

Nursing morale: what does the literature reveal?

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Abstract

There is increasing attention to nursing workforce issues such as recruitment, retention, turnover, workplace health and safety issues and their impact on quality patient care. A number of these problems have been linked to poor morale. While there has been a lack of consensus on the determinants of morale, it is clear that the outcomes of poor morale not only add considerable cost to the organisation but also impact negatively on patient care. This article provides a systematic overview of the literature surrounding nursing morale and the variables identified in the literature that impact upon morale, and discusses the implications for future research.

Aust Health Rev 2006; 30(4): 516–524

THERE IS INCREASING worldwide attention given by researchers, policymakers and administrators to nursing workforce issues such as recruitment and retention, turnover and workplace health issues. The contemporary literature has linked issues such as absenteeism,¹⁻³ retention and recruitment,^{4,5} staff turnover,^{6,7} and health issues such as increased staff accidents and health risks^{8,9} to low morale. As a result of low morale, these poor organisational outcomes are not only costly to the organisation but can also have serious impacts upon the health and wellbeing of staff and, as a consequence, place patients at risk

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What is known about the topic?

The international and Australian literature outlines a litany of causes and outcomes of poor morale on the nursing workforce. While there have been a number of international studies conducted into this phenomenon, there has been a paucity of Australian research.

What does this paper add?

This paper discusses the intrinsic and extrinsic variables that have been identified as an explanation for poor morale among nurses, and areas for future research into the phenomenon of morale. Intrinsic factors include professional worth/respect, opportunity/skill development, work group relationships and patient care. The extrinsic factors include organisational structures, operational issues, leadership traits/management styles, communication and staffing.

What are the implications for practitioners?

The literature clearly identifies low morale as being costly to organisations and a key source of poor patient outcomes and care. Understanding the key variables that impact on the morale of the largest component of the health care workforce allows managers to develop appropriate workplace strategies. ◆

of lower quality care and potentially adverse clinical outcomes.^{3,10}

Staff morale is a workforce phenomenon that confronts every organisation at some time. The understanding of morale is important because it can have tangible and wide-ranging effects and outcomes for an organisation. Morale is not a simple concept and the outcomes associated with high or low morale may impact upon staff turnover, attainment of organisational or personal goals, the ability to adopt new practices, learning new skills and the delivery of good customer service.¹¹ As early as the 1940s morale was being viewed as an important workplace issue. At the time, it was suggested that when any person holds a position of responsibility in a business, the word “morale” comes to have real meaning and refers to

something that has great importance, even if that something remains vague and illusive. At times the feelings of poor morale are difficult to articulate by those that are affected by it.¹² While there are a number of thematic variations on the definition of morale, for the purposes of this review, positive morale is seen as an attitude of confidence in the mind of the individual where they identify with a group, accept group goals and work towards achieving them collectively.¹³ The fact that there has been no unifying definition of morale goes some way to explaining the reasons why definitive empirical studies on the phenomenon have been somewhat sporadic.

The morale of nurses

A number of the writings concentrate on poor morale of health care workers and highlight a range of causes including: shortage of workers;¹⁴ overwork;¹⁵⁻²⁰ low pay and difficulties with the recruitment and retention of staff;^{15,19-22} the quality of nursing education;^{15,23} professional support and prospects;^{15,21} and the lack of recognition for job performance and professional achievement.^{19,22} The way a person responds or reacts to work and organisational stimuli has a strong bearing on their subsequent perception of morale within the workplace.

As shown in the Box, the literature surrounding the morale of nurses can be divided into a number of key themes. Equally, the themes can be separated into those that could be considered intrinsic or personal factors, and those that are more extrinsic or structural factors. This paper

Staff morale factors	
Intrinsic factors	Extrinsic factors
■ Professional worth/respect	■ Organisational structures
■ Opportunity/skill development	■ Operational issues
■ Work group relationships	■ Leadership traits/management styles
■ Patient care	■ Communication
	■ Staffing

reviews the literature that relates to these themes and offers some suggestions on the implications of current knowledge related to morale and future research directions.

Intrinsic factors

Intrinsic factors are those variables that impact upon nurses' concept of personal or professional standing within the group. It could also be argued that nurses have some control over intrinsic factors that impact upon their level of morale.

Work groups/relationships

The literature clearly demonstrates that workplace relationships between nurses can have a major impact on morale. The literature specifically examines the importance of social and group interaction and its effect on the concept of morale and suggests the stability of the group's cohesion depends upon morale.²⁴ These findings provide a basis for the positive regard for social interaction and its role in teamwork and group goal achievement. For example, in one quantitative study ($n=221$) exploring nursing turnover, one of the important variables was found to be kinship relationships.²⁵ The effect of the group and the social relationships that form among nurses is crucial in how nurses view their workplaces in terms of achievement and teamwork. Working relationships extended beyond those developed within a "craft" group, with nurses showing improved morale when professional relationships with physicians were viewed as positive.¹ The results showed that when supportive professional relationships with medical staff were present nurses reported that their work was more meaningful and satisfying, their professional knowledge and skills were utilised, and they thought less often of quitting. Additionally, the study suggested that absenteeism and turnover were significantly reduced as a result of a strong sense of community and work-group relationships fostered by the nurse manager.

Professional worth/respect

A sense of being valued was seen as the key motivator for staff. In a study of operating theatre

nurses ($n = 46$), professional worth and inclusiveness was identified by Livesley,²⁶ who states that “When constraints of the service are put before the care of staff, morale falls, resulting in a decreased standard and quality of output, which in turn leads to a loss of trained staff and a spiral of decline.” (p. 152) The exploration of professional worth involving the use of temporary or agency staff suggested that their use alongside permanent staff had an effect on morale. A higher percentage of respondents felt staff nurses resented the higher rates earned by temporary staff who did not provide the same level of care nor identify with the hospital goals.²⁷

Patient care

The delivery of quality nursing care has been considered to be an important variable in determining the morale of nurses. One study concluded that nurses working in stimulating environments exhibited improved morale.²⁸ Another large quantitative study of all nurses, midwives and health visitors in one Welsh health district ($n = 672$) argued that the two factors that dominated the nurses’ understanding of morale within their workplace were: (i) the perceived ability to deliver good patient care; and (ii) good collegiate relationships with co-workers.¹⁹ The authors continued by outlining that other important factors included feeling valued and respected, being afforded opportunities for professional growth and being allowed to use a range of skills and exercise responsibility.

Promotional opportunities/skill development

A quantitative study of nurses within one United Kingdom health authority ($n = 928$) found that while job interest remained high, many nurses considered that they were not encouraged fully to develop or utilise their skills, and that promotion prospects were poor.²⁹ The study highlighted that the variables having the strongest correlation were factors such as recognition and regard, workload, professional development, quality of care, working relationships and autonomy/decision making. The research concluded by high-

lighting that nurses, while feeling that the quality of care that they deliver was high, felt their morale was suffering because of organisational factors such as low staffing levels, lack of resources and increased workload. In another study of UK nurses, poor morale in the study group was attributed to “lack of support for education and training and frustration about the limited opportunity for promotion.” (p. 83)⁴

Extrinsic factors

Extrinsic factors take into account those variables that are controlled by the organisation or other external forces. These factors are largely out of the control of the individual nurse or the group they work in.

Organisational or structural factors

Organisational factors such as staffing, communication, training and development and management styles have all been cited in the literature as organisational variables affecting the level of staff morale among health care workers. For example, the literature argues that job satisfaction impinges upon organisational issues, and in doing so exacerbates job turnover and staff morale.²⁹ The study goes on to cite a plethora of variables that potentially contribute to influencing morale, including job interest, achievement, responsibility and autonomy, recognition, organisational policy, supervision, interpersonal relationship and working conditions.²⁹

Studies have outlined organisational factors such as changes in scheduling practices, benefit policies and organisational structures that have contributed to low morale.³⁰ One small study ($n = 41$) examined symptoms of anxiety, powerlessness and ineffective coping skills and their relationship to morale.³⁰ Findings from the study showed an increase in accidents and errors, sick leave and illness and the desire to find employment in other organisations as a consequence of low morale. The desire to find employment in other organisations is in line with research undertaken in Australia by Best Practice Australia,³¹ who report that 42% of

6800 Australian nurses surveyed expressed a desire to leave their organisations.

Staffing

Staffing and its related issues appears to be an important theme when it comes to linking staffing issues to morale. One study ($n = 1692$) argued that nurses who worked in units where there was poor “work climate” and low staffing were generally twice as likely as nurses on well staffed and better organised units to report risk factors, needlestick injuries and near misses.⁸

Further research examined improving nursing morale in a climate of cost containment.³² It is argued that faced with declining resources for health care and greater pressures to improve productivity of nursing staff, nursing administrators need to develop organisational responses to morale problems among nursing staff. The study examined morale using variables such as learning opportunities, promotional opportunities, recognition, participation in decision making, helping patients, workload, amount of responsibility, use of skills, relationships with co-workers and work schedule.³² The study found that there were a number of organisational factors that contributed to low morale including workload, learning opportunities and career advancement opportunities. Further research cites poor communication, ineffective training and development, unstructured teams, heavy workload and poor grading structures as the reasons for poor morale.²⁶

The low morale of nurses has been reviewed in terms of its effects on recruitment and retention. A 3-year longitudinal study involving nurses ($n = 518$) explored variables such as aspects of the work environment, perceived changes to aspects of the workplace, and morale. The study showed that there was an increasing tension between workload pressures and the desire to give holistic patient care. These tensions had a negative impact on morale.²⁰ There has been evidence of low morale where employees reviewed professional and structural issues from a position of hopelessness. Low morale has been linked to staff shortages and the increasing age of the current nursing

workforce.¹⁴ One possible argument suggests that there could be a feeling of helplessness of remaining nurses engendered by the nursing shortage and the record-low number of new nursing graduates to take their place.¹⁴

Organisational violence and bullying

The contemporary Australian and international literature points to the increasing levels of workplace violence facing nurses.³³⁻³⁸ While these studies point to violence and bullying leading to increased illness, sick leave, burn-out and poor recruitment and retention rates, the link to poor morale has been less clearly established. However, one quantitative study of 467 nurses across three hospitals did establish a relationship between verbal abuse and negative morale.³⁹

Organisational structures

One could argue that an examination of organisations, in the ways they are structured and operated and the methods by which they control and manage employees, could provide insights into how nurses perceive their morale and that of the organisation as a whole. In trying to explain organisational factors and culture and their effect on the wellbeing of staff, research points to a number of hospitals that are considered market leaders through low turnover and high staff morale,⁴⁰ with these so called “magnet” hospitals seeing culture as more important than wages to attract staff. As hospitals have little ability to increase wages and incentives, efforts have been concentrated on improving the work environment.

“Magnet” hospitals can best be described as those that are able to retain and attract well qualified nurses through the adoption of characteristics such as participatory supportive management styles, decentralised organisational structures, adequate staffing, flexible working schedules, professional autonomy and responsibility, emphasis on teaching and education, and career advancement opportunities.⁴¹ Additionally, it could be argued that conceptually, magnet hospitals build high nurse morale through fostering nurse fulfilment, self-esteem and employee stability.⁴² The argument

that magnet hospitals create environments conducive to positive working conditions helps solidify an important concept, namely that organisational factors play a major role in how nurses perceive their level of morale within the workplace.

Leadership/communication

Another theme that emerged from the literature was that of shared leadership and communication and their effect on increasing morale and decreasing injuries. For morale to improve, it is argued that there must be a shared vision of what both groups are trying to accomplish together, as well as an understanding of the problems and pressures on both the management and employees.⁴³ The concept of shared ownership was seen as contributing to higher morale among staff as there was recognition of their relative importance to the organisation.

Much of the empirical research on nursing morale in Australia has come from Ken Smith. Smith⁴⁴ outlined that for the purposes of his research morale had three dimensions refined from earlier studies in the 1960s: cohesive pride, leadership synergy and personal challenge. The quantitative study of 906 Australian nurses showed that morale was most affected by rostering and workload issues, communication, recognition and professional standing. Similar outcomes were observed in research conducted among nurses surveyed in England, Northern Ireland and Scotland⁴⁵ ($n = 1017$) and hospital staff preparing for a transition to National Trust Status⁴⁶ ($n = 28$).

Operational issues

The literature draws a link between job security and power relationships and how these factors impact on the psyche of the nurse. One qualitative study across 102 health care facilities ($n = 29$) explored the effect of hospital financing and its impact on the profession of nursing. Results revealed that regardless of the position in the hospital hierarchy or length of employment, all of the nurses expressed considerable anxiety regarding job security.⁴⁷ In most instances, the nurses

and hospital administrators became resentful and polarised, affecting morale among staff.

Current clinical practice fosters low morale where cost efficiency is paramount and patients are processed through the hospital system like a production line in order for a hospital to make a surplus. A friction has developed due to the dichotomy of nurses being both caregivers and financial stewards. This friction has promoted a feeling of poor morale among nurses. These perceptions of minimising costs and compromising care are heightened by the drive to redesign workforce models that promote substituting cheaper workers or increasing nurses' patient loads. Respondents spoke of how they saw their hospitals as requiring to make profits, like any other business.⁴⁷ More was expected of nursing and cuts were being made to staffing numbers to reduce the high cost of labour. This created a situation where nurses could not spend as much time with the patients and they were unable to complete their work, resulting in feelings of low morale.

Research was conducted on 195 hospital employees exploring employee perceptions of stress, workload and performance and the subsequent effect on morale.⁴⁸ The purpose of one such study was to assess the effect of budget reductions and other organisational changes on the morale of hospital employees. The study identified that employees, a company's most valuable asset, strongly influence the operational success of the companies for which they work. Organisational changes frequently create challenges for employees, which in turn affect their morale and eventually their performance. Findings from the study demonstrate that organisational changes, including integration, downsizing, and de-layering alter employees' job responsibilities, reduce job security, and change career perspectives and expectations.⁴⁸ Additionally, the study suggested that according to employees, workloads were too heavy, and quality patient care was being sacrificed for the "bottom line".⁴⁸

Nursing morale has been investigated across a number of clinical settings, including acute care

hospitals, psychiatric facilities, and community and aged care. One study ($n = 217$) took a broader view in trying to establish the determinants of morale among community health nurses. While validating that morale was an issue in the turnover of community health nurses, the study was designed to “drill down” and find the underlying causes for poor morale, not just the symptoms.⁴² Using a quantitative approach, the study examined variables such as employees perception of job demands, working conditions, adequacy of pay, adequacy of employee benefits, friendliness and cooperation of fellow employees, interpersonal relations between supervisors and employees, confidence in management, technical competence of supervision, effectiveness of administration, adequacy of communication, security of their job, identification with the company, and opportunity for growth and advancement. The research concluded that there was a link between decreased morale and increased years of experience and tenure in the organisation, and positive morale was linked strongly to the type of position and level of education. The study highlighted that as a nurse’s position became higher in the organisational hierarchy, so did the level of morale. Since morale improved as position and education increased, it may imply that individuals with low morale may well feel stagnant, not having developed or advanced in their career as they had expected. This would assume that morale could be considered as an individual trait as opposed to a group phenomenon. Significant negative relationships were found to exist between morale and perceptions of supervisors and employee relations, administration effectiveness, and communication with and confidence in management.

Conclusion

It is evident from the review of the literature that there are issues, gaps and divergent themes, as well as a variety of research approaches. Although there have been a number of descriptive studies focusing on the signs of good or poor morale, these have failed to adequately address the under-

lying issues of morale. Equally, attempts to gain greater insights have been made using both quantitative and qualitative approaches. A number of quantitative studies have relied on a narrow range of variables or small numbers of respondents making the findings difficult to interpret or generalise. Other studies have attempted to explain this dynamic personal and organisational interaction through a structured organisational theoretical approach; the outcome is a constricting attempt to put a “round peg in a square hole”. The structuralist–organisational theory approach may work well when dealing with unskilled and semi-skilled workers. However, these theories transfer poorly to settings that are more fluid and dynamic with highly educated professionals making complex decisions based on a range of tangible and intangible indicators.

Clearly then, morale is so dynamic that it would be myopic to suggest that morale problems and solutions are universal. It could be argued that individuals experience morale differently in response to their workplace. The collective pooling of individuals’ responses to their organisation and their responses to each other in light of their organisations will be vastly different from workplace to workplace. In light of this, it is perplexing that many studies attempt to provide a blanket approach to morale across a profession or workgroup. An aggregated approach demeans the personal nature of the morale experienced by each worker and dilutes the issues that are specific to each individual workplace. In practical management terms, generalising the attitudes and issues across a population may lead to poor or incorrect responses to improving morale within individual departments or facilities.

By exploring both intrinsic and extrinsic determinants of morale, the literature highlights an interesting pattern. The factors that enhance morale appear to be intrinsic factors (giving good patient care, good relationships with co-workers, feeling respected and valued), whereas the extrinsic factors dominate the factors that reduce morale (excessive workload, fears about job security, moving to trust status). There is research that has looked specifically at nursing morale that describes

the intrinsic and extrinsic factors which affect the perception of the level of organisational morale.⁴⁹ Organisational strengths were in line with intrinsic factors (desire to help others, interesting work), while concerns were focused on extrinsic factors (pay, workload, management approach).

It can be argued that morale is such a complex and interwoven phenomenon that it cannot be viewed globally, with a few quick “tweaks” to provide the universal panacea — rather, it needs to be explored from a micro perspective, considering all the different elements that combine to create a feeling of workers cohesively striving for the same outcomes. If we have unique interactions that can affect each workplace, even affect departments differently within a given workplace, how can we assume macro level analysis will provide the answers to these complex and locally based issues? It seems peculiar that if we accept this notion of variation among individuals and workplaces in the construct of morale, the broad-based quantitative approach employed by a majority of researchers may not be the most appropriate methodology. As morale affects each worker to a different degree, qualitative approaches would appear to provide “richer” personalised data to analyse. Today’s health care sector is a complex amalgam of opposing pressures — education levels, fiscal responsibility, litigious environment, technology, role expansion, purchaser–provider agreements, blurring of services between public and private hospitals, differing leadership styles, political pressures, critical shortages of skilled staff and ever increasing client expectations. These pressures are not equally distributed across the entire health sector and they combine with unique local issues to create specific, real-time morale modifiers.

It is noteworthy that while there has been some evidence of the recognition and problems associated with low staff morale among health care workers, the recent research has been largely confined to overseas experiences. The review of the literature also demonstrates that there are obvious areas for future exploration that have an impact upon cultural, structural, theoretical and work setting elements of nursing and morale. One area

for study is bringing together a wider number of variables that have been used to date in studies on morale. These variables need to be tested against morale to determine those that have the greatest bearing on the perceptions of nurses. Additionally, areas that have not been addressed adequately in the literature include, but are not confined to: qualitative methodological approaches to supplement quantitative measurements of morale, exploring morale from a range of theoretical approaches taking into account the complex and changing environment of the health care setting; exploring morale from divergent cultural environments, especially from non-Western societal and cultural perspectives; and, how workplaces will keep morale high as technology reduces interaction between nurses, and teams are being fragmented through the use of tele-medicine, emails, tele-consulting and e-teams.

Finally, as a number of Australian studies have drawn on the work of Smith from the mid 1960s, a re-examination of these concepts in light of current organisational structures and work practices needs to be undertaken. These issues and themes need to be explored more closely in relation to their relevance and in the context of Australia’s health care system and workers. Clearly, further studies concentrating on the micro issues of morale need to be undertaken, before ultimately considering the macro effect of morale on the workforce and the profession as a whole. Comparative analysis across various health professions and countries using large randomly selected and representative samples studied over time would yield results that may better inform policy development at the organisational, profession and government levels and workforce planning.

Competing interests

The authors declare that they have no competing interests.

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(Received 7/09/05, revised 5/03/06, accepted 27/04/06) □