIS encompasses questions 1-6 above, and the scale may not be used without the explicit permission of the author.*

**This section has 43 questions. The following questions are about your work environment. Please choose the answer that fits best to each of the questions.**

| | | always | often | sometimes | seldom | never/hardly ever |
|---|---|---|---|---|---|---|
| 1) | How often do you not have time to complete all your work tasks? | ○ | ○ | ○ | ○ | ○ |
| 2) | Do you get behind with your work? | ○ | ○ | ○ | ○ | ○ |
| 3) | Can you influence the amount of work assigned to you? | ○ | ○ | ○ | ○ | ○ |
| 4) | How often do you work fully staffed? | ○ | ○ | ○ | ○ | ○ |
| 5) | Do you have to work very fast? | ○ | ○ | ○ | ○ | ○ |
| 6) | Do you have a large degree of influence on the decisions concerning your work? | ○ | ○ | ○ | ○ | ○ |
| 7) | Does your work put you in emotionally disturbing situations? | ○ | ○ | ○ | ○ | ○ |
| 8) | Do you have to deal with other people's personal problems as part of your work? | ○ | ○ | ○ | ○ | ○ |
| 9) | Do you have enough time for your work tasks? | ○ | ○ | ○ | ○ | ○ |

| | | to a very large extent | to a large extent | somewhat | to a small extent | to a very small extent |
|---|---|---|---|---|---|---|
| 10) | Is your work emotionally demanding? | ○ | ○ | ○ | ○ | ○ |
| 11) | Do you work at a high pace throughout the day? | ○ | ○ | ○ | ○ | ○ |
| 12) | Does your work require you to take the initiative? | ○ | ○ | ○ | ○ | ○ |
| 13) | Do you have the possibility of learning new things through your work? | ○ | ○ | ○ | ○ | ○ |
| 14) | Can you use your skills or expertise in your work? | ○ | ○ | ○ | ○ | ○ |
| 15) | Is your work meaningful? | ○ | ○ | ○ | ○ | ○ |
| 16) | Do you feel that the work you do is important? | ○ | ○ | ○ | ○ | ○ |
| 17) | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Do you feel that your place of work is of great importance to you? | ○ | ○ | ○ | ○ | ○ |
| 18) | Would you recommend other people to apply for a position at your workplace? | ○ | ○ | ○ | ○ | ○ |
| 19) | At your place of work, are you informed well in advance concerning, for example, important decisions, changes or plans for the future? | ○ | ○ | ○ | ○ | ○ |
| 20) | Do you receive all the information you need in order to do your work well? | ○ | ○ | ○ | ○ | ○ |
| 21) | Is your work recognized and appreciated by the management? | ○ | ○ | ○ | ○ | ○ |
| | | to a very large extent | to a large extent | somewhat | to a small extent | to a very small extent |
| 22) | Do you have leadership opportunities at your workplace? | ○ | ○ | ○ | ○ | ○ |
| 23) | Are you treated fairly at your workplace? | ○ | ○ | ○ | ○ | ○ |
| 24) | Did you receive adequate orientation as a new hire? | ○ | ○ | ○ | ○ | ○ |
| 25) | Does your work have clear objectives? | ○ | ○ | ○ | ○ | ○ |
| 26) | Do you know exactly what is expected of you at work? | ○ | ○ | ○ | ○ | ○ |
| 27) | Are contradictory demands placed on you at work? | ○ | ○ | ○ | ○ | ○ |
| 28) | Do you sometimes have to do things which ought to have been done in a different way? | ○ | ○ | ○ | ○ | ○ |
| 29) | Do you sometimes have to do things which seem to be unnecessary? | ○ | ○ | ○ | ○ | ○ |
| 30) | To what extent would you say that your immediate supervisor gives high priority to job satisfaction? | ○ | ○ | ○ | ○ | ○ |
| 31) | To what extent would you say that your immediate supervisor is good at work planning? | ○ | ○ | ○ | ○ | ○ |
| 32) | | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| To what extent would you say that your immediate supervisor is good at solving conflicts? | ○ | ○ | ○ | ○ | ○ |

| | | always | often | sometimes | seldom | never/hardly ever |
|---|---|---|---|---|---|---|
| 33) | How often is your immediate supervisor willing to listen to your problems at work, if needed? | ○ | ○ | ○ | ○ | ○ |
| 34) | How often do you get help and support from your immediate supervisor, if needed? | ○ | ○ | ○ | ○ | ○ |
| 35) | How often do you get help and support from your colleagues, if needed? | ○ | ○ | ○ | ○ | ○ |
| 36) | Is there a good working relationship between physicians and staff? | ○ | ○ | ○ | ○ | ○ |

| | | to a very large extent | to a large extent | somewhat | to a small extent | to a very small extent |
|---|---|---|---|---|---|---|
| 37) | Is there a good atmosphere between you and your colleagues? | ○ | ○ | ○ | ○ | ○ |
| 38) | Are you worried about becoming unemployed? | ○ | ○ | ○ | ○ | ○ |
| 39) | Are you worried about it being difficult for you to find another job if you became unemployed? | ○ | ○ | ○ | ○ | ○ |
| 40) | Are there barriers that prevent you from leaving your current job? | ○ | ○ | ○ | ○ | ○ |
| 41) | Are you worried about being transferred to another job against your will? | ○ | ○ | ○ | ○ | ○ |

| | | very satisfied | satisfied | neither/nor | unsatisfied | very unsatisfied |
|---|---|---|---|---|---|---|
| 42) | Regarding your work in general. How pleased are you with your salary? | ○ | ○ | ○ | ○ | ○ |
| 43) | Regarding your work in general. How pleased are you with your job as a whole, everything taken into consideration? | ○ | ○ | ○ | ○ | ○ |

**This section has 7 questions. The next three questions are about the way your work affects your private life and family life.**

| | | to a very large extent | to a large extent | somewhat | to a small extent | to a very small extent |
|---|---|---|---|---|---|---|
| 1) | Do you feel that your work drains so much of your energy that it has a negative effect on your private life? | ○ | ○ | ○ | ○ | ○ |
| 2) | Do you feel that your work takes so much of your time that it has a negative effect on your private life? | ○ | ○ | ○ | ○ | ○ |
| 3) | Are there times when you need to be at work and at home at the same time? | ○ | ○ | ○ | ○ | ○ |

**The next 4 questions are not about your own job but about the whole organization you work for.**

| | | to a very large extent | to a large extent | somewhat | to a small extent | to a very small extent |
|---|---|---|---|---|---|---|
| 4) | Can the employees trust the information that comes from the management? | ○ | ○ | ○ | ○ | ○ |
| 5) | Does the management trust the employees to do their work well? | ○ | ○ | ○ | ○ | ○ |
| 6) | Are conflicts resolved in a fair way? | ○ | ○ | ○ | ○ | ○ |
| 7) | Is the work distributed fairly? | ○ | ○ | ○ | ○ | ○ |

**This section has 11 questions. The following questions are about your own health and well-being. Please do not try to distinguish between symptoms that are caused by work and symptoms that are due to other causes. The task is to describe how you are in general.**

**The questions are about your health and well-being during the last four weeks:**

| | | excellent | very good | good | fair | poor |
|---|---|---|---|---|---|---|
| 1) | In general, would you say your health is: | ○ | ○ | ○ | ○ | ○ |

| | | all of the time | a large part of the time | part of the time | a small part of the time | not at all |
|---|---|---|---|---|---|---|
| 2) | How often have you felt worn out? | ○ | ○ | ○ | ○ | ○ |
| 3) | How often have you been emotionally exhausted? | ○ | ○ | ○ | ○ | ○ |
| 4) | How often have you found it hard to go to sleep? | ○ | ○ | ○ | ○ | ○ |
| 5) | How often have you been physically exhausted? | ○ | ○ | ○ | ○ | ○ |
| 6) | How often have you felt tired? | ○ | ○ | ○ | ○ | ○ |
| 7) | How often have you woken up several times and found it difficult to get back to sleep? | ○ | ○ | ○ | ○ | ○ |
| 8) | How often have you had a headache? | ○ | ○ | ○ | ○ | ○ |
| 9) | How often have you had stomach ache? | ○ | ○ | ○ | ○ | ○ |
| 10) | How often have you found it difficult to think clearly? | ○ | ○ | ○ | ○ | ○ |
| 11) | How often have you had difficulty with remembering? | ○ | ○ | ○ | ○ | ○ |

**This section has 6 questions. The next set of questions are sensitive in nature. You can stop at any time and will not be asked why.**

**They ask about your experience at your current job in the last 12 months.**

| | | yes daily | yes weekly | yes monthly | yes a few times | no |
|---|---|---|---|---|---|---|
| 1) | Have you been exposed to undesired sexual attention at your workplace during the last 12 months? | ○ | ○ | ○ | ○ | ○ |

From whom? (Choose all that apply)

- ☐ colleagues
- ☐ manager/supervisor
- ☐ subordinates
- ☐ client/patient

| | | yes daily | yes weekly | yes monthly | yes a few times | no |
|---|---|---|---|---|---|---|
| 2) | Have you been exposed to threats of violence at your workplace during the last 12 months? | ○ | ○ | ○ | ○ | ○ |

From whom? (Choose all that apply)

- ☐ colleagues
- ☐ manager/supervisor
- ☐ subordinates
- ☐ client/patient

| | | yes daily | yes weekly | yes monthly | yes a few times | no |
|---|---|---|---|---|---|---|
| 3) | Have you been exposed to physical violence at your workplace during the last 12 months? | ○ | ○ | ○ | ○ | ○ |

From whom? (Choose all that apply)

- ☐ colleagues
- ☐ manager/supervisor
- ☐ subordinates
- ☐ client/patient

| | | yes daily | yes weekly | yes monthly | yes a few times | no |
|---|---|---|---|---|---|---|
| 4) | | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Have you been exposed to bullying at your workplace during the last 12 months? Bullying means that a person repeatedly is exposed to unpleasant or degrading treatment, and that the person finds it difficult to defend himself or herself against it | ○ | ○ | ○ | ○ | ○ |

From whom? (Choose all that apply)

- ☐ colleagues
- ☐ manager/supervisor
- ☐ subordinates
- ☐ client/patient

| | | yes daily | yes weekly | yes monthly | yes a few times | no |
|---|---|---|---|---|---|---|
| 5) | Have you been exposed to discrimination at your workplace during the last 12 months? | ○ | ○ | ○ | ○ | ○ |

From whom? (Choose all that apply)

- ☐ colleagues
- ☐ manager/supervisor
- ☐ subordinates
- ☐ client/patient

What type of discrimination was it?

_____

| | | yes daily | yes weekly | yes monthly | yes a few times | no |
|---|---|---|---|---|---|---|
| 6) | Have you witnessed any of these offensive behaviours (undesired sexual attention, threats of violence, physical violence, bullying and/or discrimination) aimed at others than yourself at your workplace during the last 12 months? | ○ | ○ | ○ | ○ | ○ |

At whom? (Choose all that apply)

- ☐ colleagues
- ☐ manager/supervisor
- ☐ subordinates
- ☐ client/patient

What type(s) of offensive behaviour(s) was it? (Choose all that apply)

- ☐ undesired sexual attention
- ☐ threats of violence
- ☐ physical violence
- ☐ bullying
- ☐ discrimination

**This last section has 8 questions. The next 2 questions ask your opinion about work-related factors and retention strategies.**

1) What work-related factors are important to you that may not have been covered in this survey?

_____

2) What strategies do you think are important for the retention of registered psychiatric nurses?

_____

**The last 6 questions are important to the study. Tell us about who you are.**

3) What is your relationship status?

◯ Single
◯ Common-law (live together for at least one year, not legally married)
◯ Legally married (and not separated)
◯ Separated, but still legally married
◯ Divorced
◯ Widowed

4) Do you have a support system? Support system is defined as people that provide you with emotional and practical support.

◯ Yes
◯ No

5) What is your age at the time of this survey?

_____

6) What is your gender?

◯ Female
◯ Male
◯ Non-binary
◯ Prefer not to say

7) How often do you work overtime?

◯ Never
◯ Rarely
◯ Occasionally
◯ A moderate amount
◯ A great deal

8) What is your highest educational qualification in nursing?

◯ Psychiatric Nursing Diploma
◯ Bachelor of Psychiatric Nursing
◯ Bachelor of Science in Psychiatric Nursing
◯ Master's Degree - Psychiatric Nursing
◯ PhD
◯ Master's Degree - other than nursing