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Barriers to Nurse Leadership in an Indonesian Hospital Setting

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Conflict of Interest:

No conflict of interest to disclose

Abstract

Background

Given the prominent role of nursing within modern healthcare environments it is essential that leadership is viewed as a key capability. However, little is known on how leadership evolves amongst the nurses in Indonesia and the barriers that exist to nurses gaining access to leadership roles. Limited attention is given to address the improvement of nurse leadership for the benefit of the nurses in the country.

Aim

To identify organizational and individual practices and how these contribute to barriers to the development of nursing leadership in the hospital setting.

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Methods

A qualitative study employing semi-structured face-to-face interviews and a thematic approach to data analysis.

Results

Four key themes are derived: (1) Hierarchical leadership and the importance of organisational structure and gender, (2) restricted perspectives, both conceptual and spatial, (3) contractual barriers and, (4) professional barriers.

Conclusion

Achieving the desired nurses' leadership skills required persistence support and education. Acknowledgement on nurses as professional entity by minimising aforementioned challenges would elevate nurses' ability to engage further both in organisation and leadership improvement.

Implications for Nursing Management

The findings of this study strengthen nursing leadership and management practice in hospital and beyond as they have helped to elucidate the nurses' viewpoints on barriers they have on leadership. This research highlighted evidence for decision-makers to bridge the gaps amongst nursing entities by, for example, encouraging regular nursing lectures for practice improvement, conducting research together/establishing research teams, or arranging interchange teaching between experienced nurses from the hospital and campus. Further, developing nursing professionals is one of the priorities for improving the Indonesian health profile, as nurses constitute the largest portion of Indonesian health workers

Keywords

Barriers to Nursing leadership, Indonesian nurses, qualitative research

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Introduction

The International Council of Nurses (ICN) action for 2009 placed nurse leadership at the heart of its proposals in tackling global challenges facing the profession (Tyer-Viola et al., 2009). Since then, interest in leadership across the profession has grown alongside an emerging evidence base demonstrating its importance in tackling the key challenges of work satisfaction, patient outcome, recruitment and retention of nursing staff. A recent systematic review on the nature of nurse leadership revealed a strong connection between a relational approach to leadership and good patient outcomes (Wong et al., 2013). Identification of fundamental factors related to these principal dilemmas has shown that management behaviours and leadership styles are strongly related to staff members' intentions to leave or stay in the organisation (Force, 2005). Nursing leadership practices and their impacts on the profession are well evidenced (Chiok Foong Loke, 2001; Fallis & Altimier, 2006). For instance, studies have shown that leadership has a direct influence on staff satisfaction, performance, and intentions to leave (Medley & Larochelle, 1995; Robbins & Davidhizar, 2007; Spence Laschinger, Wong, & Grau, 2012). In the UK, the Francis Report identified the importance of nurse leadership in the context of promoting safety and standards in acute settings (Francis, 2013).

The origin of nurse leadership remains a key question within the field (Williams & Irvine, 2009). Despite this it is recognized that the identification of nurses' perceptions and views on leadership help to conceptualise better work conditions to make the most of nurses' performances and services (Eneh, VehvilÄlnen-Julkunen, & Kvist, 2012). Indonesia is no different in this respect, an archipelagic country within the Southeast Asia region the country consists of five main islands: Sumatra, Java, Celebes, Borneo, and Papua; these areas are sub-divided into 33 provinces. The World Health Organisation (WHO) reported that the population had recently exceeded 200 million; Indonesia is now the fourth most populated country in the world after China, India and the United States of America (WHO, 2010)

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In terms of nursing availability, data from the Organisation for Economic Co-operation and Development (OECD) shown that there was one nurse per 1000 people in Indonesia (OECD, 2012). Most of these nurses were educated at diploma level, known as Akademi Keperawatan, in both private and public institutions. More recently, the nursing profession in Indonesia has been striving to develop competency assessments and accreditation procedures. After a significantly long process, the Nursing Law (Undang-Undang Keperawatan) was passed by the country's legislature under Bill No. 38/2014 (Indonesian National Nurses Association (INNA), 2014). The law addresses several critical areas such as legal protection for nursing professionals, the organisation, and professional education for nurses. In addition to this, nurses in Indonesia are expected to adhere to a code of conduct standardised by INNA or PPNI (Persatuan Perawat Nasional Indonesia). These professional standards involve nurses' responsibility for clients, community, colleagues, and their own profession (PPNI, 2012).

Aside from the law, Shields and Hartati's (2003) review on Indonesian nursing revealed that many nurses still encounter the perception that they are the "doctor's helper". Shields added that, compared to the United Kingdom or other developed countries, where nursing has its own autonomy and power, the hospital structure in Indonesia is mostly dominated by the medical profession; hence the structure leaves nurses with minimum power, and consequently little incentive to make changes or pursue higher education. This general overview of the conditions faced by nurses in Indonesia is similar to that pertaining to Bangladesh. Zaman's description of nurses as the 'ladies without lamps' is indicative of the values and norms of Bangladeshi nurses, who suffer from negative social images (Zaman, 2009). In both Indonesia and Bangladesh, Zaman (2009) observed that nurses spend a large proportion of their time undertaking 'paper-work' due to limited resources available in their workplaces for the completion of administrative tasks. Wong et al (2013) note that personal and situational (organisational) conditions are the primary barriers to nurses taking up managerial and leadership roles. Evidence from the Republic of Ireland about nurses in

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advance practitioner roles suggest that critical mass and engagement in large networks of other nurses helps to promote and sustain leadership (Higgins et al., 2014).

In the meantime, limited access is given for Indonesian nurses as opportunity to expand their leadership capabilities. Nurses viewed themselves as followers rather than leaders and less likely have confident to speak out their competences. With little available evidence on barriers to nurse leadership and the organisation in the Indonesian context, we set out to identify organizational and individual practices and how these contribute to barriers to the development of nursing leadership in a hospital setting in the country. The findings of this study strengthen nursing leadership and management practice in hospital and beyond as they have helped to elucidate the nurses' viewpoints on barriers they have on leadership.

Methods

The study was conducted in an urban hospital in Banda Aceh, Indonesia. Ethical approval was obtained from the University Research Ethics Committee (UREC) and the Hospital's Human and Research Department. A qualitative approach was utilized to address the research aim. Specifically, the study adopted a thematic design (Braun & Clarke, 2006). A semi-structured interview approach was applied to obtain qualitative data. Semi-structured interviews allow a flexible interview process, enabling the researcher to gain the interviewee's perspective and understanding on issues and events, and forms of behavior (Bryman, 2008). The interview questions were developed based on the literature review. For example, a question on "do you think this hospital can help develop and assist you to be a leader (ward; clinical directorate; hospital levels)?" (Aiken, Havens, & Sloane, 2000; McAlearney, 2006).

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The whole interview process was conducted in Indonesian. The interview duration was between 30 to 40 minutes for each participant and take place in quiet meeting room in order to provide comfort for these in expressing their opinions and thoughts. Despite the absence of standardised procedures for evaluating the impact of translation on the credibility of qualitative data (Chen & Boore, 2010), researchers who have to translate data from one language into another are required to be explicit in describing their decisions, as well as the translation procedures and the resources used (Birbili, 2000). Therefore, to check and validate the accuracy of the transcription and translation, the following strategies are employed in this research: First, we transcribed all interviews in Indonesian and analysed them; second, after collecting key messages, we translated the themes into English. In order to check the accuracy, we sought some advice and worked closely with the University of Syiah Kuala language centre, part of first author's host institution. Back-translation may be conducted at this point to ensure that the translated key information has comparable meanings in both languages (i.e., English and Indonesian).

With the aim of reaching saturation, we decided that, in this study, 20 nurses would be recruited: ten nurse leaders and ten staff nurses. This sample size was based on an attempt to be consistent with previous mixed-design nursing leadership research (Upenieks, 2003), and this sample was deemed sufficient for the purpose of gathering qualitative data (Guest et al., 2006). As part of a larger survey study of nurses in an acute setting in Indonesia, nurse respondents were asked if they would be willing to take part in a smaller qualitative study about leadership, indicating this via a short pro-forma returned to the lead author. Forty nurses showed an interest in participating in the interviews. From this list, we recruited nurses according to various criteria such as nurses' work units (e.g. medical-surgical, intensive care, or polyclinic/ambulatory care), years of experience, or most recent educational attainment. This approach is consistent with a purposive sampling strategy. These criteria were applied in order to gain a rich data set from across the hospital environment, including nurses from multiple backgrounds.

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Following transcription anonymized transcripts were imported into the NVivo Version 10. To protect the interviewees' anonymity, any identifiable information provided by the respondents, such as people's names or work units, was removed. We preferred a form of analysis that tended to be inductive, thereby allowing the inclusion of a presumption or *a priori* (such as the importance of hierarchies) as well as emergent concepts (such as spatial aspects of leadership). The inclusion of *a priori* concepts was considered appropriate since previous ideas or concepts gained from the literature and previous quantitative studies could be included as identified categories in developing themes. However, during the analysis we were mindful of remaining open to new information and concepts that may emerge from the data (King et al., 2004) to ensure that the data were generated inductively (Namey, Guest, Thairu, & Johnson, 2007). As such the stages of analysis similar to that proposed by Braun & Clark (2006) was used: familiarization, initial coding, theme identification and labelling, review and comparison.

Results

Twenty nurses participated in the study. Participants were drawn from a range of settings and positions across the hospital. See Table 1 for detailed information about the sample. The findings described the ways in which organisational and individual practices contributed to barriers to the development of nursing leadership in the hospital setting in Indonesia. These factors often intersected with wider cultural and professional cultural characteristics which contributed to this inhibition of leadership practices. In particular four key themes are described here: Hierarchical leadership and the importance of organisational structure and gender, restricted perspectives, both conceptual and spatial, contractual barriers and professional barriers. Each will now be presented in turn.

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Hierarchical Leadership and the importance of organisational structure and gender

Hierarchical notions of leadership were present across the interviews carried out with staff from all grades. Use of the term subordinate, also commonly used, characterized these hierarchical perspectives by locating leadership in a relational field. In this sense leadership was implied as a result of one's position in relation to other non-leaders. The word reflected a sense of hierarchy and boundary lines between leaders and staff. This understanding of leadership is buoyed by the notion that non leaders are both dependent and attached to leaders and that 'subordinates' are not capable of self-directed work without facilitation from a leader.

"*Leadership means…ability to lead subordinates, guide, giving input to them…guide daily activities" (Nurse 4; Head nurse; 51-60; Ambulatory Clinic (AC) = 21-25)*

"…oversee and guide the staff; that is what I meant by leadership; and also educate and accommodate them. We are working in a teaching hospital, students including from nursing are here as well; therefore, we are the ones who guide and lead them as unit leaders..." (Nurse 5, HN; 41-50; IC=21-25)

These comments rather emphasise the distance between leaders and staff. Within these data it seems that staff nurses see the leader as the one who does nearly everything for the team. The leader provides the staff with tasks or daily duties to undertake, ultimately leaving them limited room for self-innovated action. Everything that is settled by the leader appears fixed and definite for the staff, leaving them little space for questioning or reasoning on what they have been told.

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Nurturing staff independence and autonomy at work appeared to be less of a priority. In the following argument, for instance, the staff nurses were happy with this situation, reflecting that they let the leader drive them anywhere or do *the thinking* for them in the workplace. Losing work autonomy did not feel problematic or worrying as they could count on someone else to do the job and make the big decisions for them.

"Leadership for me is about someone who sets or gives the rules; or someone who makes a work structure for his/her subordinates…" (Nurse 11, SN; 21-30; MS=<5)

"Leadership means someone who gives decisions, solves any problems, and the one who manages the ward" (Nurse 9, SN; 41-50; MS = 6-10)

Nurses' view of leadership as a structural definition also implies competency as an important element within their understanding. It seemed that the two nurse respondents above are not concerned about their ability to lead, rather looking to others to do so. Personal risk avoidance was reflected by these nurses since the leader is there to guide, facilitate, and carry the burden for them in the ups and downs of their work; there is no need to worry about problems at work because someone else will deal with them.

"…we are working as a team here and indeed we need someone who can guide us. She/he sets clear rules. So, when we are in problems, we have someone who can facilitate us to go through it and help to figure out the best solutions. She/he is indeed someone who we can lean on..." (Nurse 3, SN; 21-30; MS=<5)

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Clearly, from the above discussion, leadership is seen as a context related to hierarchy, tasks, facilitation, or decisions; almost all nurses in the study interpreted leadership in this way. There was evidence that hierarchical notions of leadership such as this are reflective of an understanding that leadership require organizational legitimacy. The head nurse below recognizes the collective leadership potential of the nursing workforce, but also perceives that nurses in this context are unable to act as individual leaders in the care they provide and hence rely heavily upon a recognised leader:

"Leadership is very important for this hospital. This is because the nursing profession holds nearly 2/3 portion from the whole healthcare teams. Nurses have the longest direct contact time with patients. In a ward, a nurse is not alone, there are many of them; you can imagine if no one leads them with clear vision and mission; of course, each nurse will work in different ways; and care that is being given is different from ward to ward because [there is] no leadership within" (Nurse 18; Former leader; 51-60)

Restriction of access to positions of legitimate leadership are also framed within gender relations in Indonesia. The external and internal culture offers limited flexibility and access to such positions for female nurses. Given that nursing was understood to be a female profession, this influenced levels of expectation about legitimate positions of leadership and power. It was felt that women cannot move to higher positions or they may consider it something they do not wish to pursue. It seemed that family and home responsibilities were viewed as a priority for some:

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"…my leadership is around this little unit. All my staff are women so I think family business brings the greatest influence for them. The family conditions do influence my work…" (Nurse 14, HN; 41-50; MS=16-20)

The common cultural perspective of "women's place is at home" or the idea that women should be dedicated housewives illustrates the barrier to female nurse leadership roles or positions within the hospital.

Restricted perspectives, both conceptual and spatial

Barriers to nursing leadership are further established through a confusion about the notion of leader and manager and how the latter is viewed being the conduit for distant, more powerful, organisational leaders. This is more helpfully explored through the idea that nurse leaders saw their role as being that of a manager within a smaller defined spatial setting (e.g. a ward or unit). The nurse below suggests that nursing leadership is certainly a requirement, but has limited ambitions for such a role:

"…absolutely needed, if we don't have the leader, then everything is ruined, no one managing the unit. If no one handles the leading, how could we have the works done properly…?" (Nurse 5, HN; 41-50; IC=21-25)

Furthermore, the nurse below echoes the need to have a legitimate nurse leader, but again the role is limited to that of establishing systems and procedures and facilitating tasks and actions.

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"He/she is the one who assigns jobs to us, and builds an organised management system. The leader guides us through and is responsive…" (Nurse 11, SN; 21-30; MS=<5)

The lack of a leadership model and a figure to show the 'real' act of leading and/or managing makes it difficult for the nurses to articulate the topic. To some extent, this might mean that the head nurses' fail to model and perform leadership roles. They see the leader only as person who is in command and gives orders. Nurses in this study considered leadership as primarily an opportunity to exercise control over a group of people, thus making the leading position a main source of power. The manager, meanwhile, has a limited measure of control. The Head Nurse below draws a direct link between distant organisational leaders and the role of nursing leadership in carrying out dictates on behalf of others:

"…the leader is the manager. Although I am the leader in this unit, I am also the one who manages it. It is very important, because if there is no leader here, the staff might not know what to do. So, we are the CEO at the unit level" (Nurse 1, HN; 41-50; IC=21-25)

"On daily tasks in the unit, I am the nurse leader and am the one who manages this unit…" (Nurse 15, HN; 41-50; MS=16-20)

Responsibility, as emphasised by the head nurses above, may describe two important elements. First, it illustrates her territorial line of authority and space to execute her leading and managing skills. Second, it alludes to the reduced likelihood of the CEO (Chief Executive Officer) being present and supervising staff nurses in the ground units. In other words, the CEO's leadership at unit level is

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devolved to the head nurses. These comments further confirmed the perceptual hierarchy found in earlier data. Most of the interviewed head nurses expressed a spatial element in their interpretation of leadership. This gives the impression that their leadership is meaningful only in certain territories or physical spaces.

While some nurses felt that leading and managing roles are performed alongside each other, different opinions about leaders' roles were captured during the interviews. A staff nurse believed that leaders and managers hold distinct positions.

"…actually, leading and managing are different. You do not have to be a leader in order to manage. However, what we see in our place is that leader is the manager (laughed). I think there is no need for me to explain it further" (Nurse 10, SN; 31-40; IC=6-10)

The nurse recognised the leader's position in the unit and admitted that the manager is not the leader. The manager is the extended hand of the leader in the organisation. The manager holds control and power but with limited scope, often defined spatially or in relation to a set of resources.

Contractual barriers

The employment system in the hospital included two levels of nursing professionals: the permanent civil servant and contract-based staff nurses. Contract-based nurses, by virtue of their unsecure working conditions demonstrated a lack of confidence in recognising themselves as future leaders. They felt that they were unable to lead because they are not permanent members of staff and an entitlement to develop leadership capability was considered an opportunity open to permanent nurses, but not to them. The statement (below), by a nurse who holds a non-permanent status, implied the hopelessness of her current position. The nurse was less optimistic about her future in

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the organization. The nurse's comment indicated her dissatisfaction with the way in which the hospital treats the contract staff. However, her opinion implied a fatalistic perspective with little opportunity for change.

"As a contract-based nurse, I do not have capacity as future leader or see support from the hospital that can develop me to be in the frontline. Maybe, I am on contract basis here. It would be different for the permanent nurses, I believe" (Nurse 13, SN; 31-40; MS=6-10)

We found that surrendering to the situation was a common phenomenon when the nurses expressed their thoughts on leadership. The contract based nurses felt unenthusiastic and seemed to lack the capability to be change agents. This may be because their positions are not secure and there is no guarantee that they will one day be entitled to permanent employee status in the organisation.

"There is barrier for leadership position in here. This hospital treats the PNS (permanent) and contract nurses differently…" (Nurse 6, SN; 31-40; MS=6-10)

Professional barriers

These data suggest that the nursing workforce held leadership competencies, but that these were not being realised. Some implied that the organisation was not prepared to fully endorse and support nurse leadership and that the hospital imposed a barrier preventing nurses from reaching

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the top. The prospect of nurses holding power or exercising leadership as board members threatened established structured and leadership roles. This contrasted with nurse beliefs about the potential for them to undertake senior roles, although recognized the challenges in attaining this. A head nurse said:

"I see staff potential to be leaders. They have the potential but just sometimes nothing facilitates them to be one. They are smart; when responsibilities are given to them I am sure they can manage it. I think maybe it just because no opportunity is available…nurses are still perceived as servants although we hold high education." (Nurse 1, HN; 41-50; IC=21-25)

This opinion emphasised the lack of opportunity as the barrier to nurses' ambitions. She felt that potential leaders are available, but apparently the organisation actively neglects the talents and competences of these nurses.

Discussions relating to opportunities in leadership with these nurses led to additional issues which seemed to be strongly related to one another; these are about power and autonomy. A head nurse noted:

"All nurses have potential. They are smart…but, sometimes, other professionals do not want to be rivalled by nurses, like competing. Sometimes trust is given but it still cannot be to the fullest; [they] feel like [they are] tied up; they do not dare enough. Actually, they shouldn't be like that, other places are not like here" (Nurse 5, HN; 41-50; IC=21-25)

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The importance of leadership within the wider organisation was recognised as a critical factor in facilitating nurses to become leaders in their own right. In this sense it was felt that Executive Board members should provide an environment where nurse leadership might flourish. Such established practices around the positions of nurses within the organisational hierarchy imbued a feeling of inability or lack of confidence in one's own leadership competency, especially within the acute hospital environment. The participant below saw potential to lead (at least at an organisational level) probably within primary or community care:

"Nurses have potential to lead…well, maybe for change. Whatever or whoever the leader in the hospital, we are still below here. To lead a hospital like this I think it is impossible. Maybe we can lead in community health centre (Puskesmas)…" (Nurse 7, SN; 31-40; IC=6-10)

Discussion

These data demonstrate a number of significant challenges to Indonesian nurse leadership. In particular it is noted that hierarchy, professional, contractual and perceptual barriers were present in these data. These barriers are further re-enforced in the presence of wider cultural expectations along gender lines. Indeed this latter observation related to gender is present in the literature (Eagly, Johannesen-Schmidt, & Van Engen, 2003); which has noted communication skills, coach and mentor orientation, or ability to empower others as frequently expected leadership qualities (Anonson et al., 2014; Feltner, Mitchell, Norris, & Wolfle, 2008; Rouse, 2009). Moreover, the presence of family- or parent-like leadership expectations may indicate the pivotal role of parent figures amongst the nurses in Indonesia. These points are in line with Gani's finding that Indonesians depicted leaders as

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possessing the roles of father (wise), mother (aspirational), friend (tolerant, social, open), educator (patient), priest (moral), and pioneer (creative and intelligent) (Gani, 2004).

It is also apparent that confounding notions of leadership and management, as the effect of the conditions in which they are involved, may impede leadership development. The emphasis detected within the theme focusing on spatial management showed that the nurses see hardly any difference between the two. The almost indistinguishable perspectives on leadership and management roles may emphasize several elements; first, the lack of leadership figures in the settings; second, the inability of the organisation to expose them to leadership opportunities; third, the possibility that the nurses have always been driven into task-oriented work schemes which have therefore overshadowed the evolvement of leadership amongst them. These may have been true considering that, in all probability, attention to Indonesian nursing development is more focused on practice than on leadership. A similar concern was reflected in a study conducted amongst Lithuanian nurses in which the researchers concluded that leadership in nursing is typically assumed to be a less important aspect than skills/practice improvement (Zydziunaite, Lepaite, & Suominen, 2013).

It is, perhaps, the links between these data and elements of situational and/or organisational literature which is more compelling. It has already been noted by others that such conditions are critical in the development of nurse leadership (Wong et al 2013; Higgins et al 2014). For both, the organisation of work, collective structures and access to opportunities play a pivotal role in nurses developing leadership characteristics and roles. Here situational characteristics of acute hospital nursing are also in evidence, in the form of hierarchy, professional exclusion and contractual isolation. Nurses in this study identify a dearth of leadership opportunity and the prohibitory practices of senior hospital management as primary barriers to nurses accessing key roles within the organisation. More telling, however, is the data associated with those nurses who feel structurally excluded from leadership opportunity as a result of their marginal contractual status. Not only does this demonstrate consequences for the Indonesian context but also for those healthcare systems pursuing policies which may lead to such arrangements. Batch and Windsor (2015) note that the

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casualization of the nursing workforce may impact upon opportunities for development, continuity of mentorship and an altered view of the role of the 'non-standard' nurse, endorsing our view that the role on non-contractual nurses here were left in a state of liminality.

Such observations are, however, premised upon a relatively 'traditional' and administrative dependent view of the notion of leadership. Whilst it cannot be said that leadership and senior role are not synonymous, there remains considerable scope to understand the concept via a less managerial dependent lens. Daly et al. (2014) cite the notion of clinical leadership as that which should occupy a prominent position amongst all healthcare leaders, including nurses. Via this perspective, leadership takes up a role focused on clinical credibility, as opposed to organisational position (Daly, Jackson, Mannix, Davidson, & Hutchinson, 2014). Within such a position, leadership is possible across a range of organisational spaces and positions, focusing less on institutional legitimacy and more upon the role of the nurse in challenging established practices, empowering colleagues, maintaining professional identity and contributing to effective team working, amongst others. These perspectives of leadership are rarely visible within this group of Indonesian nurses.

Study Limitations

The study has limited generalisability. Since this study was conducted in Aceh, a province in the west of Indonesia, findings and analysis gathered from the nurses of this region may not be representative of all Indonesian nurses. For instance, the leadership views of Acehnese nurses may be different from nurses in Jakarta, the capital city. Indonesia is a country with multiple regions, tribes and ethnicities. With this richness, it seems very obvious that people from different regions will have distinct values, job and life environments, and norms. Perspectives on leadership obtained from the nurses in Aceh may introduce a general impression of Indonesian nurses, but it cannot be inferred that all nurses in the country will see the leadership concept similarly. Moreover, possible bias on translation must also be addressed. Difficulty in finding similar values to express interviews'

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contents from Bahasa Indonesian to English was unavoidable. With the assistance of language expert from the first author's institution, the language barrier was minimized.

Conclusions

This is the first qualitative study focusing upon the challenges faced by Indonesian nurses in seeking to develop individual and collective leadership in an acute hospital setting. We have highlighted a range of organisational, or institutional, as well as personal challenges. These challenges highlight the complex cultural and structural issues facing nurse leadership in the country. Whilst highly relevant to the development of nurse leadership in Indonesia, we also recognise that these findings have relevance in other parts of the world.

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Table 1 Research Participants

Person	Age Group	Education	Length of employment	Occupation	Sex	Unit of work
Nurse 1	41-50	Bachelor	>26 years	Nurse leader	Female	Intensive Care
Nurse 2	51-60	Bachelor	>26 years	Nurse leader	Female	Medical Surgical
Nurse 3	21-30	Diploma III-Nursing	<5 years	Staff nurse	Female	Medical Surgical
Nurse 4	51-60	Bachelor	21-25 years	Nurse leader	Female	Ambulatory/Polyclinic
Nurse 5	41-50	Bachelor	21-25 years	Nurse leader	Female	Intensive Care
Nurse 6	31-40	Diploma III-Nursing	6-10 years	Staff nurse	Female	Medical Surgical
Nurse 7	31-40	Bachelor	6-10 years	Staff nurse	Female	Intensive Care
Nurse 8	21-30	Diploma III-Nursing	<5 years	Staff nurse	Female	Medical Surgical
Nurse 9	41-50	Diploma III-Nursing	6-10 years	Staff nurse	Female	Medical Surgical
Nurse 10	31-40	Diploma III-Nursing	6-10 years	Staff nurse	Female	Intensive Care
Nurse 11	21-30	Diploma III-Nursing	<5 years	Staff nurse	Female	Medical Surgical
Nurse 12	21-30	Diploma III-Nursing	<5 years	Staff nurse	Female	Medical Surgical
Nurse 13	31-40	Diploma III-Nursing	6-10 years	Staff nurse	Female	Medical Surgical
Nurse 14	41-50	Bachelor	16-20 years	Nurse leader	Female	Medical Surgical
Nurse 15	41-50	Bachelor	16-20 years	Nurse leader	Female	Medical Surgical
Nurse 16	51-60	Bachelor	>26	Nurse leader	Female	Nursing Unit
Nurse 17	31-40	Diploma III-Nursing	6-10 years	Staff nurse	Female	Medical Surgical
Nurse 18	51-60	Master (Postgraduate)	>26 years	Nurse leader	Female	Former Nursing Leader
Nurse 19	21-30	Diploma III-Nursing	<5 years	Staff nurse	Female	Medical Surgical
Nurse 20	31-40	Diploma III-Nursing	6-10 years	Staff nurse	Female	Intensive Care

- SN = Staff Nurse; HN = Head Nurse; IC = Intensive Care; MS = Medical Surgical

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