PERCEIVED WORK RELATED STRESS, JOB PERFORMANCE, SOCIAL SUPPORT AND INTENTION TO STAY AMONG IMMIGRANT NURSES IN A CULTURALLY DIVERSE SETTING

BY

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ABSTRACT

This thesis measures and explores the perceived work related stress (WRS), job performance, social support and intention to stay among immigrant nurses in a multicultural nursing workforce in a diverse cultural setting at Sultan Bin Abdul-Aziz Humanitarian City (SBAHC), Riyadh region. The present research addresses gaps in the empirical literature by investigating the key work stressors experienced by immigrant nurses working in the Kingdom of Saudi Arabia (KSA) and by establishing nurses' referent levels of work stress, social support, job performance and intention to stay in their current job. In addition, the research explores the complex relationships between work stress, social support, intention to stay and job performance. The job demand control-support (JDC-S) theory (Johnson and Hall 1988) provides the theoretical background for the thesis. This theory proposes that strain (i.e., work stress) occurs when demands (i.e., work stressors) exceed coping resources (e.g. social support).

This research utilizes the case study mixed methodology approach incorporating a quantitative questionnaire survey and qualitative semi structured interviews. The eligible participants comprised 321 nurses 246 (76%) of whom returned their completed questionnaires. For the qualitative component of the study, a purposive sampling strategy was used; 20 nurses were interviewed using a semi-structured interview technique.

The quantitative data revealed that nurses' perception of WRS was occasional. The most common stressful event was

Treatment" and "Death and Dying". The reported mean for the overall job performance scale was high. The highest reported mean of the job performance subscale was for "Professional Development" and "Critical Care", and the lowest mean was for "Leadership". Moreover, male nurses reported higher level of stress than female nurses; the higher the number of patients, the higher the reported mean of stress by nurses. The reported mean of the Intention to Stay Scale [McCain Behavioural Commitment Scale (MBCS)] was moderate indicating that most nurses reported that they have a neutral perception of willingness to stay in their current placement.

The qualitative phase indicated that the nurses within this environment were experiencing high levels of WRS and struggling to achieve cultural competence; consequently, they were having difficulties in meeting the patient's cultural and spiritual needs as well as maintaining a high standard of care. Importantly, there was inadequate support by the organisation or supervisor to manage WRS. Nurses perceived their job performance as high, and they intended to stay at work due to the financial benefits they get compared to their home country. Immigrant nurses felt discriminated due to the pay difference.

In conclusion, the present research further contributes to our understanding of WRS, social support, job performance and intention to stay among immigrant nurses in KSA.

The present study demonstrates that immigrant nurses in KSA are stressed; there was a significant difference between the qualitative and quantitative results.

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CHAPTER ONE: INTRODUCTION

1.1 Introduction

In today's work environment, work stress is widely spread across employment sectors and in different types of organisations. My thesis reports an investigation into work related stress (WRS) in a specific population with a diverse cultural background, namely immigrant hospital nurses in Riyadh in the Kingdom of Saudi Arabia (KSA). The research measures WRS among immigrant nurses in Riyadh and explores the relationships between WRS and pertinent variables: job performance, intention to stay within the organisation, and social support from work supervisors and colleagues. The research also aims to suggest a comprehensive management plan to minimise the negative outcomes of WRS among hospital nurses in Riyadh-KSA.

Among the many topics that have aroused public attention in recent years, globalization has become one of the most discussed and analysed. Globalization is not easy to define and it can mean various things to various people. In the literal sense, it means the process of transformation of local phenomena into a global event, the process by which the peoples of the world are unified into one community and work together (Stearns 2010). At a broad level, globalization is a growth in the impact on human activities of the force that extends national boundaries. These can be economic, sociable, cultural, political, technical, or even biological, as in the case of illness (Goldin and Reinert 2007).

Globalization has also been named as a cause of job polarization in higher and lower skilled occupations, with

possible effects on inequality. Lower labour costs in developing countries, and dipping transportation costs, make overseas labour a more favourable option, as is the case in KSA. This has led to changing income levels for workers across the occupation, as in the case nurses from the Philippines where they earn at least three times the salary available in their home country (World Employment and Social Outlook 2015).

National and international healthcare systems are increasing with the current progression of globalisation. The global mobilisation of health workers is concurrent with the expectation that healthcare services will be provided at a high-quality level, and that safety measurement systems will be implemented. This universal movement of healthcare workers will provide the platform that finally advances the true globalization of healthcare. Moreover, the direct effects of disease, the migration of healthcare employees and patients, global engagements and expansions affect the ability of governments and healthcare organisations to meet the wellbeing needs of the population (Chen 2013).

Healthcare systems around the world are in crisis: according to the World Health Organization (WHO 2013), the world will be short of 12.9 million healthcare employees by 2035; present shortages stand at 7.2 million, a shortage that directly affects the quality of care. Globally, the number of doctors per 1,000 of population is anticipated to remain about the same between 2012 and 2015 (WORLD Bank Report 2014). According to a European commission, there will be a shortage of 230,000 physicians across the continent in the near future whilst the number of caregivers in 36 countries in

Africa is inadequate to deliver even the most basic immunisation and maternal health services (Deloitte 2014).

Rapid economic growth across Asia has led to hugely increased access to healthcare, yet coverage across the region remains uneven (Deloitte 2014). Staff shortages mean that nursing staff are regularly working overtime in order to catch up with their duties or to cover for colleagues and, as reported by the National Nursing Research Unit (NNRU) (2013) at King's College London, nurses regularly have to leave care undone because of staffing shortages. Ball et al (2013) concluded that there is a strong relationship between Registered Nurse staffing levels and the occurrence of care being left uncompleted: the more improved the practice environment, the smaller the volume of care that is left uncompleted.

The question of whether there are enough nurses with the right skills has been a hot topic of debate for decades. The strength of the discussion has increased recently following the publication of numerous prominent reports (e.g. HSE 2013A, Francis 2013,) about the quality and safety of care, leading to heightened public awareness and greater media exposure (Care Quality Commission (CQC) 2015). These reports plainly focus on what can go wrong when there are insufficient staff with the right skills and attitudes.

Staffing levels and concerns about practice environments are impacting on staff engagement across the whole workforce. For example, the 2012 NHS Staff Survey for England found that just 40% of all staff were satisfied with the extent to which they felt that their Trust valued their work; 35 per cent said that communication between senior managers and staff was

effective; 38 % were satisfied with their level of pay; only 52 per cent looked forward to going to work; and 38% had suffered work-related stress in the previous 12 months.

The topic of work-related stress among immigrant nurses, certain basic concepts about each of the two elements of this topic (migration and its prevalence in the healthcare sector, and WRS) must first be discussed. What follows is the foundation work that has guided the conceptual development of this research. It includes an overview of thought on contemporary global migration, market segmentation, and their specificities in the Middle East in general, and more specifically in KSA; the section ends with an introduction of what is known about work-related stress in immigrants both internationally and in KSA, and the key psychosocial risks. Following this, an outline of the research is offered which is meant to orient the reader to the ideas and vocabulary employed within this study of the working conditions of immigrant nurses in KSA.

There are 2 major elements of WRS among immigrant nurses which require discussion: migration and its prevalence in the healthcare sector and WRS.

1.2 **Migration and Work**

The three major forces that have led to essential adjustments in the realm of work in industrialised nations over the past are: demographic movements, expanded investment globalization, and fast innovative change (Karoly and Panis 2004; EU-OSHA 2007). These forces have affected the world of work because they have notably contributed to an ageing workforce, the emergence of new forms of employment

contracts, increased job insecurity, more work intensification, and greater use of irregular and flexible working hours. These changes in the world of work have triggered general public concern about the apparent deterioration of 'job quality', especially in Europe, over recent decades (Green 2006; EC 2008a; Hassan et al 2009).

Demographic shifts have affected the composition of the workforce, moving it towards a more adjusted distribution in terms of age, sex and race/ethnicity. These modifications in the composition of the workforce have raised growing concerns about the impact on the basic dimensions of quality of work, including aptitudes, job development, work improvement, sexual orientation uniformity, and the organisation of work affecting the harmony between work and life, diversity and non-discrimination (European Social Observatory (OSE) 2013).

At the same time, increased economic globalization has affected businesses and sections of the workforce previously protected from exchange-related competition (EC 2008a). This new period of globalization has contributed to a perceived decline in job quality among workers because it has exacerbated concerns about job insecurity and placed many workers under growing work pressures and demands. It is not just manufacturing jobs that have been outsourced to emerging countries, but also similarly higher-skilled employments in healthcare and in the service segment, such as information technology and business-preparing administrations (EC 2006). Finally, fast innovative change and expanded universal rivalry have placed a focus on the aptitudes and arrangement of the workforce, especially on the

capacity to adjust rapidly to changing advances and economic conditions.

The majority of migrants' cross borders in search of better economic and social opportunities. Economic migrants are the world's fastest growing group of migrants (United Nations Population Fund (UNFPA) 2014). Globalization has increased the mobility of workers, and a decline in fertility and working-age populations in many developed countries is leading to a mounting demand for overseas workers to sustain national economies (UNFPA 2014). New forms of migration have arisen, and many countries that once sent migrants abroad - for example, Argentina, Ireland and South Korea - are now experiencing migrant inflows as well (UNFPA 2014).

Migration is often temporary or circular, and many migrants sustain links with their home countries. While migrants make important contributions to the economic wealth of their host countries, the flow of financial, technological, social and human capital back to their countries of origin is also having a significant impact on poverty reduction and economic development. Remittances from migrants are a major source of capital for developing countries (UNFPA 2014).

1.2.1 Contemporary Migration Worldwide

The working environment and the way of work itself are both having critical impacts on health (Marmot and Wilkinson 2006). In the last few years, significant evolution has occurred in the realm of work (EU-OSHA 2007). Worldwide socio-political advancements of expanding globalization and the foundation of a free market, the development of information

and communication technology, and significant demographic changes characterise the development of the modern workplace (Kompier 2006; EU-OSHA 2007). The current key issues relevant to the changing world of work can be specifically summarised as contractual arrangements, working hours, use of new technology, telework and flexible work arrangements, and changes in the workforce (EU-OSHA 2002a). Generally, changes in the way of work and work organisation will impact on the development of new forms of employment, with both impacting occupational health and safety (OSHA 2002a) and changes in the working population (Leka et al 2008a).

Remittance flows to developing countries totalled $406 billion in 2012, an increase of 6.5 per cent over the previous year. Global remittance flows, including those to high-income countries, were an estimated $534 billion in 2012. Possibly twice this amount was transferred informally. These financial transfers are growing in significance. In many countries, they are larger than either development assistance or direct foreign investment. Available data show that women send home a higher proportion of their earnings than do men. These contributions feed and educate children and generally improve the living standards of loved ones left behind (World Bank 2013). The 2000 World Migration Report (WMR) similarly referred to the example of Lesotho a country for which immigrants contributed to about 50% for every penny of the GDP.

In 2006, the United Nations General Assembly gathered its first-ever High-level Dialogue (HLD) on International and Development, which is seen as a great developmental improvement in the universal conversation on worldwide

movement, especially at the moment when the global group recognise both that relocation was an unavoidable actuality and that it could profit both the nations and the vagrants concerned (World Migration Report (WMR) 2013 2016). The 2013 High-level Dialogue offered a timely chance to take stock of the mandates and work of the United Nations and its partners on the migration (and development) field since the first HLD. It also resulted in an important event to discuss how migration may be combined into the post 2015 United Nations development agenda. In the “Recommendations and Outcomes” paper, the HLD agreed on the key elements for improved policies and practices at the international, regional and local levels to enhance the development outcomes of migration for migrants and societies.

Key recommendations include(a) enabling orderly and safe mobility, knowing that greater movement is inevitable and indeed essential in the twenty-first century; (b) the ambition to make migration a genuine choice, instead of a distressed necessity; (c) selecting the shelter of migrants and their human rights including labour rights; access to asylum, health and decent work; attention to social protection and well-being; and the rights of all children in the context of migration – in rights-based and gender-sensitive policies and practices; (d) focusing on the human growth potential of migration, including the potential to improve the lives of individuals and families, as well as migration’s contribution to the economic growth and development of countries; (e) addressing public sensitivities of migrants and migration to counter anti-migrant sentiment, xenophobia and discrimination, and to raise awareness of migrants’ overwhelmingly positive contributions to societies of origin and destination; (f) knowing that obligatory and voluntary forms of migration are not always

easily distinct, and ensuring protection and assistance for the most vulnerable; (g) promising cooperation with all allies involved in and affected by migration, while recognising the sovereign prerogative of States to determine the entry into and stay of non-nationals on their territories, within the limits set by those States' international legal obligations; (h) finding balanced measures to combat the harmful forms and effects of migration, including cross-border trafficking in persons and smuggling of migrants, while protecting human rights.

The World Migration Report (2013) focuses on migrants moving from lower-income countries to more affluent ones, and presents findings for four key migration pathways (from the South to the North, from the North to the South, between countries of the South, and between countries of the North), as well as their implications for development. "North" alludes to high-salary nations and "South" to low- and high-pay nations, as characterized by the World Bank. Such labels have their restrictions, with diverse meanings of "North" and "South" offering differing outcomes with regard to the scale and attributes of movement in each of the four pathways. Moreover, both "North" and "South" envelop an extensive variety of distinctive vagrant circumstances and classifications.

This division is helpful for examination of the movement of immigrants in a more all-encompassing way. The key point to note is that this report considers all immigration pathways, whether they are South–North, South-South, North–South or North–North. South–South transients are monetarily imperative; because of the extent of numbers and the potential scale of settlements, yet individuals' backgrounds are a generally under-studied territory. This 'blind side' for

policymakers generally reflects the deficiency of trustworthy information regarding immigrants who move from one creating nation to another, as in the case with migration to KSA; As per the International Organisation for Migration, World Migration Report (2013), most immigration is to nations in the North yet it is practically matched by relocation to nations in the South; an ignored and probably disparaged phenomenon, given the difficulty in obtaining hard facts.

Most immigrants are from nations in the South, overall, based on the grounds that populations in those countries are higher. Be that as it may, it would seem that individuals from nations in the North are less averse to relocate. For each of the four movement pathways, the top relocation pathways are:

- North–North: Germany to the United States, followed by the United Kingdom to Australia, and then Canada, the Republic of Korea and the United Kingdom to the United States.
- South–South: Ukraine to the Russian Federation, followed by the Russian Federation to Ukraine, Bangladesh to Bhutan, Kazakhstan to the Russian Federation, and Afghanistan to Pakistan.
- South–North: Mexico to the United States, followed by Turkey to Germany, and then China, the Philippines and India to the United States.
- North–South: the United States to Mexico and South Africa, followed by Germany to Turkey, Portugal to Brazil, and Italy to Argentina.

In terms of migrants as a proportion of the overall population, nations with a smaller aggregate populace have a tendency to rank higher. Significant findings are the high number of immigrants in the South–North setting; specifically in a

percentage of the Gulf Cooperation Council (GCC) nations (86% for Qatar, 68% for United Arab Emirates, 30% for KSA, and 66% for Kuwait), (WMR 2013).

The number of global immigrants in 2010 was estimated at 214 million (WMR 2013). In the event that this number continues to grow at the same pace as throughout the most recent 20 years, it could reach 405 million by 2050. While some advanced movement is a repercussion of war (for instance, migration from Iraq and Bosnia to the US and UK), political clashes (e.g. some resettlement from Zimbabwe to the UK), and regular disasters (e.g. displacement from Montserrat to the UK following the eruption of the island's fountain of liquid magma), contemporary relocation is dominatingly financially motivated. Specifically, this is exemplified by the wide discrepancy in the money that might be earned for comparable work in diverse nations of the world (WMR 2013).

Additionally, there are, at any given time a few occupations in some high-wage nations for which there is a lack of properly capable or qualified nationals. A few nations (e.g., UK and Australia) have work focused frameworks that give legal movement visas to non-residents who ‘fit the bill’ for such depleted occupations. In this way, non-natives have a financial motivation to learn the important aptitudes and abilities needed to fill these available occupations. Nations with higher predominating compensation levels, e.g. France, Germany, Italy and the UK, are net beneficiaries of such movement from lower paid nations such as Greece, Hungary, Lithuania, Poland and Romania, (Anon 2014). On the other hand, an impression is created that immigration remains overwhelmingly low-talented, both in the North and in the

South: 44% of immigrants are low-skilled, 33% have intermediate abilities; and just 22% are highly skilled (Dumont et al 2010). Immigration by low-skilled labourers tends to assume a more prominent role in the South–South setting, which is described by unplanned, less moderate developments to neighbouring nations and is hence open to larger and lower educated parts of the general population (Anon 2014).

Finally, it is worth mentioning that some contemporary financial movement occurs even where immigrants are illegally occupied in their terminus nation, and are therefore at a real disadvantage in the job market. Unlawful workers are, for instance, known to cross in critical numbers - commonly during the evening, from Mexico into the US, from Mozambique into South Africa, from Bulgaria and Turkey into Greece, from North Africa into Spain and Italy, and from Bangladesh into India (Anon 2014).

1.2.2 Immigration in the Saudi Context

Worldwide immigration is a characterising variable in the organisation of Saudi Arabian culture and has become basic to the national economy (Almutairi 2015). Saudi Arabia was quickly converted by the oil business, which has led the Kingdom of Saudi Arabia (KSA) to change from a pastoral, agrarian, and business public view into an urban culture with extensive-scale base ventures, a far reaching social welfare framework, and an economy commanded by outside professionals ((Albaqme 2014)).

As the local general, population were unable to play a key role in their own business ventures, organisations started to

enlist highly-skilled and lower-skilled specialists from abroad. Many people from South and Southeast Asia moved to Saudi Arabia. Movement of Asian workers was particularly encouraged as it was considered that, in contrast to Arab immigrant labourers, they might be less motivated to settle, more averse to compose, and thus all the more simple to control (Migration Policy Institute 2016). Regardless of the reduction in the pace of development undertakings in the 1980s, South Asians and Southeast Asians continually constitute the largest part of the exiled populace in the Kingdom, demonstrating that interest for immigrant labourers has moved to different parts of the economy.

Estimating over $27.6 billion of outward remittance flow in 2012, the World Bank ranks KSA as the second highest remittance-sending country in the world after the USA: the United States (US$42.2 billion), Saudi Arabia (US$27.6 billion), Switzerland (US$13.8 billion), Germany (US$12.3 billion), Russian Federation (US$11.4 billion), Spain (US$11 billion), Italy (US$8.2 billion), Luxembourg (US$7.5); roughly 6.4 million workers were legally living in KSA, with actual figures most likely being much higher.

From mid-2013, expatriates made up 32 percent of the KSA population, most of them coming from South Asia (Gulf Labour Markets and Migration (GLMM) 2015. They accounted for 56.5 percent of the employed population and 89% of the private sector workforce. In September 2011, and in the face of a spurt in foreign labour recruitment starting in the mid-2000s, the Saudi Ministry of Labour introduced a policy called Nitaqat aimed at ‘Saudisising’ the Kingdom’s workforce and thereby reducing unemployment amongst Saudis. The most current data also show the scale of the

irregular migration phenomenon in KSA: the amnesty campaign which started in April 2013 allowed 4.7 million foreign workers to regularise their status, while an ongoing crackdown on illegal forced one million to leave the KSA in 2013 alone, of which (as of November 30 2013) 547,000 were deported (GLMM 2015).

KSA is ranked among the top five migrant destination countries worldwide, around a quarter workers are domestic labourers, and Human Rights Watch apprises that nearly 1.5 million female local labourers live in KSA (Faiza 2008; GLMM 2015). The great majority of legal resident foreigners are of working age, while gender proportions vary by country of origin. Filipino foreign residents have among them the greatest proportion of females, at 28.6%. In contrast, women of African origin form only 17.6% of the total foreign residents from that continent (GLMM 2014).

Western immigrant workers are typically utilised in highly skilled work occupations, although the aggregate number of Western immigrants in the Kingdom has been diminishing as a result of expanded Saudisation (making particular employments just for Saudis) in the oil industry after the jobs were given to Saudi people in 1988. More recently, terrorist assaults focusing on westerners have additionally incited many to leave the nation (Pakkiasamy 2004).

KSA is now facing an emergency on the supply and maintenance of healthcare labourers, especially migrant nurses who form a huge part of the nursing workforce - over 70% of the general nursing labour in government hospitals, and in excess of 95 percent of those in private hospitals. It has been estimated that it will require 25 years to train

sufficient Saudi Nurses to cover 30 percent of the overall need (Al-Dossary et al 2008). The reasons for the current healthcare manpower shortage are complex; however, the key element is work related stress brought on by poor work situations and working conditions, poor living arrangements, segregation, physical environment, lack of compensation, and an unfavourable work-life balance (Almalki et al 2011).

A report composed by WHO (2013) showed that KSA will face a sharp rise in healthcare services requirements over the next ten years. A range of variables, including high conception rates and expanding rates of non-transmittable sicknesses (including diabetes, tumour, cardiovascular infections and other obesity-related diseases) will put a huge pressure on the healthcare services, with a consequent requirement for more hospitals and more healthcare providers will be required. Over the next four years, more than 41,000 new hospital beds will be required in Saudi Arabia to meet the heightening demands of the rapidly developing populace of the nation, with more than USD 18 billion being focused on Saudi's healthcare services development throughout the following five years (Deloitte Middle East 2014).

This puts an extra burden on the Saudi government to contract and retain healthcare workers, including nurses; in the meantime, it ought to tempt Saudi nationals to choose nursing as a profession, although nursing is seen as a less alluring career choice for them in comparison with other callings, because socially nursing is seen as a low class and thankless vocation (Almutairi and McCarthy 2012).

In the event that foreign immigrants are not accessible for the Saudi market, the nation's open healthcare system will be in

danger. The figures shown above reflect a genuine threat to the security of the workforce trustworthiness in KSA since a greater part of the nursing staff are non-Saudi or non-Arabs who may leave the nation at any time for any number of reasons (Al Osaimi 2004; Almutairi and McCarthy 2012). The country's dependency on immigrant nurses places Saudi Arabia's healthcare facilities system in a weak position in recognition of the rising worldwide shortage of nurses (Littlejohn et al 2012).

Living and working with Muslim patients in KSA can be both an exciting and challenging experience for non-Muslim immigrants, but particular challenges are posed by religious, cultural and language differences between patients and immigrants which can result in the care provided to Muslim patients by non-Muslim healthcare providers in a hospital setting being different from the care given by Muslim staff. In particular, communication of acute clinical changes is an essential skill that maximises efficiency and compassion during the quality care delivery process.

A further consideration is that, contingent upon nationality, the working status of immigrants in KSA sometimes varies and this has been discovered, unsurprisingly, to cause negative feelings and inequity between immigrants, which in turn brings about stress-related clashes (Toh and DeNisi 2005; Goodwin and Preiss 2010). Unsuitable working conditions can be a possible cause of WRS. For instance, immigrant nurses from parts of Europe and the USA are more highly qualified and earn higher salaries than individuals from Asia, Africa and Eastern Europe. Such rewards include contrasts in lodging, rewards, travel expenses and leave allowances; similarly, open doors for advancement exist, yet

change according to workers' nationalities. This is not limited to KSA and is typical in other Arab nations, leading to additional pressure on Asian immigrants, African and Eastern European immigrant nurses (Alserhan et al 2010).

Due to the contrasts in working environment, and work place opportunity, it is obvious that WRS level, turnover and occupation performance is and will be influenced (Goodwin and Preiss 2010). In addition, immigrant nurses invest more time in non-nursing assignments and experience challenges in adjusting to the outside environment (Takeuchi 2010).

A further element leading to increased difficulties and stressors amongst Saudi Arabia's developing number of foreigners is that the nation is losing its focused edge concerning enlisting and retaining qualified staff (Rondeau 2006). Higher salaries offered to potential workers by competing countries, together with Saudi Arabia's absence of marriage contract status (where a business gives family assistance, wellbeing protection, flight tickets to relatives at the expense of the organisation), the weakness of the Saudi Riyal exchange rate, continuing clashes in the Middle East, segregation of men and women, restricted career development for females are variables that challenge the nation, thus increasing the imbalance between labour supply and interest. Hence, the immigrant nurses who remain become more liable to WRS as they endeavour to oversee heavier workloads with reduced help.

In spite of the immense volume of literature and the growth in the number of studies leading on WRS, gaps in available information are still self-evident. A portion of the research identifies with particular work situations for different work-

related groups under particular working conditions, and to the procedure by which work related stress is created under those conditions. The basic inclination is to conduct researches that focus on work related stress, and there has been only an extremely restricted study on WRS in KSA. In the meantime, there is a gap in the literature regarding the relevance of the available studies to particular social groups, especially to immigrant nurses' status, as the current literature regarding work related stress does not fit with the complexity of the multicultural societies of the present day working populace (Pasca and Wagner 2011).

1.3 Work-Related Stress and Psychosocial Hazards

The terms WRS, occupational pressure, employment stress and organisational stress, are utilised interchangeably (Vokic and Bogdanic 2007) because occupations, jobs, organisation and work are often indistinguishable concepts. WRS now ranks amongst the most severe health problems in the contemporary world (Beheshtifar and Nazarian 2013), as it can occur in any occupation and is much more predominant than in decades past (Bhatia et al 2010). Job stress can reduce the enjoyment of life, causes hypertension, decrease productivity, increase staff turnover, decrease job satisfaction, cause job insecurity, cardiac problems, and reduced auto-immunity, contribute to substance abuse and reduce the overall status of mental and physical wellbeing (Bhatia et al 2010).

Stress is defined as a mental state that is created when an individual confronts a condition that surpasses the inside or outside assets accessible to manage that condition (Lazarus 1966). More recently, work related stress has been similarly

characterised as the process that emerges where work demands of different types and complexities surpass the individual's ability and competence to adapt. It is a critical cause of disease and is known to be connected with abnormal levels of employee's absenteeism, staff turnover and different markers of official underperformance - including human error (Health and Safety Executive UK (HSE) 2008). As indicated by the World Health Organisation (WHO 2009), work-related stress is 'the reaction individuals may encounter when exhibited with work demands that are not matched to their knowledge and abilities and which challenge their capability to cope'. Moreover, WRS has been linked with work security and job performance, work components, wellbeing and self-respect issues (WHO 2004). A poor work environment and poor relationships at work, for example, unclear work outlines and work frameworks, can similarly cause work stress (WHO 2004).

The European Union reported work-related stress to be the second most predominant work related wellbeing issue, influencing 22% of workers. It revealed that more than 40 million people and almost one in three of Europe's workers report that they are influenced by stress at work (EU-OSHA 2009; WHO 2010). As such, there is strong confirmation of an affiliation between introduction to psychosocial risks and an array of health outcomes at both the singular and authoritative levels. From a broader perspective, psychosocial risks are a major occupational health concern and can have critical financial consequences for society and all types of enterprises, including small, medium and large companies (Cocker 2013).

In Austria at the national level, 1.2 million labourers report experiencing work-related stress. In Denmark, 8% of workers

report being "regularly" regularly exhausted. In Germany, 98% of works organisations confirmed that stress and the amount of work had expanded recently and 85% referred to longer working hours. In Spain, 32% of labourers portrayed their job as upsetting (Koukoulaki 2004).

In the UK, as indicated by the 2008/09 Labour Force Survey, the estimated prevalence of self-reported work-related stress at a level that was causing illness was 415,000 people (HSE 2009). Additionally, the 2009 UK Psychosocial Working Conditions (PWC) overview showed that around 16.7% of all working people thought their employment were extremely, or to a great degree, unpleasant (Packham and Webster 2009). Stress predominance in the new European Union Member States (EU-10) is particularly higher than in the old Member States (EU-15). Work-related stress was accounted for by 20% of professionals from EU-15, rising to 30% of workers from EU-10). The highest levels of stress were reported in Greece (55%), followed by Slovenia, Sweden (38%), and Latvia (37%). Lowest anxiety levels were noted in the United Kingdom (12%), Germany, Ireland, and the Netherlands (16%), in the Czech Republic (17%), and in France and Bulgaria (18%) (EU-OSHA 2009).

The available statistics show that WRS has become more costly over past years (Gianakos 2002). In the United States, the expense of WRS has been calculated at US$350 billion (about £220 billion) per year (Azagba and Sharaf 2011). It is estimated that WRS costs UK industry around £14.2 billion each year in lost income (Health and Safety Executive 2013), and caused workers to lose 11.3 million working days in 2013/14 (Health and Safety Executive 2013). Also, the cost of mental ill-health to UK business was estimated to the level

of £9 billion, excluding lost time and productivity (Shaw Trust 2006). Data from the European Union show that the cost of stress is calculated at 20 billion Euros (about £16.5 billion) each year (Azagba and Sharaf 2011). In Australia, stress related costs, including absenteeism, cost the economy AU$14.81 billion (about £9.56 billion) a year, and directly costs employers AU$10.11 (about £6.98 billion) billion a year, with a total of 32 days lost per year (Medibank 2008). No statistics are available on the monetary cost of WRS in Arab countries and particularly in KSA, but one must assume that there are costs to society as well as to individuals.

Several studies found significant negative relationships between WRS and work-life fulfilment (Wolf 2003; Nakakis and Ouzouni 2008; Harzer and Ruch 2015). It has been reported that elevated amounts of work anxiety results in increasing rates of turnover and employees leaving their jobs (Byrne 2002; Sveinsdottir et al 2006). Furthermore, a high level of WRS reduces the quality of work and performance (Kawano 2008), and in healthcare services can threaten patients' lives and security (Shader et al 2001). Suzuki et al (2004) indicated that the chances of errors increase when nurses are under abnormal pressure of work or fatigue, while Olofsson et al (2003) indicated that nursing is a high-risk job with regard to stress-related diseases.

Severe and prolonged distress is a major contributor to the advancement of burnout (Maslach et al 2001; Cooper et al 2001; Pines 2002; McVicar 2003) which generates a feeling of helplessness and hopelessness (Espeland 2006) if it exceeds the limits of the person's ability to control or cope with stressors (Landeche 2009). Other precursors including to WRS are harassment, work related bullying and

exhaustion, all of which are viewed as significant psychosocial hazards around the world. WHO (2009) and Econtech (2008) give a more extensive definition of the psycho-social dangers that can trigger WRS, including:

- Work variables, (for example, unnecessarily long hours, absurd demands, or rigid work methods prompting poor work-life offset).
- The physical nature, (for example, noise or overcrowding or ergonomic issues).
- Hierarchical pressure (including poor lines of communication and unclear assessment and responsibilities, poor leadership, and absence of clarity about management targets and methodologies).
- Work environment change (which can cause intention to leave work and high staff turnover).
- Connections at work (for instance poor relationships of staff with managers, administration and partners which may result in harassment and badgering or bullying).

Psychosocial hazards are characterised by the International Labour Organization (ILO 2016) as the associations around job nature and its content, work organisation and administration, and other environmental and organisational conditions, on the one hand, and the employees 'skills and needs on the other (ILO 1986). Psychosocial hazards in the work environment trigger WRS. Psychosocial hazards have developed in noticeably of late due to variables including expanding work tasks, (e.g. increased working hours and greater workloads), changes in organisational practices, and a changing social perception of how employees should be dealt with by directors, managers and individual workers from a legal point of view (Shen et al 2009).

Worries about psychosocial hazards at work and their associated risks on work related wellbeing and security have raised the concern of policymakers and different Occupational Health and Safety (OHS) stakeholders around the world recently. These concerns reflect the expanding predominance of WRS, harassment or provocation, and violence in general as well as workers in a changing work environment (European Commission (EC) 2010). Work place stress and bullying, including demonstrations of harassment, separation and sexual harassment, have been recognised as prominent amongst the most rapidly expanding working environment issues. In the USA, up to four million individuals are liable to encounter some manifestation of workplace bullying each year, while the UK has recently passed laws against workplace harassment (Viljoin 2013). Yet, in spite of its predominance, workplace bullying, continues to be misunderstood, and attracts little consideration from organisations. Consequently, occurrences continue to be under-reported (Viljoin 2013).

Numerous reasons exist for workplace bullying; however hierarchical changes may increase danger of developing stress. Methodologies characterised by "win-win" and "lose-lose" are viewed as a variable that may provoke riotous situations where consistency and thought have been disregarded, and where patrimonial and authoritarian administration styles prevail, rather than cooperation (Viljoin 2013).

In studies that investigated workers with work place bullying, it was observed that healthcare organisations with increased occurrences of work stressors among critical care nurses had

poor psychosocial work circumstances and a poor social atmosphere. These harmful work situations influenced the wellbeing of exploited workers and the performance of work groups (Harrison 2013). Poor or restricted human resource administration had additionally permitted workplace bullying to go unchallenged and discouraged staff from accepting managers, leaving them with the perception that they have been harassed (Fevre et al 2012).

Management of psychosocial risks goes hand in hand with the size of the establishment, whether the establishment is a part of a larger entity (company, firm) or sector (public or private) and regardless of sexual orientation of the workforce, age composition of the workforce, proportion of foreigners in the workforce, industry and the type of country (EU-OSHA 2012). Whilst larger sized establishments tend to be associated with better management of psychosocial risks, it has also been observed that management of psychosocial risks is associated with the industry to which an establishment belongs, with psychosocial risks being reported to be a less prominent issue in manufacturing and construction areas, yet significantly affecting organisations in education, health and social work (EU-OSHA 2012; Human Rights and Labour Report 2013).

In addition, the scope of management of psychosocial risks is also associated with the country to which an establishment belongs. Psychosocial risk management in Greece, Cyprus, France and Estonia scored the lowest in Europe, while selected countries in northern Europe reported higher levels (i.e. Sweden and Finland have reported higher levels of psychosocial risk management) (EU-OSHA 2012). On the other hand, private establishments are slightly worse at

managing psychosocial risks than public establishments, whereas the demographic features of an establishment (i.e. the composition of its workforce by age, gender and origin) are the least influential determinants of the management of psychosocial risk (Human Rights and Labour Report 2013).

Numerous studies suggest that stressful life events can cause physical and psychological illnesses as well as decreased employee performance. Several types of work related events, such as changes in the balance of work/family roles, taking a new job, discrimination, stereotyping, social isolation and job changes have been studied and deemed to be potentially stressful life events (Shawn et al 2005; Dangarawla 2013; OGP 2013). A life event is considered to be stressful if 'it causes changes in, and demands readjustment of, an average person's normal routine' (Kobasa 1979; OGP 2013).

There is obvious accord in the literature on the nature of psychosocial hazards; these can be categorised in ten broad categories as shown in Table 1.1. In the next section, further exploration of selected hazards will be presented in accordance with the key categories identified in the table below, with particular relevance to nurses in general, and immigrant nurses specifically.

Table 1.1 Examples of Psychosocial Hazards (OGP 2013)

CATEGORY	DESCRIPTION
Job Content	Lack of variety or short work cycles Perception of fragmented or meaningless work Under-use of skills High uncertainty Continuous exposure to people through work
Workload pace of work	• Work overload or under load Machine pacing High levels of time pressure Continually subject to deadlines
Work Schedule	• Shift working: Night Shifts Inflexible work schedules Unpredictable, long or unsociable hours
Control	• Low participation in decision making • Lack of control over workload Shift working
Environment and Equipment	Inadequate equipment availability Poor suitability or maintenance Poor environmental conditions such as lack of space, poor lighting, excessive noise
Organizational Culture and function	Poor communication Low levels of support for problem solving and personal development Lack of definition of, or agreement on, organizational objectives
Interpersonal relationships at work	• Social or physical isolation • Lack of social support • Poor relationships with superiors Interpersonal conflict
Role in organization	• Role ambiguity • Role conflict, and responsibility for people
Career Development	• Career stagnation and uncertainty • Under promotion or over promotion • Poor pay • Job insecurity • Low social value to work
Home-work interface	• Conflicting demands of work and home Low support at home • Outstanding career problems

It is essential to note that psychosocial hazards do not pose risks solely to psychological health; both physical and psychosocial hazards have the potential for detrimental effects on physical health as well as on social and psychological well-being. Furthermore, significant interactions can occur between hazards, and also between their effects on health (Naik 2013).

1.4 Aims and Objectives of the Study

The purpose of the research is to explore, describe and measure the WRS at both individual and organisation levels. To achieve this, nursing staff working at Sultan Bin Abdulaziz Humanitarian City (SBAHC) in Riyadh KSA were invited to participate in the study. The primary aim of the study is to facilitate immigrant nurses (who comprise 99 per cent of the nurse workforce at the study setting and who are experiencing a very different healthcare system, environment and working conditions) to provide information on the subject of WRS in KSA to decision makers so that they may be given the necessary support they require.

This research study uses both quantitative and qualitative case study methodologies. The use of case study mixed methods will validate and complement the results and findings by comparing quantitative and qualitative data (Jones 2004). The first phase of the study involved the use of a quantitative methodology and methods. Quantitative research describes a phenomenon and/or investigates relationships between variables by using statistical procedures on collected data, typically through surveys (Polit and Beck 2004). The study measures:

- Perceived WRS
- Perceived job performance;
- Perceived social support and recognition from work colleagues
- Perceived intention to stay and turnover rates.

The second phase used a qualitative methodology and methods. Qualitative research uses a flexible research design to investigate stories from participants who reveal their lived experiences, typically through interviews (Polit and Beck 2004). The aims of the qualitative approach are:

- To explore, understand and describe nurses' experiences of workplace stress in a culturally different acute and rehabilitation hospital setting in the Kingdom of Saudi Arabia;
- To recommend strategies for handling stress in the workplace;
- To understand the effect of WRS on nurses' job performance, intention to stay and manpower turnover rate;
- To describe the effect of social support and recognition from supervisors on WRS experience
- To describe nurses' coping mechanisms to deal with WRS.

This study might be a vehicle to highlight the importance of providing fair working conditions and to explore the issue of work stress among immigrant nurses. In addition, it may contribute to the improvement of the working environment among immigrant nurses as well as identify needed measures and policies for employers and employees in order to improve job performance among nurses. At the same time, this study will contribute knowledge and relevant information that may help in developing a new, or enhance existing WRS

models that are tailored to immigrant workers in a culturally diverse environment.

It is envisaged that this study will be of importance to Saudi healthcare leaders and organisations that experience the challenge of recruiting and retaining immigrant nurses of a high quality. The challenges of recruiting include the cost of moving immigrant nurses to Saudi Arabia in a timely manner, turnover, and the challenge of developing a Saudi nursing workforce (Al-Osaimi 2004). Since 2005, recruitment trips to foreign countries by nursing directors yielded lower qualified applicants (Huda 2007). In this time of global nursing shortage, successful recruitment and retention initiatives that depend on the ability and willingness of healthcare organisations to attend to nurses' concerns and create work settings attractive to both old and new recruits can reduce turnover rates (Cameron, et al 2004), as does sufficient training provided to immigrant nurses in terms of pre-departure training, which includes language training, cultural training, and practical training (Galenda 2016).

1.5 Structure of the Thesis

Following this introductory chapter, Chapter Two outlines the key theoretical models of WRS starting with the person-environment fit model by French et al (1982), moving to the Job Demand-Control model by Karasek (1979), the adopted Job Demand-Control-Support (JDC-S) model by Johnson and Hall (1988) and finally the Effort-Reward Imbalance model by Siegrist (1996).

Chapter Three focuses on WRS among immigrant nurses and studies that contextualise the focus of this study. WRS,

job performance, intention to stay and social support will be explored in further detail. This section gives a review of the issue of WRS impact, adapting components, and directing variables on both people and organisations.

The fourth chapter demonstrates in detail the methodology and methods used for the research. The section begins by justifying the utilisation of the case study mixed methodology approach followed by further exploration of the methods used, sampling and data collection process, data analysis, quality of case study research and validity and reliability. Key ethical challenges will also be discussed in detail in this chapter.

The fifth chapter presents the quantitative method results and discussion of WRS, job performance, social support and intention to stay among immigrant nurses.

The sixth chapter presents the qualitative method results and discussion of the findings of the study variables of the research and findings from interviews.

Finally, in chapter seven, conclusions and future directions of the study findings, its restrictions and qualities and suggestions for future exploration will be presented.

CHAPTER TWO

WORK-RELATED STRESS: THEORY AND IMPACT

2.1 Introduction

The problem of WRS is huge in growing nations that are prone to fast and severe economic and social progressions (e.g. in KSA), where there is an expanded interest in the adjustment of immigrant workers, over-riding of patient outcomes, reorientation of the work related wellbeing framework, and generally poor working conditions (Ortiz 2013). The current division between working conditions and the (physical) work environment makes the consideration of WRS harder to differentiate by the majority of Occupational Health and Safety experts (Houtman et al 2007; Ortiz 2011). Even though an array of research can now be documented on the extent of reasons and outcomes of WRS in developed and industrialised countries, WRS is still an issue which is a long way from being recognised. Therefore, almost no information is accessible from developing nations like KSA (Ortiz 2011), which prevents us from evaluating the amount of employment strain due to psychosocial stressors in nations such as KSA, and in particular restricts the possibility of contrasting the outcomes of these assessments with studies of nations in which it has been measured more frequently; such evaluation is needed to increase the awareness of the WRS issue and to promote further studies.

While most work-related stress research focuses solely on the workplace, Cox and Griffiths (2010) underline the need to consider the wider context by drawing out commonalities of the main theories of work-related stress. Their key critical

conclusion for the research under discussion is that the main theories offer a typical structure in portraying an arrangement of occasions and methodology which includes both environmental parts and the individual, mental, physiological and behavioural segments, and that these parts communicate with the more extensive connection of the significant social, authoritative, and societal situations. This is supported by the fact that researchers' involvement in work-related stress has been primarily within the domain of Occupational Health and Safety (Cox and Griffiths 2010).

WRS has been seen as the after effect of inconvenient working conditions, as well as causing poor physical and mental health (Cox et al 2000; Leka et al 2003; WHO 2010). WRS has been conceptualised both as an input variable, and as an outcome of a condition that is alluded to as anxiety, which makes it troublesome to clearly differentiate between input and output (D'Amato and Zijlstra 2003). For example, while in a few studies anxiety and sickness are recognised to be a result of working conditions, different studies see work-related stress as creating mental wellbeing issues (e.g., Hromoco et al 1995; Schultz et al 1995; Moustaka and Constantinidis 2010). This can cause a problem because it makes it confusing to understand and differentiate between the cause and effect of WRS and has an impact on the understanding of the interactional nature of work related stressors and the environment (WHO 2010).

Studies have demonstrated the impact of employment strain (in occupations with low levels of popularity and low control) on hypertension, coronary illness and mental pain, musculoskeletal issues, diabetes, psychiatric ailments, gastrointestinal sickness, work related and activity accidents,

cardiovascular mortality, liquor related ailments, absenteeism, resting issues, discouragement, tension, work fulfilment and mental prosperity, amongst others (Karasek et al 1981; Karasek 1988; Johnson and Hall 1988; Theorell and Karasek 1996; Van der Doef and Maes 1999; Schnall et al 2000; Mcclenahan et al 2007; Rydstedt et al 2007; Salavecz et al 2010; Ortiz 2011).

This Chapter explains the theoretical framework used and the function that it serves in the research. A theoretical framework is a conceptual model of how one theorises or makes reasonable sense of the relationships among numerous issues that have been recognised as significant to the problem (Cargan 2007). A valuable theoretical framework "should add to the definition of the phenomenon of study (WRS) that is comprehensive enough to release the variations in interpretations by researchers but narrow enough to offer limits and direction to literature retrieval" (Patterson et al 2001).

2.2 Theoretical Framework of the Study

There are a number of models and theories of WRS (El Shikieri and Musa 2012). Each has its specific issues and, in some respects, its insufficiencies. Below, four of these models are considered which include: the person environment fit theory developed by French et al (1982), the job strain model, developed by Karasek (1979), the effort–reward imbalance model, developed by Siegrist (1996) and finally, the Job Demand-Control-Support (JDC-S) model (Johnson, and Hall 1988).

Later and more thorough theories regarding WRS highlight the need for the connection and fit between the individual and his or her environmental domain. Connections between diverse working conditions create work situations that are better for people's physical social and mental wellbeing (Griep et al 2011). By looking at the WRS as a peculiarity between the individual and his or her specific work environment, further investigation and better understanding can illustrate why one person would endure and battle on and yet another person would adjust and flourish. The interactional nature of stress is pertinent in this study because there is an expanding need for immigrant nurses in the working environment. Long, indeterminate or unsocial hours, working far from home, taking work home, unreasonable levels of expectation, bias, work insecurity, and occupation migration may all unfavourably influence staff work performance, and their willingness to stay at their present place of employment. This undermines the need to unwind and find personal satisfaction outside of work, which is an essential support against the stresses brought on by work. Also, additional local pressures may come to bear because of being an outsider and the absence of social support from family and supervisors; for example, childcare obligations, monetary stresses, and accommodation issues may influence an individual's concentration at work. Subsequently, an endless loop is set up in which the stress created in one aspect of one's life, work or home, overflows and makes adapting to the new work environment more troublesome (Griep et al 2011).

2.2.1 Person-Environment Fit Theory (P-E Fit Theory)

The Person-Environment Fit Theory (P-E Fit Theory) was developed by French et al (1982). It is one of the popular supported conceptual models in the field of WRS (Cooper 1998) and embodies an inclusive concept that necessarily includes an individual's compatibility with many systems in the occupational environment (Kristof-Brown et al 2002). According to Schreuder and Coetzee (2002), P-E Fit is defined as a match between diverse abilities and competencies and the needs of the employment. The central premise of the theory is that stress arises from the fit or congruence of the person with the environment and not from the person or the environment separately (French et al 1982). It proposes that poor fit may prompt physiological stress or psychological stress or both (Sadri 1997). Edwards et al (1998) emphasised three distinctions relative to fit; the initial one is between environment and person, the second is between the subjective representation (an individual's perceptions of the work environment) and the objective representation (reality of the work environment), and the third is between demands and abilities. Brewer and McMahan-Landers (2003) inferred that a difference between requests and capacities actuates methods for adapting, which impacts objective and subjective situations. The concept of P-E Fit fundamentally indicates that alignment between people's characteristics and their occupational environments leads to positive outcomes for both the individual and the environment (Sekiguchi 2004). People are more powerful, more fulfilled and more dedicated to their employments when their particular qualities match the attributes of their situational environment (Awoniyi et al 2002).

Although different studies have tested the reasons and conclusions of P-E Fit, little is thought about how persons join together ideas about themselves and their surroundings into discernments of P-E Fit. Immediately, the relationships between discernments of the individual, environmental domain, and P-E Fit could appear redundant, given that P-E Fit is characterised as the match between the individual and environment (French et al 1982; Muchinsky and Monahan 1987; Chatman 1989; Kristof 1996). Nonetheless, this interaction's may not be so clear within the psyche of the individual. For instance, when individuals think about whether their pay surpasses or misses the mark regarding the sum they need (Hollenbeck 1989; Sweeney et al 1990), do they figure a subjective contrast between their apparent and coveted pay? At the point when individuals say their capacities surpass the prerequisites of their employment (Bolino and Feldman 2000; Johnson and Johnson 2000), do they rationally subtract recognitions of their capabilities and occupation demands? At the point when individuals say their qualities fit those of the association (Adkins et al 1994; Lovelace and Rosen 1996; Jeffrey et al 2006), does this mean their qualities and those of the association are seen as equivalent? At the point when managers say they are like subordinates (Turban and Jones 1988; Zalesny and Highhouse 1992), do they rationally contrast themselves and their subordinates and report the after effect of that correlation? These enquiries strike at the precise importance of P-E Fit and how individuals experience it, yet call for research that might address why such questions have gone unanswered (Kristof 1996; Meglino and Ravlin 1998).

The P-E Fit research has been criticised primarily for lack of conceptualisation of the environment (E) component of fit (Schneider 2001).

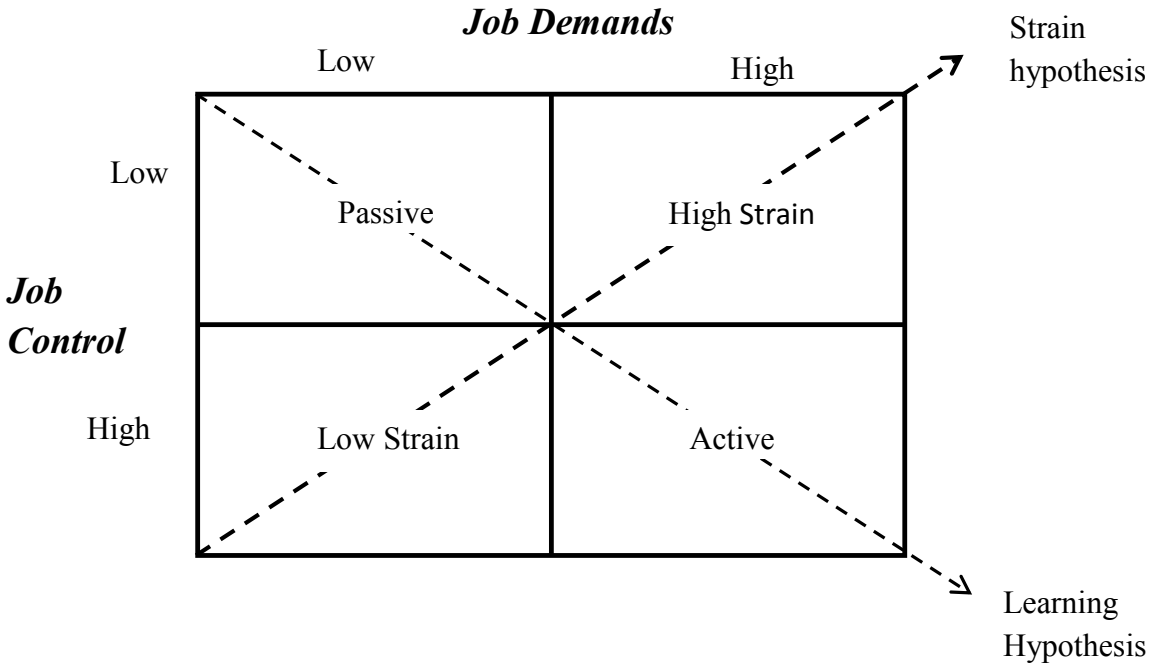
2.2.2 The Job Demand-Control Model

The job demand control model (JDC model) was developed by Karasek (1979): it proposes that WRS is especially brought on by fusion of high occupation requests such as expanded work requests and low occupation control. The JDC model was one of a kind in that it concentrated on the environmental connection between psychosocial requests and physiological ailment and its connection to the everyday stressors experienced by employees in the work environment (Karasek and Theorell 1990). The JDC model conceptualises employment strains as a composite of work environment requests and control (Karasek 1979) (see Figure 2.1). The model proposes two speculations which came to be known as the “learning hypothesis” and the “strain hypothesis” (Van der Doef and Maes 1999) and has come to be viewed as the most powerful model concerning WRS (Johnson and Hall 1988; Bakker and Demerouti 2008; Kobayshi et al 2008; Yahaya et al 2010; Demerouti et al 2015). Job requests allude to the work load or time pressure (Karasek 1979). The occupation control angle comes from the idea of aptitude prudence and practicality (the width of abilities utilised by the workers) and choice power (the worker’s power to make a choice in relation to their life that meets their expectations). The idea of control, or choice scope, is really twofold: aptitude perception and choice power (Karasek 1989). Expertise caution implies the level of ability needed, the capability to take in and the use of imagination at work, the advancement of aptitudes and the capacity to learn (Karasek 1989).

The strain hypothesis has gained more consideration in the literature. It declares that the recognition of low levels of popularity and low control will cause mental strain (Van der Doef and Maes 1999; Bakker and Demerouti 2006). For example, immigrant nurses are required to perform their employment quickly, care for at least six patients every shift with little support as they are in a diverse cultural setting, (High Demand); at the same time, in the KSA it is common that immigrant nurses have no power or part in making any choices identified with their occupation (low control) when they lack self-sufficiency, are paid low wages and feel insecure concerning their employment. This is acknowledged as a primary wellspring of work related stress which is considered as psychosocial risk. Unsurprisingly, nurses feel that they are controlled by other healthcare providers and that they are subordinate, as every other caring role is prioritised but not nursing care (Aldosary et al 2008).

The learning theory specifies that acceptance happens when the person sees levels of high demand joined by high control (Van der Doef and Maes 1999; Bakker and Demerouti 2006). It is based on the presumption that expanded control at work will emphatically influence an individual's inspiration to learn (Paulsson et al 2005; Park 2007). High control is proposed to permit workers to adapt to levels of high demand at work, which results in preventing them from strain and influences learning (Delange et al 2003; Park 2007).

Figure 2.1 Karasek's Job Demand-Control Model (Adapted from Karasek 1979)



It is argued that the quality of the JDC model lies in its straightforwardness, yet on occasions this can be seen as a shortcoming, since the presence of complex working systems is decreased to just a handful of variables (Bakker and Demerouti 2006). Because the JDC model concentrates on work over-load as the principal indicator for stress, this straightforwardness gives no equity to actuality as revealed by studies on WRS which have generated a far-reaching rundown of high demands that need occupational assets as potential indicators, and not just high job demands (Halbesleben and Buckley 2004). This raises the question whether the JDC model is suitable to apply to all occupations. Additionally, Karasek's conceptualisations of demands and control have been criticised as being excessively expansive. It has been agreed that the idea of demands be recognised and the physical and emotional requests accomplished at work (de Jonge et al 1999). stated that control in the work

environment is similarly multi-dimensional, covering the control over the request of work errands, the nature of work, execution and the amount of output, the pacing of work, the nature of the environment, strategies and methodology, official objectives and intention to stay in the organisation or even leave the occupation.

2.2.3 Job Demand-Control-Support (JDCS) Model (Johnson and Hall 1988)

The JDCS (Johnson and Hall 1988) model is an extension of the original Karasek (1979) model comprised of demand and control to which the notion of social support is added in predicting stress outcomes. Other models in the same category have been proposed subsequently to predict stress outcomes in organisations (Siegrist 1996; Hobfoll and Shirom 2000; Bakker and Demerouti 2008 Demerouti et al 2015).

The JDCS model has been assuming a central part in studies examining the impacts of work-related psychosocial components on morbidity and mortality (de Lange et al 2003; Klein et al 2011). The model is based around the so-called iso -strain theory which states that the most noteworthy strain (i.e. high risk of poor psychosocial well-being) will be noted when the demands of the occupation are high and observed control (job decision latitude) and social support are low (Van der Doef and Maes 1999). In spite of the fact that the support component was not generally included in the model, the present research entailed checking the literature relating for where nurses in general and immigrant nurses in particular stressed their requirement for support. Suggesting the incorporation of this variable is fundamental to the circumstances regarding immigrant nurses. Support has

been interfaced to nurses' apparent employment performance, intention to stay, staff recognition (Abu Alrub 2007) and to wellbeing results and the occupation fulfilment of experienced nurses (Munro et al 1998).

Evidence shows that job demands, job control and social support create the main and additive effects on strain/wellbeing (Van der Doef and Maes 1999; De Lange et al 2003; Hausser et al 2010) which is pertinent to the majority of immigrant nurses in KSA who are left without families, or friends, and have to cope with the new work setting, thereby putting their wellbeing at risk. Pisanti (2012) conducted a study among nurses to test the core hypotheses of the job demands-control-support model (JDCS) of Johnson, and Hall (1988). In order to refine and extend the JDCS model, Pisanti analysed the direct and interactive role of three coping strategies: task-oriented, emotion-oriented, and avoidance-oriented coping. The results indicated that job control and social support combined collectively ($p<0.001$) with job demands to explain the wellbeing outcomes (explained variance between 6% and 28%). Coping strategies accounted for additional variance ($p<0.001$; explained variance between 4% and 15%) in all outcomes except in job satisfaction; support was found for the main effects of coping. Coping strategies did not moderate the impact of job characteristics on burnout and wellbeing. Emotion-oriented coping emerged as the most important predictor and was consistently associated with higher burnout levels and lower wellbeing levels.

The JDCS model continually holds a focal place in research on WRS and wellbeing, notwithstanding the rise of different models in the area (de Lange et al 2003; Bakker et al 2008).

In the JDCS model, employment demands are important to measured workload; occupation control alludes to the apparent flexibility which allows the worker to choose how to meet these requests; social help alludes to "overall levels of helpful social interaction available on the job from both co-workers and supervisors" (Karasek and Theorell 1990, p.69). The JDCS model anticipates that high employment demands combined with lack of job control and poor social support will adversely influence psychological and physiological stress (Van Der Doef and Maes 1998, 1999). Furthermore, the JDCS model predicts the impacts of high employment demands on these stressors will be moderated by improved job control and by work-based social support (Van Der Doef and Maes 1998; de Lange et al 2003).

The JDCS model has been found to anticipate the rate and predominance of cardiovascular ailments (Steenland et al 2000; Belkic et al 2004) and to foresee cardiovascular mortality (Kivimaki et al 2006). The developed JDCS model incorporates manager and colleague social support as real occupation aspects having immediate consequences for individual areas of mental and physical wellbeing (Karasek and Theorell 1990). Most studies on the JDCS essentially summed up the distinctive wellsprings of social support to make an aggregate social help scale (Belkic et al 2004). Past surveys of prospective studies which analysed the impact of the JDCS on stress related mental issues (Nieuwenhuijsen et al 2010) and on mental prosperity (Hausser et al 2010) proposed that it is essential to recognise work colleagues, family support and manager social support, as having all the more frequently a bigger impact in anticipating mental health conclusions (Shirom et al 2011).

Empirical research has confirmed the existence of value differences across cultures (Bond and Smith 1996). As a result, there is reason to expect cross-cultural differences in the application of the JDC and JDCS models to nurses' stress (Gelfand et al 2007; Baba et al 2013). Hence, it is helpful and useful to use the JDCS model in the Saudi context cultures. The JDCS model has universal significance although it works somewhat differently within different contexts (Baba et al 2013).

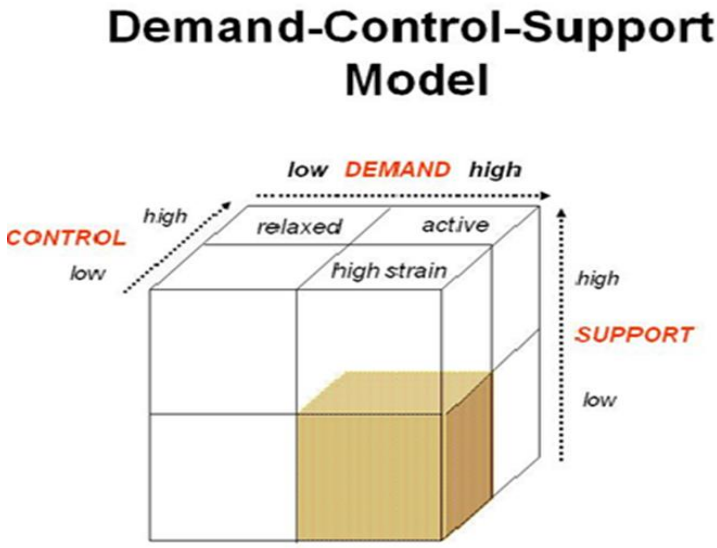
The JDCS framework has been chosen as the most appropriate for this study on account of its adaptability and its ability to identify the psycho-social enquiry about beliefs, perception, coping, views and practices related to WRS among immigrant nurses; additionally:

- It acknowledges that there is a critical level from a motivational perspective which can become an intermediary to stress, for example staff recognition, social support, payment and equity of pay as being those considered to be major psychosocial risks in KSA.
- It considers job control, employment burdens and social support, and in particular how they interact and contribute to job WRS.
- It considers how WRS might be directed and thus how it influences the organisation.
- It includes all the variables under investigation in this study.
- It considers both negative and positive outcomes and recognises that demands and support in certain situations, such as in KSA where the culture, regulations, policies, the composition of the healthcare system and work environment are unique.

- It has been applied to studies of WRS, burnout, work-family interface and has been utilised by researchers to have a better understanding of how job characteristics are linked to performance (Bakker et al 2004).
- In the immigrant's context, the demands-resources classification can be particularly useful in providing a systematic examination of the various unique conditions describing the circumstances of being an immigrant nurse and the transition period of becoming an immigrant nurse, similar to the status of the nurses in the current research setting.
- The JDCS model is considered capable of being generalised because it fits in different cultural contexts and has been used in different environments involving discrimination, inequality, and employees working in different roles under different cultures with different motivation expectations (Yeung 2004), which fits very well in the current research setting's unique work environment.

The current study sought to examine selected concepts that may be derived from the JDCS model only. This study examined stressors, moderators to stressors, and how these are perceived by immigrant nurses working in KSA. Specifically, combining the JDCS model processes in an additive sense leads to the development of the proposition that when both job demands and support are high, it is expected that employees will develop strain and motivation, while when both are low, the absence of strain and motivation can be expected. Consequently, the high demands-low support condition should result in high strain and low motivation while the low demands-high support condition should have as a consequence low strain and high motivation (see Figure 2.2).

Figure 2.2



Other considered models have been criticised seriously, so they were not adopted in this study. The person-environment fit theory has been criticised primarily for lack of conceptualisation of the environment component of fit (Schneider 2001). The Effort-Reward Imbalance model (see 2.2.4) was criticised because it postulates that salary, esteem reward and status control are the most important job resources that could compensate for the effect of job demands on strain. It did not include autonomy (Burr 2010; Griep 2011). The Job Demand-Control Model (discussed in 2.2.2) was criticised for not taking workers' individual characteristics, such as the difference between a person's background and culture, into account (Parkes 1991), and for being unclear about the mechanism of coping.

Considering the richness of the conceptual background, it can be said that the hypothetical premise for WRS can be interactional and focused on the structural qualities of an individual's collaboration with their environment. The foundation may also be transactional and focus on the

cognitive process and emotional reactions related to person-environment interactions (Tabanelli et al 2008).

2.2.4 Effort Reward Imbalance Model (ERI)

Siegrist (1996) suggests that advancement of stress related illness is brought on by the imbalance between high exertion (extrinsic job demands and intrinsic motivation to meet these demands) and low rewards (such as salary and esteem).

The Effort-Reward Imbalance (ERI) Model, originally formulated by Siegrist and colleagues (Siegrist, and Weber 1986; Siegrist 1996), has received considerable attention in occupational health research merely due to its predictive power for adverse health and well-being outcomes (van Vegchel et al 2005). The ERI Model has its origin in medical sociology and emphasizes both the effort and the reward structure of work (Marmot, Siegrist, and Theorell 2006). According to the ER work-related benefits depend upon a reciprocal relationship between efforts and rewards at work. Efforts represent job demands and/or obligations that are imposed on the employee, such as time pressure and working overtime. Occupational rewards distributed by the employer (and by society at large) consist of money, esteem, and job security/career opportunities. More specifically, the ERI Model claims that work characterized by both high efforts and low rewards represents a reciprocity deficit between high ‘costs’ and low ‘gains’, which could elicit negative emotions in exposed employees. The accompanying feelings may cause sustained strain reactions. So, working hard without receiving adequate appreciation or being treated fairly are examples of a stressful imbalance. Another assumption of the ERI Model concerns individual differences in the experience of effort-

reward imbalance. It is assumed that employees characterized by a motivational pattern of excessive job-related commitment and a high need for approval (i.e., over commitment) will respond with more strain reactions to an effort-reward imbalance, in comparison with less overcommitted people.

As per the model, an inequality between effort used (i.e., occupation demands, and commitments) and rewards (i.e., advancements, wages, increments) leads to increased stress levels. Social support, reward and recognition that are proportionate to the amount of effort made leads to a lessening in stress levels and enhances the desire of staff to stay in their job. The pertinence of the ERI imbalance model has been affirmed over a wide range of employments and people with distinctive socio-demographic profiles: the model is used in many countries, specifically in Europe, USA or Japan as well as in different locales of the world (Tsutsumi and Kawakami 2004).

The key reason for immigrant nurses to leave their native country to go and work in Saudi Arabia is for better financial compensation. As a case in point, Filipino immigrant nurses acquire 3 times their usual pay by working in Western healthcare facilities in Saudi Arabia contrasted with working in the Philippines (Otvos 2005). However, with worldwide competition for immigrant nurses, pay is not by any means the only component to think about. One may accept that if pay were the main inspiration for foreigners working in Saudi Arabia, then immigrant nurses might remain in their jobs, but this is not the case.

The ERI model puts particular emphasis on the social aspects (i.e., the work role) and specifically its fundamental concepts, on the grounds that, as shown by the model, the job role is essential in fulfilling the individual right toward self-needs. The working environment offers an open door to securing personal advancement (e.g., successful employment execution), self-respect (e.g., regard and recognition), and coordination toward oneself (e.g., having a place with noteworthy support). As indicated by the model, effort at work is used as a component of social gain that responds to exertion by offering a satisfactory reward (Siegrist 1986; Siegrist and Peter 1997b). Rewards are disseminated by three kinds of work-related prizes: cash, regard, and status control. Low promotion prospects, constrained employment conditions and work instability are all cases of poor status control. On the other hand, the ERI model has been criticized on the grounds that it hypothesises that compensation, regard, prize and status control are the most critical employment effects that could make up for the impact of job demands on stress. It did not include individual people difference and preferences, some may consider moral support and recognition as the most rewarding experience for the efforts made (Griep 2011).

As previously discussed, the employee contributes exertions or efforts and expects rewards. As indicated by Siegrist (2002b), high exertion/low remunerate conditions prevail when: (1) work contracts are inadequately identified or individuals have no choice decision in the work place (e.g. because of low level of expertise, absence of promotion opportunities, unstable work conditions); (2) employees acknowledge this unevenness for key reasons (e.g., expecting future increases); and (3) employees show a

particular cognitive and motivational example of adapting to demands described by extreme work-related responsibility ('overwork'). Workers experiencing excessive work-related over-responsibility misinterpret the relationship between the demands at work and their own particular ability for adapting. They think little of the extrinsic demands and overestimate their own adapting abilities, while remaining oblivious of their own commitment to the inequality between exertion and rewards (Siegrist 2002b).

Bakker et al (2000) conducted a study among 204 German nurses to test the hypothesis that an imbalance between high job demand and low rewards is associated with increased burnout and the depletion of nurses' emotional resources: the result supported the hypothesis by showing that nurses who experienced ERI, experienced higher level of stress. In a more recent study by Kikuchi et al (2012), the effects of ERI on quality of life among nurses at a Japanese general hospital were investigated. The four effort-reward ratios (physical health, psychological domain, social relationship domain and environment domain), and over commitment scores significantly correlated with poor health functioning in the four domains.

2.3 Summary

This chapter has shown that a number of theoretical models have been developed to explain the incidence of work related stress. The reasons behind choosing the JDCS model for use in the present study have been presented in detail. Chapter 3 will explore the literature regarding WRS which will focus greater attention on the occurrence of WRS among immigrant nurses in general and immigrant nurses in KSA in particular.

Relevant to psychosocial risks and WRS among immigrant nurses in particular will be reviewed to contextualise the focus of this thesis. Further variables included in this research will also be explored further. To create a clearer picture, the relationship between WRS, job performance, social support and intention to stay will be offered. Particular attention will be given to the literature concerning immigrant nurses in Middle East.

CHAPTER THREE

WRS AMONG NURSES

3.1 Introduction

This extensive study is the first to examine and measure WRS using a range of variables among immigrant nurses in the KSA. The chapter reviews and comprehensively investigates the available literature on WRS and psychosocial risks among nurses in general and immigrant nurses with work related stress. It similarly highlights the prevalence of WRS in Arab countries (together with KSA) and other countries, in addition to the relationship of WRS with job performance, intention to stay and social support from colleagues. The detailed issues affecting the level of WRS are also argued. Burnout among immigrant nurses will be reviewed because the relationships between WRS and burnout among immigrant nurses were additionally explored in some studies.

Assessing knowledge about the WRS of nurses in general and among immigrant nurses in KSA specifically first requires an understanding of several concepts. Given the lack of precedent in the scientific literature, how “immigrant” is defined is significant; the concept was usually not defined clearly in current literature, and Saudi definitions suffered the same lack of specificity, especially in the public health field (Malmusi et al 2014). Besides the pragmatic need for clarity, the ideological implications of defining should not be overlooked.

In Saudi, working permits are granted with residency on a temporary basis, therefore one may legally reside in Saudi with the condition that in order to work legally, the permit must be renewed yearly. The legal concept of a foreign worker differs from the legal concept of an immigrant worker. All immigrant workers are foreigners (persons not in possession of Saudi nationality), but not all foreigners are considered immigrants. For example, the following people are not considered immigrant workers: Gulf country citizens; foreign workers who cross the border regularly to work; foreign workers with temporary work visas; diplomats; people with high posts in business or public administration.

Generally, and as already explained in the first chapter, WRS assumes a low priority in KSA. Resources available to immigrants are limited; information and research are inadequate (Nuwayhid 2004). It is therefore important to study psychosocial risks and WRS in KSA to address the gap in the surveillance system. Improving the professional capacity of immigrant nurses is important for improving working conditions.

At the end of this chapter, a point will be made with regard to the sensitivity of this research due to the cultural diversity power.

3.2 Work Related Stressors in Nursing

Nursing is a stressful job. Excessive and prolonged stress can lead to distress, burnout or physical illness in an individual (Martin-Fernandez et al 2009). For the organisation, stress can result in staff absence, increased staff turnover and increased costs, all of which can contribute

to further stress for staff (Martin-Fernandez et al 2009, Francis 2013). The UK Health and Safety Executive (HSE) (2013a), through the Management of Health and Safety at Work Regulations 1999, identifies stress as a Health and Safety issue and requires all organisations, including the National Health Services (NHS), to undertake stress risk assessments for staff to identify and prevent stress-related ill health. Increased stress has been linked to a reduction in compassion and caring in healthcare (Firth-Cozens and Cornwell 2009) and has become a major concern following the Francis (2013) inquiry.

Caring for people from different ethnic backgrounds demands intercultural communication, which occurs when both sides attempt to understand the cultural frame of reference. Consideration of individual value systems and lifestyles should be included in the planning of nursing care for each client. Nursing is “a learned, humanistic and scientific profession/discipline that focuses on human care and caring activities to assist, support or facilitate individuals or groups to maintain/regain their health/wellbeing" (Leininger and McFarland 2002, p46). This definition reinforces that mental status is the heart of nursing and transcultural nursing, in order for nurses to do their job well. Professional growth and development starts with compassion, patience and support (Douglas and Lipson 2008) and encouraging nurses to engage in educational activities can ease their transition into the international setting. Providing culturally competent nursing care requires time, expertise and experience to refine, develop and expand awareness and abilities to provide such care. To this end, nurses must continuously strive to become more attentive towards diverse languages, habits, beliefs and behaviours (Benkert et al 2005).

Nurses are more likely than other healthcare professionals to experience ill health because of stress, with 2,730 cases per 100,000 nurses of sick leave because of work-related stress in 2011/12 (HSE 2013b). Workers in the UK experiencing work-related stress in 2011/12 took an average of 24 days off work (HSE 2013b). In a survey of 10,000 nurses by the Royal College of Nursing (RCN), 62% of nurses questioned reported that they had considered leaving the profession because of stress (The Guardian 2013).

The growing complex world of healthcare services creates the need and interest for nurses to learn and consistently perform more complex tasks. In today's climate of cost regulation, healthcare providers request productive and powerful delivery of nursing administrations. Rapid changes in the healthcare system and the promotion of health awareness have expanded patients' ideas of what nurses ought to do and provide (Zhong et al 2006). Nurses' managers therefore expect capable and productive nurses to work for the organisation, particularly when procuring immigrant nurses (Abu Alrub 2007). A newly hired nurse is obliged to have the vital knowledge, attitude, qualities, abilities and the adaptability to work under pressure which empowers them to give effective expert administration and safe healthcare delivery (Morolong and Chabeli 2005). However, requesting nurses to care for patients without being given appropriate orientation may result in serious consequences for patients and staff.

Other important components recognised in the research as contributing to WRS could be fear about being disengaged and segregated because of race and ethnicity, work

unreliability (Huang 2004; McCarthy et al 2010); a sub-standard nature of work relationship with the manager and role conflict (Moideenkutty et al 2008); a dangerous deficiency of nurses working at the bedside (Milliken et al 2007), the expanded role of the nurses that has prompted increased workload obligations for healthcare practitioners (AMAHP 2003); and part equivocalness (Amanda and Gangaram 2010).

Due to the nature of psychosocial risks it is important to gain an understanding of the potential stressors in more depth: in the discussion that follows below, the researcher reveals some of the job demands, resources and support which nurses experience and the way in which these touches on the development of WRS by increasing its likelihood or mitigating its inception or severity.

3.2.1 Job Content and Interpersonal Relationships at Work

Interpersonal connections at work constitute the regular communication between colleagues, or supervisors and workers. Interpersonal relationships might be depicted from an individual perspective or from an authoritative perspective. The individual viewpoint refers to how each party assesses the relationship. If the point of view is changed to capture the interpersonal connections at a hierarchical level, then how those connections exist inside the relationship is measured at management level (Stoetzer 2010). The way staffs communicate with one another within the hierarchical framework and structure might be a noteworthy cause of stress: perhaps there are challenges when designating tasks; perhaps an absence of administration preparation, or

a lack of confidence in subordinates, or no apparent demarcation between the individual capacities of administration and employees. Another possible reason for stress is identity conflict because of, for example, a difference in religion or language, stress levels, gender, social class, or a different level of education and learning (Letvack et al 2008). Poor relationships may emerge between an immigrant and an administrator because of social standing and education framework, and this could result in a lack of understanding of each other's role and obligations, temperament and the rise of stress levels and a decline in the quality of job performance (Stranks 2005).

One of the major stressors related to job content among nurses is role conflict. Role conflict requires a single person to make decision around conflicting requests that may undermine the individual's assets and in this way triggers physical and emotional stress (Hobfoll and Freedy 1993; Jenny and Syed 2011).

Conflict is a normal phenomenon in any business. Conflict in organisations has been defined as "the interaction of interdependent people who perceive opposition of goals, aims, and values, and who see the other party as potentially interfering with the realization of these goals" (Putnam and Poole 1987, p.72). The occurrence of 'interaction' between persons who perceive such opposition of goals highlights the role of communication in organisational conflicts. Conflict is the face of this incompatibility (Lee and Lee 2015). Organisational conflicts are unavoidable and studies show that about 20 percent of workers' time is spent on handling conflicts (El Dahshan et al 2014; Tallodi 2015). Therefore, dealing with conflicts is of interest to both experts and

researchers (Gupta and Sasidhar 2011; El Dahshan et al 2014). An earlier study (Gupta and Sasidhar 2010) analysed interactive conflicts in contemporary organisations in India. The study outlined through analysis the relationship between the conflict circumstances encountered, why they were triggered, how they were fixed, and the time taken for conflict resolution and whether the capacity to interconnect helped to resolve conflicts successfully. Organisational conflicts may be produced due to a communication gap, lack of confidence, conflict of interests, competition, and several other individual or situational factors.

Role conflict happens when an individual is "torn" by clashing employment demands or by doing things she/he prefers not to do. This happens most often when an individual is relied upon to perform in prescribed ways by a diverse group of individuals (Wang et al 2016). Past examination has distinguished critical connections between role conflict and emotional exhaustion and, to a lesser degree, between role conflict and depersonalisation (Leiter and Maslach 1988). According to a meta-analysis (Schaufeli and Buunk 2003), role conflict shared 24% of the variance with emotional exhaustion, 13% with depersonalisation, and 2% with personal accomplishment. On the other hand, Lait and Wallace (2002) found that men who suffered more role conflict had better work fulfilment, and higher related employment stress.

Role conflict brings about opposing demands on the worker, as in the situation where a nurse and their manager have different expectations, and the need to establish a midway point to adjust the opposing demands is bringing on stress (Harris et al 2006).

Conflict, at a sensible level, can be valuable to an organisation when it stimulates innovative and resourceful problem solving, illuminates issues, and permits fundamental problems to rise to the surface (Wang 2016). Conflict is thought to progress production by causing a useful level of strain and cause competition between members (Aboshaiqah 2016). Consequently, conflict is a beneficial phenomenon to have within a lively and changing system. Numerous studies (De Dreu 1997; Aboshaiqah 2016) propose that conflict when used properly can be seen as a positive energy. In today's diverse organisational environment, the prospect of using conflict as a motivating force to sustain competitive spirit, growth and innovation is commanding. Attention has therefore moved from avoidance of conflicts to management of conflicts (Callanan et al 2006; Aboshaiqah 2016).

At the same time, the nature of a job and the perspective of the employees are the core causes of role conflicts. Such conflicts will occur more quickly when incompatible demands arise from several sources against the nature of management (Aboshaiqah 2016). In determining role conflicts, employees will discuss or talk to their colleagues and sometimes accept help from the administration. Role conflicts at work can be restrained by constant management of information sharing, casual discussions and also by providing clear job descriptions (Aboshaiqah 2016).

Studies on management strategies in decreasing role conflict amongst Staff Nurses (Kleinman 2004) discovered that the causes of conflict between hospital nurses and healthcare workers included authority positioning and hierarchy, the capability to function as a group, interpersonal connection

skills, and the perception of accomplishment in numerous roles at varying levels. A study aimed at discovering the relationships between job satisfaction and managerial commitment, role conflict and ambiguity, and demographic variables related to the retention of nurses within the Chinese healthcare workforce discovered that there is a positive relationship concerning job satisfaction and organisational commitment and a negative relationship concerning job satisfaction and role conflict and ambiguity (Wu and Norman 2006). Another study exploring the relationship between burnout and role conflict and role ambiguity in nurses and physicians at a university hospital in Turkey showed that the nurses had considerably greater levels of role conflict, role ambiguity and burnout compared to the doctors (Tunc and Kutanis 2009). Multiple regression analysis indicated that role conflict and role ambiguity might help to explain the higher level of burnout experienced by nurses compared to doctors.

In a case study describing the expansion, structure and process of a broad system for handling conflicts in a Norwegian city hospital the dispute tools in the hospital were more shaped towards reinforcing the management skills of clinical leaders and managers in general (Skjørshammer 2001). By changing the methods that managers and professionals use to handle disagreements, the hospital anticipated a decrease in the effects of conflicts and an understanding of its benefits. This was accomplished through applying new measures for managers and professionals to process disputes. The policy process of the new system was outlined according to an action research method characterized by generating change through discussion and the use of local expertise (Hammadi 2013).

Although strain is frequently seen as a negative emotional reaction to work that could inevitably prompt a negative influence (Rothbard 2001), some studies have recommended that a negative influence may expand inventiveness. For example, Ludwig (1992) found that depression and the level of inventive accomplishment are fundamentally connected with one another. As per George and Zhou (2002), data produced by negative emotional states can impact on an individual's effort and innovativeness at work. Furthering this concept, a few studies embrace a positive perspective towards role conflict. Chang and Tang (2010) found that individuals saw role conflict as having a positive and immediate effect on their inventiveness while some uncertainty contrarily helped self-sufficiency.

A study issued by the American Association of Critical Care (AACN) that defines the environment of ITU nurses' reports that 25-32% of all the nurses in the sample felt that the feature of their dealings with their peers was either "fair" or "poor" (Scott et al 2006). Lateral aggression (which is also known as horizontal violence) refers to hostile and violent behaviour by persons or group members towards other associates or groups of members within the larger group to which they all belong. This type of animosity, hatred and aggression has been defined as one of the main types of intergroup conflicts (Boateng and Adams 2016). Such adverse approaches take the form of back-stabbing, hate filled gossiping, demeaning gestures and continuous carping criticism, and tries to increase the stresses of others disproportionately (AACN 2004; Dunn 2003; Hastie 2002). The morale of nurses who are the targets of this type of gratuitous horizontal violence progressively worsens, and as the spiteful harassment progresses, all the symptoms of stress, depression, low self-

esteem and job fatigue that are the signs and indicators of burnout increase. (Alspach 2004; Mckenna et al 2003).

One of the key relationships in clinical settings is the physician-nurse relationship. Once the nurse and physician work collaboratively to establish goals for their patients and to design suitable courses of care and conduct, the product is a strong and effective working relationship in which the nurse feels valued, acknowledged and appreciated. Several nurses, however, feel that physicians do not respect them for their particular understanding and skills. This unsurprisingly results in relationships in which nurses are highly stressed and forced to tolerate unpredictable amounts of unprofessional rudeness and embarrassment which eventually upsets not only their personal contentment and professional achievement, but also the quality of care that patients receive (Jansky 2004; Chau et al 2015). Vioulac (2016) revealed a survey of a select number of nurses and physicians who worked in a big complex of hospitals. The bulk of respondents (92.5%) reported observing some level of disturbing activities by physicians in the setting of the hospitals in the group. Equally, the physicians and the nurses in the study agreed that such behaviour exerts a severely negative consequence on staff wellbeing, WRS and the approach of other staff members towards patient safety and the overall level of patient care; that it decreases the efficiency of teamwork and that it negatively affects the results of patient care.

Conflict with physicians was identified as the most severe source of stress in a study conducted by et al Zhang et al (2016) in which he evaluated the severity of sources of stress in 170 nurses in different wards of Isfahan University

hospitals. NSS questionnaires were handed to nurses about half an hour after the start of morning, evening and night shifts. In another study that tested the nurse-physician relationship it was found that poor relationships between the doctors and nurses were the main cause of patient dissatisfaction and emotional and psychological exhaustion on the part of the nurses, all of which are indications of WRS and burnout (Sears et al 2005).

The best nursing settings are, without doubt, improved by respectful relationships between nurses and nurse supervisors. Leaders and managers have been recognised as vital for the development of nursing teams (Kosinska and Niebroj 2003), and operative and courteous clinical supervision can stimulate productivity and self-governing behaviour in nursing professionals (Berggren and Severinsson 2006). Regrettably, the relationship between nurses and their supervisors has regularly been labelled in research as lacking in trust and held up by poor and unsuccessful communication (Cline et al 2003). Ulrich et al (2006) established that nurses in ITU environments regarded the level of respect that they received from their managers as the lowest they had experienced in any nursing capacity. This in itself is a reason for deep worry because patients in ITU are most likely to need focused, well-adjusted and considerate therapeutic interventions.

The poor interactions that nurses experience in their careers have caused a massive number of harmful professional and personal concerns that directly affect the excellence of care that nurses are competent to give to patients, and the level of enjoyment and accomplishment that all nurses ought to be able to experience in their work. Poor relationships in nursing

occupations eventually cause enormous numbers of nurses to leave their jobs and specialities, and to leave their units. Poor relationships between nurses and their supervisors consequently impose much more damage on patients, on the nurses themselves, and on the nursing occupation in general, than might appear to be the case to an outside observer (Stone et al 2006).

3.2.2 Workload

Escalations in the workload of nurses is one of the frequently cited reasons for WRS and burnout (Aiken et al 2002; Demir et al 2003; Embriaco et al 2007; Poncet et al 2007; Hayes et al 2015; Mauno et al 2016). The huge quantity of research that has been conducted into the effects of increased nurse workloads has evidently demonstrated how unfavourably increased workloads affect a nurse's physical and mental health.

Workload refers to the association between the demands of the work and the time in which it has to be performed and the resources that are available to the nurse who must implement it (Maslach and Leiter 1997). Unrealistic outlooks on these three components show initially as an excessive workload and ultimately as WRS that might lead to burnout. It is very obvious that too much work and irrational demands will quickly exhaust even the most capable individual's existing sources of energy and will eventually lead to a state in which recovery becomes difficult (Maslach et al 2001).

Stressors for nurses normally defined in research incorporate workload and pressures connected with demands of the contemporary nature of the world (World Health Organisation

2010), unpredictability of staffing and booking, finishing an overload of non-nursing assignments with not enough time and settling on choices under pressure (Fox 2003; McVicar 2003; Goh et al 2016). Two of the main reasons for WRS in the NHS are the growing demand on health services and continual organisational change. Some nursing staff in the NHS have to deal with violent and volatile patients, others deal with distressing and harrowing circumstances, and others have an absence of support or are not receiving enough communication about changes affecting them (Health and Safety England (HSE) 2016).

Increased workload has had a significant impact on job stress for nurses (Mastracci et al 2015; Hayward et al 2016). Aiken et al (2002) reported that in hospitals with the highest patient workload (i.e. the number of patients the nurse looked after), surgical patients had a higher mortality rate and nurses had higher WRS than those healthcare workers with a lesser workload.

The following year, Aiken et al (2003) directed a cross-sectional study from the acute care hospitals inside the state of Pennsylvania (N=168 hospitals, n=342 surgical patients). The study looked at measures of core patient outcomes, for example mortality and failure to save (i.e. death in surgical patients) and related to these components of nursing work (attendants, highest level of credentials, nurses' workload and mean years of experience) and hospital attributes (size, showing status and innovative capacities). Aiken et al (2003) found that every 10% increment in the number of nurses with higher educational degrees diminished the danger of mortality and of failure to recover by 5%. Nurses have higher slip rates when exhausted (Rogers et al 2004); they are

candidly depleted, they see more stress with longer work shifts (Hoffman and Scott 2003; Percell et al 2011); they see more error results with increased work load (Aiken et al 2002). Besides this, the lack of time available, due to an increased work-load, to give patients emotional support and cope with tiredness, doctors' criticisms and conflicts with immediate supervisors (Knae 2009; McCarthy et al 2010) can also cause difficult situations for nurses.

Hamaideh et al (2008) aimed to determine the occupational stressors among Jordanian nurses. The NSS was used to collect data from a convenience sample of 464 nurses who were working in 13 Jordanian hospitals; workload was identified as a key stressor. AbuAlrub (2006) aimed to replicate previous results about occupational stress among 263 American nurses using a Web-based method, compared with 300 Jordanian nurses. By using the NSS, Jordanian nurses identified the most common sources of occupational stress: "Workload" and"Patients and families", while for American nurses they were: "Conflict with other nurses" and "Workload".

The importance of the nursing workforce to patient wellbeing and outcomes has been recorded (Percell et al 2011). As a case in point, a late study has identified that expanded work hours, work stress and poor cooperation among staff are associated with hospital acquired infections in those patients they are caring for (Virtanen et al 2009). There are numerous significant implications that come from compelling nurses to cope with too much work, supported by research which has shown that excessive nursing workloads undesirably affects the safety of patients. Montgomery (2007) has confirmed that fatigue, insufficient sleep and excessive and unsuitable

workloads will (irrespective of discipline) have a major effect on the occurrence of medical mistakes that compromise the safety and even the survival of patients.

Increased nursing workload raises the incidence of WRS, burnout and related sickness in nurses in their private and professional lives. A study conducted by Li and Lambert and Lambert (2008) established that nurses who work in intensive therapy units quote nursing workload as the greatest serious job stressor to which they were exposed. This is confirmed by reports from other studies. In a study that Hamaideh et al (2008) undertook in hospitals in Jordan, nurses identified workload as the second most serious work-related stressor. These researchers found that bigger workloads were not only linked to higher patient acuity, but also to systemic work issues: nurses were expected to carry out non-professional tasks such as transporting and recovering food trays, housekeeping responsibilities, the moving of patients, and ordering, organising and performing supplementary services that should not have been their responsibility. Too much work therefore steadily correlates with advanced levels of emotional exhaustion in nurses.

Patients with greater levels of serious sickness generally require more nursing staff to accommodate the extra workload and physical demands. Proper staffing practices are therefore required to meet the expanded workload levels for the staff (Kim et al 2016). Work overload, otherwise called role overload, is recognised as a critical stressor clearly linked with regards to the weight (amount over-load) and nature (qualitative over-load) of the workload (Gholamzadeh et al 2011).

Challenges associated with providing complex care with decreasing resources are common in healthcare today (RCN 2014). Healthcare settings can be under-staffed and often have high staff turnover, which has a negative effect on the experience and expertise available for patient care in the clinical area (Francis 2013). The increase in work-related pressures inevitably leads to stress or other ill health, causing sickness and absences, which leads to further understaffing and stress for the remaining staff. Healthcare work is demanding and workplaces need to look at how individuals can be given the resources to better manage these demands and what the workplace can do to minimise the demands being placed on nurses.

In the study by Qiao et al (2011), a sample of 96 new graduate nurses in central China completed four questionnaires including NSS. The results showed that death and dying, workload and inadequate preparation were the most common sources of nursing stress. The descriptive correlational study by Wang et al (2011) aimed to assess the association between occupational stress and coping strategies of Hong Kong nurses working in surgical units. Outcomes demonstrated that, workload, absence of help and lack of organisation are the most widely recognised words relating to stressors for nurses.

Lin et al (2016) stated that nurses in the UK reported lack of staff as the first source of occupational stress. In a study by Currid (2008), eight UK nurses at acute mental health departments within a London mental health trust were interviewed (five male and three female nurses). The results showed that the nurses experienced a lack of resources and a poor home/work balance. Hawkins et al (2007) investigated

the occupational stressors in hospice nurses and addressed the potential effect of their attachment styles on stress and coping experiences. The results showed that the most common sources of stress were “Death and dying” and “Workload”. This finding was supported by Regan et al (2009) who conducted a cross-sectional study using questionnaires to assess the coping strategies of 87 UK ICU nurses. The most frequently reported job stressor as measured by NSS was workload, and the second was death and dying.

3.2.3 Work Schedule

The nature of nursing professions requires extended periods of time at work, doing shift work, and being on duty throughout unsocial hours which can give rise to additional tensions in the interface between employment and work-family outcomes (Chaney and Castro 1989; ILO 2015). This amplifies the distinction between the workload and obligations of nurses from that of other workers, and also between different nurses working in different specialities and units. The inflexibility in employment causes stress at both occupational and personal levels in immigrant nurses (Oginska-Bulik 2006). When contrasted with other professional groups, nurses have been recognised as the group with the highest level of stress (Oginska-Bulik 2006).

Historically, night work has been viewed as undesirable and was permitted only when strictly needed (Abu Alrub et al 2009). Night shift nurses make do with fewer staff than on other shifts, have decreased access to supervisor guidance, diminished managerial involvement and negligible clinical leadership. The contrasts between daytime and evening nursing shifts are not generally recognised, causing poor

understanding between the shifts and possibly prompting work related stress. The Royal College of Nurses (2012) has recognised shift work as having an impact on the work performance of nurses. They discovered a noteworthy association between general employment performance and shift work, with the quality of performance being the greatest for nurses on the day shift, followed by night, evening, and rotating shifts.

Bambra et al (2008) found that the introduction of a compressed working week (working longer hours, but over fewer days) improved the work-life balance of shift workers. Various organisational factors were also examined in another Australian study of 530 nurses working shifts (Pisarski et al 2008).

Abu Alrub and Alzaru (2008) established that poor mental wellbeing, which incorporates high levels of WRS, relates straightforwardly to undesirable working conditions, for example, working in shifts and badly organised hours, bias of staff members' salaries, the exchange of staff from their designated clinical area to an alternate unit to cover nursing deficiencies; this is exceptionally regular among nurses in any healthcare setting, but means that nurses are normally less acquainted with the new unit than their usual unit. Forcing staff to work in units where they do not usually practice causes a raised level of disillusionment and stress, which is therefore connected with higher turnover of staff (Abu Alrub 2004; Jamal 2007; Abu Alrub and Alzaru 2008). In a further study, Purcell et al (2011) indicated scheduling as a source of stress among 197 American registered nurses as indicated by the NSS.

3.2.4 Control

Individual control alludes to one's belief that they can influence key components of the work demands in the work environment, for example, work pacing, work systems, social collaborations, regulations, policies, rules and strategies (Griep et al 2011). Recent confirmation now exists proposing that control recognitions are specifically identified with improved mental and physical benefits and assumes a buffering role by disaffirming the negative effect of other employment demands (Fox et al 1993; Siegrest et al 2004; Griep et al 2009; Siegrest et al 2009; Griep et al 2010; Griep et al 2011). Additionally, certain organisational level strategies can enhance workers' wellbeing by permitting the representatives to have control over their separate obligations (Ala-Mursula et al 2005; Griep et al 2010). Although a few areas of particular control are controlled by more extensive authoritative approaches, an individual's direct manager is assumed to have a huge effect on this situation, for example, in choice making where the nurse's experience is adjusted on the grounds that the manager settles on the choice.

Critical thinking is a fundamental ability in all nurses. Without the capacity to create and practise this ability through making choices, nurses are denied the opportunity to enhance their critical thinking; in the long run, this may affect their competency and may cause stress. Moreover, clarifying role expectations and setting particular objectives can upgrade a nurse's recognition of control over performing his or her obligations and giving the nurses an improved feeling of control over their performance evaluation and career advances. The HSE (2016) focused on the imperativeness of allowing individuals the freedom to speak out in connection

with work performance. Nurses feel frustration when data is not given to them and when they are not asked to take part in choice making (Church 2016), yet they discover dynamic methods for reformulating, directing and converting the demands of their roles (Grzywacz and Smith 2016).

An increase in involvement in organisational authority on the part of nurses should be helped by formally permitting them the essential time and compensation to be involved in important discussions and decisions about their work (Raiger 2005). In addition, Regan et al (2016) have identified that nurses who work in organisations where they are involved in the participatory decision-making process exhibit advanced levels of organisational commitment, empowerment, job satisfaction, and lower levels of stress and are less likely to leave their nursing career than nurses who are exempted from involvement in the decision-making processes.

When nurses are empowered by being involved in decision making processes, their expectations of what they will find in the work place and the actuality of the work place are likely to be far more balanced. Such nurses appreciate a sense of being in control of their work, they feel satisfied with what they accomplish, they feel pleased and appreciated for their actions, they experience a deeper sense of community with their colleagues, they have a sense of being equally treated, and they accept as true that their individual values are in line with the values of the organisation (Hewko et al 2015). Under the circumstances defined above, nurses experience much higher levels of engagement and suffer far less often from stress, burnout and its predisposing signs.

3.2.5 Organisational Environment, Culture and Function

The hospital organisational culture and function refers to the physical environment, social structures and social interaction (Barbour et al 2016), including treatment/nursing/caring processes and actions and the relationships between patients and staff. The organisational culture and function has been widely examined in different healthcare settings. What is indeed known is that a holding and supporting environment is important in order to establish a good serving agreement in patient care and enhanced staff morale (Johansoon 2004).

It has been noted that there is a relationship between the physical environments in healthcare settings and worker/organisational outcomes (Alvarado 2007). Researchers have additionally recognised various studies that link the physical environment with patient and staff outcomes (Ulrich and Zimring 2004; Dendaas 2011). Environmental psychologists contend that the physical environment is an undervalued element in WRS (Dendaas 2011).

Studies on work-related stress provide evidence that the physical environment of work influences an employees' job performance, work fulfilment and work stress levels (Lu et al 2016). Evidence recommends that environment comfort comprised no fewer than three progressively related classes: physical, mental and practical (Lu et al 2016). Environment comfort incorporates fundamental needs such as wellbeing, cleanliness and availability. Effective support is characterized as an ergonomic support for clients' performance of occupation-related assignments and exercises. Suitable lighting, ergonomic furniture and enclosed rooms are illustrations of useful comfort measures. Mental comfort

results from a sense of belonging, proprietorship and control over workspace (Lu et al 2016). It is for the most part expected that the enormous burden of workload and continually changing work environment may build the predominance of stress among nurses (Lu et al 2016).

The ward culture is closely related to the quality of care, as perceived by patients (Tuvesson et al 2012); violence and aggression, which form an aspect of the ward atmosphere, have also been reported to be a source of stress in various studies in psychiatric care (Tuvesson et al 2012).

The psychosocial work culture and function is another factor of potential importance for stress of conscience, as it has been found important for nursing staffs' working situation. Unlike the ward atmosphere, with its focus on treatment and patients, the psychosocial work environment emphasises the situation for the nursing staff in terms of organisational conditions for their work and relational aspects among the nursing staff and between staff and managers (Tuvesson et al 2012).

Previous research in healthcare has shown that the psychosocial work culture is vital for the staffs' sense of job satisfaction, and is important in relation to stress. (Ward and Cowman 2007; Van Bogaert et al 2013; Fujita et al 2016). The work culture and function has also found to be related to nurses' moral sensitivity (Ganz et al 2015).

The hierarchical structure and mood of an organisation influences the conduct of its members. Some of these moods are customs, relationships, conviction, belief systems, standards, religion and process (Swiger et al 2016). The

possibility of losing opportunity, character and self-sufficiency can result in problems, for example, the absence of investment in decision making, the lack of effective consultation, limitation on practices (such as wearing a head scarf for all female staff), no feeling of belonging and poor communication between the members (Park and Kim 2009). There is solid proof that better support and camaraderie inside an organisation leads to lower staff turnover, higher quality of performance and a better state of physical and mental wellbeing (Andrews and Dziegielewski 2005).

Al-Aameri (2003) used the Occupational Stress Indicator (OSI) (Cooper et al 1988) to determine the sources of stress among nurses in public hospitals in Riyadh city. The major source of stress detected was the organisational structure and environment. Organisation culture and function have an impact on individual employees' perceptions of patient safety and is thought to influence mutual safety behaviour (O'Donnell et al 2016). Despite a general change in the understanding of patient safety from attention to issues at an individual level as a cause of poor patient safety to organisational issues (Andrews and Dziegielewski 2005; O'Donnell et al 2016), there is incomplete knowledge concerning which specific features of the organisational climate could affect a particular side of safety culture. A study in an Australian hospital suggested that general organisational climate and culture was an indicator of staff understanding of work safety (which the authors termed "safety climate"), which was connected to safe work actions (Andrews and Dziegielewski 2005). Nonetheless, both organisational climate and safety climate were collective measures, and associations between specific subscales were not considered.

3.2.6 Role Ambiguity

Role ambiguity is shown by lack of clear objectives, conduct, procedures and assignment outcomes, which cause stress due to the problem of knowing where to put effort into the role and also having the ability to judge one's own performance with respect to demands. Role conflict and role ambiguity are "chronic" stressors in any employment, i.e. they are acknowledged as being hard to change and linked with long-term strain and burnout (Beehr et al 1997; Abu Alrub 2007; Chiu et al 2009).

In the event that an individual does not have sufficient information about his/her job (role ambiguity) these demands of employment will lead to shortfalls in meeting work targets, desires and the breadth and responsibilities of the work. More than that, it may result in diminished job satisfaction, higher stress levels, higher turnover rate, and diminished employment performance (Jamal 2007; Fried et al 2008). Establishing expectations might be characterized as an organised and formal approach to categorically stating the responsibilities, obligations, and desires of a given organisational position. Wilson (1988) said that without the setting of responsibilities, an employee does not recognise what is expected of them and subsequently they will have a tendency to perform below what is required (Ho et al 2009; Qian et al 2015).

Much research suggests that role ambiguity and role conflict is negatively correlated with job satisfaction, job involvement, performance, tension, tendency to resign and job performance variables (Shalley and Gilson 2004; Moster 2008; Jayawardene et al 2011). Typically, role ambiguity and role conflict constructs are discussed together. Research has

shown that role ambiguity and role conflict have different causes (Irvine 2010) and therefore potentially different interventions. Nei et al (2015) has even suggested that different types of role ambiguity may have different causes. Schobe et al (2016) believe that role ambiguity is amenable to managerial "intervention" where programmes are implemented to diminish its effects, and implementation may be less difficult to conduct than interventions for role conflict. Tunc and Kutanis (2009) found that nurses showed significantly higher levels of role conflict, role ambiguity, and burnout compared to physicians, while Smith (2011) stressed that role ambiguity and role conflict may impact on nursing case managers' job satisfaction and job performance.

3.2.7 Career Development

When persons start out in their jobs, they at first experience a deal of passion for their chosen role. A fresh employee is usually full of vitality, is prepared to work hard, and finds his or her job stimulating and exciting. Nevertheless, if this primary eagerness is changed by circumstances such as poor supervision, lack of participation, obstruction and poor measurement and management, the new employee begins to feel sceptical, unappreciated, ignored and undervalued. It is these situations that lead to a feeling of cumulative powerlessness in workers. When the idealistic potential that the person takes to the job is undermined by disorganisation and poor management, the employee begins to withdraw both physically and mentally from the situation and ultimately begins to present with early symptoms of WRS and burnout, such as absenteeism, cynicism and depersonalisation. It is for these reasons that a principal plan for promotion should be drawn up for all workers, because tangible objectives for

job development support a sense of personal achievement. The realisation of job advancement and promotional prospects are effective in decreasing WRS among professionals (Khamisa et al 2015).

Anxieties over career and development have been proposed as two key regions of potential work related stressors; the first arises due to the absence of employment security, fear of redundancy, obsolescence or enforced early retirement; the second occurs as a result of ranking conflicts, under- or over-development and dissatisfaction with hitting the career ceiling (Cooper and Marshal 1978; Moorhead and Griffen 1992; Khamisa et al 2015). Staffs consistently recognise professional advancement as a vital variable since it is through development that they acquire money and standing. Throughout the early career stage, this and the capability to adjust rapidly to changing circumstances is as a rule compensated by the organisation (Cooper et al 2008). Once an employee arrives at the middle management level, however, he or she may experience lack of progression and fewer job opportunities (Cooper et al 2008). The staff working in the hospital setting where this study is taking place, and immigrants working in KSA, have limited opportunity for advancement, compensation and benefits; similarly, senior posts are restricted for particular nationalities, which could result in a significant source of stress and may result in a high turnover rate and diminished productivity (Al-Omar 2003; Zaghloul 2008).

Schabram and Maitlis (2016) state that numerous workers experience fulfilment when they accept that their future prospects are high. This may transform into open doors for progression and development in their current working

environment, or improve the possibility of discovering alternative employment.

3.2.8 Home-Work Interference

The connections between life outside and life inside an organisation can be a potential source of WRS. These include family issues, fiscal challenges, life emergencies, the clash of personal beliefs with those of the organisation and the clash of work and family demands i.e. the stress established from the distinctive roles one person may play both at work and at home (Cooper et al 1988; Kinman and Jones 2005).

Work and home are the two central domains in the majority of people's lives. These days many people in many nations experience problems meeting work and family demands. A study of an of the US workforce discovered that at least 40% of employed people felt that work interfered with their family life (De Croon et al 2004). Similar and even higher figures have been reported for Dutch employees (Geurts et al 2003) and for the Canadian workforce (Duxbury and Higgins 2001). A meta-analysis by William et al (2016) showed that work/home (WH) interference, often referred to as work/home conflict, is unfavourably associated with a variety of work, family, and particularly, stress-related outcomes (Duxbury and Higgins 2001; Kinman and Jones 2005; William et al 2016).

The most extensively quoted definition of work/family conflict is that of Greenhaus and Beutell (1985, p77), who define the concept as 'a form of inter-role conflict in which role pressures from the work and family domains are mutually incompatible'. In other words, contribution to the work (family) role is made

more problematic by virtue of participation in the family (work) role. However, the emphasis of the definition is decidedly one-sided on the adverse influence of work on the home field.

Due to the entry of women into paid employment, both men and women have to perform multiple roles. According to Greenhaus and Beutell (1985) the area of balancing paid work and family duties rests on two basic hypotheses. The role-strain hypothesis states that multiple roles create stressful conflict. The basic concept is that people have limited time and energy, and thus the more roles they have to fulfil, the greater the need to set priorities of expectation (Greenhaus and Butell 1985). On the other hand, the expansion hypothesis claims that multiple roles can serve as a buffer against stress (Sierber 1974; Thoits 1983). This occurs because the different resources provided by several roles overshadow the potential stressful effects that multiple role engagement has on welfare (Nordenmark 2002; Parker et al 2012).

Many studies from the year 2000 onwards have shown that workers believe that it is harder to juggle their working lives with duties at home, and work-life conflict, discomfort and stress are becoming the norm. A late Australian Survey of Social Attitudes by Wilson et al (2005), for instance, reported that in excess of 70 % of those aged 18-65 wanted to invest more in relaxation interests or with their family, and about 40% needed to invest less time at work.

There is strong proof that the cost of poor work-life balance on people, families and public opinion in general is high. Canadian analysts have assessed the impact of work-family conflict on the social insurance framework to be as high as

C$2.8 billion (Thornthwaite 2004). Similarly, various past audits and meta-examinations have shown that encounters of high work-life conflict are linked to lower work fulfilment and managerial duty and weakened physical and mental wellbeing, and cause stress at work (Beauregard and Henry 2009; Amstad et al 2011). Recent data from The University of Melbourne issued the Household, Income and Labour Dynamics Report in Australia which have shown that work-family strain causes decreased physical and mental health throughout the subsequent year (Magee et al 2012).

Among nurses, it is not surprising that a typical topic arising in the research was the management of paid work, closely followed by childcare issues; overseeing caring obligations was a key issue for both mothers caring for their children and grandmothers supplying child care to grandchildren (Duke et al 2010). The difficulties and challenges for handling work and care within the setting of shift work is also a shared theme in research of health professionals, including nurses. Shift work is seen to both support and hinder workers' capacities to achieve both work and care (Maher et al 2010). Lindsay et al (2009) and Skinner et al (2011b) note that shift work can allow nurses successfully to coordinate care and home work with their partners, with casual shift work offering the greatest choice of suitable shift schedules. A sequence of US studies of doctors and nurses showed that the balance between real and preferred work schedules was a robust and steady predictor of work/life conflict and psychological distress, and a stronger predictor than the simple extent of working hours (Barnett et al 2008). Consistent with this, Pisarki et al (2008) observed that greater control over work surroundings, including shift allocations, was associated with reduced work-life conflict in Australian nurses.

Most of the nurses working in KSA are on single status contracts (no family housing, no health insurance to family, no air-ticket to family, not allowed to bring family members). Therefore, if a family crisis or emergency arises, there are too many obstructions for them to overcome to be able to attend to their family matters. For instance, it takes a long time to arrange to travel outside of KSA because expatriates may not leave the country unless they apply for an Exit/Re-entry Permit. This permit usually takes 24-72 hours to be issued and costs around US$100; also, staff passports are detained by their employer. Unsurprisingly, the majority of migrant nurses find themselves forced to leave their children with their family in their home countries as they cannot bring their children with them.

3.3 WRS among Migrant Nurses

The factors that contribute to the decision-making process of nurses to migrate, and the factors that attract nurses to migrate to host countries, have been studied by organisations and individual researchers for some time (Kingma 2006; Mitchell 2009). Migration from many developing countries occurs because of the increase in the number of qualified, skilled nurses. Developed and even some developing countries that have a strong financial economy, such as KSA and other Gulf countries, attract nurses from both developed and developing countries (Goh and Lopez 2016). For example, more nurses who are Bangladeshi work in the Middle East than in Bangladesh itself (Kingma 2006). In some developing countries, nurse immigration has caused a serious problem to the home healthcare sector; Ghana, for

example, lost 382 nurses through migration in 1999, which represented 100% of the nurse graduates that year.

Statistics do not generally reflect the true number of nurses returning to their country of origin after working overseas (Kingma 2006). However, in the Caribbean, nurses' immigration was considered to have contributed to the country's development due to the fact that nurses returned to their country after achieving personal and professional growth (Kingma 2006).

Developing countries cannot compete with developed countries. In return for sending nurses abroad, remittances provide a strong economic incentive for the source country, as in the Philippines (Buchan et al 2005; Goh and Lopez 2016). KSA is a stepping-stone for many immigrant nurses. The push–pull factors bring nurses to Saudi Arabia and the push–pull factors send them to other countries or back home (Mitchell 2009). KSA remains the second most favoured destination for Filipinos and South Africans (Goh and Lopez 2016). Saudi Arabian nurses do not migrate (Mitchell 2009).

Key pull factors for immigrant nurses in KSA are free furnished housing, high salaries compared to home countries, free flights, untaxed income and free utilities. Compound housing offers facilities such as restaurants, gyms, swimming pools, cinemas, supermarkets and dry cleaners. Free airfare tickets home, depending on nationality and whether the nurse signs a 1- or 2-year contract, are considered an incentive. Additional attractive features include a minimum of 21 vacation days, free healthcare, travel opportunities, and personal and professional growth. Other pull factors include some families being able to travel and live with the immigrant

nurses, an end-of-contract bonus (2-week salary paid by the hospital for 1 to 5 years of service and a 1-month salary after 5 years of service).

Kingma (2006) described the case of permanent and temporary migrant nurses and the variables that caused nurses to leave their country of origin: the economic migrant, the quality-of-life migrant, the career-move migrant, the partner migrant, the adventurer migrant, the survival migrant, and the return migrant. The “contract worker” (Kingma 2006; Mitchel 2009) describes the immigrant nurses in KSA. Contract periods range from 1 to 3 years, with the organisation being the sponsor of the immigrant nurses. Performance, attitude, abiding by the law of the country, and demand determine whether immigrant nurses will receive another contract.

More specific information and data are needed about nursing immigration (Goh and Lopez 2016). Goh and Lopez 20160 raised the need of improved data collection for source and recipient countries, stating. that qualitative research (for migrant nurses) may help policy makers to decide whether employment abroad meets the nurses’ expectations, whether migration will be temporary or permanent, and whether certain circumstances might influence the nurses to return home.

A more recent area of research must include the role of recruiters and the recruitment process. Recruiting a nurse can cost up to US$10,000 and take up to 2 years to process (Spetz and Given 2003). The Philippine Overseas Employment Administration (POEA 2004) advertised on the Internet, “Things you should know about working in KSA.”

The POEA is one of three safety mechanisms for Filipino nurses wanting to migrate (King 2003). The nurse interested in migrating may have to pay processing or finder's fees. King (2002) also noted that some private recruitment companies take advantage of Filipino nurses, knowing that there are more applicants than available positions abroad. Nurses have paid private recruiters more than the maximum fee to secure a position, only to find that the position did not exist or that they must wait for a position to arise (King 2003).

Musoke and Yiga (2015) described an area of research in which the ICN warned nurses that developed countries were not paying "market-related salaries" to health-care workers from developing countries (ICN 2007). A further accusation that was later unsubstantiated by data, accused KSA of promising better pay but not following through. Contracts in the Kingdom are factored according to the nurse's home country's inflation rate, cost of living, salary, education, training, experience, employer, and other factors (Mitchell 2009).

Variances in pay were the baseline incentive for providing a nationality and skill mix that complemented the activities of the foreign nurses in KSA. That is, middle and upper nurse managers are typically Western (often with backgrounds in the military and Western hospitals), and they supervise the lower skilled nurses (Mitchell 2009).

A research study by Buchan et al (2005) examined foreign nurses' motivations, career plans, and reasons for travelling to the United Kingdom for work and concluded that financial opportunity was not the only pull for nurses immigrating to the United Kingdom. Professional development was a key

motivator for nurses to leave their home countries. Most of the respondents (60%) in the survey stated that they planned to remain in the United Kingdom for 5 years. Sixty-three percent of Filipinos and 40% of South African nurses stated that they would move to another country (Buchan et al 2005). The author himself is an immigrant nurse to the UK: his main reason for migrating from Jordan was for professional development and educational opportunities, which have proved successful.

Organisations such as WHO and ICN called for national strategies for recruitment and retention planning that included encouraging former nurses to return to work (Buchan et al 2005). Although the recommendations by WHO and ICN contributed to several policy statements by national governments and nursing organisations, external recruitment of a country's valuable human resources continues unabated (Buchan, Parkin and Sochalski 2003).

Moreover, the nursing shortage is affecting all nations in varying levels of crisis. The Joint Learning Initiative defined a workforce shortage as "the minimum desired level of coverage at 80% and partly by the empirical identification of health worker density associated with that level of coverage" (as cited in WHO 2006, p11). The Joint Learning Initiative updated the analysis for the WHO (2006, p12) report and determined that countries with fewer than 2.02 to 2.54 health-care professionals per 1,000 people (counting only physicians, nurses, and midwives) face a critical shortage of healthcare workers. According to the Joint Learning Initiative's definition, 57 countries were critically short of healthcare workers. Thirty-six of the 57 countries are in sub-Saharan Africa (WHO 2006).

The 1991 Gulf War created a crisis in human resource management for KSA. Hospitals were short-staffed as foreign nurses left the country to return home (Mitchell 2009). The loss of foreign nurses made Saudization a priority. “Human resources development can be argued to be a more realistic, reliable and pervasive indicator of development than any other single factor, since it is invariably a necessary condition for all kinds of growth” (Alsahlawi and Gardener 2004, p180). KSA’s own workforce is reluctant to enrol in a profession that is fraught with family, cultural, and religious conflicts; it is difficult to segregate unrelated men and women in the hospital setting, as is dictated by their cultural orientation; it is the cultural practice for women to cover their faces in the presence of an unrelated male; working hours for nurses’ conflict with family obligations. For reasons, such as these, nursing is regarded as an undesirable profession. Instead, students aspire to elite careers such as medicine, architecture, engineering and business. Lack of planning and long-range calculations has contributed to the lack of potential students for the nursing profession (Mitchell 2009), although attitudes and cultural mind-sets have been changing with the influence of the rising unemployment of educated females (Mitchell 2009).

In KSA, healthcare sectors are continuously experiencing major changes due to social, client related, governmental, technological and economic pressures (Abdulatif Bahnassy et al 2014). These changes will influence the nature of healthcare establishments, such as the hospital work environment. Role conflict is a major problem among health workers in KSA hospitals. Based on the information collected from the workers of several healthcare organisations in the

KSA, it was evident that educational background had a substantial influence on role conflicts at work, followed by the type of profession, which was also significant (Abdulatif Bahnassy et al 2014).

3.3.1 Adjustment of Migrant Nurses

The hypothetical idea of socio-cultural adjustment has been proposed and characterized in the literature on immigrant workers (Searle and Ward 1990; Ward and Searle 1991; Ward and Kennedy 1992; Bozionelos 2009). Socio-cultural adjustment identifies with the capacity to "fit in" or successfully connect with parts of the host society (Ward and Kennedy 1992; Bozionelos 2009). Socio-cultural adjustment has been connected with variables that advertise and encourage a society to take in and achieve the social abilities of the host society (Bozionelos 2009). The socio-cultural idea of adjustment is focused around social adjustment in principle and it highlights social conduct and functional social aptitudes underlying attitudinal components (Bozionelos 2009; Neiterman and Bourgeault 2015; Bach 2016).

Neiterman and Bourgeault (2015) contended that the level of culturally diverse change ought to be dealt with as a multidimensional idea. In their proposed model for worldwide adjustment, Black and Stephens (1989) made a refinement between three measurements of in-nation adjustment: (1) adjustment to work; (2) adjustment in accordance with communicating with host nationals; and (3) adjustment to the general non-work domain. This hypothetical system of universal modification covers socio-cultural parts of adjustment and it has been underpinned by an arrangement of empirical investigations of US immigrants and their

spouses (Black and Stephens 1989; Black and Gregersen1991a; Bolino and Feldman 2000; Bozionelos 2008; Bozionelos 2009). McEvoy and Parker (1995) additionally discovered support for the three measurements of immigrant adjustment. Immigrant adjustment and general work adjustment is arranged in the immigrant work space as necessary.

Cultural assimilation style as an indicator of an immigrant's adjustment is not settled among immigrant workers; however, Ward and Rana-Deuba (1999) discovered huge connections between cultural assimilation style and adjustment on detachment, incorporation and assimilation when testing the hypothesis with immigrant workers in Nepal. There are two significant schools of thought on cultural assimilation. The first is that it is a uni-dimensional procedure where a (minority) immigrant makes behavioural and attitudinal progressions to fit in with the (overwhelming) host society (Van de Vijver and Phalet 2004); this is additionally alluded to in the cultural assimilation writing as the assimilations approach (Dona and Berry 1994). The second hypothesis is that cultural assimilation is a bi-dimensional procedure where immigrants choose the degree to which they need to adjust to the host nation society (Van de Vijver and Phalet 2004). The uni-dimensional model has been scrutinised for accepting that an immigrant must reject their home society in favour of the host nation and that it prohibits immigrants who work to keep up their home nation society within the host nation (Van de Vijver and Phalet 2004; Arends-Toth and Van de Vijver 2007). Conversely, the bi-dimensional model considers more adaptability in the degree to which immigrants choose or decide not to keep up their home nation

culture and to receive the host nation culture (Dona and Berry 1994).

Nurses who take on migrant occupations in KSA have little time to adjust to the host society before they are required to perform autonomously with no supervision, as the introduction system is short (Bozionelos 2009). Such nurses in KSA are immigrants by their own choice (Bozionelos 2009) and are prone to face adjustment issues, which may lead to disappointment in their occupation and their new employment. Late experimental examination has demonstrated that issues with adjustment are identified with decreased job performance and work exertion (Ramalu 2010). Nursing does not permit a relapsing level of performance at any stage, for the conclusions of a slip or misbehaviour could be very serious at all levels - proficiency, moral, money related, social and persona l (Morrisey and Nelson 2007).

Language boundaries are viewed as an obstacle to immigrant nurses adjusting to their new work situations. Sternberg et al (2016) asserted that language capability was one of the requirements before entering the new work environment if the host nation language is not the same as the immigrant's mother language. Verbal communication (especially when not on a face-to-face-basis), for example, making a request over the phone, can be extremely stressful on account of the absence of non-verbal prompts, and can lead to new stresses for multicultural nurses (Yi and Jezewski 2000). Effective communication relies upon a common language, a condition that does not exist in hospitals in KSA,and this could be at the root of numerous issues (Feely and Harzing 2002; Selmer 2006). Although English may be used when in discussions

with a Saudi host, nationals may encounter extreme difficulty in the absence of a basic vocabulary. Even in the case of conversation between generally fluent speakers, communication can be exceptionally misleading, as it may hide cultural differences. Individuals certainly think in their own particular language as indicated by their own particular cultural standards, which may not be completely comprehended by others (Selmer 2006).

Families' adjustment and immigrant employees' own adjustment and the strains of being an immigrant worker have been greatly researched in different studies (Bikos et al 2007; Haslberger and Brewster 2008). In almost all studies, a positive connection was found between spouses' adjustment and that of the immigrant employees' own adjustment. Lack of adjustment by spouses was largely cited in the failure of international employments and was recently considered a main predictor in immigrant employees' adaptation (Black and Gregersen 1991; Bhaskar-Shrinivas et al 2005; Haslberger and Brewster 2008). It has been established that social support correlates with high female spousal adjustment (Copeland and Norell 2002; Bikos et al 2007) and lack of support, particularly from friends, related to maladjustment and depression (Copeland and Norell 2002).

Immigrants' spouses can possibly experience an identity disturbance process, which suggests that in an emergency, any interruption procedure is joined to an emergency circumstance (Harrison 2001). As indicated by this, immigrant workers' work adjustment affects their families' multifaceted adjustment, and the family's culturally diverse adjustment can influence the immigrant employee's work adjustment. In the same study, it was found that a large amount of family

support, family communication, and family flexibility was identified with a family's diverse cultural adjustment measured at six months into the work assignment (based on meetings with the immigrant worker and the immigrant spouses).

Late studies in the environment adjustment field typically refer to local turnover literature and global turnover literature, and utilize a multi-factorial investigation of both the work and non-work components. The following components have been tested: diverse cultural adjustment, fulfilment (separated into work and non-work fulfilment), organisation commitment and family connection that may have an effect on the choice or thoughts behind leaving international employment. It appears that organisational commitment (affective and normative) and employment fulfilment have a negative connection to withdrawal cognition, while spouses' adjustment was specifically interfaced to immigrant workers' adjustment, and challenges in spouse adjustment were connected with withdrawal cognition. The level of obligation of the immigrant worker around his/her family exhibits as a reinforcing variable in this connection (Shaffer and Harrison 1998; Garonzik et al 2000); a later study demonstrated additionally that support is contrarily connected to withdrawal cognition (van der Heijden et al 2009).

Studies indicate that immigrant workers meet three sorts of adjustment difficulties: general adjustment, work adjustment, and interaction adjustment. General adjustment includes living conditions and host nation culture. Work adjustment includes job satisfaction and wider employment status and responsibilities. Interaction adjustment includes interacting with residents in the host country (Kraimer et al 2001).

It is normal for support to be provided both from the family and the employer (Okechukwu et al 2016), but the employer is specifically responsible for remuneration and rewards and pre-departure support actions. These actions augmented to by helping general adjustment. Whilst immigrants anticipate logistical support, in particular the employer's support towards work adjustment and interaction adjustment, the family should also offer psychological support on a regular basis to cope with the new work environment. The allocation of roles connecting the home and the host employer is significant as immigrants make the differentiation which in turn reflects on perceived employer WRS (Kraimer et al 2001; Okechukwu et al 2016).

3.3.2 Cultural Competencies among Migrant Nurses

As explained earlier, immigrant nurses moving to another nation to work may have limited knowledge or experience of different nursing skills, having just the essential understanding of the new work environment's society, setting and healthcare services system (Joshua-Gojer 2012).

One of the aims of cultural competency is to help individuals to speak with others from different societies and to build associations with them. It teaches individuals to handle sudden circumstances in a different culture (Maude 2011) and aims to help them to see issues from the viewpoint of another from an alternative culture, to lessen stereotyping and to instruct individuals to understand their own particular prejudices and to educate proper behaviour practices (Maude 2011).

Multicultural understanding may result in recommendations on how a nursing team made up from different cultures can learn to work together to ensure excellence in patient care. Several authors have stressed that familiarity with cultural dissimilarities and values is an important attribute in a cross-cultural encounter (Foronda 2008). To this end, before starting work in the ward area, the expatriate nurse should have knowledge of and information about the local culture, background and hospital, as well as the health system in the country. In addition, it is vital that they understand how education is carried out in the nursing school (Lal and Spence 2016). Prior facts and knowledge about the health system and protocols might therefore prevent immigrant nurses from being disappointed by the KSA healthcare system.

Another consideration of the immigrant nurse's position may relate to the way that nursing procedures and protocol might not be consistent with that in their home country. A nurse's professional commitment might make it difficult to accept these different standards and protocols. Immigrant nurses are hired and trained in order to support the healthcare system in KSA. This may suggest that, while it is important for them to acknowledge and work within the KSA health system, it is difficult to work within another culture (Lal and Spence 2016). Knowing that the immigrant nurses are doing the best they can in the light of their own culture might not be recognised, due to lack of knowledge about adjusting to, and working in a different culture.

A key component for the successful interchange of information in a cross-cultural encounter is that immigrant nurses can communicate with patients and families together in basic Arabic language. Identification of language barriers

with patients and families, as well as finding solutions to overcome them by providing a translator, is therefore critical. Incoming immigrant nurses are often unaware that many immigrant nurses in KSA have had problems with speaking Arabic because of a lack of education in the Arabic language provided by hospitals during previous employment, and prior knowledge of this would have been helpful.

A study by Waxin and Panaccio (2005) stated that cultural competency preparation improves overall adjustment, work adjustment and interaction adjustment. They found that universal experience encourages work adjustment but agreed that for those who had no previous experience of working abroad, preparing immigrants through a cultural competency program was advantageous.

Some studies suggest that achieving cultural competency might be best in-nation, after entry (Maude 2011). In-nation immigrants will accept immediate input. Pre-departure preparation has similarly been recognised as successful, particularly those programs that improve cultural mindfulness and attitudes in the immigrants. Pre-departure culture competency is most regularly utilised by multinational organisations as there is clear evidence that such preparation encourages immigrants to adjust in the new society. (Maude 2011).

Immigrant nurses working in KSA can bring distinctive social qualities, cultural values, practices and dispositions with them that can vary enormously from those found in the host nation of their patients and work colleagues. Inevitably, the variety of cultures now cooperating with patients in hospitals conceals numerous potential clashes. The idea of cultural

competency has arisen from attempts to help to avoid these clashes. It is a way of thinking, with related courses of action that to aims to improve and enhance the quality of healthcare services by lessening social and cultural incongruities (Maude 2011)

Nurses and other healthcare providers spend years in school learning how and when to treat patients for given indications, yet teaching them how to associate with patients currently falls upon the health service supplier. Social and cultural competency, or the exhibited knowledge and practice of healthcare service experts to communicate respect for the cultural beliefs and qualities of patients, has turned into a desirable issue in the health awareness industry (Bennett et al 2015). Individuals who exceed expectations in adjusting to these differences earn the trust and improve the comfort of their patients and work colleagues, and thus enhance staff confidence, reduce stress and increase work performance.

When healthcare professionals integrate cultural ideas into their management plans, patients will be more eager to comply. When patients obtain care specific to their needs and cultural principles, they feel at ease with the care workers and feel their opinions are appreciated. Giving staff the opportunity for instruction on cultural differences in the work area provides an open door for the reduction of social and cultural gaps, making stronger connections between satisfied patients and culturally-educated caregivers.

In KSA, cultural competency does not occur prior to immigrant nurses departing from their home countries; some hospitals give informal short sessions on cultural skills, which

do not match the actual needs, and which could lead to culture shock, WRS and possibly cause early departure.

3.4 WRS Moderators

As highlighted earlier within the work-context, WRS is a problem with a strong impact on workers, organisations, and communities (e.g.Vagg and Spielberger 1998 Fernández et al 2015). Stress occurs when a person “is hard-pressed to deal with some obstacle or impediment or looming threat.” (Carver and Connor-Smith 2010, p684). People cope with WRS in diverse ways to prevent or diminish it directly (i.e. decrease the stressor) or indirectly (i.e. reduce related distress); (Carver and Connor-Smith 2010). Personality traits have frequently been highlighted to explain how people cope with stressful situations (e.g. Grant and Langan-Fox 2006; Connor-Smith and Flachsbart 2007; Fernández et al 2015).

The ability of an employee to work in a diverse working environment and in unique working conditions makes the feature of stress moderator (job resource) as a coping mechanism method fundamental to any organisation, as well as those in KSA. The key core job resource in stress study is job control, defined as decision latitude or autonomy (Karasek 1979). Job control has been found to lessen strain directly (Van der Doef and Maes 1999; Park and Gang 2007) and to moderate the effects of high job demand on strain, such that individuals with more experience in autonomous decision-making have less strain resulting from high job demands (Karasek 1979; Van der Doef and Maes 1999; Bozionelos 2009).

In their Canadian investigation of stress at work and mental ill health, Mauno et al (2016) contended that by making optional changes in the way that work is composed and overseen, it is possible to enhance working conditions and moderate the negative impacts, which lessens the negative beginnings of stress for workers, their families, managers, and society.

3.4.1 Social Support

Social support is a combination of social relationships, emotional and behavioural interactions, and an individual's perception of the adequacy or availability of different types of support (Button 2008). Social support moderates the relationship between healthcare-related occupational stress and the physical and psychological health of nurses; good social support results in a good quality of life (Button 2008). Conversely, low social support has been linked to poor physical and psychological health and an increase in the susceptibility of nurses to psychiatric-related sickness (Bradley and Cartwright 2002). Social support has also been found to improve well-being and to decrease the levels of stress and burnout that are associated with the work environment, and to enhance job satisfaction (Carlson and Perrewe 1999).

Many sources of social support have been identified for healthcare workers and nurses. Sources of social support come from work (i.e. supervisors, colleagues, and co-workers) and from home (i.e. family members, spouses, and friends) (House 1981). AbuAl-Rub (2009) investigated the effect on job performance of social support from co-workers among Jordanian hospital nurses. The results showed that

the perceived social support from co-workers enhanced the level of reported job performance. The results also showed that demographic variables of co-worker support explained 20% of the variance in job performance. Additionally, social support from co-workers enhanced the level of job performance, decreased the level of job stress, and enhanced work commitment (AbuAl-Rub 2004; Hamaideh et al 2008; Mrayyan 2009). In a further study, a high level of social support was found to be connected with a low level of burnout among mental health nurses (Shamia et al 2015).

The current study focuses on the support received by co-workers or supervisors for the immigrant nurses at Sultan Bin Abdulaziz Humanitarian City (SBAHC). The need for support and the dependence on the members of the healthcare profession has been widely recognised (Godinez et al 1999; Amos 2001; Casey et al 2004; Dicico-Bloom 2004; Mulvaney et al 2016). Many nurses reported that they felt supported by colleagues and mentors (Allan and Larsen 2003; Kovner et al 2007; Boyd-Turner et al 2016) and that work group cohesion was high (Kovner et al 2007).

Social support is recognised as having an immediate, quieting impact on workers in distressing circumstances and additionally acts as a "support". The buffering impact is an alternate method of demonstrating a moderating effect, such that stressors are less likely to cause stress in workers with solid social support (Fenlason and Beehr 1994; Abu Alrub 2007). Experimental studies have discovered little support for the buffering impact, yet impressive evidence of the immediate, added effect of social support on stressors has been discovered (Beehr et al 2000; Abu Alrub 2004; Abu Alrub 2007). Migrants who left their colleagues when they

moved on to a new occupation ended up with almost no social support, as is instanced by the migrant nurses in this study.

Social support is also acknowledged as being a constructive manifestation of interpersonal relationships counterbalancing other adverse elements at work. It seems that the absence of social support is not limited to the absence of buffering measures; although less social support can of itself cause stress or strain. One way that social support can cause stress is related to the level of help expected from colleagues, workers or managers. Ordinarily, normal and constructed customs of interpersonal association will set the standard for what is recognised to be a basic level of support. Lower level degrees of support can prompt stress among employees because of a feeling of loss of job security (Van der Doef et al 2000; Stoetzer 2010).

The idea of social support is confusing as it incorporates a range of different components that each can be measured, including capacity (e.g. emotional support, substantial support), source (e.g. co-workers, companions, spouse, manager and director), and structure (e.g. recurrence of social associations, system) (Hobfoll and Vaux 1993; Abu Alrub 2008). Cohen and Wills (1985) illustrated the role of social support as "emotional, enlightening, social companionship and instrumental". Gottlieb (1983) referred to these types of capacity when he characterized social help, implying that it has advantageous emotional or behavioural impacts on the beneficiary. Cobb (1976) characterized emotional support as the level of help that makes one feel important, regarded, minded and esteemed.

Supportive environments arise from the social support given by supervisors, organisation managers or by the general perception of social support given by the organisation. A steady supportive organisation is one in which leaders consider the well-being of employees and value their contributions (Abu Alrub 2009). This kind of organisation may also support managers and supervisors in their support of employees (Weigl et al 2016). In such an environment, employees may exhibit more commitment to the organisation, have better job satisfaction, and improved morale. They are additionally considered as being less likely to think about leaving the organisation (Portoghese et al 2015).

The relationship between leaders' behaviour in connection with social support and nurses' rising work stress and job performance was tested by Boamah and Laschinger (2015). The results showed that greater availability and access to support structures translated into lower levels of employment stress and greater work performance. The managers who gave greater support fundamentally influenced the employees, perceptions of their formal and casual powers and additionally had impacted positively on the overall organisation performance by strengthening the sense of belongings among employees. The study underpins the manager's role in the commitment to improve work performance and lessen the stress level between staff members.

Abu Alrub (2004) investigated the associations between WRS and social support from managers and that from colleagues. The result demonstrated that staff members who saw that they were given more social support by their managers experienced less stress in their employment. In a later study,

Abu Alrub et al (2009) investigated the direct impact of social support from co-workers and administrators on the stress level and job satisfaction of nurses working in hospital settings in Jordan. The results showed the significance of the positive direct impact of social support from both colleagues and administrators.

A study directed by Park and Gang (2007) highlighted the impacts of social support associated with work stressors on mental stress expectancy in healthcare services settings using the Karasek's JDC-S model. The results indicated that social support was an essential interpersonal constructive buffering component. Social support was identified with employment control and depressive manifestations in a basic connection. Only the fundamental impact model was basically acknowledged in variously levelled regression analysis. Extended social support was associated with low depressive manifestations, which shows that social support had a positive relationship with healthcare employees' mental wellbeing. The key part of the JDC-S model was supported, however, by interaction between demands, while control and support failed to be supported.

Xiao et al (2014) stated that immigrant nurses require strong support in enhancing their confidence and expertise. Transition support that starts within one environment and then moves on to the next has been classified into two types. The main kind of support is material, which may incorporate cash, instruments, individuals and a supportive working environment. The other, mental support is principally concerned with counselling advice from managers or work colleagues (Thompson 2014). Such support can certainly insure people from the harmful impacts of stressors

connected with a new work environment by helping to support feelings of self-respect and acknowledgement (Thompson 2014). This help might similarly have an instructive capacity to help people to predict, hold and adapt to potential stressors in practical ways, and may additionally basically satisfy the need for social companionship and friendships that may help the sense of belonging. Support from managers and work colleagues may also have an active function by supplying people with the resources and skills required to help combat the source of stress (WHO 2004).

3.4.2 Involvement and Staff Recognition

Involvement and staff recognition are considered to be great stress moderators, with which an individual empowers himself/herself to deal with reality, through methods such as remembering her/his limits, being able to discharge strain, being able to help with decision making, and focusing on specific issues (Cooper et al 1988). Nurses who are included in decision making show independence, are recognised by their managers and are equitably remunerated. Thus, they are inspired in their work, and their stress levels are brought down (Abu Alrub 2007). Happell et al (2013) showed that involvement of staff members in decision making has a huge positive impact on their sense of fulfilment. This additionally enhances the usefulness and competence of the staff. Their research proposed that nurses who had more autonomy and self-governance and more staff involvement in their practice showed a greater level of job satisfaction and retention, thus supporting the findings of past studies (Happell et al 2013).

Employees' inclusion in the decision-making process has a positive impact on work performance. Nurses who take an

interest in and help with policy making in the organisation are more valuable while nurses who seldom join in or who exclude themselves have a tendency to be less productive. Decreases in WRS level and improvement of performance through involvement result from the human need for recognition, regard and status (Barnes et al 2016). Involving workers in the decision-making process of an organisation also saves time, decreases stress, prevents truancy, discourages a high staff turnover rate, and prevents grievances from building up. It similarly enhances productivity, good morale and attitude, improves the quality of patient care and has been shown to result in increased profits (by up to 40%) in a few US organisations (Abu Alrub 2009).

The importance of immigrant nurses in delivering quality healthcare services is recognised by managers, supervisors and researchers (Singh 2000; Squires and Amico 2015). Immigrant nurses' attitudes and behaviours significantly affect patients' perceptions of the service as well as a general assumption about the whole hospital. This is an important reason for hospitals to find ways to manage nurses effectively and to ensure that attitudes and behaviours are maintained in order to ensure a quality service. Appreciation and recognition from a supervisor can additionally help to fortify the immigrant nurses' identification with the organisation (Moyce et al 2015). Taken together, both the active assistance and rewarding working relations with supervisors might in this way improve immigrant nurses' confidence in performing essential assignments (Moyce et al 2015).

Recognition of immigrant nurses acts as a motivator to help people to work and perform better; however, not all immigrant

nurses are motivated by the same factors. A nurse may become motivated, appreciative and feel acknowledged in the working area when he or she obtains job satisfaction by receiving what they believe is important for themselves and their self-esteem. This illustrates the connection between needs recognition, satisfaction and motivation (Lambrou et al 2010). A nurse's recognition leads to a higher level of job satisfaction which is considered an important indicator which affects both the nurse's performance and the quality of patient care delivered. As the nurse's recognition decreases, job satisfaction decreases with it, leading to an increase in the tendency of the staff member to leave his or her employer (Zaghloul et al 2008; Abu Alrab and Al-Zaru 2008).

3.5 Potential Impacts of WRS among Nurses

There are different conclusions of WRS on both the immigrant nurses and the healthcare organisation (Mostert et al 2008). As indicated by Donoso et al (2015), manifestations of WRS have a critical impact on workers' mental and physiological wellbeing, absenteeism and productivity within organisations.

WRS and its manifestations have generally been acknowledged in stress research as dependent variables. As a result of WRS, a variety of widespread physical, mental, and behavioural reactions to stressors is evident. WRS has additionally been conceptualised in respect of particular employment variables such as job dissatisfaction, and organisational variables such as turnover and non-attendance (Mostert et al 2008).

Within the main aim of this study, the following variables are selected as being most relevant to the subjects under

investigation: job satisfaction, morale, turnover, absenteeism, diminished efficiency, and job performance.

3.5.1 Job Satisfaction

Work satisfaction is characterized as the degree to which the worker enjoys his or her occupation. It alludes to one's cognitive (evaluative), effective (or passionate), and behavioural reactions to one's work, as evaluated by one's assessment of employment characteristics or attributes, occupation-related behavioural plans, and emotional reactions to incidents that arise at work (Locke 1969). People with a higher level of WRS are normally unsatisfied with their work and therefore do not enjoy working in the organisation (Ahsan et al 2009). They may feel frustrated when there are difficulties with customers and work colleagues; this may leave a negative effect on the organisation itself. Hence, it is pivotal for workers and employers to perceive the stress and the stressors that cause negative impacts (Ahsan et al 2009). Numerous studies have found that WRS influences workers' fulfilment and general performance at work. As indicated by Griffin et al (2009) occupation satisfaction has a significant association with WRS.

Job satisfaction among immigrant nurses is a multidimensional phenomenon that is influenced by numerous variables. Autonomy has been recognised as the strongest indicator of their work satisfaction and reflects positively on nurse retention (Boyle et al 1999; Upenieks 2000; Ea et al 2008; Goh et al 2015), which is acknowledged as a huge issue. Sengin (2003) backed Hinshaw and Atwood (1984) who’s far reaching written review recognised variables that impact on nurses’ work satisfaction. These variables

incorporated: (1) demographic variables: training, knowledge, and position in the hierarchy; (2) job attributes: independence and compensations; and (3) organisation environment components: level of professionalism, type of unit, and planning of the nursing delivery care model (Shaver and Lacey 2003).

Purani and Sahadev (2008) conceptualised six segments that include work satisfaction: compensation, self-sufficiency, task prerequisites, hierarchical policies, interaction, and expert status. Pay is characterized as the dollar compensation and incidental advantages accepted for individual work done. Self-sufficiency is the measure of occupation-related autonomy, activity, and flexibility either allowed or needed in day to day exercises. Tasks or exercises that must be carried out as a general component of the occupation are acknowledged job prerequisites.

The potential for inequity amongst similar groups of workers can be demonstrated inside the framework of organisational justice theory (Gelens et al 2013; Della Torre et al 2015; Sue et al 2016) and the related hypothesis of distributive equity (Homans 1961). In KSA, immigrant employees compared work environment inputs, occupation demands, compensation and profits gained with those from various nationalities (Gelens et al 2013). These comparisons were made utilising data from writing, media and inner association interchanges, together with working environment perceptions and revealed that both the wages and benefits of nurses undertaking the same work varied for immigrant westerners (Goodwin 2010). For the aforementioned reasons, inequity can be relied upon to increase, which is considered as a dissatisfaction factor (Bardenheier et al 2012; Gelens et al

2013) since workers anticipate that returns will be equitable. It is additionally accepted that a difference in the salaries of work colleagues with the same set of responsibilities and workload has a negative impact and represents a danger to the satisfaction, productivity and service quality of any organisation (Hopkins 2008; Gelens et al 2013).

Aiken et al (2002) discovered that work disappointment and dissatisfaction in nurses was most prevalent in the United States (41%), next in Scotland (38%), then in England (36%), in Canada (33%) and in Germany (17%). One third of nurses in England and Scotland and more than one fifth in the United States wanted to leave their employments within 12 months of data gathering. Additional striking results, further demonstrated that 27% to 54% of the nurses in all nations who were under 30 years of age anticipated leaving their employment within 12 months of data gathering. With regard to the work environment, about one third of nurses in Canada and Scotland felt that they took an interest in creating their own work plans compared to more than one half in the other three nations. When compared with other nations, nurses in Germany (61%) reported that they were more satisfied by opportunities for career advancement, while nurses in the United States (57%) and Canada (69%) felt more satisfied by their pay rates.

Fried et al (2008) directed a meta-analysis to study the connections mediating the impact of work satisfaction and intention to leave on role stress, and work performance. The results demonstrated that employment stress was identified with job performance both specifically and indirectly through work satisfaction and intention to leave; that is, if workers were satisfied by their employment, their performance,

productivity and gainfulness expanded, while unsatisfied workers' apparent performances fell short of that of the satisfied staff.

In an alternate meta-analysis survey review completed by Shirom et al (2008), the mediating impacts of employment satisfaction and intention to leave and their consequences for the connections between role ambiguity, role conflict, and work performance were researched. Their survey included both distributed and unpublished studies directed over a period of 25 years, bringing about 113 autonomous samples with more than 22,000 people (total n=22000). The results of this study indicate that role stress has a critical impact on both work performance and mental responses, which ought to give a sign to employers that they should make solid investments in building strong structures to enhance performance and maintain the competitiveness of the organization. Equipping employees with what is required to gain their satisfaction will reduce undesirable consequences such as chronic role stress, role conflict and role ambiguity at work place. The study additionally proposed that the procedure by which role stress influences work performance is unpredictable as a result of the inclusion of related mental encounters, particularly work satisfaction and intention to leave.

The scholarly study on the Magnet hospitals provided groundwork for a North American healthcare system that showed proof of retaining nurses (Aiken et al 2000; Kramer and Schmalenberg 2003). Kramer and Hafner (1989) explored variables in hospitals that were retaining nurses, hence the name Magnet. Magnet hospitals developed organisational attributes that were encouraging to nurse job satisfaction and tenure. Kramer and Hafner surveyed and

interviewed nurses from 46 Magnet hospitals to explore the situation and developed the NWI (Nursing Work Index). The attributes included “adequate staffing levels; flexible scheduling; strong, supportive and visible nurse leadership; recognition for excellence in practice; participative management with open communication; good relationships with physicians; salaried rather than hourly compensation for nurses; professional development; and career advancement opportunities” (Aiken and Patrician 2000).

Key components of disappointment and dissatisfaction included work redesign and administration. Human services cuts and redesign have influenced the working nurse, bringing about trouble for managerial positions (for instance, director of nursing, associate directors and managers), increased patient loads in spite of rises in patient dependency, and increased obligations regarding other staff on the unit (Aiken et al 2001). Nurses reported investing time on non-nursing tasks such as delivering food trays, transporting patients, and cleaning rooms with the consequence that they did not have time for essential nursing care, (for example, oral cleanliness, skin health management, teaching, and support; (Aiken et al 2001).

Reengineering continues to jeopardise the issues confronting the nursing profession. Adequate nurse staffing has been shown to be beneficial to patient wellbeing issues and safety issues and to reduce dissatisfaction (Kingma 2006). Aiken et al (2002) concentrated on employment satisfaction, patient-to-nursing staffing ratios, and the relationship with surgical patient outcomes and retention of nurses in 168 Pennsylvania hospital facilities, and presumed that higher patient-to-nursing levels helped patient mortality and failure to save

within 30 days of admission. Failure to save was characterized as "deaths following complications" (Aiken et al 2002, p1987). The findings inferred that a staffing ratio of one nurse to six patients brought about more 2.3 deaths for every 1,000 patients and 8.7 extra deaths for every 1,000 patients with complications (Aiken et al 2002). Aiken et al (2002) completed the study by evaluating and reassessing the patient's postoperative status and how it impacted on nursing competence: outcomes were poor, including nurse dissatisfaction and intention to leave. As indicated by Kulwicki (2006) nurses are the most visible healthcare providers and will keep on forming the mainstay of healthcare strategy for the world's general population. Re-engineering of services, chronic diseases, and nurse-to-patient ratios are issues that influence patient safety and patient outcomes when looking at the severe worldwide shortage of nurses. Patient safety and wellbeing and nurse satisfaction are related specifically to nurse-to-patient ratios in a few studies (Kane et al 2007; Aiken et al 2012; Purpora and Blegen 2015).

Algwaiz and Alghanim (2012) aimed to determine the type of occupational stress and its association with job satisfaction in public hospitals in KSA. A descriptive-cross sectional study was conducted on a sample of 148 Saudi nurses using the Expanded Nursing Stress Scale (ENSS). The results indicated that the most stressful subscale was dealing with patients and their families.

3.5.2 Job Performance

Nursing job performance mirrors the quality of care provided and subsequently patient outcomes. Poor job performance is considered to be a hazard factor for patient safety (Sun et al 2012). WRS is related to decreased work performance, decreased quality of care, increased infection in hospitals and lower patient satisfaction (Cimiotti et al 2012; Wang et al 2012; Farquharson et al 2013). To guarantee nurses' work performance and quality care, there is a need to identify variables contributing to lowered stress and increased welfare among nurses Wang et al (2015).

After an extensive literature search, it was discovered that research utilised distinctive outlines and tools to study this relationship. Definitions of job performance were not found in the recent nursing literature. This may be because of decreased interest in job performance in the 1990s. Job performance was as often as possible characterized utilising Schwirian's (1978) tool: Schwirian created this tool to measure the job performance of nurses. This tool has been utilised widely by researchers in the nursing field (Brasler 1993; Redd and Alexander 1997; Abu Alrub 2007).

According to EU-OSHA (2012b), the three most common criteria for evaluating immigrant success include completion of the foreign assignment, cross-socio cultural adaptation and performance of the foreign assignment. Evaluation of technical performance, organisational commitment, motivation and managerial performance assesses expatriate performance. While performance is also dependent on the expatriate's capacity for cross-socio cultural adjustment, psychosocial workplace strain will have a negative impact on their ability to adjust, both at work and in general (Martin and

Walker 2014). It is therefore likely that expatriates who are better adjusted to the foreign environment will be able to perform their tasks more efficiently.

The impact of work-related stress on job performance has been explored by numerous researchers (Jex 1998; Jamal 2005; Foley et al 2005; Kirkman et al 2006; Jamal 2007; Vischer 2007; Almalki 2012). Job performance can be acknowledged as an action in which an individual is fit to effectively carry out the task assigned to her/him. There are four essential speculations on the relationship between stress and job performance: the negative linear, positive linear, reversed U relationship and no relationship between the two (Jamal 2007). The negative linear hypothesis is focused around the premise that stress at any level devours an individual's opportunity, vitality, and maintenance, detracting from the current workload and thus hindering performance (Jamal 1985). Contrary to the negative linear hypothesis, the positive linear hypothesis is focused on the belief that stress and tension present difficulties to people, which thus enhances performance (Sharma 2016). The inverted U hypothesis of the stress-performance relationship speaks to a merger of the negative (stress is bad) and positive linear hypothesis (stress is good) by proposing that expanding stress respects a point, past which it gets bad (Abu Alrub 2007). Consistent with the positive linear hypothesis, the inverted U recommends that a few stresses are important to inspire the ideal job performance and is, therefore, functional (Seyle 1976). As indicated by Lawrence and Lawrence (1988), WRS is potentially reflected in low productivity, low self-confidence, non-attendance, and weakness. Nurses who revel in good physical and mental wellbeing are more

equipped for giving quality care than nurses who endure excessive WRS and its consequences (Abu Alrub 2007).

Differentiating between organisational variables that nurses see as affecting the quality of their job performance is paramount data for nurse managers, supervisors and instructors who shape nurses' job performance, and is additionally important for researchers who study job performance (Griep et al 2011; Hayes et al 2015). Nurses are in the best position to decide which variables impact their job performance and the level of this impact. Nurse executives and managers need to know which organisational variables impact on nurses' performance and the relative level of the impact so that they can find the ideal organisational environment which will allow nurses to accomplish their highest level of capability and effectiveness. This learning will help nurse leaders and managers to work out which variables are necessary and need to be viewed as the lead effort to improve performance and productivity. Buerhaus et al (2015) contended that productivity and quality in healthcare services settings are exceptionally reliant on the qualitative parts of human performance. Qualitative performance is imperative in advertising customer satisfaction, which is a key element in upgrading the appeal of any organisation.

It is believed that a nurse who is performing well is expected to achieve a better outcome. Such a nurse will boost the productivity of the organisation, will improve the financial status of the organisation and will advance the standards of care delivered to clients. Improving the management of nursing resources and their better utilisation is a vital requirement for the financial viability of any organisation

employing nursing staff (Abu Alrub 2007; Buerhaus et al 2015).

In Iran, a descriptive, correlational study was conducted by Gazanizad (2010) to investigate the relationship between WRS and job performance among staff nurses and to compare WRS and job performance between ITU and non-ITU nurses. Information was collected by using questionnaires which included the Nursing Stress Scale, the Schwirian Six Dimension Scale of Nursing Performance, and a demographic questionnaire. The results showed that nurses who reported high levels of job stress appraised their performance at consistently high levels. This suggests more stress leads to more challenges which in turn lead to optimal performance.

Results indicated that ITU nurses have higher mean job stress scores than non-ITU nurses, but it was not significant. Mean job performance scores were significantly higher in ITU nurses than non-ITU nurses. Of the demographic variables, significant differences in stress scores were found for types of work unit, education levels, years of experience, and sole bread winner versus non-sole bread winner. Similarly, job performance scores were significantly different for type of unit, marital status, worked shift, and sole bread winner versus non-sole bread winner. These results are significant and useful to hospital administrators and can help in evolving appropriate coping strategies for WRS and hence in reducing the stress of nurses working in all the units of a hospital, and especially in ITU nurses.

Another longitudinal study exploring the relationships between occupational stressors and work performance was

conducted by Edward et al (2007) among university staff members, trainee nurses and part-time employees to study the causal relationship between work, stressors and work performance. This study provided support and evidence to previous research, which proposed that there is a negative relationship between workplace stressors and job performance (Jex 1998; Siu 2003). Conversely, the findings of a study conducted by Van Dyne (2002) were inconsistent with the results derived by Edward et al (2007) with regard to the nature of the casual relationship between work factors and job performance; the causal patterns being in the opposite direction.

Contrary to the above-mentioned findings, Keijsers et al (1995) found a positive relationship between stress (burnout) and job performance as stress (burnout) increased. The study included ITUs from which nurses were recruited to test the hypothesis that burnout is related to poorer subjective and objective performance. Results indicated that subjective performance measures had a negative correlation with burnout indicators. However, the objective performance measure had a positive correlation with burnout. The researchers explained the unexpected positive relationship between objective performance and burnout as due to the highly technological environment. Thus, the technological equipment enhances objective performance but, at the same time, decreases perceived personal performance and increases stress and burnout.

Abu Alrub (2004) undertook a correlational descriptive study to measure the effect of perceived job-related stress on perceived job performance among nurses in different departments and investigated the effect of social support from

co-workers on job stress, job performance and the stress-performance relationship. The results indicated a negative correlation between job stress and social support; that is, participants who experienced more social support from co-workers reported less job stress. Equally, increased levels of stress resulted in decreased perceived job performance. The use of a Web-based survey to collect the data provided only a convenience sample, which limited the generalisation of the results. Other limitations of using Web-based research are potential multiple completion of the survey tool and the difficulty of computing responses (Duffy 2002).

A later study conducted by Abu Alrub (2008) among nurses in Jordan investigated the relationship between job stress, staff recognition, intention to stay and job performance, and tested the effect on stress of staff recognition of performance. The results indicated a significantly negative correlation between job stress and staff recognition for competent performance and recognitions between job stress and recognition for excellent performance were negative and significant. This suggests that staff who perceived having better recognition for their performance experience decreased the level of occupational stress. At the same time, there was a positive significant correlation between competent performance and staff intention to stay.

3.5.3 Intention to Stay

High rates of staff turnover can have a negative impact on staff members' productivity and their capacity to meet patient needs. Increasing amounts of work, cause increased burdens for the rest of the staff, decreased staff satisfaction, and consequently cause the quality of care to deteriorate (Hayes et al 2006).

Nurses' intention to leave is considered a direct threat to the quality of nursing care, as it causes a vacuum where less-experienced staff becomes responsible for highly sophisticated technical patient care. As a result, organisational performance may suffer if the nurse who is resigning has unique and exceptional skills or holds a key position in the organisation that is difficult to find a replacement for. Additionally, the responsibilities of the person who resigned will have to be taken on by those who remain, thereby affecting the job performances of those who are assigned the additional workload (AbuAlrub et al 2015). The presence of a high rate of nurses' intention to leave may cause frequent disturbances and changes to the duty schedule. As a result, this may increase staff frustration, which ultimately could lead to direct conflicts between employees who remain (AbuAlrub et al 2015). If highly experienced and qualified staff members continue to leave the hospital, serious consequences might follow as a result of the progressive loss of highly qualified staff.

In the setting of traditional immigrant nurses, most studies have discovered that well-adjusted migrants have fewer plans to return home before fulfilling their exile assignments (Bhaskar-Shrinivas et al 2005; Chiba and Nakayama 2016). Chiba and Nakayama 2016 found that Japanese immigrant

nurses who were adjusted at work and to the general environment had fewer expectations to return from the US than those less adjusted. In general, Bhaskar-Shrinivas et al (2005) affirmed a negative correlation between adjustment and withdrawal comprehensions. Withdrawal propositions might be characterized as a multi-dimensional idea (Hartigan 2015) incorporating three different measurements: aims to withdraw from the occupation; plans to withdraw from the manager or organisation; and expectations to desert the chosen profession or occupation.

Turnover also influences retained nurses by decreasing organisational commitment and increasing WRS, which can result in additional turnover (Castle 2006). There is no published annual turnover rate among nurses working in KSA. Since the quality and capabilities of nurses are critical for the quality of patient care (Chang and Cheng 2007), turnover of competent nurses could cause detrimental influences on the nursing climate and the organisation (Orsolini-Hain and Malone 2007).

Organisational commitment (Bentein et al 2005) and job stress (Abu Alrub and Al-Zaru 2008) in nurses are known to be significant predictors of the intention to leave. Several authors have noted there is a high number of nurses with low levels of organisational commitment and high levels of job stress who intend to leave the profession (Kim and Lee 2006, Chang and Cheng 2007; Beecroft 2008). Nurses with higher levels of job stress tend to experience higher levels of burnout, leading to an intention to leave (Dickinson and Wright 2008).

Chiu et al (2009) conducted a study to examine the effect of job demand, job control, intention to stay and social support. The findings confirm the results from other studies that work stress is an important predictor of a nurse's intention to stay (Hayes et al 2006). However, the results also show that the major predictor of a nurse's intention to stay is job dissatisfaction, while the major predictor for job satisfaction is psychological empowerment. Social support from supervisors and co-workers can increase the intention to stay and in keeping with other study results, information and support from supervisors may reduce work stress (Searle et al 2001). Therefore, hospital managers and nurse supervisors should implement ways to offer nurses more social support and practical assistance at work.

Numerous researchers have attempted to answer the question of what determines an employee's intention to quit their job by investigating possible antecedents (Kramer et al 1997, O'Donnell 2105, Takahashi 2016). While actual 'quitting' behaviour is the primary interest of employers and researchers, the intention to quit is argued to be a strong substitute indicator for such behaviour. In his study, Moore (2002) found that the lack of job satisfaction is among the factors that contribute to an individuals' intention to quit his job; however, it is important from both the hospital administrators' and the individual's perspectives to understand which factors of job satisfaction are related to the intention to quit from the nursing profession. Alam and Mohammad (2010) investigated the level of job satisfaction and intent to leave among Malaysian nurses. The objectives of the study were to examine the level of perceived job satisfaction and intention to leave.

3.6 Overview of Current Research

WRS researches and studies among immigrants are mainly conducted in developed countries. Limited studies have highlighted the importance of WRS in developing countries and in KSA specifically. KSA has a very unique work environment in a diverse cultural setting; the available data is restricted and not conclusive in terms of impact among immigrants and the concrete nature of WRS. The key issues at risk are the occurrence of WRS and its consequences on immigrant staff and patient safety, and economic impact on many workers in KSA; there is limited or no knowledge and information about how WRS affects immigrants' job performance, intention to stay and social support - there is a lack of policies and legislation, and, if these do exist, there is lack of enforcement.

On a closer look, the limited available studies on WRS that were conducted in KSA provide a weak knowledge base. At present, we require more strong evidence to raise awareness, to motivate policy makers, stimulate action, and to help in possibly introducing a framework to deal effectively with WRS among immigrant nurses.

This thesis set out with the review of the latest literature on the level and impact of WRS on job performance, intention to stay and social support globally, but particularly in immigrant nurses in KSA. The results revealed that, while there is much research on WRS in general, and while there is growing evidence for a link to the negative health effects in developed countries, little is known about the situation in KSA.

The lack of consistency in the findings might be a function of variation in the dimensions of stress and performance

assessed, and the use of different measures with different levels of validity and reliability. More research is needed to study the effects of WRS on job performance using reliable, valid, sensitive measures for the nursing population.

The current research study is unlike any formalized research conducted in Saudi Arabia. Therefore, a mixed methodology approach was selected for the purpose of this study. The key reasons for this selection relate to the following strengths; firstly, the strength of the research design means that the quantitative approach can provide a wealth of data from a good sample size; the second strength of the study design is that the quantitative data elements can expand the data analysis potential. That is, by using different quantitative techniques (bi-variate and high-level multi-variate techniques) results will be more robust. The third strength of the study design is the qualitative approach that captures some of the individualised experiences that are not collectable by using straightforward quantitative approaches. By approaching the study of WRS from both philosophical perspectives, a greater depth of knowledge can be obtained about the living experience of being an immigrant nurse and the impact of this on stress level, job performance, and intention to stay - the interaction between WRS and social support. As Bryman (2003, p12) concludes, “When quantitative and qualitative research are jointly pursued, much more complete accounts of social reality can ensue.”

3.7 Summary

This chapter has provided an overview of the current literature on WRS and sources of WRS, in addition to studies about the effect of stress and adjustment strategies among nurses in general and immigrant nurses specifically. An increased level of WRS may place nurses at a higher risk for problems and reduced mental well-being. It is vital to have knowledge about the level of nurses' perceived stress and their correlated symptoms and their ways of dealing with stress, in order to fully appreciate the experiences of the nurses and to support them in handling their stressful situations and in improving their welfare.

The key conclusions from this method are related to the occurrence of WRS, sources of stress, consequences of stress, and symptoms among nurses worldwide. Nurses were found to have more WRS when compared with other occupations (Jayawardene et al 2011). Built on existing literature, the most regular sources of WRS were "Workload" and "Conflict", as determined in numerous studies in different nations (Emilia and Hassim 2007; Hoolahan et al 2012; Garcia-Izquierdo and Rios-Risquez 2012). Broadly, WRS among nurses was found to be linked with job performance and intention to stay (Lin et al 2010). Diverse types of coping and adjustment approaches were used by nurses to deal effectively with WRS (Yoder 2010).

Information collected on the causes of WRS is occasionally secondary to the main aim of the study and was collected only to assess the link between stressors and other variables (Brunero et al 2008; Hoolahan et al 2012). As there are few studies conducted in KSA (which would have been imperative literature for appraisal and review), it is hard to establish a

picture of WRS among immigrant nurses there. The existing studies' results can therefore only be generalised to hospital nurses in general and not necessarily to immigrant nurses working in the diverse culture setting of KSA.

The systematic method of literature review highlights the problems found in some papers which did not define the prevalence of WRS or its related concepts. This approach and the wider literature helps to deliver the justification for an additional investigation of WRS among immigrant nurses as well as informing the choice of variables considered vital in relation to WRS. Finally, a great deal of research has been carried out recounting WRS and the adjustment of nurses globally, but none has been written about WRS and its relation to performance, intention to stay and social support among immigrant nurses in KSA. Looking at the current situation of immigrant nurses, there is a necessity to conduct this study.

The following chapter describes in further detail the methodology employed in this research in order to achieve its aims and objectives.

CHAPTER FOUR

METHODOLOGY AND METHODS

4.1 Introduction

This chapter is important because the methodology section of this study will answer two main questions: How was the data collected for this research? And, how was it analysed. The methodology is the theoretical underpinning of my research and informs the methods I chose to identify, select, and analyse information applied to understanding the issues surrounding the WRS, job performance, social support and intention to stay, thereby, allowing the reader to critically evaluate a study's overall validity and reliability.

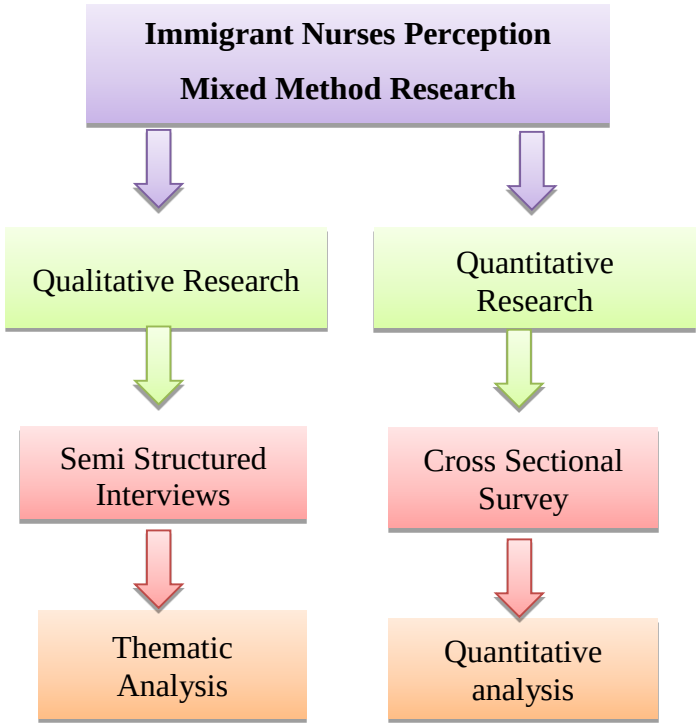
The focus of this Chapter is to present the research methodology and methods and their appropriateness for the study. A combination of quantitative and qualitative methods was used to answer the research questions and I begin this chapter with an overview of the case study mixed methodology research, showing why this was appropriate for the study. Following that a description of the method used will follow, were I will reiterate my research questions, beginning with the quantitative methods, sampling and recruitment strategy and data collection methods.

Following my quantitative presentation, the qualitative methods will be presented, including participants and recruitment strategy, data collection methods and data analysis. Ethical issues surrounding methods and quality will follow. Finally, a summary is given.

Case study research was chosen because it is able to provide a rich understanding of the phenomenon under study as explained throughout this chapter.

The purpose of this study was to explore, describe and measure the WRS at both the individual and organizational levels around immigrant nurses in KSA, in relation to job performance, intention to stay, and social support from work colleagues including supervisors, given that this is an under-explored arena in KSA. A broader aim of the research was to raise awareness of WRS. In this sense, it is hoped that this research will inform decision makers and policy makers about the importance of WRS and its prevalence and impact in the nursing migrant population in KSA with the aim of promoting their health and well-being.

Figure 4.1 Data Collection Approach



4.2 Case Study

Case study emphases on one experience (Denscombe 2008) inspecting the 'when', 'how' and 'why' in context/situ and the researcher having little effect over proceeding (Yin 2003). The 'event' of this study was the occurrences of WRS among immigrant nurses. Within the KSA no published study had measured or explored the occurrence of WRS on immigrant nurses' outcomes in the work setting. Stake (1989) underline the importance of selecting an 'extraordinary' case which applied here. The investigator had limited control over sources, impact and consequences of WRS, as an immigrant nurse himself.

Additionally, case study research also incorporates the positivist perspective. Positivism holds that objective reality is independent of the human mind (thoughts and perception) and is therefore knowable and measurable and is driven by causal law (De Vries 2004). Thus, the positivist researcher focuses on measuring the phenomenon through systematic empirical investigation (Young, 2005). The positivist assumption is that the inquiry is objective and value free so the researcher will attempt to control the research environment during the study (Gliner and Morgan 2000). Case study from the positivists 'perspective employs structured methods such as surveys and experiments (Cavaye 1996).

Case study research accommodates multiple methods, using multiple data sources and data collection methods (Hancock and Algozzine 2006), in order to gain a detailed and holistic understanding of the phenomenon. For this reason, the application of case study design is defined as a comprehensive research strategy‖ (Yin 2009). Morse and

Chung (2003) argue that the utilisation of multiple methods in a research project is beneficial and leads to holism as it provides different perspectives about a phenomenon that cannot be achieved by qualitative or quantitative methods alone. This premise is also supported by Foss and Ellefsen (2002), that the complexity of human experience requires multiple means to obtain a comprehensive picture. Thus, adopting multiple methods in this case study provides strength to the study findings.

Three different types of case study as described by Yin (2009) are exploratory, explanatory and descriptive. The exploratory case study is used in this study to explore the WRS phenomenon under study where the WRS has no clear, single set of outcomes. The purpose of exploratory research is to acquire insights and in-depth understanding of the structure of the WRS in order to develop propositions and hypotheses or theories (Scholz and Tietje 2002) that can be tested with future research and it is best used to answer what ‘questions (Yin, 2009). The explanatory case study used to explain the causal links where the researcher seeks to explain why or how the phenomena is happening in a real-life context. It mainly seeks answers to the why ‘questions. The descriptive case study is used to describe the phenomenon and its context. Descriptive research may seek answers to who ‘, what ‘or where ‘questions. In general, the case study is best used when intending to answer how ‘and why ‘questions (Yin 2009).

This study has an exploratory nature, because the researcher has sought to develop an in-depth understanding of the issues related to WRS among a culturally diverse immigrant nurses and how this impact job performance and intention to

stay, at the same time understand how social support from colleagues' impact WRS at the organization of SBAHC in the Riyadh, KSA where nurses are culturally different from each other and from the patients. In addition, the reason for this study being exploratory is because of the uniqueness of the Saudi culture, which has a combination of Arabic culture and Islam which is different from the western world and the large number of immigrant nurses providing care for the indigenous people of Saudi Arabia.

The exploratory case study is appropriate because of the lack of prior research in this area. The findings from this study can thus inform theory building and contribute to knowledge. It also contributes to the development of further propositions that can be verified by further research and provides recommendations and guidance on the issue of WRS in a culturally diverse setting, job performance, social support and intention to stay.

The use of multiple sources of evidence in case study allows the researcher to reflect historical, attitudinal and behavioural issues with a key advantage of 'converging lines of enquiry' (Yin 2003 p 98). Patton (1987) considers four different forms of triangulation; data, investigator, theory and methodological. Denscombe (2008) further delineates time and space within data triangulation. Yin (2003) considers true triangulation requires corroboration from more than one data source which occurred in this study.

Yin (2003) backings the split-up of the case study data base and reports as a method of always being able to return to the full data set rather than those chosen for a particular report. This was implemented within this study. Each data set was

kept and analysed independently prior to cross analysis within and between units and participant groups. Thirdly a clear chain of evidence from conception to the finished report allows for transparency of validity and reliability. The use of multiple methods allows the researcher to be more confident of a result if it arises from a convergence of different methods, as well as enabling the researcher to improve the accuracy of judgment about a phenomenon through the collection of different kinds of data, confirming the credibility and validity of study findings obtained by different approaches and different data sets (Dunning et al 2008).

Bergman (2008) claimed that the findings from one method could be used to assess the accuracy of findings obtained by another. This may enrich our understanding by allowing for the discovery of new or deeper dimensions (DePoy and Gitlin 2015) which may not fit a current theory or model. It is also suggested that multiple and independent measures do not share the same weaknesses or potential for bias (Creswell 2013), and although each method has assets and liabilities, triangulation purports that it exploits and neutralizes the assets rather than amplifies the liabilities (DePoy and Gitlin 2015).

Case study has no fixed epistemological, ontological or methodological position. Luck et al (2006) contended that case study is depicted as a paradigmatic bridge‖ that provides researchers with openness in regard to methods selection. Each side of the bridge is a distinct paradigm; hence, the research question and the purpose of the study determine whether one should apply qualitative or quantitative methods or both in the study, for the purpose of this research, both methods were used. Case study research

usually draws on multiple methods; for this reason, it can be epistemologically diverse (Luck et al 2006). The epistemological perspectives usually include interpretivism and positivism, both of which have different assumptions about the nature of knowledge and require different approaches to research. The strength of case study is that it brings together different views of knowledge regarding a specific phenomenon such as WRS. This process takes place in data analysis (Yin 2009) where both qualitative and quantitative data reconcile. As a result, a conclusion drawn from case study research is likely to be convincing because it is drawn from multiple perspectives (Mills et al 2010). Thus, these different epistemologies add to the authority of the findings.

There are major differences of opinions among qualitative researchers on matters of ontology and epistemology as well as the methods to be used and criteria of evaluation. There are also disagreements about the nature, purpose, status and practice of its methods. A large number of authors take a predominantly method-based approach; authors such as Miles and Huberman (1994) and Patton (2002) put emphasis on data collection techniques. Another approach is to classify qualitative research according to research traditions, i.e. whether phenomenological, grounded theory or ethnography, amongst others. Authors such as Creswell (2007) and Denzin and Lincoln (2005) prefer this approach, which has the advantage of being based on systematisation of knowledge providing a sense of order and orientation. On the other hand, it has the disadvantage of oversimplification, ignoring the issues of the research question and conceptual frameworks used and the way these issues can shape the research process and the findings. In addition, some researchers have

decided to classify qualitative research according to the research question or the method of analysis (Creswell 2013).

Although the majority of qualitative researchers' stress that qualitative research is inductive in nature, in contrast to quantitative research which is deductive, there are qualitative researchers who argue that both can be used for different purposes and at different times, and that qualitative research can be done in a deductive way where prior assumptions are tested on new cases (Glaser and Strauss 1967). Retroduction, which is defined as the movement backward and forward between theory and data or the combination of deduction and induction, is said to be a characteristic of qualitative research. The degree of deduction or induction and which one follows the other depends on the research question Murphy et al (1998).

Studies using qualitative research in health care have been criticised for the misguided separation of method from theory and of technique from the conceptual underpinnings (Lambert and McKevitt 2002). However, qualitative health researchers respond by stating that the choice of method and how it is used can perfectly well be matched to what is being studied rather than to the methodological leanings of the researcher (Mays and Pope 1995). It has been suggested that incorporating qualitative research method experts into health research teams enriches research and ensures that the right methodology is used for answering the right questions. Finally, using qualitative methods in health-related research has resulted in more insight into health professionals' perceptions of lay participation in care and identification of barriers to changing healthcare practice

Plewis and Mason (2005) maintain that quantitative and qualitative methods form a good basis of research for studies that are applied to WRS and Chrisopoulos et al (2010) claim that the combination of qualitative and quantitative explorations is able to distinguish the sources of WRS among workers, particularly those exposed to a remarkable ecological and working conditions as in the case of immigrant nurses in KSA. The researcher highlighted that the different quantitative and qualitative information gathered and analysed might give various sources of merging proof (Johnstone 2004).

The number of mixed methods phases suggested by Creswell is well defined; it is built on how the quantitative and qualitative data collection and analysis interact. For the purpose of this research, the adopted design was the convergent design. The convergent design has merely one phase, in which quantitative and qualitative data are combined during analysis. The aim of using this design was to obtain complementary data relating to the same topic of WRS and then to compare the resulting datasets from each design.

The weaknesses of using the multiple-methods approach as cited in the literature pertain to the effort required to complete such studies. Creswell (2003) identified these weaknesses as the knowledge and training of the researcher to conduct a mixed method, reviewers who may not be familiar with mixed methodology, audiences who may not be familiar with the mixed-method design, the extent of the data collection effort, and the volume of required resources. To address these threats, assistance in the preparation of the mixed-method

design was sought from Nottingham University coursework, the thesis supervisor, and external sources.

4.3 Research Methods

The suitability of the methods must be reliant on the nature of the research and the questions they seek to answer. In this study, the assumptions of case study research design were met. First, it is appropriate to investigate a complex contemporary phenomenon within its real-life context, and the phenomenon in this study is contemporary – the effect of the WRS level on the multicultural immigrant nursing workforce, job performance, social support and intention to stay. It is a complex and multifaceted phenomenon. Second, WRS is highly contextualised and cannot be isolated from its context. It requires multiple methods and data sources to comprehensively understand it from different perspectives. The Case to be studied in this research is the Multicultural immigrant nursing workforce'.

The definition of the case leads to the formulation of the research question or questions. Defining the research question is considered the most critical part in a case study (Yin, 2009) as the research question focuses and guides the study. In addition, it provides clues to determining the most relevant method to be used. In general, the research question is composed of both substance and form, which refer to what the study is about and the structure of the question respectively.

Given that the overarching purpose of this study was to measure and explore the effect of WRS at the individual levels around immigrant nurses in KSA, in relation to job

performance, intention to stay, and social support from work colleagues including supervisors, also a broader aim of the research was to raise awareness of WRS. The research questions of this study are:

- What is the perceived level of WRS and the perceived level of job performance?
- What is the perceived impact of social support from work colleagues on job performance and WRS level?
- What is the immigrant nurse's intention in relation to staying working at the current hospital, and how does the perceived level of WRS impact job performance?

The selected demographic factors included gender, age, nationality, religion, nationality, education level, and year of working as a nurse, years in current hospital, marital status and continuing education status (Appendix C). The selected work environment factors included type of hospital, title, contract type, and number of patients cared for per shift. The demographic and work environment factors were important considerations when exploring immigrant nurses in KSA. The country is male dominated, yet the majority of nurses are female. There is an assumption that older nurses with more experience tend to stay longer. Older nurses have older children, the salary may be for retirement, and experience assists in job advancement. The factors that pull immigrant nurses to KSA included the immigrant nurse's nationality and circumstances at home. KSA is the home of Islam and many Muslims come to Saudi Arabia to work for that reason (Mitchel 2009). Salary and benefits varied from hospital to hospital depending on nationality, experience, and education level. Contracts for immigrant nurses in staff positions (including charge nurse) were for the immigrant nurses only, not for their family. Married immigrant nurses work to support

their family at home, however many married immigrant nurses leave because of family pressures, young children, or the death of a caregiver (Mitchel 2009). As no consistent data exist, nursing directors assume that an immigrant nurse with family in KSA will work longer in the Kingdom.

4.3.1 Research Population and Research Setting

Bryman (2004) characterizes "populace" as the universe of units from which the specimen is chosen. He further clarifies that these "units" may not so much mean just individuals; they might additionally be towns, places, red blood, and so on. Polit and Beck (2004) characterize "population" as the whole gathering of cases in which a researcher is concerned. The populace is likewise depicted as "open" or as "the target". Polit and Beck expressed that an available populace is “the aggregate of cases that follow to the designated criteria and that are accessible as a pool of subjects for the study.” (Polit and Beck 2004, p14), while they describe the “target population” as “the aggregate of cases about which the researcher would like to make generalizations.” (Polit and Beck 2004).

Deciding on the research population is considered a prerequisite of survey design (Cohen and Manion 1985, 1994; Mayoh and Onwuegbuzie 2013). Research aims to learn new things about a large group of people by conducting the research on a much smaller group of people. The population frame is a listing of all the elements in the population from which the sample is drawn (Borg and Gall 1989; Gorard 2010). Awda and Malkawi (1992) indicated that the type of problem and purpose of the study determine the population. Borg (1981) and Borg and Gall (1989) argued that

the most important criteria in selecting the population is choosing people who will provide the information a researcher wants and needs.

The population for this study is all the immigrant nurses who were working in the inpatient and outpatient care units in the Sultan Bin Abdulaziz Humanitarian City (SBAHC) in Riyadh at a time when the researcher conducted the study. The total number of nurses who were working at that time totalled 360 immigrant nurses. SBAHC is a major private medical surgical hospital in Riyadh, KSA. The hospital has 400 beds, however only 290 beds were operational at the time of the data gathering for the study. The hospital relies heavily on immigrant nurses who comprise all nursing staff members, with not a single Saudi Nurse in the nursing department. English is the spoken language in the hospital and it is one of the essential criteria for selecting nursing candidates.

At the time of conducting this research, SBAHC employed nurses from a variety of different nationalities. Around 72% of nursing staff members were from the Philippines, 8% from Jordan, and the rest were from India, Malaysia, Slovakia, South Africa, UK, USA, Canada, Lebanon and Palestine.

Measurement of the research variables was based on the available literature concerning WRS amongst immigrant nurses. Thus, immigrant nurses were the best qualified people to provide responses to the questionnaire and interviews. It is also worth identifying the reasons for choosing KSA, and the city of Riyadh specifically, as the place in which to conduct this research.

- KSA is where the researcher works as an immigrant nurse; meaning the researcher is able to gather the required information for his research without any difficulties regarding language, cultural differences, and time issues and so on. At the same time, the researcher understands all the ethical issues concerned in conducting research in KSA.

- The researcher himself worked as immigrant nurse, who in turn helped in understanding the study context, culture and healthcare system.

- KSA employ a large number of immigrant nurses from different countries, were you can find over 20 nationalities of nurses in the same hospital, which serves the purpose of this research as the main population of interest are immigrant nurses.

  In regards to the nurses' level or nursing grade, the hospital where this study has been conducted has a policy that all staff hired in the nursing department and other clinical departments in the hospital will be appointed at the entry level of III (i.e. staff nurse iii, nurse aid iii, charge nurse iii, etc.), two years later, this staff will be promoted to level II, after two years of being at grade II, staff will be promoted to level I. This measure was introduced in 2007 as an incentive to staff and as part of the retention plan, although there have been concerns that all staff are put on the same entry level, without giving consideration to the number of years of experience or educational level the staff had; so, whether the staff had ten years of experience as registered nurse or only two years of previous experience, they would still be assigned to the same entry level. When the current study was being conducted, the majority of staff from the nursing department were at level II

(34.1%), followed by staff at level I (29.3%), which indicates that most of the staff who participated in the study had been working for more than two years at the study hospital. The proportion of participants at entry level III was 25.2%. Study sample and sampling technique will be detailed in the next chapters.

A single hospital in Saudi Arabia may employ over 40 nationalities (Mitchel 2009). The nursing diversity makes credentialing a difficult task for nursing administrators. For effective and safe healthcare delivery, it is imperative the multicultural workforce is competent in its practice. Nurses recruited from around the world must meet the human resource requirements for employment, including licensure, training, education, experience, and specialty. All potential employees must pass a full medical examination.

A potential employee who has Hepatitis B or HIV/AIDS will fail the medical exam. A potential employee with a chronic condition might pass the medical exam, depending on the extent of required healthcare or anticipated sick time. The potential employee must pass an English test and have their nursing credentials verified (Mitchel 2009). Since January 2005, the Saudi Nursing Directorate has required all nurses to have a Saudi license (Saudi Health Care Commission 2005).

4.3.2 Quantitative Methods

Quantitative examination is the examination of phenomena that prompts exact estimation and capability, frequently including a thorough and controlled configuration (Polit et al 2001). The quantitative research methodology is one logical strategy for getting data, regularly under states of extensive control, and the investigation of that data utilizing factual strategies (Polit and Hugler 1997).

This component of the research sought to answer the research question regarding immigrant nurses' perceptions of the levels of WRS, job performance, social support and intention to stay. There are many different data collection methods that can achieve the aims and objectives of a study. The survey method is commonly used in descriptive research and is appropriate for obtaining information about phenomena such as the beliefs, attitudes, points of view and behaviour of a group of people (Thomas, Nelson, & Silverman, 2005). It can also be used to determine the relationship between events. The strength of survey questionnaire is its ability to collect a large amount of responses over a short, specific period of time, and it widely represents the target population. In addition, a questionnaire is an efficient and effective data collection technique when the researcher is seeking participants 'responses for specific items that answer the research question (McNabb, 2002). Thus, in this study, a validated instrument was used to examine the nurses 'perceptions of the WRS, job performance, social support and intention to stay at SBAHC. The instrument is discussed in detail below in terms of content reliability and validity.

4.3.2.1 Population Sample

After checking with the criteria for participation, 321 nurses were eligible to participate in the study. As an overview of the sample population, 13% of the nurses were between 20 and 25 years of age 19.1% were 26 to 30 years old 29.7% were 31to 35 years old 20.7%were 36to 40 years old, 8.5% were 41 to 45 years old and 8.9% were over the age of 46.

A sample is a subset of the population elements about which information is collected (Polit and Beck 2004). According to Bryman (2004), a sample must be representative of the population if one hopes to make generalizations about the findings from the sample to other similar populations. Bryman also makes another important point about the representativeness of the sample by stating that biases can occur when a sample does not represent the population from which it has been drawn. Since sample bias may be either conscious or unconscious, a researcher's personal preferences, leanings and interests may affect the way in which he/ she chooses a sample (Babbie and Mouton 2001). Proper sampling methods will allow the researcher to choose a small number of respondents from a larger population, thereby keeping the costs of the research in terms of money and time to a minimum without forfeiting the possibility of generalizability (Hofman and Patel 2015). One method of sample selection is the probability sampling method. Another cause of bias is a researcher's implicit criteria for inclusion (Bryman 2004) and therefore the researcher should make the greatest possible effort to consciously exclude bias as far as possible by using a sampling method that ensures that bias will be avoided.

An alternative method of sampling is the non-probability method. It is a feature of non-probability sampling methods that not every element of the population has an equal opportunity of being included in the sample. According to Burns and Grove (2003), although this method decreases the chance that the study can be generalized to other circumstances, it is the one that is most commonly used in nursing studies. Babbie (2005) is of the opinion that non-probability sampling methods can be used to research situations that do not permit the kinds of probability sampling methods that are used in large scale surveys. The most common and widely used non-probability sampling methods include convenience sampling, random sampling, purposive sampling, snowballing sampling, and theoretical sampling methods.

Patton (2002) asserted that selecting a heterogeneous sample of participants helps the researcher to capture and describe the chief themes that yield up two types of data: high-quality case description that might be helpful in documenting uniqueness and an important shared pattern of commonalities across the participants. To achieve a heterogeneous selection of participants for this study, a simple random sampling technique of healthcare professionals (registered general nurses, nurse managers, nurse supervisors, practice development nurses and licensed practical nurses) from diverse backgrounds was selected to merge themes from different healthcare professionals, and to gain in-depth data from their experiences with WRS. Simple random sampling proposes that each member of the population has an equal and independent chance to be one of the sample members. “Independent” means that the selection of one person does not influence in any way the

selection of another individual (Cohen and Manion 1985 and 1994; Borg and Gall 1989; Cohen et al 2000; Balnaves and Caputi 2001; Hofman and Patel 2015).

Positivists recommend random sampling in which any member of the population (in this situation, immigrant nurses) has an equal chance of being asked to participate in the study. A cross sectional, non-experimental research design was used in this research to measure and explore the relationship between WRS, job performance, social support and intention to stay. The design is non-experimental because no new changes were introduced and it was cross sectional across all units at the same point in time. The entire population meeting the inclusion criteria for the study sample was selected for this study. Targeting the entire research population has been widely adopted in many studies (Burns and Grove 2005).

An important methodological goal for any research is the ability to draw conclusions about larger populations. This depends on the representativeness of the sample. A representative sample is one in which the sample's characteristics mirror the population from which it comes. Associated with the issue of representativeness is how the level of representativeness is demonstrated. Of main importance to the achievement and demonstration of representativeness in this study were the methods by which respondents were selected to participate. Other issues important to this matter included sample size and the representativeness of the sample's work environment to that of the population from which it was drawn. Addressing this matter went to the centre of being able to abstract valid conclusions about populations from sample data.

As part of the criteria for research approaches, the participants were; (a) immigrant nurses (b) who had been working for a minimum of three months at the research setting and (c) had a minimum of three years' experience since attaining their nursing degree. These criteria were necessary to ensure that the respondents were well-oriented with the organization, had overcome the initial stress of working in a new environment, and had worked in similar situations. Registered nurses and licensed practical nurses were used because both of these groups encounter many of the same stressors and are both regarded by the public as "nurses".

In determining the sample size for the factor analysis for the quantitative sampling, Comrey and Lee (1992) offer the following guidelines: sample size of 50 is considered to be very poor, 100 or more is poor 200 is fair, 300 is good and 500 is very good. As a general rule, a sample size of 300 is comforting when performing factor analysis, however solutions that have several high loading variables (>.80) do not require such a large sample size and 150 cases is considered sufficient (Comrey and Lee 1992). The statistical analysis performed in this study involved correlations and regressions. In determining an appropriate sample size, Tabachnick and Fidell (1996) recommend that we need a margin of error less than 2.5% with 95% confidence intervals above 90%, for this research we aim over 90%.

$N \geq 50+8m$ or testing multiple correlations or,
$N \geq 104+m$ where m is the number of independent variables and $\alpha=0.05$ and $\beta=0.20$
N was calculated both ways to determine what procedure produced the highest number of cases.

Using the first formula, a sample size of 178 was generated:
N ≥50+(8) (16) =178

Using the second formula, a minimum sample size of 120 participants was required. So,
104+16=120

Based on the abovementioned calculations for the present study, a sample size of 321 immigrant nurses was obtained. A representative random sample of immigrant nurses for the present study was recruited from each ward at the research setting.

Borg and Gall (1979 1989) argued that the general rule of choosing the size of the sample is to use the largest sample. Borg and Gall (1989), Munn and Drever (1990), Gorard (2001) and Balnaves and Caputi (2001) argued that the size of the sample should be large enough to satisfy the needs of the study so that the researcher can, to some extent, be confident to generalize the results. In the same context, Cohen and Manion (1985 1994) and Cohen et al (2000) reasoned that selecting the sample size depends on the heterogeneity of the population; the greater the heterogeneity, the larger the sample that must be selected. They also state other factors influencing sample size are the nature of the population and the purpose of research; otherwise there is no clear-cut answer. Cohen and Manion (1985, 1994) and Cohen et al (2000) mentioned that an example size of 30 ought to be the base if a researcher is wanting to utilize factual examination.

The reason for selecting a large sample in this study was to obtain a sufficient response rate and to ensure a

representative sample. This is constant with Borg and Gall (1979 1989), Munn and Drever (1990) and Gorard (2001) who stress the importance of choosing a large sample size to ensure the necessary confidence with the data.

Purposive examining was utilized as a part of the qualitative examination approach as this was acknowledged to be more suitable (Miles and Huberman 1994; Wood and Brink 1998). The sample was picked purposively since that all respondents were characterized as worker immigrant nurses and all were working at SBAHC (de Vos et al 2002). This guaranteed that despite the fact that the specimen was constrained regarding a generalization to the populace, the examples and similitude between the experiences of respondents would be apparent through situational examination.

By selecting purposive sampling, the subjects were judged to be representative of the phenomenon being examined, whilst also being knowledgeable about the research due to their experience. This contributed to gathering highly informative data for this study (Brink et al 2006).

Purposive samplings are not free from predisposition or bias. Participants may be selected out of ease or on the recommendation of knowledgeable persons (Lopez et al 2012). At the point when a sample is measured accurately, it becomes legitimate and valid for the sample, hence giving internal legitimacy and validity. By giving consideration to its characteristic bias, purposive sampling can give dependable, reliable, robust and vigorous information. Along these lines, any feedback of bias might be maintained at a strategic distance from when the essential objective is to find meanings

(Morse and Field 1995; Joyce et al 2015). The quality of the strategy actually lies in its purposeful bias (Tongco 2007). In this study, a few measures were taken to guarantee reliability, validity and quality and legitimacy to minimize bias (Polit et al 2001).

4.3.2.2 Recruitment Strategy

Following ethical clearance, the researcher had support and access to recruit participants. The researcher had a meeting with the Director of the research department to describe the purpose and aims of the study and the data collection process. Authorization was given to access the units and approach participants. A memorandum was also sent to the nurse managers and educators to inform them about the research. In the preparation process to access the field, the researcher conducted two presentations for the nurse managers and clinical resource nurses from the participating units. The duration of each presentation was 40 minutes. The reason for the presentations was to outline the purpose and significance of the research as well as the research process, and to assist the researcher to access their units. The audience acknowledged the significance of the research and they were keen to support the study. The researcher accessed the lists of nurses working across the hospital.

The total number of the population in these units was 360 nurses. The novice nurses who had less than three months ‘experience at SBAHC were excluded because they were still in the probationary period and do not have enough exposure to working in KSA; therefore, the number was reduced to 321 nurses who meets the inclusion criteria.

4.3.2.3 Data Collection and Instrument

The objectives and research questions determine the nature and the scope of the data needed to be collected. In this research, the objectives and research questions called for data to be collected on a range of concepts including WRS, sources of stress (stressors), stress levels, impact of WRS and WRS moderators.

The most probable source of bias likely to influence this study was common method bias which arises because of the way that the criterion variables are obtained from the same individual (Podsakoff et al 2003). This can occur when participants responding to inquiries posed by the researcher may have a tendency to look in depth and rational in their responses and may probe for similarities in the surveys asked to them-in this manner preparing relations that might not generally exist at the same level in real life settings. This 'consistency effect' is liable to happen when respondents are accommodated to give review records of their personality and recognition (Podsakoff et al 2003). With a specific end goal to decrease the impact of response pattern biases, measures were utilized that had distinctive scale response formats (never/occasionally to well/very well) and converse coded items were incorporated.

The key prerequisite for reliable and valid measurement was addressed by selecting study instruments which were considered to have satisfactory psychometric properties, and which could be relied onto generate solid, valid and substantial results for utilization with immigrant nurses. The choice of a reliable and generally acknowledged instrument

to measure the study model's variable (WRS), was recognized to be vital for the present study, particularly since one of the researcher's points was to build the level of WRS around a sample of immigrant nurses working in KSA. The second prerequisite relevant to the choice of instruments was a clear organization process, simply- worded guidelines, and easily comprehensible survey items. This was accomplished by picking instruments that had been particularly designed to meet these necessities.

As all the study tools had originally been developed in western nations, an attempt was made during the pilot stage by exploring input from respondents and work colleagues, to check whether these instruments were significant to immigrant nurses in KSA. A pilot study was conducted with twenty nurses to cover all nursing units in different specialities to determine the clarity of questions, effectiveness of instructions, completeness of response sets, time required to complete the questionnaire and success of data collection technique. Pilot subjects were asked to comment on the applicability and appropriateness (validity) of the questionnaire to the KSA context. The results indicated that the tools appeared to be appropriate to meet the research questions. All questions were answered, no clarity of questions was required. The researcher determined that it would take an average of twenty-five (25) minutes to complete the questionnaire. In addition, the members under examination were all immigrant nurses, and had previously worked in western standard healthcare facilities like SBAHC. At the end of every survey, a free content section was included for the respondents to include extra remarks, which were analysed and reported in the final result.

The semi structured interviews provided a rich, personal account of immigrant nurses experiences of living and working in Saudi Arabia. A second consideration for using semi structured interview data was to corroborate or validate the quantitative data and assess the relationship of constructs to the theoretical framework.

For the purpose of this research, four questionnaires were used. In addition to these questionnaires; a further questionnaire was used to collate demographic and specialised types of information from the research sample. These variables included: gender, age, educations and knowledge, nationality, experience, speciality, marital status, shift patterns and overtime work.

4.3.2.3.1 Work-Related Stress

The expanded nurses stress scale (ENSS) was used (Appendix D) to measure the independent variable of work stress. The ENSS is an expanded and updated revision of the classic Nursing Stress Scale (NSS) developed by Gray-Toft and Anderson (1981b). The NSS was the first instrument to target nursing stress rather than general job stress. The original 34 items of the NSS measured the frequency and major sources of stress in patient care situations.

There have been major changes in healthcare delivery and the work environment of nurses since the development of the NSS which stimulated French et al (2000) to identify stressful situations that were not reflected in the NSS and develop an expanded version useful for diverse work settings. First, focus groups in Canada comprising registered nurses (RNs) and

licensed practical nurses (LPNs) from diverse work settings identified 20 stressful situations not included in the NSS. Secondly, a survey of 18 RNS and 18 LPNs used the NSS to test the 20 additional items. The survey contained open-ended questions to identify further stressful situations. In all, 25 additional stressful situations were reviewed to determine a conceptual fit with the original seven scales of the NSS. Of the 25 additional stressors identified, 14 showed a conceptual fit with five of the seven original NSS subscale; three were grouped in a new subscale reflecting discrimination in the workplace, and eight were grouped into a new subscale concerning patients and families. The researchers then tested the 57 item ENSS in a larger sample (*N*=2 280) after which two items were removed from the instrument. The completed ENSS contained 57 items in nine subscales: (a) Death and Dying, (b) Conflict with Physicians, (c) Inadequate Emotional Preparation, (e) Problems Relating to Peers, (f) Problems Relating to Supervisors, (g) Work Load, (h) Uncertainty Concerning Treatment, (i) Patients and their Families, and (j) Discrimination. The 57 items were arranged in a five-point Likert scale. The responses options were 'never stressful' (1), 'occasionally stressful' (2), 'frequently stressful' (3), 'extremely stressful' (4), and 'does not apply' (5) (French et al 2000). Internal consistency reliability was assessed using Cronbach's coefficient alpha.

The 57-item ENSS demonstrated improved reliability (α=0.96) (French et al 2000) over the original NSS (α=0.89) (Gray-Toft and Anderson 1981b). Individual subscale reliability ranged from α=0.88 (problems with supervisors) to α=0.65 (discrimination). Factor analysis for 'discrimination' showed that the items on sexual discrimination accounted for more variance than did the one item on ethnic discrimination.

The ENSS developers recommended that the discrimination items be used only as separate measures of stress until further instrument testing could be performed (French et al 2000). Discrimination validity of the ENSS was examined by computing Product Moment Correlations with overall Life Stress (r=0.17, p<0.001 [one-tailed test]) and Health Problems Index (r=0.34, p<0.01 [two-tailed test]) (French et al 2000).

Construct validity was assessed through correlating the subscales to measures of health problems. Correlation fell between 0.12 and 0.34 providing evidence construct validity (French et al 2000). Construct validity was also tested through testing the correlations between the subscales and one question measuring overall life stress. Although the correlations ranged from 0.07 to 0.17, they were significant and in the hypothesized direction given evidence of the concurrent validity (French et al 2000).

The ENSS was designed in a simple and understandable English language form and as all staff members working at the research setting speak and write English fluently, there was no need to translate the original questionnaires into the respondents' respective dialects. One of the criteria from the human resource department is that all prospective hired expatriate staff must take an English language test. Only those that pass the test are processed for hiring.

A key reason for choosing the ENSS as a quantitative measure of WRS among immigrant nurses is that not only does the scale measure WRS generally, but also different subscales of the phenomena under study, which best describes the researcher's perception of the theories on

WRS.

Nursing studies which have used the ENSS, including Williams and Hajistavropoulos (2015), Andal (2006), Masamura (2006) Harris et al (2006) and Shepley et al (2008) have found a statistically significant relationship among RNs who had negative perceptions of the physical work environment. Perception of the physical environment was positively related to job satisfaction in bivariate analysis.

French et al recommended further research in larger samples using this expanded and updated version of the older NSS. Although the ENSS showed reliability in different studies, the scale has been criticized for the potential of the subscales to not reflect other stressors that affect specialty areas. Continuing research in specific areas of job stress was recommended to be applied in different specialty areas (Andal 2006).

4.3.2.3.2 Job Performance

Job performance was measured by utilizing the Schwirian Six Dimension Scale of Nursing Performance developed by Patricia Schwirian (Schwirian 1978) (Appendix E). The scale was developed and tested from 1974 to 1977 and has high reliability (Schwirian 1978). It consists of a list of nursing activities that nurses engage in at different degrees of frequency and quality. The scale was chosen for its ability to evaluate the quality of performance and developmental patterns of immigrant nurses over the first one to two years of practice. The scale can be broken into subscales to determine six subcategories of nursing performance, which

are: leadership; critical care; teaching/collaboration; planning/evaluation; interpersonal relations/communication; and professional development (Appendix XXX). Schwirian (1978) states, “The Six-D Scale is a useful instrument for the development of a substantive body of valid information regarding the most effective means of preparing, organizing, and evaluating performance of nurse graduates in administering the highest quality of nursing care.” (p351).

In this study, this measure consisted of a 52-item rating scale, where 1 indicated “not very well” 2 indicated “satisfactory”, 3 indicated “well”, 4 indicated “very well”, and X indicated “not expected in my job”.

The intent of the study was to measure job performance subjectively. The rationale for choosing this approach was based on the belief of the researcher that the participant was in the best position to evaluate his/her performance, especially when he/she was reassured that the results were confidential. In addition, since job stress and other variables in the study were also measured subjectively, obtaining data about all the variables from the same participant might be more reliable. Furthermore, objective and subjective performance are not completely unrelated (Hoffman et al 1991; Alexander and Wilkins 1982). In a review of the literature, Cable and DeRue (2002) suggest that subjective performance might be a more valid measure of performance than has been generally claimed.

McCloskey and McCain (1988) compared four sets of performance data from two studies conducted in 1983 and 1987 in which the Schwirian Six Dimension Scale of Nursing Performance was used. The findings concerning

relationships between subjective self-ratings of performance and ratings by their head nurses indicated “remarkable agreement on the skills that nurses perform well and those that need improvement” (p308). The Spearman rank correlations between head nurse ranking of staff nurses’ performance and the staff nurses’ own ranking were 0.787 for the 1987 data and 0.823 for the 1983 data.

The Six-D Scale was piloted by Schwirian (1978) and tested on a small group of recently graduated RNs that worked in a local hospital based on requirements from the US Department of Health, Education, and Welfare (Schwirian 1978). Construct validity was established through collaboration of developers, consultants, and pilot respondents. Reliability was established using Cronbech’s alpha, with coefficients ranging 0.844 to 0.978 (Schwirian 1978). The behaviours included in the scale were representative of what the School of Nursing faculty members deemed as “effective nursing performance” and a “successful nurse” (Schwirian 1978). The scale initially comprised 76 items that were then decreased to 52 items, deleting items that were least useful in determining nursing performance. Schwirian (1978) states, “The uniformly high reliability values of the Six-D subscales attest to their potential utility for assessing nursing performance” (p350).

The reported Cronbach’s alpha for each of the subscales was 0.75 for leadership, 0.82 for teaching/collaboration, 0.88 for planning/evaluation, 0.80 for interpersonal relations/communications, and 0.86 for professional development. McCloskey (1983) found test-retest reliability coefficients for an interval of three weeks to be 0.77 (self-rating) and 0.97 (head nurse rating) and found the inter-rater

reliability of head nurses with their assistant head nurses to be 0.89 for the total scale.

Meretoja and Leino-Kilpi (2001), when reviewing instruments for measuring nurse competence, reported that repeated use of instruments was limited. At the time of their review eleven instruments were in their early stage, and only one instrument, the Six-Dimension Scale of Nurse Performance, was reported as used repeatedly (Meretoja and Leino-Kilpi 2001).

Although the tool was developed to self-assess performance, the authors suggest that it may be used by employers or educators to appraise performance. Since then the scale has also been tested for validity and reliability in other studies (Bartlett et al 2000; AbuAlrub 2004).

4.3.2.3.3 Intent to Stay

The McCain Behavioral Commitment Scale (McClosky 1990) was used (Appendix F). This is a commonly used tool to help determine the factors affecting nurses' intent to stay within the hospital setting. WRS plays a key role in the retention of nurses within the hospital setting: retention is defined as the commitment of the nurse to stay in their current position.

The McCain's Behavioural Commitment Scale utilizes questions about the employee's intent to remain in the present job as a measure of behavioural commitment. The dependent variable of intent to leave employment is an internal perception of the probability that the nurse will terminate employment with the organization (Price and

Mueller 1981). It refers to individual perception rather than behaviour and is seen as a contemplative stage linking the attitudinal component of job satisfaction with the behavioural component of turnover (Alexander et al 1998). Intent to stay and commitment are separate, though related concepts used by some researchers. These imply positive characteristics that are inversely related to turnover (Blegen 1993; Taunton et al 1997; Cowden and Cummings 2015).

This parameter was also measured using a five-point Likert scale with five items focussing on organizational commitment as being both an attitude and behaviour; the scale ranged from 1 indicating “strongly disagree” to5 indicating “strongly agree”. The overall alpha was reported as 0.88 (McCloskey and McCain 1990). Organizational commitment has been defined as an attitude and a behaviour. According to McCain, behavioural commitment is a function of the things people do, or are prevented from doing.

The content validity of the McCain’s Behavioural Commitment Scale was based on the literature and the judgment of a panel of experts. Test-retest reliability with a sample of 59 nurses resulted in a correlation of 0.77. Integration measured at two different times resulted in alpha coefficients of 0.75.

4.3.2.3.4 Social Support

Social Support has been defined as the product of interpersonal work relationships that has the feasibility to promote the well-being or coping abilities of the recipient (Hobfoll and Vaux 1993). It was measured using McCain and Marklin social integration scale (McCloskey1990) (Appendix

G). The scale consists of eight items that are rated on five-point scale, where 1 indicates “strongly disagree” 2 indicates “disagree”, 3 indicates “undecided”, 4 indicates “agree” and 5 indicates “strongly agree”. The eight items measure the social support provided by work colleagues.

The McCain and Marklin scale was created for a 1990 study evaluating job contentment and has consistently proven reliability with an alpha co-efficient above 0.70 (McCloskey 1990; Abu Alrub 2004 and 2006). The test-retest reliability of the social integration scale was reported by McCloskey in 1990 as 0.77. The alpha coefficients for the scale at two different times of six months apart were 0.75 and 0.72. Content validity was established by literature review and panel of experts.

After reviewing the relevant literature, existing instruments were selected and questionnaires were designed to ensure that they closely fitted the conceptual definition of the variables, and were valid and reliable.

4.3.2.4 Theoretical Measures for the Job Demand, Job Control and Social Support Measures

In order to further test the theoretical measures for the JDCS model, all variable selected were based on questions taken from the ENSS questionnaire developed by Gray-Toft and Anderson (1981b), McCain and Marklin social integration scale (McCloskey1990) and the Schwirian Six Dimension Scale of Nursing Performance developed by Patricia Schwirian (Schwirian 1978).

The Workload scale of the Sources of Work Stress from the ENSS questionnaire was used to operationalise job demands. The scale consists of seven items where immigrant nurses is asked to indicate the degree to which his or her workload is a source of work stress for him or her. Sample items are all the variables measuring the seven job demands variables that got selected from the ENSS questionnaire “not enough time to provide emotional support to patient, unpredictable staffing and scheduling, breakdown of computer, not enough time to complete all my nursing tasks, floating to other units that are short-staffed, and too many non-nursing tasks required such as clerical work”. This scale measures the workload and time pressure components of the job demands dimension of the JDCS model.

The Lack of Autonomy scale of the Schwirian Six Dimension Scale of Nursing Performance was used to operationalise job control. The scale consists of eight items that provide an indication of the degree to which an individual feels that he or she is limited in their ability to function autonomously, whether it be due to constraints imposed on them by the actual work environment, or by the nature of their job. The scale measures the decision authority component, which Wall et al. (1996) have described as the central aspect of job control.
Varible items includes “assume new responsibilities within the limits of capabilities, accept responsibility for own actions, display self-direction, guide other healthcare members in planning for care, accept responsibilities for the level of care provided by those under your direction, being able to communicate feeling of acceptance of each patient and a concern for patient welfare, seek assistance when necessary and being able to delegate responsibilities based on assessment of priorities of nursing care needs”

The third independent variable, s*ocial support*, was measured using all eight items derived from McCain and Marklin social integration scale (McCloskey1990). Sample items are: “I feel comfortable with my co-workers, and can talk to them easily about personal matters” and “I am able to turn to my co-workers when I need help on the job”.

4.3.2.5 Reliability of the Questionnaires Utilized in the Study

Validity is “the extent to which scores on a measure relate to scores on other measures” (Cone and Foster 2003, p156). Different categories of validity (such as construct and convergent) depend on the subject matter under investigation. Creswell (2002) noted, “Reliability means that individual scores from an instrument should be nearly the same or stable on repeated administrations of the instrument, they should be free from sources of measurement error, and they should be consistent.” (p180).

The Cronbach alpha test for internal consistency was performed to assess the reliability of the WRS (ENSS), job performance (SSDPSNP), intention to stay (MBCS), and social support (MMSI) questionnaires. Table 4.3 presents the results of the reliability test for the ENSS scale and each of its subscales and compares the results with those of Gary-Toft and Anderson’s (1981) study. The results of the Cronbach alpha test showed a high reliability of the ENSS used in the present study (0.96). The coefficients for the subscales in the present study were almost equal to (workload, death and dying) or higher than the coefficient alphas reported by Gray-Toft and Anderson (1981).

Table 4.1 Comparison of the Alpha Coefficients of the Nursing Stress Subscales for the Present Study and the Study of Gray-Toft and Anderson (1981).

ENSS Subscales	Alpha Coefficients for the Current Study	Alpha Coefficients for the Gray-Toft & Anderson (1981) Study
Workload	0.88	**0.77**
Inadequate Preparation	0.74	**0.75**
Death and Dying	0.80	**0.77**
Uncertainty over treatment	0.88	**0.80**
Conflict with Physicians	0.80	**0.68**
Conflict with other Nurses	0.88	**0.68**
Lack of Support	0.85	**0.64**
Overall Scale	0.96	**0.89**

To ascertain the internal consistency and reliability of the Schwirian Six Dimension Performance Scale of Nursing Performance (SSDPSNP), the reliability of the whole scale and its six subscales and were compared to those reported by Schwirian (1978). Table 4.4 shows the results of the analysis and comparison. The coefficient alpha for the whole scale was high (0.95) in the present study.

Table 4.2 Comparison of Alpha Coefficients of the Schwirian Six Dimension Scale of Nursing Performance for Staff Nurses for the Present Study and for the Schwirian (1978) Study.

Schwirian Subscales	Alpha Coefficients for the Present Study	Alpha Coefficients for the Schwirian (1978) Study
Leadership	0.70	**0.77**
Interpersonal Relations and Communication	0.82	**0.75**
Professional Development	0.92	**0.77**
Critical Care	0.78	**0.80**
Planning and Evaluation	0.72	**0.68**
Teaching and Collaboration	0.83	**0.68**
Overall Scale	0.95	**0.89**

Reliability of the Intention to Stay Scale [McCain Behavioural Commitment Scale (MBCS)] by McCloskey (1990) reported a Cronbach's α of 0.88 for this scale. The coefficient alpha for the scale was very high (0.78) in the present study. The tool was reported to have face and content validity.

Reliability and internal consistency of the Social Support Scale [McCain and Marklin Social Integration Scale (MMSI) (McCloskey 1990)] was performed. The coefficient alpha for the scale was very high (0.70) in the present study. The test re-test reliability reported by McCloskey in 1990 was 0.77.

4.3.2.6 Procedure

Quantitative and qualitative date collection was concurrent; data was collected in February 2011. Data collection is the process of gathering information from different sources to answer research questions (Creswell 2002, p11). The use of multiple data sources in this study is indicative of the complex situation faced by immigrant nurses in KSA. Data was collected from a demographic survey, four instruments focusing on nurses' perceptions (of WRS, intention to stay, job performance and social support) and semi structured interviews that focused on WRS.

Over a three weeks' period, all immigrant nurses meeting the criteria for the study (n=321) were sent a sealed envelope containing a letter of introduction, an information sheet which described the study and the study questionnaires. Distribution of the surveys was by internal mail, through the nursing office. When the surveys were completed, the immigrant nurses placed them in a plain envelope and dropped the envelope in a locked box in the designated office. Participants were free to withdraw from the study at any time.

4.3.2.7 Data Analysis

The quantitative data from the study was investigated utilizing the Social Package Sciences System (SPSS) form 16 for Windows. Preceding the primary investigation, the frequencies of all variables were analysed to survey the exactness of information entrance and missing qualities. Unvaried missing information for the study variables ranged from 1% to 2.1% Subscale scores were computed for respondents who addressed the larger part of things in every

subscale. The dispersion of the dependent variables was additionally analysed to guarantee the suppositions for linear regression models.

Multiple regression examinations were directed on the dependent variables independently to figure out which demographic variables were prescient for every dependent variable. Categorical demographic variables were changed over into dichotomous dummy variables and those in which 90 percent or a greater amount of the respondents fell into the same dichotomous category were not included (Tabachnick and Fiedell 2007). This excluded the gender and shift worked. Any variable that was significant in anticipating the dependent variable at more or equivalent 0.005 was held.

Percentages and frequencies were additionally used to depict standard information on knowledge, standard deviations and extents were ascertained for consistent variables before performing inferential statistics; t-test and ANOVA examination were additionally utilized.

With a specific end goal to investigate the connections between variables WRS, job performance, intention to stay and social support, a non-experimental approach was adopted. The buffering impact of social support on WRS, performance and intent to stay was likewise researched.

Non-experimental research is a procedure of systemic observational request in which the immediate control of autonomous variables does not exist, in light of the fact that they are intrinsically not equipped for being controlled (Kerlinger and Lee 2000), for example, the constructs measured in this study. Relational research tries to figure out

how two or more variables are identified with one another (Elmes et al 1999). Normally, social research does not include control of variables, as do experiments, so the information that is connected is frequently called ex post facto information. Kerlinger and Lee (2000) expressed that there are three shortcomings of non-experimental research: (1) the powerlessness to control free variables, (2) the absence of force to randomize and (3) the danger of improper translation. Given these shortcomings, it was further noted that in the fields of psychology research, social science and education, non-experimental research designs are needed in light of the fact that significant examination of the issues within these subjects did not prompt experimental enquiry. Studies in these subjects lead transcendently to a controlled enquiry of a non-experimental kind (Kerlinger and Lee 2000).

To achieve the end goal of this study, correlational, descriptive, multivariate and explorative research as a sort of graphic social and explorative examination was utilized, as it permits the researcher to at the same time focus the degree and bearing of the relationship between dependent and independent variables.

The objective of correlational research is to base the aberrant nature of the relationship in information permitting the researcher to equitably build variables that are nearly partnered and affecting of one another. Additional benefits of correlational studies are the way they might be utilized to investigate issues that can't be analysed with experimental methods. Furthermore, correlational research permits the researcher to focus the level of the relationship between the variables under study. The primary down-side is that it can't

be utilized to show circumstances and connections of end results between variables (Tabachnik and Fidel 1996).

4.3.3 Qualitative Methods

As highlighted earlier in this research, within qualitative research, data takes the form of words rather than numbers. During analysis, these data are reduced to themes, then categorized and evaluated subjectively. Researchers can be more flexible when exploring phenomena in their natural setting instead of being restricted to a moderately narrow group of behaviours. There is more accentuation on description and discovery; researchers look for a mentally rich, in-profundity understanding of the individual. The relationship between researcher and the object of the study is closed. Ralphet al (2002) argued that they used a qualitative approach method for their research because it provides rich descriptions and explanations of the situational influences; it is based on words not numbers. Qualitative research methodology also reflects the result from the sample's viewpoint, not from the researcher's viewpoint.

According to Gall and Borg (1999), adopting the qualitative approach is appropriate for theory development, defining important variables, hypothesis generation, organizational structures and problems and studying new phenomena.

There are many types of methods that can be applied when using this approach, such as case study, interview, group discussion exchange, member perception, documents and records analysis. The main advantages for using qualitative research methods are identifying and clarifying specific responses, especially those related to the attitudes and

behaviour of the respondents, and acquiring an in-depth understanding their organizational climate. In addition, qualitative methods help to gain more insights into people and their situations and help the respondents to think about their own world and consider the way they construct their reality (Borg and Gall 1989). For the purpose of this study, the case study methodological approach has been selected. The following section will explore further the rational for using it.

4.3.3.1 Sample and Recruitment

A purposive, non-probability sampling strategy was used to recruit immigrant nurses to participate in the interview. Purposive sampling is a qualitative sampling strategy which is used to sample people who have experience of the phenomenon under study. Participants are selected if they are considered to be knowledgeable about the phenomenon (Silverman 2009). Thus, eligibility criteria were determined that were essential to a purposive sampling strategy (Crewell 2003). A purposive sample of 20 qualified immigrant nurses was chosen. All consenting participants had been working at SBAHC for a minimum of three months, all had good English communication skills, and all are immigrants having received at least a diploma in nursing not less than three years before the time the study was conducted. The characteristics of participants, are detailed in chapter six.

This study divided the sample population into four groups based on their areas of experience. The first group consisted of five nurses working in the medical surgical units and spinal cord injury units. The second group had five nurses working in the emergency department, haemodialysis unit and

outpatient clinics. Five nurses working in the intensive care unit, paediatric unit and operation room made up the third group. The last group comprised five nurses working in the brain injury, women's health and stroke units.

Regarding the sample size for the qualitative component, the guiding principle for the sample size was completeness. Completeness refers to all the gained information that provides an overall sense of the meaning of a concept, theme and process and that adequately answers the study question (Schutt 2011). Thus, qualitative research focuses on gaining deep and rich information regardless of the number of participants (Jones 2002). Yelland et al (2016) contends that an adequate sample size in qualitative research of 90 is neither too large nor too small as long as it results in a new and richly textured understanding of experience (p153). In this study, the sample size was 20 immigrant nurses.

4.3.3.2 Data Collection

Interviewing is the most frequently used method of qualitative data collection.Yin(2009) asserts that the interview as data collection is considered one of the most important methods in case study research, because most case studies deal with human affairs; therefore, the information needs to be taken and interpreted through the eyes of the informants. Thus, semi-structured interview was used in this study to explore the multicultural immigrant nurses' experiences in terms of WRS, social support, intention to stay and job performance.

According to Merriam (2009), the semi-structured interview is used if the researcher wants to gain specific information from

the informants as it is guided by the issues being explored. Yin (2009) clarified that interviews are guided conversation rather than structured investigation, which means that the researcher will follow the line of inquiry and guide the conversation towards the problem under investigation. In this method, therefore, the researcher endeavours to cover a list of questions or issues that are fundamental to addressing the research question. There is flexibility concerning how to word the questions and they should be more open ended questions. The researcher is allowed to digress and probe, depending on the interaction during the interview. The researcher will continue to interview and probe until it is felt that no more data will be gained (Merriam, 2009). The strength of this interview method is that it allows the researcher to focus directly on the case study topic (Yin, 2009). In the present study, the interview content was influenced and framed by the underpinning conceptual framework of WRS. Written informed and signed consent (see appendix I) which explained the purpose of the study was required for participation in this study prior to starting the interview. The interviewer was given clear instructions to answer all questions asked by potential study participants prior to enrolling them once their eligibility was confirmed. The informed consent process in this study involved an explanation of the study's purposes and procedures, and anticipated risks and benefits. Consenting participants were informed that they could stop participation at any time without penalty, simply by notifying the researcher or the interviewer of their decision. Each participant was given a copy of the signed consent form to keep. Participants has been made aware that the interview will take between 40 and 60 minutes. Participants were given a deadline to return the signed consent form to participate in the study three days prior to the

scheduled interview. Prospective participants were given the proposed venue and the time of the interview.

There are three broad types of qualitative methods that have been used on WRS research. The most commonly used method has members of an occupational group such as nurses, describe in their own words, or in writing or orally, their individual work experience. This method was selected as it best fitted the purpose of the study. Many WRS studies have employed this method (Iwasaki et al 2004; Thelwell et al 2007). The researcher requested the nurses to describe in their own words the working conditions and their feelings in relation to working in a diverse working environment; this was not constrained to fit the response alternative found in questionnaires, the stock-in trade of quantitatively oriented, WRS investigators (Irvin et al 2010). The two other types of qualitative research methods involve investigators who situate themselves in the workplace observing workers on the job, and participant observation where the researcher works at the kind of job he or she intends to study and describes elements of the phenomenon being investigated.

The selection of the co-researcher for this study followed the guidelines set forth by Moustakas (1994) who identified several criteria essential for interviewer to possess so that meaningful information would be presented in the interview. The following five criteria were said to be essential: experience with the phenomenon under investigation, considerable interest in understanding the meaning of his or her own experience, an ability to articulate that experience in a detailed and meaningful way, an agreement to participate in a tape-recorded interview and agreement to the possible publication of the investigator's research data. To be

selected, co-researchers must acknowledge and agree to these criteria.

A semi-structured interview guide was developed with the help of my supervisor at the Nottingham University. Key findings in the literature of work stress in nursing, job performance, social support and intention to stay among nurses were used in the development of the questions. The questions were developed through an iterative process that involved returning to the literature and consulting with the nursing experts on several occasions.

In all questions developed. In the interview, they progressed from nonthreatening questions of general invitation whereby the interviewee could become comfortable with the process to more specific questions. The questions did not encourage particular response, no leading questions or prompts questions were used (e.g. do you have too much work?). Questions used early in the interview began as follows, “Explain to me about….” Questions at the mid-point of the interview focused on stress, while questions near the end of the interview asked about feeling for leaving there beloved one, family and colleagues back home, and if this have any effect on them. This order of questions was used to establish trust and comfort with sharing, while also ensuring that topics central to the study were explored.

Participants were interviewed individually and face to face. The advantage of interviewing participants face to face is that it allows the researcher to capture verbal and non-verbal responses and through facial expressions and other body language the researcher can detect if the participant experiences any discomfort, or stress (Leedy and Ormrod,

2005). A suitable office environment was provided for the participants in order to make them feel comfortable, to ensure privacy and to minimize any opportunity for interruptions. Appointments for the scheduled interviewees were planned with the immigrant nurses; one interview was planned every regular normal working day. Participants were on day shift duty on the day of the interview to avoid having to come to the work area during their days off. Their managers were told about the scheduled interview to arrange appropriate coverage of patients' needs. The interview took an average of 40 to 60 minutes to complete, depend on participant's response, too short interview will not be able to gain enough information to cover subject under study, and longer than 60 minutes will result in participants losing interest, which impact the interview quality.

The interviews in this study consisted of the process of interview, interview recordings and memoranda, and transcription. A semi-structured interview guide (Appendix B) was used in this study to ensure that each participant was asked the same questions. Time spent in collection of the demographic data (Appendix B) helped the interviewer establish a good level of rapport with the participants, which helped facilitate candour on the part of participants. The interviewer made every effort to maintain a neutral attitude with non-judgmental verbal and non-verbal behaviours. Collection of the demographic data started after the consent form was signed and a copy of the signed form was given to participant. The interviews were audio recorded to ensure accuracy in data collection, and the tape recorder was placed in full view of the participants.

It is essential that the techniques researchers utilize to collect data allows them to gain information which are useful to their study. To ensure this, the interview guide used in this study was tested in a pilot study and revised. Mr X is the co-researcher, a colleague, was initially recruited to conduct pilot interviews for this study. The aim for the pilot interviews was to pre-test the appropriateness of responses. After orienting Mr X to the background of the study, two immigrant nurses working at SBAHC were chosen for the pilot interview sessions. Data collected during the interviews were recorded on an audio tape and transcribed. Participants were told about the nature of the interview, which participation was voluntary and they were assured of confidentiality. From these interviews, the importance of asking for specific and significant work-related examples to solicit rich descriptions of processes underlying the use of the semi-structured interview approach was learned. At the same time, two questions were found to be distracting, so appropriate changes were made.

Although the interview guide ensured that each participant was asked the same questions, Mr X was instructed to adopt a flexible process that facilitated narrative conversation (Kvale 1966) and encouraged the participants to speak freely, using their own words in response to questions asked. The following are sample questions from the interview guide: (1) Describe to me in your own words the stress that you may encounter as a nurse in your current job (2) Tell me about the ways in which stress influences your work performance and your patients (3) Tell me about the level of WRS you encounter as a nurse in your current job. The detailed and complete interview guide is found in Appendix (B). In order to determine whether the participants experienced

WRS/stressors, their awareness of emotional or physical responses to stress in the past three months (e.g., sleep deprivation, anxiety, a tight stomach, absenteeism) was considered as a meaningful indicator. The extent to which the stress impacted was not addressed in screening; the fact that if the employee described having experienced a physical or emotional reaction to what they perceived as a stressful event was sufficient for their account to be considered a meaningful example of work stress (Lazarus and Folkman 1984; Kabat-Zinn 1990; Bora et al 2015; Zhang and Zyphur 2015).

Writing field notes helped the researcher recall the participants' dialogue or actions, which could be extended to include the 'reflexive validity', and affect the focus and direction of data collection (Waterman 1998). Thus, Mr X kept writing field notes or diaries to reflect on the process of research and facilitate documenting issues of major or minor significance that he had faced during the interview.

The collection and interpretation of the transcribed interviews was influenced by the researcher's own experiences and exposure to WRS. Therefore, it was crucial to be aware of the personal values and assumptions brought to this study. The understanding of WRS was improved by experiences with insight.

To ensure accuracy of all recordings, the first two interviews were listened to before continuing the interviews with the rest of the participants. Furthermore, each transcript was reviewed for accuracy by simultaneously listening to the tape and reading transcripts. In addition to the participants' narratives, the researcher's own experiences as an immigrant nurse were other sources of data in this case study of

practice. These experiential data were also analysed as the conduct of the study was processed. The personal experiences of the researcher described the reactions to the events that took place before and during the study.

The language choice in this dissertation, in presenting the data gathered and analyses, was personal and informal to characterize logical, positivist research reports. The personal voice is an acknowledgment that the researcher is a participant in the case being studied, that he made choices in the course of the research that would have influenced what data were collected and reported, or not collected, and that the explanation that was finally offered was one that was unavoidably influenced to some extent by his own worldviews (Erlandson et al 1993; Hutchinson and Johnston 2004).

4.3.3.3 Data Analysis

The study involved the implementation of quantitative and qualitative data analysis methods to analyse the data. The dependent variables were hospital characteristics (job performance, intention to stay, social support) and WRS. The independent variables included a subset of demographic data and work environment variables.

To explore and better understand the qualitative data obtained from the semi-structured interviews, a thematic data analysis was conducted (Braun and Clarke 2006). The semi-structured interview information was transcribed and summarised. Evolving themes were acknowledged across all participant immigrant nurses. The aim was to highlight possible matches or discrepancies in participants' opinions

and viewpoints of the topics being considered. Patterns, relations, ideas, and clarifications in the information were acknowledged and understood. More information is presented in the relevant chapters.

The interviews were transcribed verbatim by the researcher, which helped to immerse him in the text and gain familiarity with employee's language, and ability to use "in-vivo" codes. To be sure that the transcriptions were accurate, the transcripts were read a number of times before beginning analysis and any potential errors were cross referenced with the audio recordings. Interview text was managed using manual techniques.

Data were analysed according to a phenomenological psychological method developed by Giorgi (1985) and deemed appropriate for use with studies conducted as a phenomenology of practice (Van Manen 2002). The four essential steps of the Giorgi method, used in the analysis of this study's data, are described in the following paragraph. The first step of data analysis involved the reading and re-reading of each transcript by the investigator in order to get a general sense of the whole story or reflection presented by each participant. Next, the researcher read through the data a third time and marked those places in the narratives where a transition in meaning occurred, from a psychological perspective, and identified these as the 'meaning units'.

All similar meaning units identified throughout the data from the entire study group were then gathered together and labelled with terms that represented the various clusters of psychological insights being expressed at each level of abstraction. Also during this third step of Giorgi's process,

inductive logic was used to order the meanings and insights into themes and conceptual categories that best represented the subjective reflections described by the participants. Finally, in the fourth step, the researcher synthesized all of the transformed meaning units (themes and conceptual categories) into consistent statements that communicated the shared insights about the meaningful experiences the study group revealed.

While reading the transcripts, identified transitions in meanings were marked as meaning units. Specifically, when one of the female participants reflected upon her expectations of coming to the KSA, she revealed that she thought it might be stressful. However, when she actually arrived here to live and work, she became aware of the reality that what she anticipated was indeed real and the reality was actually more stressful than her pre-arrival expectations. She said, “I knew that it would be stressful. But nobody really told me personally that it is this stressful!”

The transition from her perceptions to reality was identified and marked as a meaning unit by the investigator. All similar meaning units revealed by many participants about life, stress and work in the KSA being ‘hard”, “harder than they thought”, “stressful”, “discrimination” or “fair”, were similarly marked in each transcript, aggregated and transferred into a separate document and labelled using direct expressions or words of the participants in order to stay close to the data.

In the previous example, the meaning unit “it was stressful” was identified as a transition, labelled using the direct expression, “it was stressful”, and entered into Codebook I as a meaning unit. Expressions of similar meanings throughout

the entire study group were identified, labelled, and added to the ‘it was stressful’ meaning unit. After intensive examination of all similar expressions clustered into the ‘it was stressful’ meaning unit, and a comparison of them with other direct psychological expressions of difficulties the expatriate nurses met with, inductive reasoning yielded a larger, more complex and parsimonious awareness of many things that expatriate nurses described as being “stressful”. This re-organization or re-coding of previously isolated meaning units of “stress” things into larger, more abstract clusters was recorded in Codebook II. For example, the more abstract clusters of the different types of “stress” experiences described and expressed by the expatriate nurses were organized and were labelled “reality was more stressful than the dream”, which gave a unified context to the internal psychological meanings expressed by each participant. This process continued until all psychological expressions of what the expatriate nurses found “stressful” in their experiences were exhausted: that is, until all were identified, aggregated, and labelled with the most appropriate terms.

In the next step, the groupings of “hard” things revealed in the reflections of the immigrant nurses and labelled accordingly as conceptual categories of psychological meanings were organized and displayed in Codebook III. At this point, specific verbatim descriptions taken from the transcripts were permanently affixed to the conceptual categories that emerged when individual and collective meanings collapsed to form these units of meanings. Movement of the researcher back and forth between the data and the conceptual categories that were emerging from them continued throughout all coding operations. Specifically, the researcher systematically went back and forth between each conceptual

category and the raw data to test for goodness of fit. Descriptions of data that no longer fitted the emerging context were moved or re-coded to conceptual categories that were more compatible in terms of consistency in meanings. This inductive exercise is closely related to the constant comparison strategy used in grounded theory methods. Determining the best-fit conceptual category for any expression of meaning often requires help from the investigator's free imaginative variation.

Together with the previous example, direct psychological expressions of immigrant nurses revealing that their realities were more stressful than their dreams fitted well within the conceptual category labelled 'Everything is more stressful than expected' This category label emerged from the collapse of all descriptions the expatriate nurses offered about finding life and work environment in the KSA more difficult than expected. At the beginning of the data analysis process, it might have seemed that separate categories were easy to identify. However, as inductive logic was applied to the organization of similar meanings so that abstraction permits theoretical efficiency, attention was focused on the avoidance of jumping to conclusions too early. As data analysis and reduction continued, the researcher focused closely on whether or not new conceptual categories were emerging.

In fact, expressions of meanings overlapped more often than expected among the stories of the study group, even though participants represented three different ethnic identities and came from three different homelands. Their experiences as expatriate nurses were amazingly similar and parallel, making it possible for all data to be analysed together rather than in separate aggregates. In the Final Codebook, conceptual

categories in which meanings were grouped were examined for logical interrelationships.

In the process of satisfying the existence of logical consistency, theme labels discerned through phenomenological intuition emerged for the clusters as described in the following example. The example conceptual category of “Everything is more stressful than expected”, along with the conceptual categories clustered with it because of similar psychological meanings, was subjected to a final analysis of theoretical consistency during which the emergent theme “A shocking reality” came to be as the label that unified collective meanings organized there. Thus, a thematic label is not the result of a "listing" of meanings expressed as conceptual categories, but is a representative “structure” which supports certain interrelationships among the concepts naively expressed by the subjects.

The determination of the essential categories and themes and their ultimate expressions remain subject to constant scrutiny and revision until the whole process of analysis is completed, when data saturation and redundancy are achieved (Lincoln & Guba 1985). In all these cases, the categories were tested against the descriptions or instances of data and vice versa.

4.4 Ethical Considerations

Ingleby and Oliver (2008) argued that the researcher needs to take research ethics into consideration on all points of the study, ranging from designing the research questions to interpreting the results and presenting the findings. Moreover, Wong and Nather (2015) argued that ethics should be one of the first areas taken into considerations when designing any research project and should continue through to the write-up and work field phase.

Behi and Nolan (1995) explained that these ethical considerations affect many aspects of the research design and process and help researchers decide whether the research study is ethically acceptable. Stang (2015) further argued that it is essential that researchers are not only familiar with the ethical guidelines, but are willing to implement these ethical considerations in the research whenever appropriate. He also added that it is crucial to discuss all the ethical considerations with the study participants. Therefore, before conducting a research study, there are some ethical considerations that researchers need to consider to protect the participants from any potential harm, to avoid any exploitation and to ensure no personal benefits are derived from the study. Respect and sensitivity were demonstrated toward participants (Polit and Beck 2004).

Privacy and confidentiality was respected throughout and the participants' information was not revealed. Participants were known to the researcher, as he works as a director of nursing to the same organisation. Privacy is violated if a participants' information is collected or revealed without their awareness. Protecting the privacy of participants has been gained by

assuring confidentiality. Confidentiality involves managing the participants' information in a way that keeps them unidentified (Behi and Nolan 1995; Bryman 2001; Langdridge 2003; Steane 2004; Creswell 2008; Ingleby and Oliver 2008; Stang 2015). The researcher preserved anonymity by assuring respondents' that information would be treated completely confidentially. Questionnaires were sent by internal mail from the relevant unit manager rather than from nursing office. The immigrant nurses were requested to put their completed questionnaire in an envelope provided for them. Lastly, when interpreting the findings, each interviewee or questionnaire was given a code, instead of being referred to by name. Coding allowed the researcher to assure anonymity and protect the respondents' privacy to eliminate identification. It also enabled the linking of information with responder and the comparing of findings from quantitative study to the findings of the qualitative study, as well as protecting data from outside access (Behi and Nolan 1995; Steane 2004; deMarrais and Lapan 2004). The only way of identifying respondents or the transcribed interview findings was to check the questionnaire code against the name list which was only available in a locked and password protected file in the researcher's computer. A further benefit of coding was to enable targeting of non-respondents for the questionnaires so as to save sending questionnaire reminders to all participants and as explained above, to compare findings of what participants said in the interview with what he/she filled in the questionnaire. This was made clear to the participants prior to completing the questionnaire or prior to the interview.

Ethical approval was secured from Research and Development Departments at SBAHC on 14th of February

2010 this was followed by permission from the University of Nottingham School of Nursing Midwifery and Physiotherapy Ethics Committee (old name before it changed). Approval was secured on the 17th of December 2010 under reference number MS06122010 (see appendix H).

As stated earlier, prior to conducting interviews, consent form was secured and signed prior to conducting the interviews, the co-researcher Mr X took the written informed consent. For the quantitative phase of the study, the return of completed questionnaires indicated approval and willingness to participate in the study. Information sheets were given to all participants.

Data that was stored in a computer accessible only to the researcher by means of a secure personalised log-in process. Only the researcher had access to the completed questionnaires in order to ensure confidentiality and protection of the participants (Data Protection Act 2010). All data gathered will be destroyed or deleted after five years of completing this study. The interview tapes, demographic data, assessment instruments, signed consent forms and transcripts were kept in a locked filing cabinet with access restricted only to the researcher. The tapes will be magnetically erased and destroyed upon completion of the research. Records that includes questionnaires, transcripts, and all personal data, with the exception of the tapes (as data tapes will be transcribed verbatim), will be kept for at least six years after the completion of the study as evidence to support the findings of the study as recommended by the European Code of Conduct for Research Integrity. The written research report and publication of findings will not contain the actual

names of the participants. The attribution of any quotes used will be altered so as to protect the identity of participants.

The role of the researcher that took precedence above all other roles was ensuring adherence to the ethical considerations stipulated by Nottingham University and SBAHC. The concept of beneficence adopted in the nursing school was considered: Above All, Do No Harm. Rossman and Rallis (1998) say that moral and ethical principles include privacy and confidentiality regarding the information shared with the researcher. Hence the participants in this study were viewed as the researcher's 'patients' whose interests must be protected. Consequently, they offered their insights and participated in the research; nevertheless, there was still an obligation on the researcher to tell the findings accurately. It is inappropriate to force specific words and findings to participants, all identifiable perspectives of the participants are delineated in the research, not just the ones that substantiate the research questions.

When examining the ethical background of the study, there was awareness of the possible vulnerability of the immigrant nurses. Their vulnerability could lead to exploitation, with immigrant nurses who agreed to participate in the research doing so because they felt obliged, or out of gratitude, or to please the researcher or because they thought that declining the request would affect their professional development path (Richards and Schwartz 2002; Lee and Kristjanson 2003). The researcher also debated on the tension between the risk of causing distress to immigrant nurses as a result of being interviewed (Seamark et al 2000; Takesaka et al 2004) versus giving them the opportunity to contribute to the research and to tell their stories (Kellehear 1998; Seamark et

al 2000; de Wit et al 2015). The conclusion was that every effort was made to ensure that participants had opportunities to decline or to withdraw and that they had not felt coerced into taking part at any stage in the research process.

SBAHC committed to the maintenance of high ethical standards in the research undertaken by its staff whether supported directly by the SBAHC or funded from external sources, and recognized its obligation to ensure that research undertaken under its auspices was conducted with appropriate standards, and conformed to generally accepted ethical principles. As a senior member of staff, it was the researcher's responsibility to maintain the ethical standards and research governance of SBAHC.

There were different ethical challenges that the researcher faced throughout the research process. Ethical challenges can arise at different stages of a research project. During each stage, researchers are confronted the tricky task of decreasing the effect of likely power imbalances between themselves and their co-researcher(s) (Greenfield 2010). The aim of this research was focused to move towards more collaborative, egalitarian, open relationships as opposed to exploitative, instrumental ones; understandings of the former are found in the fullness of the researcher's open relation (Heron 1997), hence the importance of engaging a mutual participation where "dialogue, parity and reciprocity" are threaded through all phases of research (Heron 1997).

It is important to note that it is not always possible to avoid a conflict of interest, and in itself, a conflict of interest is not necessarily wrong or unethical. What is important however, is to appropriately identify/disclose and effectively manage any

actual, perceived or potential conflict of interest situations, every effort made to avoid any influence on the data collected from the immigrant nurses that may be perceived as potentially vulnerable (Organization for Economic Co-Operation and Development (OECD) 2005).

In a rapidly-changing public sector environment, conflicts of interest will always be an issue for concern. A too-strict approach to control the exercise of private interests may be in conflict with other rights, or be unworkable or counter-productive in practice. Therefore, the issue of conflict-of-interest was identified in the context of this study's, and was discussed thoroughly with the head of the research department at the study setting and the researcher's supervisors at the university in order to seek to strike a balance. This involved identifying risks to the integrity of the organization, participants, university and public officials, prohibiting unacceptable forms of conflict, managing conflict situations appropriately, making organizations and individual officials aware of the incidence of such conflicts, and ensuring effective procedures were deployed for the identification, disclosure, management and resolution of conflict-of-interest situations (Minifie 2011).

Given the potential emotional and personal nature of the project and especially the researcher's position as a director of nursing at SBAHC, a member of nursing staff, Mr X, acted as an interviewer and undertook all the qualitative data collection alone, and Mr X was the only one present at the interviews (co-researcher). Mr X worked in the education department and had no management responsibilities, and so conducted the interviews to avoid any conflict of interest: he was given a rigorous orientation about the study prior to

commencing. This co-researcher holds a master's degree in Nursing and had experience in conducting research. Such strategies are regarded as a means for the researcher to attempt to decrease the status imbalance between themselves and their interviewee, and to position themselves as someone who can be considered equal in terms of situated knowledge.

Mr X was selected in specific due to the fact that he was known in regards to his knowledge in research, he is an immigrant nurse himself, and his honesty to questions and his ability to participate in discussion with the interviewee. The co-researcher selection was based on the discussion and decision made between the researcher and the supervisors, as it was decided that advantages outweigh the disadvantages if the researcher conducted the interview himself. As explained earlier, the co-researcher was provided with a guide interview sheet including the areas to be covered. Removing the researcher enabled the participants to feel more relaxed, think and reflect on their chosen answers, and possibly to come to terms with any emotions evoked, choosing when to talk and for how long at any time. For these co-researchers' interviews, can capture the cross-temporal relation between the present in which the participants are remembering and the remembered past, exploring how the past is made sense of in the present. The researcher of course, still guiding the research.

4.5 Quality of case study research

Three values which are vital to guiding high quality case study research are using multiple confirmation sources, creating a database and sustaining a chain of evidence. Obedience to these values rise the validity and reliability of case study findings. Triangulation in data gathering by using multiple data sources and methods allows the realization of a rich understanding of the phenomenon (Creswell 2003). As a result, triangulation of data enhances the findings and conclusions derived and can be more convincing and accurate. In this study, the researcher used multiple data sources, namely, the survey and interview, and multiple methods that included quantitative and qualitative methods.

Therefore, this case study design provides a very strong approach for gaining an in- depth understanding of the phenomenon, which would not be achieved by using a single data collection strategy.

The second principle in conducting high quality case study research is to create a case study database which organises and documents the collected data. The case study researcher should develop a formal database that can be available and retrievable for audit (Yin, 2009).

As the data in this study were collected by means of interview and surveys, each one is a component of the case study database. Yin (2009) states that case study notes must be classified in such a manner that the researcher or other persons can access them at a later date. To facilitate review of the documents, an electronic copy has been made and saved as a portable document format (PDF) in order to

minimise physical storage space. The survey materials have been sorted and saved in the computer file as part of the case study database. Yin (2009) recommended that the researcher make an annotated bibliography to facilitate storage and retrieval. The final principle adhered to, to increase the study reliability is to maintain the chain of evidence which will aid the reader (external observer) to follow the evidence process or trace the steps from the research question to the conclusion, or conversely, from the conclusion to the research question (Yin, 2009).

4.6 Validity and Reliability

The quality of case study research can be established by four common tests which include construct validity, internal validity, external validity and reliability (Yin, 2009).

These areas need to be addressed in this research. Construct validity is defined as the establishment of operational measures for the study concepts. Thus, in order to ensure construct validity in case study research, it is essential to use multiple sources of evidence (triangulation), to establish a chain of evidence and to have key informants review the draft report. These principles of construct validity were applied and maintained throughout the current study. As mentioned previously, the data were gathered from different sources (surveys, interviews and document review) using multiple methods. In addition, the study‘s steps and processes were clearly defined and explained to facilitate understanding of the research process. Within research, internal validity is usually used to establish a causal relationship between conditions and is mainly a concern for case studies with an

explanatory nature. Internal validity was enhanced in this study by using pattern matching.

External validity is related to the generalizability of the case study‘s findings to other domains. This can be enhanced by replicating this study in a multicultural immigrant nursing workforce and obtaining similar results.

Finally, reliability exists when ―the operations of a study such as data collection procedures can be repeated with the same result‖ (Yin, 2009). For instance, if the researcher documents the procedures in the study and another investigator repeats the same study, the later investigator will obtain the same results. The main objective of reliability is to minimise the risk of errors or bias.

4.7 Conclusions

This chapter outlined the research methodology that was used in this study, namely the case study. The philosophical perspectives in case study research were discussed, as case studies can be conducted from several epistemological perspectives, such as interpretivism and positivism. This research used mixed methods to investigate the WRS, job performance, social support and intention to stay among immigrant nurses at SBAHC in Riyadh, KSA, It is an exploratory. This chapter highlights and inspects the key drives of qualitative and quantitative approaches to the study of WRS, job performance, social support and intention to stay. Up until recent times, the concurrent use of both approaches has been viewed as critically conflicting, and this resulted in major gaps in inclusive research and understanding of the difficulties of psycho-social reality: the

effect of these questionable disadvantages has been the formation and growth of a “false dichotomy.” Therefore, qualitative researchers worked naively in a world apparently and imaginatively unlike that of quantitative researchers. Today, psycho-social studies and certainly WRS researchers are increasingly employing mixed method approaches and recognising the complementary benefits.

Chapter 5 discusses the findings and results of the mixed-method research study.

CHAPTER FIVE

QUANTITATIVE RESULTS AND DISCUSSIONS OF WRS, JOB PERFORMANCE,

SOCIAL SUPPORT AND INTENTION TO STAY AMONG IMMIGRANT NURSES IN KSA

5.1 Introduction

This chapter presents the results that form the empirical findings obtained from the quantitative method, namely, the WRS survey, job performance survey, social support survey and intention to stay survey also the discussion of the findings. There are two main statistical approaches to the quantitative data, namely descriptive statistics and inferential statistics. Descriptive statistics were used to analyse the characteristic variables of the study. Inferential statistics were used to investigate the differences between the groups in terms of the perception of WRS, job performance, social support and intention to stay at SBAHC. Thus, this chapter will address the response rate; descriptive statistics including frequency, mean and standard deviation; reliability and validity; normality test and inferential statistics.

5.2 Response Rate

The researcher adopted a structured approach for data collection in this phase of this study by gathering information from different sources (questionnaires) to answer research questions (Creswell 2002). Multiple sources of data explained the complexity of the immigrant's' situation in Saudi Arabia. The data included a demographic survey, one instrument on work stress, one instrument on social support and one

instrument on staff intent to stay in their current job. Data collection methods are an integral part of research design; proper choice will enhance the value of the research and should enable the researcher to achieve the research purposes.

Each participant in the main study was issued with a questionnaire package identified by his or her name on the envelope. The envelope contained an information letter, the four questionnaires and an empty envelope for the return of the completed questionnaire.

All questionnaires were sent through pre-addressed envelopes using the internal mailing system and were distributed to all nurses (n=321) who met the selection criteria. After two weeks 190 (59%) prospective non-respondents were identified using the codes that were used in the initial mailing list; reminders were sent for them to participate in the study, and after another two weeks 246 (76%) completed questionnaires were returned.

It was decided in this study to use questionnaires to explore immigrant nurses stress and other variables as explained earlier. The questionnaire surveys were disseminated to the immigrant nurses at SBAHC. Those nurses who have deeper knowledge about immigrant nurses stress, its sources, impact and adopted coping strategies are, more than other people, those who can best answer the questions being asked.

5.3 Findings

Quantitative results of the various analyses are presented in this section; summary of the results is presented after each measurement, for clarity and as a foundation for discussion in the next sections. The demographic data were analysed using descriptive statistics. Analysis of variance (ANOVA) and post-hoc comparisons were used to analyse the relationships between the demographic variables and the means for WRS (ENSS), job performance (SSDPSNP), Intention to stay (MBCS) and social support (MMSI). Regression analysis was used to test the effect of WRS, social support on job performance. Regression analysis to test the effect, also used on WRS, social support on the intention of nurses to stay at work. Demographic data were summarized in frequency tables. The correlation was examined using the Pearson correlation test.

5.3.1 Sample Description

This section details the demographic characteristics of the participating full-time nurses. A total of 321 invitation letters and questionnaires was placed in the nurses' mail boxes in the study setting. As explained earlier in this chapter, out of the 321 invitations, 246 participants (76.6%) completed and returned the questionnaires (complete questionnaires). 9 questionnaires that had a significant amount of missing data and were therefore excluded from the results presentation. The demographics of the sample are presented in table 5.1.

Table 5.1 Summary of Demographic Characteristics of the Study Sample (N=246)

Variable	Mean	Std. Deviation *(SD±)*
Years as a Nurse	10.0	6.9
Years Working At SBAHC	4.3	6.4
Variable	**Number**	**Percentage (%)**
Age		
20-25	32	13
26-30	47	19.1
31-35	73	29.7
36-40	51	20.7
41-45	21	8.5
46-50	12	4.9
Over 50	10	4
Gender		
Male	57	23
Female	189	77
Marital Status		
Married	143	58.1
Single	83	33.7
Divorced	4	1.6
Widow	3	1.2
Educational Level		
Diploma/Associate	68	27.6
Bachelor	158	67.5
Master	4	1.6
Other	4	1.6
Unit		
Inpatient	241	98
Clinics	4	1.6
ER	1	0.4
Usual Shift Worked		
Rotating	170	67.8
Day	69	29.2
Night	7	3.0
Title		
Staff Nurse	163	67.1
LPN's	83	33.7
Nurse Level		

I	72	29.3
II	84	34.1
III	62	25.2
Other	28	11
Hours Worked Per Week		
Less than 48	53	23.5
48	122	54.0
49-60	51	22.5
> 60	0	0.00
Nationality		
M	30	9.5
B	38	13.5
D	178	77.0
Religion		
Muslim	59	23.0
Christian	174	72.2
Hindu	2	0.8
Other	11	4
Number of Patients Cared per Shift		
1	4	1.9
2	11	5.1
3	9	4.1
4-6	35	16.1
7-9	83	38.2
> 9	75	34.6

The final study sample consisted of 246 subjects (N= 246). About three quarters (n= 189) of the sample were females (77%) and 23% were male nurses (n= 57). Nearly 85% of the nurses were aged between'' 20-40. The majority of the nurses (n= 170, 67.8%) worked rotating shifts, 7 nurses worked the night shift (3.0%), 69 nurses worked the day shift (29.2%). The majority of nurses worked 48 hours per week (n=122, 54%), 53 nurses worked less than 48 hours per week (23.5%), and 51 nurses worked 49-60 hours per week (22.5%). On average, more than two third of the nurses cared for more than seven patients per shift.

There were only four nurses (1.6%) with a master's degree in nursing. The majority of the participants held a bachelor's degree in nursing (n=158, 67.5%), the rest of the nurses (n=68 27.6%) held a nursing diploma degree (minimum of three years study) of and only four (1.6%) stated that they held another type of nursing degree when this study was conducted.

Even though the inclusion criteria stated that nurses must have a minimum of three months experience in the study hospital, it was interesting to find out that the mean years of experience of the participants in the research setting was 4.3 years with standard deviation of 6.4 and the mean years of experience as a nurse was 10.0 years with standard deviation of 6.9, which indicates that the overall experience of the participants was satisfactory whilst also showing that Saudi Arabia is able to recruit experienced staff.

Participants in the research setting were younger than the average age of 45 years in North America (61.8% of participants were up to 35 years of age). A significant number of participants originated from Southeast Asia (77%). The Southeast Asian group (region D) consisted of participants from the Philippines, India and Malaysia. There were fewer Western nationalities (region B) in Saudi Arabia (n=32, 13.5%) due to competition at home. The least represented nationalities were staff from the Middle East (Region M). The Middle East participants were from Jordan, Syria, Palestine and Lebanon. The majority of participants were Christians (n=174, 72.2%), with fewer Muslims (n=59 24%).

Staff nurses accounted for 66.3% of participants and LPN's 33.7%. The majority of the participants stated they were married (58.1%), while only 33.7% stated that they were single.

5.3.2 Reliability of the Questionnaires Utilized in the Study

A Cronbach alpha test for internal consistency was performed to assess the reliability of the WRS (ENSS), job performance (SSDPSNP), intention to stay (MBCS), and social support (MMSI) questionnaires. Table 5.2 presents the results of the reliability test for the ENSS scale, the whole scale and for each subscale and then compares the results with those of the study by Gray-Toft and Anderson (1981). The results of the Cronbach Alpha test showed a high reliability of the ENSS used in the present study (0.96). The coefficients for the subscales in the present study were almost equal to (workload, death and dying) or higher than the coefficient alphas reported by Gray-Toft and Anderson (1981).

Table 5.2 Comparison of the Alpha Coefficients of the Nursing Stress Subscales for the Present Study and the Study of Gray-Toft and Anderson (1981).

ENSS Subscales	Alpha Coefficients for the Current Study	Alpha Coefficients for the Gray-Toft & Anderson (1981) Study
Workload	0.88	**0.77**
Inadequate Preparation	0.74	**0.75**
Death and Dying	0.80	**0.77**
Uncertainty over treatment	0.88	**0.80**
Conflict with Physicians	0.80	**0.68**
Conflict with other Nurses	0.88	**0.68**
Lack of Support	0.85	**0.64**
Overall Scale	0.96	**0.89**

In regard to the internal consistency and reliability of the Schwirian Six Dimension Performance Scale of Nursing Performance (SSDPSNP), the reliability of the whole scale and its six subscales and were compared to those reported by Schwirian (1978) s. Table 5.3 shows the results of the analysis and comparison. The coefficient alpha for the whole scale was high (.95) in the present study.

Table 5.3 Comparison of Alpha Coefficients of the Schwirian Six Dimension Scale of Nursing Performance for Staff Nurses of the Present Study and in the Reported in Schwirian (1978) Study.

Schwirian Subscales	Alpha Coefficients for the Present Study	Alpha Coefficients for the Schwirian (1978) Study
Leadership	0.70	**0.77**
Interpersonal Relations and Communication	0.82	**0.75**
Professional Development	0.92	**0.77**
Critical Care	0.78	**0.80**
Planning and Evaluation	0.72	**0.68**
Teaching and Collaboration	0.83	**0.68**
Overall Scale	0.95	**0.89**

Reliability of the Intention to Stay Scale [McCain Behavioural Commitment Scale (MBCS)] by McCloskey (1990) reported a Cronbach's α of 0.88 for this scale. The coefficient alpha for the scale was very high (0.78) in the present study. The tool was reported to have face and content validity.

Reliability and internal consistency of the Social Support Scale [McCain and Marklin Social Integration Scale (MMSI) (McCloskey 1990)] was performed. The coefficient alpha for the scale was very high (0.70) in the present study. The test re-test reliability reported by McCloskey in 1990 was 0.77.

5.3.3 Means, Standard Deviations, and Ranges of the Scales Used in the Present Study

The means and standard deviations of the scales used in the present study are presented in Table 5.4 and discussed in the following section. The reported mean of the overall job stress scale was described as occasional. The highest reported mean of the job stress subscale was for the “workload”, and the lowest was for the “Uncertainty over Treatment” and “Death and Dying”. The reported mean of the overall job performance scale was high. The highest reported mean of the job performance subscale was for “Professional Development” and “Critical Care”, and the lowest mean was for “Leadership”.

The reported mean of the Intention to Stay Scale [McCain Behavioural Commitment Scale (MBCS)] was moderate indicating that most nurses reported that they have a neutral perception of willingness to stay at their current placement of work. The reported means of the social support scale as reported by the McCain and Marklin Social Integration scale (MMSI) was moderate to high indicating that the majority of nurses perceived that they are getting good social support from their co-workers.

Table 5.4. Means and Standard Deviations of Each of the Scales Used in the Present Study

Variable	Mean (SD)
WRS(on a scale from 0-4)	0.9 (0.49)
Workload	1.5 (0.81)
Inadequate Preparation	0.94 (0.56)
Death and Dying	0.62 (0.65)
Uncertainty over Treatment	0.50 (0.37)
Conflict with Doctors	0.93 (0.45)
Conflict with other Nurses	0.78 (0.57)
Lack of Support from supervisors	1.00 (0.70)
Patients and Their Families	0.63 (0.66)
Discrimination	0.65 (0.67)
Job Performance (on a scale 1-5)	2.92 (0.67)
Leadership	2.82 (0.76)
Interpersonal Relationship & Communication	3.09 (0.73)
Professional Development	3.77 (1.00)
Critical Care	3.25 (0.82)
Planning and Evaluation	3.05 (1.00)
Teaching and Collaboration	3.09 (0.78)
Intention to Stay (MBCS) (on a scale 1-5)	3.04 (0.91)
Social Support (MMSI) (on a scale 1-5)	2.22 (0.96)

5.3.4 The Relationship between the Demographic Variables and the Scales Used in the Present Study

The dependent variables (Job performance, and Intention to Stay) and the key independent variables including job stress, social support and demographic variables were entered into a correlation matrix to examine relationships between variables. The correlation matrix for all variables is summarized in tables 5.5, 5.6 and 5.7. Table 5.5 summarizes the results of the Pearson correlation test among the key variables and the level of significance. The correlation matrix was done to help the researcher identify which variables would be entered into the regression analysis.

Table 5.7 indicates the significant correlation found between the dependent variables (Job performance, and Intention to Stay) and between key independent variables job performance and education level ($r=0.18$, $p<.01$), and shifts worked by the nurse ($r=0.14$, $p<0.05$). Significant and moderate correlation was found between the intention to stay at current workplace (MBCS) and job performance ($r=0.25$, $p<.01$), educational level ($r=0.11$, $p<.05$), shift worked by the nurse ($r=0.18$, $p<.01$), and the number of hours per week worked by the nurse ($r=0.16$, $p<.01$).

Significant correlations were also found between WRS (ENSS) and gender ($r=-0.11$, $p<.05$) and level of education of the nurse ($r=0.12$, $p<.05$). In addition, social support (MMSI) was found to be significantly correlated with job performance ($r=0.18$, $p<.05$), and gender ($r=0.16$, $p<0.05$).

Table 5.5 Correlation Matrix

Variables	Unit	Title	Level	Years	Gender	Age	Nationality	Religion	Marital Status
Unit	1	0.132*	-0.109	0.057	-0.087	0.024	-0.218**	-0.012	0.063
Title	0.132*	1	-0.108	0.208**	-0.129*	0.205**	-0.226**	-0.117	-0.066
Level	-0.109	-0.108	1	-0.474**	-0.054	-0.329**	0.328**	0.130	0.207**
Year As Nurse	0.057	0.208**	-0.474**	1	0.193**	0.740**	0.018	-0.097	-0.194**
Gender	-0.087	-0.129*	-0.054	0.193**	1	0.111	0.266**	0.163*	0.097
Age	0.024	0.205**	0.329**	0.740**	0.111	1	0.111	-0.006	-0.216**
Nationality	0.218**	0.226**	.0328**	0.018	0.266**	0.111	1	0.495**	0.109
Religion	-0.012	-0.117	0.130	-0.097	0.163*	-0.006	0.495**	1	0.075
Marital Status	0.063	-0.066	0.207**	-0.194**	.0097	-0.216**	0.109	0.075	1
Education	0.049	0.034	0.008	-0.268**	-0.154*	-0.232**	-0.025	-0.030	-0.014
Years SBAHC	0.044	0.072	0.628**	0.390**	0.027	0.196**	0.000	0.025	-0.111
Shift	-0.081	0.352**	0.135	-0.113	0.151*	-0.059	0.140*	0.028	-0.045
Hours Worked	0.089	-0.118	0.052	-0.112	0.048	-0.029	0.004	-0.018	0.020
Number Of Patients	-0.118	0.093	0.077	0.032	0.088	0.075	0.193**	0.083	0.096
Overall Score of the ENSS	-0.084	-0.011	-0.041	0.021	-0.039	-0.058	-0.068	-0.105	-0.009
Overall SSDPSNP Score	0.030	0.141*	-0.098	-0.017	-0.111	-0.005	-0.087	-0.003	-0.030
Overall Score for MBCS	-0.005	0.051	0.089	-0.061	0.009	0.042	0.081	0.125	0.008
Overall Score for MMSIS	0.047	-0.029	-0.042	0.155*	-0.062	0.070	-0.005	-0.015	-0.012

Table 5.6 Correlation Matrix

Variables	Education	Years SBAHC	Shift	Hours Worked	Number of Patients	Overall ENSS Score	Overall SSDPSNP Score
Unit	0.049	0.044	-0.081	0.089	-0.118	-0.084	0.030
Title	0.034	0.072	-0.352**	-0.118	0.093	-0.011	0.141*
Level	0.008	-0.628**	0.135	0.052	0.077	0-.041	0-.098
Years As Nurse	-0.268**	0.390**	-0.113	-0.112	0.032	0.021	-0.017
Gender	-0.154*	0.027	0.151*	0.048	0.088	-0.039	-0.111
Age	-0.232**	0.196**	-0.059	-0.029	0.075	-0.058	-0.005
Nationality	-0.025	0.000	0.140*	0.004	0.193**	-0.068	-0.087
Religion	-0.030	0.025	0.028	-0.018	0.083	-0.105	-0.003
Marital Status	-0.014	-0.111	-0.045	0.020	0.096	-0.009	-0.030
Education	1	-0.089	-0.127	-0.028	-0.115	0.119	0.180**
Years SBAHC	-0.089	1	-0.154*	-0.008	0.097	-0.067	0.117
Shift	-0.127	-0.154*	1	0.490**	0.319**	-0.022	-0.144*
Hours Worked	-0.028	-0.008	0.490**	1	0.224**	0.011	0.067
Number Of Patients	-0.115	0.097	0.319**	0.224**	1	-0.010	-0.090
Overall Score of the ENSS	0.119	-0.067	-0.022	0.011	-0.010	1	0.132*
Overall SSDPSNP Score	0.180**	0.117	-0.144*	0.067	-0.090	0.132*	1
Overall Score for MBCS	0.113	0.029	-0.179**	-0.162*	0.024	-0.021	0.250**
Overall Score for MMSIS	0.044	0.075	0.000	0.071	-0.074	-0.016	0.182**

Table5.7 Correlation Matrix

Variables	Overall Score for MBCS	Overall Score for NSBS	Overall Score for MMSIS
Unit	-0.005	0.009	0.047
Title	0.051	0.158*	-0.029
Level	0.089	-0.119	-0.042
Years As Nurse	-0.061	-0.008	0.155*
Gender	0.009	-0.156*	-0.062
Age	0.042	-0.020	0.070
Nationality	0.081	-0.135*	-0.005
Religion	0.125	0.008	-0.015
Marital Status	0.008	-0.053	-0.012
Education	0.113	0.144*	0.044
Years SBAHC	0.029	0.023	0.075
Shift	-0.179**	-0.198**	0.000
Hours Worked	-0.162*	-0.129	0.071
No. of Patients	0.024	-0.112	-0.074
Overall Score of the ENSS	-0.021	0.013	-0.016
Overall SSDPSNP Score	0.250**	0.466**	0.182**
Overall Score for MBCS	1	0.351**	0.104
Overall Score for MMSIS	0.104	0.173**	1

** Correlation is significant at the 0.05 level; ** Correlation is significant at the 0.01 level.*

Analysis of variance (ANOVA) was used to further test the relationship between demographic variables and the reported means of job stress, job performance, and intention to stay and social support. Findings indicated a statistically significant relationship between the demographic variables gender, the number of patients cared per shift, shift worked, education level, and nurse level and the other variables measured with the questionnaires that included job stress, job performance, intention to stay and social support.

Significant differences were found between the level of education and job performance and social support (see Table 5.7). Tuckey's test showed that nurses who had nursing experience of 7-10 years reported higher a perception of job performance than nurses who had 1-3 years of nursing experience. The difference in the mean was statistically significant (F=2.78, P=0.04).

Table 5.8 Analysis of Variance Indicating the Relationship between Nursing Educational Level and Job Performance and Social Support.

Variable		Diploma	Bachelor	Master	Other	F-Test	P
Job Performance	Mean	**2.97***	**3.36***	3.86	3.08	3.84	**0.005**
	SD	1.05	0.56	0.22	0.22		
Social Support	Mean	**2.18***	2.26	**1.79***	**3.13***	2.59	**0.04**
	SD	0.99	0.89	1.65	0.96		
	N	10	19	18	22		

**Tuckey's Test (0.05). The mean difference is significant at the 0.05 level.*

The result of the ANOVA test showed that the type of work shift that the nurses were into was related to intention to stay. There was a statistically significant difference found between the work shifts and the reported mean of intention to stay ($F=2.69$, $p<0.05$). Nurses who worked Day and Night shifts reported higher means in favour of staying at the workplace than those who worked rotating shifts.

In regard to gender difference, significant differences were found between gender and the reported mean of WRS ($F=3.6$, $p<0.05$). Male nurses reported higher levels of stress than female nurses.

There were significant differences between the number of patients the nurse cared for during a shift and the reported mean of WRS (F=2.2, p<.05). The higher the number of patients the higher the reported mean of stress experienced by nurses.

5.3.5 Bivariate Analysis

In order to investigate the relationship among WRS, social support, staff intention to stay and job performance, bivariate Pearson Product Moment Correlation test was applied. The result of the analysis is illustrated in table 5.9

Table 5.9 Summary of Pearson Correlations (r) among the Variables under Study

WRS (ENSS)	Intention to Stay (MBCS)	Social Support (MMSI)
0.13*	**0.25****	**0.18***
	0.35*	**0.17****

** Correlation is significant at the 0.05 level; ** Correlation is significant at the 0.01 level.*

The above table indicates that significant relationships existed between WRS level and staff performance, job performance and social support. Nurses with a higher level of WRS reported less performance, while nurses that received good support reported better performance and less level of WRS.

5.3.6 Step-Wise Regression Analysis

Regression analysis was used to test the outcome of work stress on job performance, multivariate logistic regression models were developed. Model were first run for each of the seven stress subscales in the ENSS to test for associations with job performance measures. Work stress was entered into regression analysis as an independent variable and job performance was the dependent variable. Regression analysis showed that WRS variables explained only 1.7% (R^2=0.017; F=4.32, p=0.04) of the variation in job performance, but it was statistically significant refer to table 5.10. This relationship was found to be statistically significant as the p value was <0.05. In the second step, the models were re-run to include a set of mitigating factors that could potentially protect against outcomes associated with work stress. These factors included co-worker support and supervisors.

Table 5.10 Predictive interaction between stress and job performance

variable	R^2	F	P value
WRS variables	0.017	4.32	0.04

In order to examine the impact of Social Support on Job Performance, social support was entered into regression analysis as an independent variable and job performance was the dependent variable. Regression analysis showed that social support variable explained only 3.3% (R^2=0.033; F=8.38, p=0.004) of the variation in job performance, but the result was statistically significant, refer to table 5.11. This relationship was found to be statistically significant as the p-value is <0.05.

Table 5.11 Predictive interaction between Social Support and job Performance

variable	R^2	F	P value
Social support	0.033	8.38	0.004

The next step in regression analysis was to enter background variables that showed significant correlation with job performance, social support, and WRS into the regression analysis model to examine their effect on the results. The independent variables gender, education level, shift worked, the number of hours worked, the number of nurses cared for per shift, and nurse level were entered into the regression analysis model. The reason those variables were entered into the regression analysis was because they showed significant correlation with one or more of the variables under study (job performance, job stress, social support, intention to stay). The results of the regression analysis when added the education level showed that the addition of these variables contributed an additional 9.3% (R^2=0.93; F=1.83, p=0.04) of the variation in job performance to the previous variables tested above (job stress and social support), and for the rest of the variables as explained in table 5.12 below. This relationship was found to be statistically significant as the p value was <0.05.

Table 5.12 Predictive interaction between job performances, job stress, social support and intention to stay

variable	R^2	F	P value
Education level,	0.93	1.83	0.04
shift worked	,737	510.323	>.001
number of nurses cared for per shift	,788	337.170	>.001
the number of hours worked	798	237.140	0.005
Age 25-30	805	184.541	0.014

In order to investigate the relationship between WRS and intention to stay, regression analysis was used. WRS was entered into regression analysis as independent variable and intention to stay was the dependent variable. Regression analysis showed that WRS variable was not a significant factor and did not contribute to the variation of intention to stay among nurses. (R^2=0.000; F=0.111, p=0.74). This relationship was not found to be statistically significant as the p-value was >0.05.

The relationship between social support and intention to stay was tested by conducting regression analysis. Social support was entered into regression analysis as the independent variable and intention to stay was the dependent variable. Regression analysis showed that social support was not statistically significant and contributed only 1.1% (R^2=0.011; F=2.64, p=0.001) to the variation in the intention to stay, see table 5.13. This relationship was not found to be statistically significant as the p-value was >.05.

Table 5.13 Predictive interaction between social support and intention to stay

variable	R^2	F	P value
social support	0.011	2.64	0.001

The assumptions of regression were checked by inspecting the distribution and the residuals plot. The assumption of normality was examined by drawing the distribution of the regression-standardized residuals of mean scores for job performance and intention to stay and was found to be normally distributed (bell-shaped) (see Figures 5.1 and 5.2).

Figure 5.1 The Distribution of the Mean Scores of Job Performance

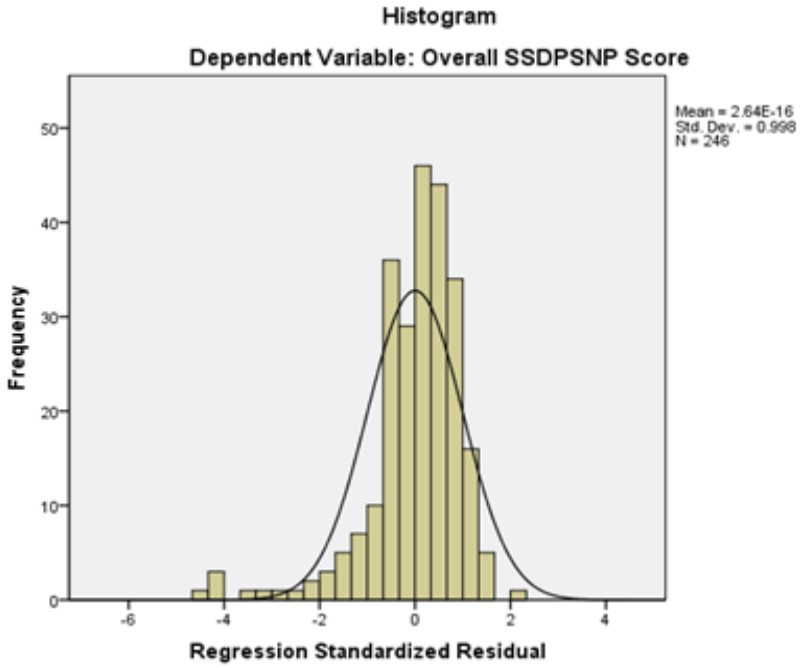
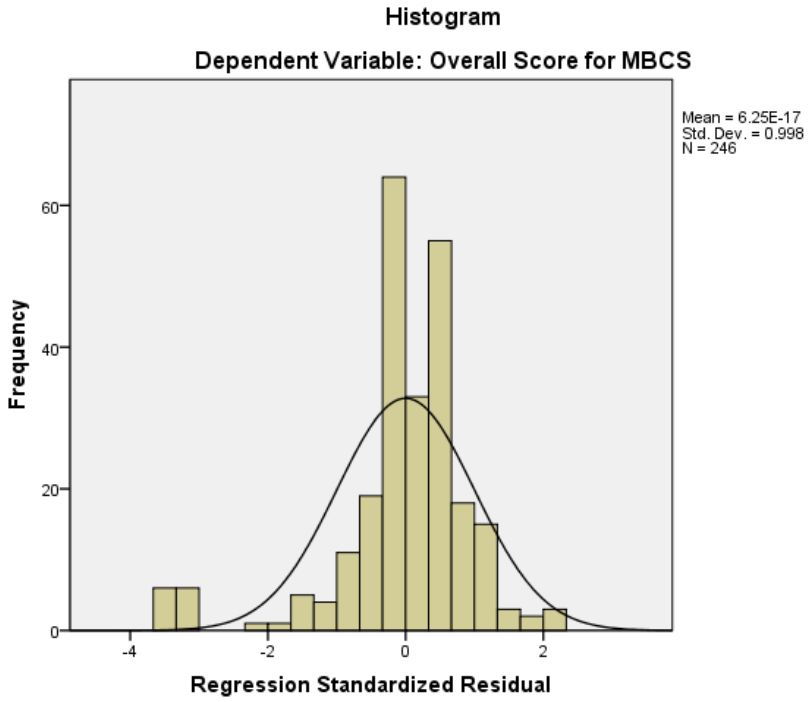
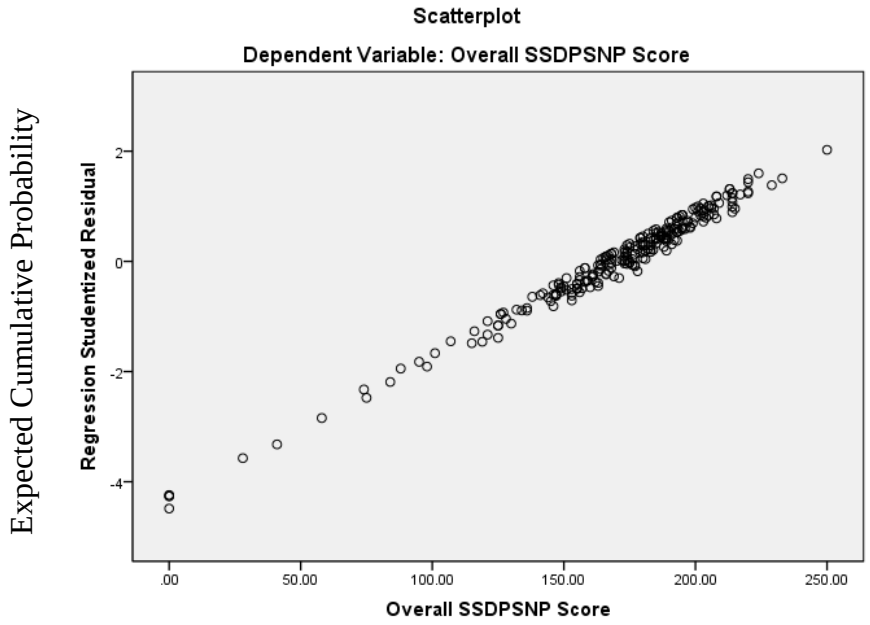


Figure 5.2 The distribution of the mean scores of Intentions to Stay



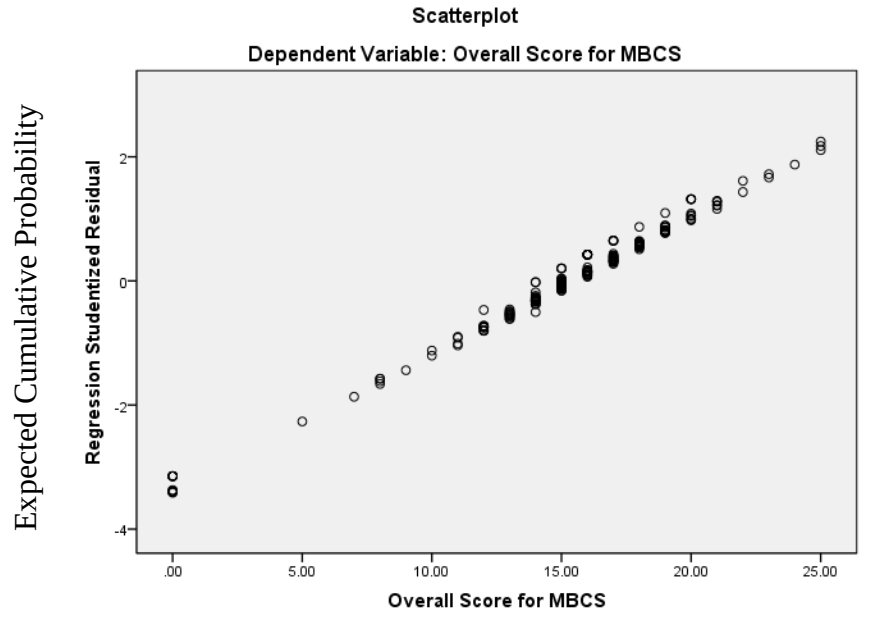
Next, the assumption of homo-scedasticity was analysed to evaluate whether the residuals were scattered arbitrarily throughout the reach of the anticipated worth of the variables (job performance and intention to stay). In fact, a succession or a vector of irregular variables is homoscedastic if all arbitrary variables in the grouping or vector have the same limited fluctuation (Bekker and Ploeg 2005). The plot of the residuals and the anticipated quality of the job performance were inspected. Note that the discoveries structured a band of equivalent width overall qualities of the forecast line. Besides, the discoveries did not group or structure an evident example (Figure 5.3). The ordinary likelihood plot was inspected and the perceptions fall near the line in the typical likelihood plot (Figure 5.4). The findings attest to equal variance and independence of the residuals or errors.

Figure 5.3 Normal probability plot of observed vs. expected cumulative probability for job performance



Observed Cumulative Probability - Job Performance

Figure 5.4 Normal probability plot of observed vs. expected cumulative probability for Intention to Stay



Observed Cumulative Probability - Intention to Stay

The Durban-Watson coefficient *d* test was performed to test for the independence of findings (test for autocorrelation). The value of d was 1.97, which attests to the independence of findings leading to uncorrelated error terms (absence of autocorrelation). As a rule of thumb, *d* should be between 1.5 and 2.5 to indicate independence of the results. The possible value of *d* ranges from 0 to 4. A value of 0 indicates positive autocorrelation, and a value of 4 indicates negative autocorrelation. Autocorrelation leads to biased estimates of standard deviations and significance (Fox 1993).

Multi-collinearity examines the correlation between two or more independent variables entering the regression model. Multi-collinearity is a statistical term for a problem that is common in technical analysis. That is when one unknowingly uses the same type of information more than once. One needs to be careful and not utilize technical indicators that reveal the same type of information. The researcher checked for the presence and/or severity of multi-collinearity using three influence diagnostic parameters: variance inflation factor (VIF), Eigenvalue, and condition numbers. The VIF for nursing grade was 1. This indicates no inflation due to multi-collinearity. The Eigenvalue was 1.91. Eigenvalues near zero (<0.10) are an indication to suspect inter-correlations among predictor variables. The condition number was 1.0, far below the caution point of 30. Thus, these findings support the position that there is no or little multi-collinearity among the variables in this regression model.

5.3.6.1 Further Model Regression analysis

Correlation is used to determine the correlations between two numerical variables. The categorical variables were included in regression analysis to determine the relationship between dependent and independents variables. The only numerical values in my study are, experience, demand, control and support.

The initial correlation analysis indicated that the only significant and strong correlation between experience and social support (*r* = 0.281), see table 5.14.

Table 5.14 Correlations

Variables	1	2	3	4
1. Experience	-			
2. Demand	0.022			
3. Control	0.073	0.104		
4. support	0.281**	0.052	-0.042	

Note: *p <0.005. **p<0.001: 2-tailed.

Further Pearson correlation tests were performed to test if the job demand multiplied by support correlate with the multiplied job demand and job control effects add to the prediction and test if there are any interactional relationship associated with the model variables. The result of the correlations indicate that there is a strong and significant relationship between Job demand x support and job demand x control (*r* = 0.822). See table 5.15.

Table 5.15 Demand x Support Correlations with Demand x Control

		Demand x Support	Demand x Control
Demand x support	Support Pearson Correlation	1	.822**
	Sig. (2-tailed)		.000
	N	266	266

**. Correlation is significant at the 0.01 level (2-tailed).

Two hierarchical multiple linear regression analyses were performed. In the first model, job control was the dependent variable while in the second model, job demand was the dependent variable. In both models, in order to control for socio-demographic variables, in the first step of the regressions age category, education level category, years of experience, shift category, number of patient's category and number of patients cared for category were included. In the second step all the variables measuring the seven job demands variables "not enough time to provide emotional support to patient, unpredictable staffing and scheduling, breakdown of computer, not enough time to complete all my nursing tasks, floating to other units that are short-staffed, and too many non-nursing tasks required such as clerical work".

Job control (autonomy) variable also included, it consists of eight items "assume new responsibilities within the limits of capabilities, accept responsibility for own actions, display self-direction, guide other healthcare members in planning for care, accept responsibilities for the level of care provided by

those under your direction, being able to communicate feeling of acceptance of each patient and a concern for patient welfare, seek assistance when necessary and being able to delegate responsibilities based on assessment of priorities of nursing care needs”

The third independent variable, s*ocial support* that got included in the second step of the regression analysis, it was measured using all eight items derived from McCain and Marklin social integration scale (McCloskey1990). Sample items are: “I feel comfortable with my co-workers, and can talk to them easily about personal matters” and “I am able to turn to my co-workers when I need help on the job” were included, as well as the interaction terms.

Due to the high number of factors in the study, I have chosen to present all categories and variables with significant results and some other key variables. The entry method used was forced entry, as this was indicated to be the least influenced by variations in the data, and to provide the most reliable betas (Field, 2012).

In Model 1, the independent variables were entered into the interaction terms. Looking at the interactions between the dependent variables (job control) and nurses with the age group between 26 years old and 30 years old had a significant interaction (Beta = -.094, $p < 0.015$), suggesting that the mean immigrant nurses perception of job control decreased among nurses on that age group. The result shows also that nurses with Diploma education level have less perception with job control compare to nurses with Bachelor and Master Degree (Beta = -.092, $p < 0.021$). Job demand was also a significant predictor of strong interaction with job control (Beta

= -2.474, $p < 0.001$), suggesting that nurses with high job demand experience less control on their job. In regards to the number of hours worked by nurses, the result indicate that nurses whom worked 48 hours a week had better perception of job control compared to other shifts worked (Beta = .079, $p < 0.043$). In terms of the interaction between the demands x control variables and job control variables, a strong and highly significant linear continuous relationship found between the study predictors (Beta = .092, $p < 0.043$).Table5.16 provides further information on the regression analysis.

Table 5.16 Model 1 Job Control Hierarchical Linear Regression

Variables	B	SE	β	P value
Gender	-.070	.093	-.202	.636
Age group (26-30)	-.142	.058	-.094	**0.015**
Experience	.006	.004	0.078	.068
Shift (evening)	-0.048	.049	-.038	.333
Education level category (diploma)	-.129	.055	-.092	**.021**
Number of patients group (5)	-.48	.055	-.034	.382
Hours worked group(48)	0.112	.055	.079	**.043**
Demand	-2.287	.168	-2.474	**>.001**
Support	0.034	.106	.023	.746
Support x demand	-.047	.050	-.125	.385
Demand x Control	.674	.029	2.826	**>.001**

In Model 2, the independent variables were entered into the interaction terms. Looking at the interactions between the dependent variables (job demand) and nurses experience, the result indicated that there was highly significant interaction among nurses with more years of experience, suggesting that they had less job demands (Beta = -.166, $p < 0.001$). At the same time, nurses with Diploma degree experience higher demand (Beta = -.192, $p < 0.012$) while nurses with master degree experienced less job demand (Beta = .145, $p < 0.045$). Finally, the result shows that nurses doing evening shifts, experience higher level of job demand (Beta = -.299, $p < 0.004$).

Table 5.17 Model 2 Job Demand Hierarchical Linear Regression

Variables	B	SE	β	P value
Gender	.084	.075	.082	.264
Age group (26-30)	-.288	.148	-.149	.053
Experience	.015	.007	-.166	**.001**
Shift (evening)	-.299	.103	-.209	**.004**
Education level category (diploma)	-.292	.114	-.192	**.012**
Education level category master	.744	.369	.145	**.045**
Number of patients group (5)	.191	.118	.124	.108
Hours worked group(48)	.017	.122	.011	.890
control	.111	.077	.103	.153
Support	.102	.121	.064	.398

5.4 Discussion

The results presented in this chapter have indicated a generally average perception of WRS for immigrant nurse workers in KSA.

In order to compute total stress score for the quantitative part of the research, the scores on all 57 items were added together. In order to measure scores on specific subscales, the appropriate items were added together. A list of situations that commonly encountered by nurses in the work setting was provided, and nurses were requested to indicate how stressful would be for them. In each case, the level “Never stressful” was scored as 0, 1 “Occasionally stressful” 2 “Frequently stressful”, 3 “always stressful”, 4 “Does not apply”. Addressing missing data depended on the extent of the problem. While several options were available (some more complicated, such as using a regression method to estimate missed scores), the researcher substituted missing values with mean scores for individual items and proceeded to calculate the subscale score for any individual who had answered the majority of items in any subscale. In the case of the “Death and Dying” subscale, for example, an individual would have to have answered at least 4 of the 7 items that comprise the subscale. Otherwise, the subscale was not constructed, and the individual was scored “missing” for that specific subscale.

The reported mean of the overall job stress scale was moderate (0.9), which indicated occasional occurrences of stress. The highest reported mean of the job stress subscale was for the “workload”, and the lowest was for the “Uncertainty over Treatment” and “Death and Dying”.

Participants have identified workload under work conditions as the most frequent issue they deal with while working in KSA. The ENSS finding indicated that the mean average of WRS due to workload was 1.5 (which indicates occasional/frequent occurrences). Participants noted that due to patient workload increasing, nurses cannot provide holistic care to patients. These conclusions are reinforced by a number of studies (Lee 2003; Tyson and Pongruengphant 2004). With regard to the comparison of perceived stressor types in other studies, Govender (1995) pointed out that "Workload" was identified as the greatest perceived source of stress. Workload was identified as a major source of stress in different nursing studies (Rout 2000; Escot et al 2001; Lee 2003; Bianchi 2004; Parikh et al 2004; AbuAlRub 2006; Sveinsdottir et al 2006; Lambert et al 2007; Emilia and Hassim 2007; Zaghloul 2008; Al-Kandari and Thomas 2008; El-Jardali et al 2008; Pal and Saksvik 2008; Purcell et al 2011; Wheeler 2010; Gouzou et al 2015; Mauno et al 2016).

Reduced budgets for hospitals and health care is a worldwide issue resulting in a bigger workload per nurse (Su et al 2009) and is not a problem unique to KSA. High workload and growing WRS among nurses is well known in various countries, causing reduced job satisfaction (Sellgren et al 2009) and significantly increasing staff intention to leave the organisation which will, as a result, lead to a worsening nursing shortage (Duffield and O'Brien-Pallas 2003).

The study indicated that there is a significant relationship between the number of nurses and the numbers of patients cared for, the higher the number of patients, the higher their level of WRS. With a low number of nurses, there is a big potential for reduced quality of care which will impact patient

safety (Bailit and Blanchard 2004; Sochalski 2004; Lang et al 2004). A high workload experienced by a nurse affects the nurse, other nurse's colleagues, the nature of nurse-physician collaboration (Baggs et al 1999), nurse-patient communication (Davis et al 2003) and teaching or direction of new nurses. The nurse to patient ratio can be used as a quality indicator to compare units and their patient outcomes in relation to the number of nursing staffing each shift (Lang et al 2004; Amaravadi et al 2000). Increased workloads and understaffing at the unit level has a negative impact on patient outcomes and results in more hospital deaths (Aiken et al 2002; Needleman et al 2002; Patterson 2013). Maben et al (2007) conducted a study among newly qualified nurses in the UK. The survey found that nurses often began their career with strong ideals, but after just two years many were disillusioned and the standards they had held felt compromised and difficult to uphold. Burnout was common and many nurses changed jobs or felt compelled to leave the profession altogether. If better staffing levels could alleviate stress and allow nurses to sustain their ideals with regard to the standard of patient care, burnout and dissatisfaction could be reduced.

Globally, lengthy work shifts and overtime are also increasing in nursing as a result of staff shortages (Rogers et al 2004), which can also cause increased WRS among nurses (Park et al 2010). Employing additional nurses would be the ideal method to decrease the workload for nurses (Chang et al 2005), but in reality, this is the toughest strategy given the economic resources (Riahi 2011).

Immigrant nurses in KSA are likely to do non-professional jobs such as handing out food trays, housekeeping duties,

moving patients, organising, performing auxiliary services and answering the same questions to several members of the same family concerning the same patient's condition (Zuraikat 2011).

In regards to the gender differences and the level of WRS stress, the findings from the questionnaires indicate that male nurses have a higher level of WRS than female nurses. Several studies found no relationships between WRS and the gender of a nurse (Joudeh 2003; Lindo et al; 2006; Patterson and Bell 2007; Mojde et al 2008; Sharma et al 2008; Mansour et al 2011). Some studies found that male nurses had higher occupational stress (Saada et al 2003; Tankha 2006; Al-Kandari and Thomas 2008) while others showed that female nurses had higher occupational stress (Asker and Ahmad 1988; Jayawardene et al 2011).

With regard to the perceived social support, the reported means of the social support scale as reported by the McCain and Marklin Social Integration scale (MMSI) was moderate to high, indicating that the majority of nurses perceived that they are getting good social support from their co-workers. A significant relationship was found between social support and intention to stay and job performance. Bakker et al (2000) found that supervisors buffered the negative effects of the job demands. Schmieder and Smith (1996) showed how high supervisor support levels buffered the negative effects of the job demands and decreased the feelings of emotional exhaustion. Social support is also mentioned to be important because it provides stress relief and enhances the immigrant nurses' self-confidence (Jose 2010).

Social support is one of the current important concepts in health systems worldwide. Job performance encompasses the quality and quantity of tasks accomplished. The purpose of the study was to investigate the effect of social support from co-workers on job performance. Data were collected using a questionnaire, which included the Schwirian six-dimension scale of nursing performance (Schwirian 1978), the McCain and Marklin social integration scale (McCloskey 1990). The findings of the study showed that social support from co-workers enhanced the level of job performance. It also showed that nurses who were older and more experienced had a higher perception of job performance.

The reported mean of the Intention to Stay Scale [McCain Behavioural Commitment Scale (MBCS)] was moderate indicating that most nurses reported that they have a neutral perception of willingness to stay at their current placement of work. Regression analysis showed that WRS variable was not a significant factor and did not contribute to the variation of intention to stay among nurses ($R2=0.000$; $F=0.111$, $p=0.74$). This relationship was not found to be statistically significant as the p-value was >0.05.

In this study intention to leave was used as a proxy for measuring actual turnover. Intentions to leave are the best predictor of turnover itself (Irvine and Evans 1995). However, previous research examining turnover and intention to leave is somewhat unclear because of a lack of clarity in both the conceptualization and measurement of turnover. As others have noted, definitions of turnover have been varied and include voluntary and involuntary turnover, the leaving of a particular position, leaving an organization or leaving the profession (Hayes et al 2006; O'Brien-Pallas et al 2006;

Coomber and Barriball 2007). Measurement has also been inconsistent with some researchers measuring intention to stay while others measure intention to leave or measure turnover as the number of vacant positions (Tai et al 1998). Measurement of turnover can also be compromised by the inaccuracy of record-keeping (Chenevert et al 2016). Studies are not always clear about the definition and measurement of the concept (Hayes et al 1998; O'Brien-Pallas et al 2006). Thus, comparisons in studies of turnover are difficult to make (Tai et al 1998).

It is important to study the determinants of immigrant nurses' intention to leave their current job (Kovner et al 2007) whilst recognising that some turnover of jobs is expected. It's been found that nurses with less than three years of experience, who had educational preparation from a degree program and who were expecting job instability were likely to consider leaving their current position (O'Brien-Pallas et al 2005). Another study of nurses in Nevada with five years of experience or less found that 30% of the sample had left their first nursing position within 1 year of employment, rising to 57% after 2 years. The most frequent reason given for leaving (26%) involved concerns over patient care and safety as a result of WRS; 22% of reasons for leaving were to move geographical location or to a different area of nursing 22% were to do with the work environment and 21% were due to employment factors (Bowes and Candela 2005).

In the current study, there was a statistically significant difference found between the type of shifts worked and the reported mean of intention to stay. Nurses who worked either Day or Night shifts reported higher means in favour of staying at the workplace than those who worked rotating shifts.

Nurses who worked more than 5 nights per month reported more depression. A study by Fukuda et al (2008) found that nurses who worked night shifts reported more depressed mood than nurses who worked day shifts. A study by Muecke (2005) that examined shift related differences in chronic fatigue and the contribution of sleep quality anxiety and depression to chronic fatigue among 142 female critical care nurses showed that night nurses reported more depression and poorer quality of sleep.

Nurses working more night shifts reported higher levels of WRS. Studies have shown that working night shifts can have a negative effect on work performance, sleep, physical and emotional health, drug use and level of occupational stress (Brown-DeGgne 1998), mental health disturbances (Iwata and Egashira 1997) and safety and well-being of nurses (Monk et al 1997). Parikh et al (2004) concluded that shift duty was significantly correlated with the level of stress among nurses. The study by Mohamed et al (2011) and Arafa et al (2003) indicated that Egyptian nurses who worked rotating shifts had higher stress than those nurses who worked straight morning. A study by Madide (2003) revealed that working night shifts caused psychosocial and physiological distress to nurses in South Africa, particularly those who worked a quick rotation. A study by Jones et al (2015) revealed that rotating shift nurses in the USA reported the most WRS, then the afternoon day and night shift nurses. Dall'Ora et al (2016) concluded that nurses on rotating night shifts are riskier to stress. Sadeghniiat–Haghighi et al (2008) indicated that night shift work carries a health risk as it produces symptoms similar to symptoms of mild or moderate stress.

The relationship between WRS and job performance was found to be significant; immigrant nurses with a higher level of WRS reported poorer performance while nurses that reported better performance had a lower level of WRS. At the same time, immigrant nurses in this study rated themselves as high performers; the more experienced nurses reporting the highest performance. Many organisations fail to recognise the actual cost of WRS each year because they do not address triggers for stress effectively (Haris 2001). While contrasting study, results have been reported with regard to the relationship between WRS and job performance in the working environment (Healy and McKay 2000; Abu Alrub 2004), WRS has the potential to be a major cause of diminished productivity, reduced efficiency, poor staff performance and a negative impact on the quality of work itself (Hannigan et al 2004).

When nurses were asked about stress due to experiencing discrimination regarding ethnicity or sex, it was surprising to the researcher that this issue was not a concern to the immigrant nurses (0.65), especially since the feedback the researcher received from individual nurses and managers and the views of many nurses highlighted during their exit interviews has indicated that nurses are very unhappy with the way the system works in KSA in respect of payment according to their nationality and not their competency or educational background. This is in addition to the restriction that female nurses are not allowed to drive or go shopping by themselves because of their gender and should be accompanied by male relatives. Immigrant nurses in the health care sector experience discrimination coming mostly from their co-workers as well as experiencing a lack of

information and guidance and wishing for greater appreciation of their professional skills (Koivuniemi 2012).

According to Esquible et al (2014), prejudice can be defined as a strongly held opinion about a group of people and it often leads to differential treatment. In order to avoid cultural conflicts and misunderstandings that can lead to discrimination, it is important that not only immigrant nurses but also other hospital staff respect and understand the foreign culture (Spector 2004).

In regards to job control in model 1, significant negative relationship were found between job control, education level, age, job demand and hours worked by nurses. Demand was found to have one of the highest interactions with both control and control x demand, it was observed to have the same impact. Job control is all the more vital when it comes to enacting job demand. The results that was generated from the interaction in model I lends to support to the notion that having more control in the job acts as a mediator, allowing individuals to deal better with some job demands. The positive beta suggests that as control increases, the negative effects of working under high job demands get buffered to a certain extent, allowing employees to perform better (Table 5.15 and Table 5.16). In model 1, an interaction was also observed between control and nurses aged between 26 to 30 years old, suggesting that nurses with less social support from family, as the majority of nurses in this age group are single, left their families at the home country.

Nurses with less education level perceived less perception of job control. Regular nursing training and education plays an important role in providing the highest-quality care and in the

delivery of evidence-based medicine. However, most nurses do not receive any further specialized training after gaining a nursing qualification. Nursing schools are under pressure to offer accelerated programs to meet growing workforce demands and provide students with the knowledge they require to care for an aging population (Baumbusch et al 2012).

Nurses that worked as fulltime (48hours), had better perception of job control compared to other worked hours, suggesting that the buffering effect of job control was stronger when balanced working hours and workload were high compared to when the working hours were more .In other words, work-life balance practices strengthened the moderating roles of job control and work-life balance practices on nurses perception of job demand. Working long hours can lead to a state of stress and fatigue, which reduce individual resources, directly impacting productivity (Alserhan et al 2011).

Another aspect explored in this study in model 2 of job demands as dependent variable. Our analysis showed that nurses in the age group between 26 and 30 years old, had higher perception of job demand, similar to model I result. The effect observed was negative in both models. Nurses with master degree had less perception of job demand while nurses with diploma degree had higher perception of job demand. Shift pattern (evening) have an impact on job demand, nurses on evening shifts experienced higher level of job demand, because finding a balance between work and personal life implies that there are no conflicts between the demands placed on individuals at the workplace that would spill-over in their personal life and vice versa (James, 2011).

Furthermore, having a good personal life balance, many times means that a worker has increased autonomy over his or her working environment, another factor which encourages performance (James, 2011). Damaging life balance is a harmful; on one hand employees feel they do not have sufficient time to deal with their work demands, and on the other hand people do not have enough time to recover and take care of themselves, their family or other matters in their personal life. As a result, stress increases, relationships at work deteriorate as increasing pressure breaks down communication, learning and idea exchange between colleagues (James 2011). It is clear therefore that in such conditions job performance will decline.

Considering that job demand had a negative correlation with job control, the relationship here points towards the fact that better job control might actually act towards decreasing the challenge felt when faced with high demands, which might in turn hinder the nurses performance and impact patient care. Maintaining a balance between offering the right amount of control to workers to balance demands is therefore a topic that needs to be further investigated in other studies. Nurses who experience more control in their working environment might be more willing to perform better, as they feel more appreciated and more capable (De Spiegelaere et al 2014).

When nurses enjoy a higher degree of flexibility and freedom in their work, sense of job control will be higher, thus alleviating job stress. However, if the work is not flexible and supportive, job control element alone does not produce any impact on stress. The significant three-way interaction found in this study indicates that the link between job demands and job control is influenced by both the perceived level of job

control and social support. Hence, other than job content, job context may also influence the nature of job demands on stress outcome (Karasek, 1979).

5.5 Summary

Despite numerous studies that have addressed stress in nursing, this issue continues to be a popular topic amongst researchers because of its consequences on individuals' health and the organization. For this study, expatriate nurses working in a diverse cultural setting were surveyed to determine stress contributing factors that frequently occur in the workplace and their effect on staff job performance and retention. Likewise, it tried to establish the moderating effect of social support and staff recognition on job performance and stress.

Responses to ENSS indicated that immigrant nurses had moderate levels of stress. The most common stressful event was the "workload" while the lowest were the "Uncertainty over Treatment" and "Death and Dying". The reported mean for the overall job performance scale was high. The highest reported mean scores for the job performance subscale were for "Professional Development" and "Critical Care", and the lowest mean was for "Leadership". Male nurses reported a higher level of stress than female nurses and the higher the number of patients being cared for, the higher the mean stress score was.

The reported mean of the Intention to Stay Scale [McCain Behavioural Commitment Scale (MBCS)] was moderate indicating that most nurses reported a neutral perception of willingness to stay at their current placement of work. The

reported mean of the Staff Recognition Scale as reported by the Nurse Supervisor Behaviours Scale (NSBS) indicated that the majority of nurses perceived that their performance was moderately recognized by their supervisors. The reported means of the Social Support scale as measured by the McCain and Marklin Social Integration scale (MMSI) were moderate to high indicating the majority of nurses perceived that they were getting good social support from their co-workers.

The result of the ANOVA test showed that the type of work shift the nurses performed was related to intention to stay. There was a statistically significant difference found between the work shifts and the reported mean of intention to stay ($F=2.69$, $p<0.05$). Nurses who worked either Day or Night shifts reported higher means in favour of staying at the workplace than those who worked rotating shifts.

Significant contrasts were found between the level of education and job performance and social support. Tuckey's test showed that nurses with 7-10 years of nursing experience reported a higher perception of job performance than nurses who had 1-3 years of nursing experience. At the same time, nurses in Level I reported a higher mean for the perception of social support by their supervisor than those nurses in Levels II and III.

Regression analysis was used to test the outcome of occupational stress on job performance. WRS was entered into regression analysis as an independent variable and job performance was the dependent variable. This relationship was found to be statistically significant as the p value was < 0.05.

This chapter has considered the methods that inform the research and the rationale for the use of the quantitative method. It outlines how the chosen approach complements the mixed methods approach used in this thesis. It focuses on the four standard questionnaires used in the quantitative part and how they were used in immigrant nurses in KSA. An open-ended section for free-text followed the questionnaires to give a clearer picture of WRS in nurses. An outline is provided of the different data analysis techniques used to answer the study questions.

The result of JDCS model analysis supported the model, significant negative relationship were found between job control, education level, age, job demand, nurses shift pattern and hours worked by nurses. Demand was found to have one of the highest interactions with both control and control x demand, it was observed to have the same impact. Job control is all the more vital when it comes to enacting job demand. The results that was generated from the interaction in model I lends to support to the notion that having more control in the job acts as a mediator, allowing individuals to deal better with some job demands. The positive beta suggests that as control increases, the negative effects of working under high job demands get buffered to a certain extent, allowing employees to perform better

The next chapter reports the qualitative design and the findings elicited by the data collected from the semi-structured interviews.

CHAPTER SIX

QUALITATIVE RESULTS AND DISCUSSIONS OF WRS, JOB PERFORMANCE, SOCIAL SUPPORT AND INTENTION TO STAY AMONG IMMIGRANT NURSES

6.1 Introduction

According to Borg and Gall (1989, p380),
"Qualitative approach is much more difficult to do well than quantitative research because the data collected are usually subjective and the main measurement tool for collecting data is the investigator himself."

This chapter presents the results of the qualitative component of this case study, which comprised semi-structured interviews followed by an outlines the deductive analysis conducted according to this framework. This is followed by the discussion of findings.
Conducting semi-structured interviews will add to this research to generate an improved exploration and understanding of how immigrant nurses perceive WRS in an environmental setting that is not encouraging the avoidance of the psychosocial risks.

The rich data gathered from the interview produced meaning units and the researcher used inductive logic to label similar units. For the majority of the nurses interviewed, English is their second language; therefore transcripts of interviews contain grammatical errors. Instead of applying grammatical corrections to the transcripts that may have distorted the original intent of what the participants wanted to communicate, the transcripts have been left in their original form. Excerpts of interviews that have been included in this

chapter to support the explicated themes are from original transcripts of interviews. The only alteration has been the inclusion of punctuation such as full stop, commas, and question marks and so on in order to make the participant quotes more understandable and logical. This helps the researcher to present the participant descriptions concisely and completely while maintaining the integrity of the data.

In order to understand the factors that the nurses understood to be the causes of WRS, the co-researcher asked the respondents to describe the challenges and stressors that they encountered in their work at SBAHC, at the same time, they were asked to rate the level of stress in the same way it was rated in the questionnaires, i.e. never, occasionally, frequently and very frequently. The co-researcher also encouraged all of them to share their personal insights and experiences. What follows below is a discussion of the key factors that were consistently raised by the immigrant nurses.

6.2 Demographic Information for the Interviewees

The characteristics of the individuals included in the population were used as the basis of selection to reflect the diversity and breadth of the sample population. Necessary measures were taken to ensure that there were participants from different backgrounds and gender in the selected sample. There were 14 females and six male participants in this phase of the study whose ages ranged from 23 to 42 (M=33).

In this research, eight conceptual categories emerged when the participants were asked about the sources of WRS. These were: workload, cultural competency, inter-relational

conflict, language barrier, physical environment, family-related matters, death and dying and discrimination.

The sample population was also determined by taking account of cultural backgrounds. The respondents of the study consisted of twelve (60%) Asians, nine (45%) women from the Philippines, one (5%) woman from India, two (10%) men from the Philippines. Six (30%) employees stated they were Caucasians, four (20%) males from the Middle East (two from Jordan, one from Palestine and one from Lebanon), one (5%) British female and one (5%) Canadian female. Two (10%) respondents were Africans; both were female. Seven (35%) of the employees were single and thirteen (65%) employees were married. All participants were able-bodied. Staff experience with mediation ranged from two years to 28 years (M=10.67; SD=8.21) as a nurse and from 9 months to 8 years (M=3.61; SD=2.1) working as a nurse in the hospital where the research took place. All employees worked full time with 48 hours of duty every week. Table 6.1 and 6.2 below summarizes the characteristics of the selected sample as group and as individual participant.

Table 6.1 Demographics Information for the Interviewees

Demographics Information for the Interviewees **Interviewee**	**Qualifications**	**Gender**	**Experience (years)**	**Marital status**
Nurse 1	Bachelor of Nursing	male	7	single
Nurse 2	Bachelor of Nursing	female	17	married
Nurse 3	Bachelor of Nursing	female	28	single
Nurse 4	Bachelor of Nursing	female	8	married
Nurse 5	Bachelor of Nursing	male	9	married
Nurse 6	Bachelor of Nursing	male	5	single
Nurse 7	Bachelor of Nursing	male	9	married
Nurse 8	Bachelor of Nursing	female	9	single
Nurse 9	Bachelor of Nursing	female	5	married
Nurse 10	Bachelor of Nursing	male	7	single
Nurse 11	Master of Nursing	male	14	married
Nurse 12	Bachelor of Nursing	female	7	single
Nurse 13	Bachelor of Nursing	female	6	married
Nurse 14	Bachelor of Nursing	male	22	married
Nurse 15	Bachelor of Nursing	female	14	single
Nurse 16	Bachelor of Nursing	female	2	married
Nurse 17	Master of Nursing	male	12	married
Nurse 18	Bachelor of Nursing	female	10	married
Nurse 19	Bachelor of Nursing	female	10	married
Nurse 20	Bachelor of Nursing	female	11	married

Table 6.2 Summary of Respondents' Characteristics (Qualitative Phase)

Group	Numbers/Title	Gender	Nationality	Unit Location
I	5 Nurses	4Female 1 Male	3 Filipino 1 South African 1 British	2 General Surgical 1 Spinal Cord Injury unit 2 General Surgical Unit
II	5 Nurses	4Female 1 Male	3 Filipino 1 Jordanian 1 South African	1 Emergency room 2Haemodialysis unit 2 Clinics
III	5 Nurses	3Female 2 Male	2 Filipino 1 Indian 1 Lebanon 1 Palestinian	2 Intensive therapy unit 2 Paediatric unit 1 Operation room
IV	5 nurses	3Female 2 Male	3 Filipino 1 Canadian 1 Jordanian	2 Brain injury unit 2 Women's health (Gynaecology) 1 Stroke

6.3 Findings

Eight key themes emerged from the interviews. The qualitative data analysis sought to identify the main themes and sub-themes regarding the factors that affect the job satisfaction of immigrant nurses in working in SBAHC. All of the interview participants were interviewed in the English language and further agreed to the use of two digital audio recorders. The interviews were transcribed on the day of each interview. Table 6.3 summarises the eight themes and the

sub-themes that were extracted from the data. The following eight themes and sub-themes are provided as the findings of the qualitative interviews:

Table 6.3 Content Analysis of Narratives about the Sources of Occupational Stress

Theme: Sources of Occupational Stress

Theme: Sources of Occupational Stress		
Conceptual Categories	Sub Categories	Frequency
	Nurse-Patient Ratio	(9 nurses)
Workload	Documentation	(7 nurses)
	Floating Assignments	(4 nurses)
	Time Pressure	(4 nurses)
Cultural Competency	Cultural Shock	(8 nurses)
	Culture Knowledge	(5 nurses)
Inter-Relational Conflict	Nurse-Nurse Conflict	(3 nurses)
	Nurse-Nurse Supervisor Conflict	(5 nurses)
	Physician Conflict	(5 nurses)
	Nurse-Relative/Patient Conflict	(5 nurses)
Language Barrier	Communicating with interdisciplinary units, patients And patients	(7 nurses)
Physical Environment	Extreme heat and dust affect health	(3 nurses)
Family-Related Matters	Missing family's presence and	(3 nurses)
	Conservative culture	
Death and Dying	Process of dying	(3 nurses)
Discrimination	Racism	(13 nurses)

6.3.1 Workload

Workload was one of the factors that consistently emerged during the interviews as a stressor in the working lives of the nurses. Eight nurses (40%) in total out of all participants verbalised that they experience high level of stress at work One of the respondents summarized this by commenting:

Nurse 15, who has 14 years of experience in nursing and hold Bachelor Degree in Nursing says *"I think basically here the bottom line is here there is a lot of stressors, frustrations and more work, I always experience high level of stress because of too much work"*

Other participants stressed:

Nurse 6, who has 5 years of experience says *"…there are few times that we go home late, we have many patients, there is too much task…if you are the team leader and you are handling nine (9) patients and other responsibilities, I am stressed all the times, this can't continue…"*

Nurse 9, who hold a Bachelor degree in nursing and has 5 years' experience as a nurse *"just as usual, more work with fewer nurses, we are used to this, I am not able to sleep well during the night because I am stressed all times and thinking about work"*

Nurse 3, who has 28 years of experience as a nurse in general and 12 years in KSA says "I have no more time to take my break, the unit is always full, and the patients here are very demanding, this caused me high level of stress all the times"

Nurse 19, who has 10 years as a nurse says *" I have a problem every shift with the number of patients I am looking for, and not only the numbers, it's the dependency, the patients are very demanding and require a lot of care, I have raised this issue to my manager many time, but no use"*

Nurse 13, who has 6 years' experience as a nurse *" I am looking after 8 patient every night, do you think this is fair, if I have to give medication and do all writing, documentation and feed many of them, I will have no time, it's too much"*

Nurse 1, who has 7 years' experience as a nurse says *"If you look at our patient care, it is getting very bad, more incident reports, more patient falls and more pressure ulcer, we always short and still expected to do everything to patients, this is not realistic, patient safety is a major concern to me and that is not how I dreamt about when I became a nurse, when I go home, I still think about patients and can't sleep because of too much stress all the times".*

Nurse 17, who has 12 years' experience as a nurse *"More nurses are taking sick leave or not returning from annual leave, all this because of the hard work we do, no break is taken, I am having frequents incidents of stress every time I come to work, from supervisor, patients and families"*

The subthemes that emerged from this theme of workload are discussed below.

6.3.1.1 Nurse–Patient Ratio

Throughout the interviews, it became clear that one of the major stressors that the nurses experienced was the necessity of having to nurse more than six patients at a time during a shift. When the co-researcher sought to find out what the ratios were, the following statements ensued:

"The most stressful maybe is the shortage of staff here in the city because; we don't have a lot of staff which make things more complicated …"

The nurses here expressed their frustrations at having to nurse more than six patients at a time during a shift. They felt that this requirement created risks not only for the patients but also for the nurses concerned. Nine nurses (45%) participants commented that the number of patient care is high, nurse 4 with 8 years nursing experience and, nurse 6 with 5 years' experience and nurse 11 with 14 years nursing experience stated that they usually take care of six to eight patients every shift, and that is tiring and cause them a lot of stress. Nurse 3 with 28 years of experience in nursing, nurse 8 with 9 years' experience, nurse 14 with 22 years nursing experience and nurse 19 with 10 years' experience stated that they are avoiding doing night shift anymore, because the number of nurses during the night is much less than the day, they have to wash the patient and there are no enough nurses on every shift.

Nurse 1, with 7 years' nursing experience stated that *"What about this issue of six patients. Ratio of six is to one? Is it really practical? Or is it endangering the lives of patients? It is very risky, the type of our patients are very different from*

other patients, they are fully dependent on nurses. I am telling you it is dangerous….., you're going to harm these patients"

Nurse 2, with 17 years nursing experience mentioned that *"You can't just cope because of the workload. So, you are left a cut in between and what you'll do you'll put your priorities right according to you but when the bosses come they are like you are not doing anything".*

According to Unruh (2008), the implications of specific nurse-patient ratios in specific clinical situations have not yet been scientifically determined. In spite of this, nurses' organizations have made their own recommendations for an optimal nurse-patient ratio. Among the organizations that have made their views clear on this matter are the American Public Health Association (2005), the New Jersey hospitals and the California's nurses-patient ratio (2010). It is a unanimous view of these prestigious professional organizations that the ideal nurse-patient ratio in general acute units should always be 1:4. The proof obviously demonstrates that sufficient staffing and adjusted workloads are key to accomplishing great patient, attendant, and budgetary results (Agency of Health Research and Quality, AHRQ 2012). A large study conducted in the United States concluded that the higher the patient-nurse ratio, the higher were the incidences of patient mortality, nurse burnout and nurse job dissatisfaction. This study showed that an increase of the patient-nurse ratio by a factor of one increased the incidence of burnout and job dissatisfaction by 23% and 15% respectively, while raising the nurse-patient ratio from 4:1 to 8:1 more than doubled the level of job dissatisfaction among nurses (Audit Commission 2001:3).

Storch (2005 p219) expresses surprise at the way in which this evidence is generally ignored by noting that, “there is a substantial amount of good research evidence on the relationship between nurse staffing and patient outcomes that seems to be ignored”.

The findings in this research are supported by similar findings in other studies that have cited the nurse to patient ratio as the leading cause of stress and burnout in nurses. In a study that focused specifically on English nursing staffing ratios, Rafferty et al (2007) found that those nurses in hospitals with the heaviest patient loads were 71% more likely to experience high levels of burnout and job dissatisfaction than nurses in hospitals with more favourable nurse-patient ratios. According to Jenkins (2004), the lack of adequate staffing was the key stressor for nurses, while dealing with demanding patients was the most stressful aspect.

6.3.1.2 Documentation

At the beginning of every shift nurses are required to document all the activities and circumstances that affect the patient and his or her health care. Documentation provides evidence of the kind of care that is being given and the response of patients to that care, and it therefore constitutes an essential link between the care that is being provided and the condition of the patient. Since documentation also permits those concerned to make an evaluation of the care being provided, it acts as a means of communication between all those who are involved in the provision of health care in a particular case. In spite of this, the participants in this study reported the necessity for documentation as a source of stress. Seven nurses (35%) nurses (Nurse1, nurse 12, nurse

15, nurse 16, nurse 17 and nurse 19) expressed the opinion that there was too much documentation work that had to be completed and that the process of doing so was too tedious. Nurse 17 of the participants expressed her point of view in the following words:

Nurse 17, with 12 years nursing experience stated that *"…Stress is mostly work related. … Have to work with this documentation system, this gives more stress in work time especially if we have more load. When the doctors are doing their rounds or we have more orders, if we have complicated cases, it is harder to make the documentation"*

Nurse 12, with 7 years' experience stated that *"… maybe about the documentation, I don't know who decides on the papers, but if it is possible for somebody to decide on the paperwork, I think they can really rethink and to check on the paper work we are doing. Most of it you will find you are doing 2 or 3 times and it's basically the same thing. Why did you write it there, let's use one chart. That's why you'll find you have so many charts to write so even remembering – give me one, write everything there, I will do it and do it very nicely"*

The nurses felt that because the required documentation was repetitious and time-consuming, it interfered with their work and prevented them from giving the best possible service to their patients. Some even noted that documentation had become such a problem that the relatives of patients sometimes commented on the amount of time that they spent writing. Here is an extract from the interviews on this topic:

Nurse 16 "a lot of writing but you don't touch pts. It's very true. If I'm supposed to assess my patient 2 times in a shift, when

is that I'm supposed to write all that, make sure that the lab results are there, you have a nursing care plan and make sure the dates are all there, the names of the patients, in the morning, if your initial assessment form is not filled fully, you fill that one, you haven't seen it you are seeing it this morning, what are you telling me?"

The implications of the nurse-patient ratio and the process of completing documentation were also established during these discussions. The nurses felt that documentation became particularly excessive when they had to provide care for seven or more patients at the same time. Here are some of the remarks the participants made:

Nurse 15, with 7 years of experience state *"Ok, what happens, I think the ratio of nurses should remain one nurse to four patients because when it becomes six to seven, and you have a lot of documentation, you have a lot of papers to write, you have a nursing care plan, our charts are so detailed and you have to fill all of them. If you have to fill them accurately and give that care and plan your care that you'll be able to deliver to your patient, then the ratio has to be one to four because mostly what happens, you'll plan that care, but you'll find you doing it as a routine, because somebody will come the following day, checking whether you have a nursing care plan, so you just plan your care and some of these things you are not going to be able to meet them. You're just planning them for routine and to satisfy somebody. So, can we work? Can we do things that are realistic? I think documentation is too much. We can compile them and reduce some of those things because they are repetition. And that is part of a stress to us"*

Nurse 15, with 14 years of experience says "the challenges of writing too much especially when you have six patients. It's really very tiring. Because you are expected to perform and you are expected to write and you are expected to do everything and at the end of the day you are just burned out"

Some participants felt particularly unhappy about the issue of documentation because it was inevitable that their supervisors would reprimand them if they had not completed the necessary documentation regardless of the number of patients that they were being required to handle. The participants made it clear that it was a common practice among nurses to document what they had not done in order to avoid the repercussions of not having completed the documentation.

Nurse 19, with 10 years nursing experience *"And also a lot of writing as well. Uhhmm it also takes you away from patient care to an extent … and ahh the fact that you're scared. Ok yah, you could create time work on the patient and sit down to write later. But should your big person come and see that you have not this that should have been done this far then your explanation may not be acceptable … In fact, you are even safer documenting what you have not done and then do it later (laughter from the participant) which is a big risk to the patient and also unethical, I am not saying I am doing this, but I know it happens".*

Nurse1, with 7 years of nursing experience stated that *"then the other thing I would say is that we do things to avoid like I'll write that I have taught a patient to avoid being asked a question. I'll write … There are some forms which we write. In the essence, I haven't taught but because I don't want that*

thing that can make you stay for another hour, or somebody to nag you – ok I don't mean it nagging if it is a procedure or whatever. If you haven't managed, you haven't managed. But it comes to a point where it should be done regardless of what and what and what. So most of the time I'll write whatever I'll write so that I don't get that bashing, so I can go home on time".

Nursing documentation as a source of stress has already been cited in other studies of nurse burnout, for example, incomplete documents and missing documents (Gugerty et al 2007; Sehlen et al 2009).

6.3.1.3 Float

Floating of nurses from their original units was considered to be a source of stress. Emotions about nurses floating were mixed, some recognized that not floating might be a nurse satisfier and possibly a patient satisfier. In the meantime, it was noted that closed units make less staffing less adaptable and eventually make it harder to cover sick time, vacation time, and other absences (Hart and Warren 2015). Four nurses (20%), with 11.5 years means of nursing experience highlighted their concerns in regards to float to other units. Participants made the following comments:

Nurse 2, with 17 years of nursing experience stated that "Maybe because I am not used to working in a different section… not comfortable working with other units… being floated is part of our job. But I think … the one floated to do general help but the ones stressed were those left…in the unit...with less one staff…"

Nurse 1, Nurse 4 and nurse 11 with means of 9.7 years of nursing experience stated that "I do not like to float, when I come to do my shift every day, I pray I will not be called by the nurse supervisor to be floated to another area, this is not fair, whenever I float, I will have more patient load"

Nurse 18, with 10 years of experience says that "it's is very usual to get called by the nursing supervisor to be asked to float, this is very stressful, I don't like going to other units"

Nurse 20, with 11 years' experience says "I get lot of stress when I have been asked to go to clinical areas where I have no experience, and not used to".

Floating can cause nervousness among nurses who float to units where they don't feel they have expertise. Sensible use of floating and well-managed float pools facilitates retaining nurses on "home" units where they frequently feel they can practise most effectively. While the overall idea of floating is a familiar one, nurse "floats" may mean something different at different hospitals. The use of float pools has encouraging results with regards to reduced (or no) use of outside agencies, better staff satisfaction, self-scheduling, reduced stress for regular (non-float) staff, and improved flexibility with staffing (Hart and Warren 2015).

Qualitative workload covers demands that are too complex for the expatriate nurses to perform because such workloads are beyond their abilities. This includes role ambiguity, making presentations, greater responsibility when the doctors are not around and difficulty in the use of specialist equipment.

6.3.1.4 Time Pressure

The participants in the interviews also expressed how much they were stressed by the pressure of time during shifts. They related these time pressures to heavy workloads and poor and inadequate staffing. In total 4 nurses (20%) (nurse 2, nurse 8, nurse, nurse 13 and nurse 14) with 13.5 years mean years of experience reported that they felt so exhausted and stressed by the end of their shifts that they could not even attend to their own personal needs such as, for example, preparing and eating a proper meal. As an example, below comments made:

Nurse13, with 6 years of experience stated that *"the nature of the unit and the conditions that are handled there it makes you work with the sense of urgency of time. Like, for example, you have seven things that are all being termed as urgent and you have to come up with a priority, it could be one it could be seven … workload also becomes an issue in that you are always having something to do at one particular time. So, if for some reason, you go out …you run out of time if you had 2 things you needed to have accomplished by lunch time that lags behind all through the day"*

Nurse 14, with 22 years' experience stated that *"imagine from morning to evening, and like, you have two patients who are critically ill, even going for lunch, you don't even get time to go for lunch, or you take your lunch at 3 PM. So, it is quite stressing for us."*

Since the effects of time pressure and its implications for nurse stress have already been identified in various studies, this information supports what the participants in this study

reported as a factor that leads to the development of occupational stress. In a study by Adali and Priami (2002), time pressure was coupled with caring for the critically ill and heavy workloads as major factors that adversely affected the mental and physical health of nurses, and that therefore contributed to the onset and development of stress. In another study, Camerino et al (2008) identified "time pressure" as a lack of time to complete all the necessary work tasks of the nurse, thus making it one of the most significant causes of stress.

6.3.2 Cultural Competency

Cultural competency is a very important factor to ensure proper preparation when workers start new jobs in a culturally diverse setting. Immigrant nurses may lack the skills for and familiarity with the new work environment and may have limited experience in dealing with the new complex working environment, culture, health system and country's regulations (Moreno et al 2015). Problems with adjustment are related to work performance and work effort (Yu 2014). Socio-cultural adjustments relate to the ability to "fit in" or successfully interact with members of the host culture (Bozionelos 2009). It has been associated with variables that promote and facilitate culture learning and acquisition of social skills in the host culture (Yu 2014). Variations in culture, especially when working in Saudi Arabia, also constitutes a source of stress for expatriate nurses. Three of the nurses (15%) stated that:

Nurse 14, with 22 years' experience as a nurse says "*Here in the City…the way we talk to Muslim patients...they are very conservative…so we are misunderstood because they talk about so many things that should not be done…"*

Nurse 17, with 12 years of experience and master degree in nursing says that *"it is a very strange place from home, people have different culture and understanding from my country, this is a very new experience to me, but it is at the same time stressful"*

Nurse 19, with 10 years of nursing experience says *"being able to understand other culture will surely help me to better communicate and understand my work"*

6.3.2.1 Culture Shock

Culture shock is "the tendency for people to become confused and disoriented when adjusting to a new culture" (Greenberg and Baron 2003, p188). The first phase of culture shock lasts a few months and includes optimism and excitement about the new culture. After several months, individuals enter the second phase of culture shock where they experience frustration and confusion while attempting to learn about and adjust to their new cultural surroundings. This is the low point in the process that should dissipate after 6 months (Kirch 2008).

Eight nurses (40%) highlighted their concerns in regards to the Saudi culture, and that they find it very difficult to cope. Six nurses with 11.3 years of nursing experience (nurse 1, 5, 8, 14, 19 and 20) stated that they feel shocked, and that there are many difference in their own culture and Saudi culture, the other two nurses stated the following:

Nurse 4, with 8 years nursing experience “I found it very, very different this hospital. This is the harshest nursing environment I’ve ever been in. Speaking for my own hospital, systems are bureaucratic, it is a culture of blame, everybody is blaming, and they don’t look at what part of the systems enabled that person to make a mistake”

Nurse 7, with 9 years nursing experience says that “the feeling of culture shock happened to me when I was new to this place, I got scared, patients and family think hospital is their home, they do not respect nurses”

Hospitals in Saudi Arabia combine collectivist cultures, individualist cultures, and multicultural societies. Such diversity in the hospital setting makes organizational cultures unique in every organization. The employees working within the organization best described organizational culture.

6.3.2.2 Cultural Knowledge

The concept of cultural knowledge embraces the process of learning about cultural worldviews that are different from one’s own but which are critical for cultural competence (Almutairi et al 2014). Five nurses (25%) explored their prejudices toward the practice of Saudi nationals, using their own cultural background as the criteria of an acceptable culture.

Nurse 6, with 5 years’ experience says *“…the culture affects my work; I was stressed when this patient did not allow me to do a procedure because of different culture… for them, it is not accepted…”*

At the same time, nurse 10 with 7 years of nursing experience applied a rigid Anglo perception of social etiquette as the standard for shopping and Saudi national behaviour, failing to comprehend the social roles these acts play in Saudi life and how time can have a different meaning to the one expected by the Western world:

"it is very annoying the efficiency of people in this place, they are very slow, I think people are laid back here, not like at home, things are done well and fast"

In light of the nurse's limited knowledge regarding the cultural beliefs and practices in the Saudi context, the participants' experiences indicated that some of them used critical thinking skills when they examined their patients. They reported, for example, that some people, especially the elderly, tend to withhold information about their pain due to cultural norms around pain. Some people tolerate pain stoically as they believe that their sins will be taken away from them if they do so and that they will consequently attain greater rewards in the hereafter. Nurse17 with 12 years nursing experience described how knowledge of such aspects of the patient's culture enables better care:

"You will find that old patient, he is in pain maybe, or I see that there is a possibility that he is in pain, look at the operation or whatever he has done. And you will know that the patients could have a pain and the patients may be saying 'la la la ma feeh alam' [no, there is no pain]. And you see that because of his culture that he does not want to show that he is in pain. So, for you just to say even if it is ok, I can give you something for pain even if it is shwayah [a little], is it only

shwayah. Most of the time patients say that no, he does not have pain, but you as a nurse you know that it is a very painful operation that he had, and you have to think that this patient will have pain"

Sometimes the nurses perceived culture as a hindrance to effective care provision; however, generally they all tried to apply their cultural knowledge to elicit undisclosed complaints and to make their patients comfortable. For example, they understood that Saudi people are very religious, subscribing to the fatalism of 'God willingness'. They frequently described how Saudi people believe that health and sickness are caused by God and how they readily accept what God has in store for them. The following illustrate this idea:

Nurse 11, with 14 years of nursing experience says *"Saudi people are more religious and they believe in God willing and everything from God. Also, here the patients believe their disease is from God and their health … whatever they get is by God's will"*

Nurse 12, with 7 years of nursing experience says *"They come here with crying child. So, I said this is the ward hospital ok? The virus can go to the small one, they said it's ok, that is 'kada and kadar' so this is 'written by Allah' by our God so if the virus is meant for this child I will accept it".*

6.3.3 Inter-relational Conflict

Collaboration between the health care providers, an organization's administrators and the relatives of patients is critical to ensure that the patients are given appropriate treatment and care. Unfortunately, however, collaboration is

not always achieved among those concerned, and this can lead to the development of conflicts between the nurse and the other parties with whom they come into contact. Shimizutani et al (2008) noted that all forms of conflict are interrelated. They point out, for example, that nurse-nurse or nurse-physician conflicts are closely related to the conflict that arises between nurses and patients and their relatives. The escalation and interrelation of these conflicts add an immense burden to the stresses that nurses already have to bear. These researchers suggest that increases in the incidence of nurse-nurse conflicts and nurse-relative conflicts elevate the scores of other stressful factors and that such increases ultimately lead to stress.

Herr (2015) stated that the main reason for stress at work focuses on the nature of the relationship in the workplace. The enormous pressures of practising a profession in a stressful and constantly changing environment may increase the prevalence of stress among nurses (Ledgister 2003).

6.3.3.1 Nurse-Nurse Conflict

Three nurses (15%) with the mean years of nursing experience of 10.3 years explained that their relationships with their fellow nurses were not always good, as is suggested by the remarks below:

Nurse 1, with 7 years of nursing experience says "there's something else I want to add. There's also a stressor that also comes from within ourselves. Maybe I may not mention … I may not say it's a particular group but I've had instances where a colleague reports the other colleague … without

even discussing. Maybe there's an issue. We're in the same group, you wonder why, your colleague cannot come to you and tell you what you did not do, and instead they go and complain"

Nurse 11, with 14 years of nursing experience says" Actually me I have been a victim of such incidents. Just another nurse working in another unit at night comes and looks at my chart he sees what I have not done this, calls the boss, in the morning boss comes straight to what I have not done directly and there is something inside"

Nurse 19, with 10 years of experience says "Exactly. There are those of us who feel so sweet and so clever that we can actually go and discuss the rest of us with the bosses. I mean that is really de-motivating. It demoralizes, because how do you for heaven's sake feel that I'm the worst and you go and discuss me in a very high powered eh, kwani who the hell are you (laughter) and then of course that will ripple down of course the wrong way, yah and you won't be happy."

The feelings expressed by the participants had been reflected by nurse participants in other research studies that have shown that nurses have a difficult time in making transitions to new work environments. In a study by Casey et al (2004), a novice nurse described the difficulties she experienced with peer relationships. She felt that these difficulties were attributable to a lack of acceptance and respect on the part of other nurses and that this had made her transition into the new working environment much more difficult than it should have been.

6.3.3.2. Nurse-Nurse Supervisor Conflict

This sub-theme was discussed extensively and was related to many other themes. Some nurses expressed the opinion that they preferred to work shifts at night and on weekends because at such times they were able to enjoy a minimal amount of contact with their supervisors. Five nurses in total (25%) with 10 years of nursing experience as a mean stated the following:

Nurse 17, with 12 years of experience says "I enjoy working at night…. with minimal supervision … I'm able to work perfectly … and comfortably … if I work during the day, especially on a week day ... eh ... Every time I work, I'm panicking the papers will be found on the floor… I'll be … I'll be insulted or I'll be … So, I prefer working at night and especially the time I work comfortably is at night, weekends……Because it is very, I am bombarding it as a dictatorship. You are going to do appraisal so you are not expected to say no""

Nurse 20, with 11 years of experience says "let me tell you some of these experiences are so traumatic and degrading, you know. For an adult to get to a level of, you know, you know (gestures). You know for an adult to get to that level and it's not on any specific personal issue that person is really stressed, that person s really traumatized. That I shall see you (the supervisor) from this side…. you have nothing specific but I'm sure you shall pick on something so, you are not better than me or smarter than me"

The nurses described how their immediate supervisors used what they called a "dictatorship" mode of management.

Nurse 2, with 17 years of experience says "Mmm I think what I'd say is that. I would say there is autocratic mode of management"

This dictatorial and non-consultative style of supervisor has led nurses to feel that they are not supported and trusted by their immediate supervisors. The nurses felt that they were unable to approach their supervisors about important problems in matters of procedure because of the fear of supervisors that had been instilled in them and because of the apparent unapproachability of their supervisors.

Nurse 13, with 6 years of nursing experience says "So all the nurses have very low esteem. They are demoralized and uuhh everybody feels like taking off. Because you can't actually sit down and have a proper discussion with the boss. You will be threatened, you will be abused…you'll be traumatized and you'll be threatened even with sacking on the spot. So, that makes it a very hostile environment to work in"

Nurse 7 with 9 years of nursing experience says "alternatively just observe peoples moods. Such that if there is a day this particular person is away, people can speak.... and laugh. People can share. You can walk in confidently but this other day, people are like what have the voices got to say first, who's around, I can say it or ... you know. You are so panicky…. I mean…there is a tension, apprehension. You know, you don't know what shall be picked at this time. It comes…. I think it's a very unhealthy way of life"

The widespread occurrence of nurse-supervisor conflict has been established in many research studies on burnout. In a study by Flecher (2001) of 1,780 nurse respondents, it was

found that the quality of supervisor support and supervision was lowest for nurse managers. The nurses in the study described the following difficulties: inadequate unit leadership, a frequent turnover of nurse managers, prolonged physical absences on the part of the supervisors of units, and the failure to address important problems. In the latter case, the nurse managers simply swept the problems aside or were not even aware that they existed. The evidence shows that they were mostly also unaware of all the difficulties relating to staffing issues.

6.3.3.3 Nurse-Physician Conflict

A factor identified by the nurses that leads to the development of stress, are the conflicts that occur between nurses and physicians. Because the research setting is such a complex organization, it needs to employ a large number of expatriate staff in different roles. Among these employees, physicians and nurses are indispensable for the efficient operation and organization of a hospital. The interactions between physicians and nurses, therefore, constitute an extremely important function in the provision of service, equal in importance to the soundness of the hospital's infrastructure. Some of the participants in the study noted that some physicians made comments to the effect that particular nurses should not be allowed to handle their patients. Such comments are obviously a source of extreme humiliation, stressful and demoralizing. They were also of the opinion that some of the physicians treated them like machines. Working with the medical team causes stress on the immigrant nurses. Six nurses (30%) with 9.8 years of nursing experience as a mean claimed that:

Nurse 1, with 7 years of experience says "it is very annoying the way I get treated, especially from my supervisors and the medical team, they demand a lot and whatever you do, there are not happy and complaining".

Aside from the stress that progressed from patient care, the immigrant nurses also avoid some doctors who easily get angry, some participants made the following comments:

Nurse 6, with 5 years nursing experience says "…when the doctor came and the doctor seems like to have not a good way of communications with the nurses, … it gives me stress because maybe some other times the staff will not entertain the doctor or maybe they try to avoid the doctor… that time. The doctors have a special character that sometimes they are arguing what ah, the nurses complain to the doctor regarding the patients' needs."

Nurse 3, with 28 years' experience as a nurse says "…that sometimes they are not listening to us or they are ignoring our opinions about the things which happen here… this will make you disappointed and feel that you are useless here. You just follow orders like a machine…"

Nurse 7, with 9 years nursing experience says "I think the doctors, they are some, but not all. They make us feel like we are not doing like … yeah. Because they like, harass you and create an emergency which is not an emergency. In that case, you feel like, they are actually taking you, like, a machine and it is as if you don't know what you are doing. You feel frustrated at the end of the day even if you came in …"

Nurse 2, with 17 years nursing experience says "even here there are some doctors who will say. You see, if your patient is given to that nurse, that one is better. This one, I don't like, you see?"

That this kind of conflict is highly widespread in clinical settings has also been expressed in other studies. In a study of Zambian nurses, Munthali, Bowa and Odimba (2008) reported that 29% of respondents attributed their conflicts with doctors as a major source of workplace stress. This is confirmed in a study undertaken by Rosenstein (2002), who conducted a survey of nurses, physicians, and healthcare executives in a variety of different hospitals and in which the respondents reported some degree of disruptive physician behaviour in their institutions. It also reported that both the physicians and the nurses in the study agreed that such conflicts undermine the confidence and morale of nurses. Some of the participants stated:

Nurse 13, with 6 years nursing experience says "I think the doctors – they are some, but not all. They make us feel like we are not doing like … yeah. Because they like, harass you and create an emergency which is not an emergency. In that case, you feel like, they are actually taking you, like, a machine and it is as if you don't know what you are doing. You feel frustrated at the end of the day even if you came in"

The respondents also agreed that such conflicts adversely affect the attitudes of all members of staff to patient care, but they inhibit the effectiveness and viability of teamwork and that they exert negative outcomes on patient care. These findings of further supported by Demir and Kasapoğlu (2008),

who undertook a qualitative study on Turkish nurses with the purpose of obtaining more information about the influence of nurse-physician relationships on the therapeutic effectiveness of hospitals. These researchers established that the situations that made nurses most uncomfortable in their work arose out of the conflicts they had with the physicians with whom they had to work. They claimed that the physicians did not respect them, that they (the physicians) had poor communication skills that they acted in a superior manner and interfered with the work of the nurses in a way that made their tasks even more difficult.

6.3.3.4 Nurse-Relative/Patient Conflict

The immigrant nurses also experienced the lack of trust and respect from patients and their relatives with patients calling and demanding many things from them. The relationships between nurses and patients and the relatives of patients should be a therapeutic one, but since nurses have to work closely with people who hold different values and beliefs and who have been raised in cultures that are different from their own, relationships with such people can be a source of conflict and disagreement. This was expressed by the nurses in this research. Five nurses (25%) with 10.2 years of nursing experience as a mean verbalised the following:

Nurse 9, with 5 years of nursing experience says "there is a patient here … with traumatic brain injury; at times, they are very impatient and they are very irritable … they want you to do anything for them."

Nurse 17, with 12 years of nursing experience says "it is very hard to get on very well with patients or their family here, they are demanding too much and never listen to you, this is very stressful and I get fed-up"

Nurse 3, with 28 years of nursing experience says "when a relative comes and I answer patients relative and I tell her this is this and then she goes and says the nurse was rude- you should first come to me and ask me what happened, how did this go? And in most cases, even in most offices, you cover your people then apologize and all but don't go bombarding the same nurse in front of this patient who you expect to live with the same pt, how will the patient trust you."

Nurse 5, with 9 years of nursing experience says "what I feel is that the relatives have been given so much freedom, such that a relative can come shout at a nurse, go to the office, somebody sits there and listens to this relative … When a relative comes and I answer pts relative and I tell her this is this and then she goes and says the nurse was rude …"

Nurse 6, with 5 years nursing experience says "so if something, even if it's not anything major, the patient family will just call. Like we had a patient just two days ago, the patient could tell the nurse call for me my doctor so and so. Then when the nurse is trying, the patient is calling the doctor on the mobile. When the nurse going to give him a feedback ati "I can't get the doctor, the phone is engaged" at "I've already talked to him" so you feel just there, you feel intimidated".

6.3.4 Language Barrier

With respect to language, the nurses indicated that during the general nursing orientation the hospital introduced them to some Arabic terms frequently used in patient care. In addition, courses in the Arabic language were available throughout the year. Although the classes were free and they were encouraged to take advantage of these opportunities to become more conversant with the language, the participants found that their work schedules were very tight and their workload very high, which hindered their attendance. The frustrations that nurses experience often arise because of language difficulties (Dicicco-Bloom 2004; Xu 2007). In order to carry out assigned tasks effectively, the nurses have to communicate with colleagues in their department as well as with other interdisciplinary units. The language barrier brings about stress in the workplace, especially when dealing with non-English speakers. Seven nurses (35%), with 11.5 years nursing experience as a mean stated the following:

Nurse 8, 9 years nursing experience says "…sometimes when communicating with others, you need to repeat your sentence once, twice, thrice just to make sure that they got exactly your point and we have mixed nationalities, my colleague as a non-English speaker and even myself, … we have to make sure that we have the same idea on the tasks that need to be done…".

Communication included interdepartmental communication, language barriers and cultural habits that impede effective communication. Participant 3 described an incident:

Nurse 3, with 28 years nursing experience says "when an inpatient arrived in the outpatient department for a procedure.

When taking the patient back to his room, I tried to explain to him how to apply dressing and pressure on his wound to know how to care for it, I couldn't, and there was no one speak Arabic to help at that time, I have to go to my unit without explaining well to the patient, this is frustrating sometimes"

Nurse 9, with 5 years nursing experience says "using translators to gain information from a patient does not provide good care. I wanted to be able to hear the information myself because I am not sure what the translator has said and if the patient is getting the correct information"

Nurses 4 and 11, 15 and 19 with 11.6 years nursing experience as a mean stated that the hospital has a policy that the speaking languages are Arabic and English. Nurses stated that they hear the nurses speaking to each other in their own language that others can't understand. They stated this is not a problem if the conversation is personal. When it comes to patient care, the policy is to speak English or Arabic only, speaking in other languages cause stress to us as many staff do not adhere to the policy.

6.3.5 Physical Environment

Physical work affects both job performance and job satisfaction (Newsham et al 2004). Griep et al (2011) highlight the importance of the interaction and fit between the individual and his or her environment; different working conditions can result in work environments that are either favourable or less favourable to an individual's mental, physical, social and psychological health. The extreme weather in KSA added to the immigrant nurses' stress in the workplace. Three nurses (15%) with 7.2 years nursing

experience as a mean raised a concern in regards to the physical environment:

Nurse 9, with 5 years nursing experience says "the weather is a little bit stressful, especially now it is getting near summer and the centigrade is getting 50."

Nurse 7, with 9 years nursing experience says "I am worried about my health, you know, I have a lack of sleep actually… is one of the causes of stress because of temperature and the air conditions."

Another participant disclosed that:

Nurse 8, with 9 years nursing experience "It is more stressful on summer time, I really feel sick because I am very sensitive to heat, you can't do anything outside for almost 7 months, days and nights"

6.3.6 Family Related Matters

Other stressors outside the workplace include conflicts between home and work life for those who have young children to care for (Jackson et al 2007). Nurses are exposed to a wide range of human emotions due to the nature of their job; conversations with family and friends trigger stress (Gillespie and Kermode 2004; Halvorsen 2006; Gholamzadeh 2011). Increased levels of work and family-related stress have been associated with greater health risks, lower performance, lowered productivity at work, reduced life expectation, higher work-related strain, increased anxiety level and decreased marital satisfaction (Small and Riley 1990; O'Driscoll et al 2003). The expatriate nurses at SBAHC

found it hard to work effectively when they were thinking of their family back home. They wish to be with the family after work. Three nurses (15%), with 11.5 years nursing experience as a mean stated the following:

Nurse 1 with 7 years nursing experience says "…when I go home from duty still have stress because I am not with my family, no life, I am missing my children back home, they are not there for me, doing always the same thing, work and back to sleep…"

While another nurse declared that:

Nurse 2, with 17 years nursing experience says "…that's also one of the factors, one of the stressors I had, being away from my family, I see them every two years only for one month because I can't afford to pay for an extra ticket…"

Still another nurse stated that:

Nurse 20, with 11 years nursing experience says "Because if you are lonely, if you are over stressed with work, when you go home everything will be kalas! Because the family is there to support you, but for us, it is very difficult… to be far away from your mother, from your brothers and sisters..."

6.3.7 Death and Dying

Watching a patient suffer and feel helpless when the patient fails to improve or may be dying can cause distress amongst nurses (Huang 2004; McCarthy 2010; Negi and Bagga 2015). Death and dying are another stressful experience for some of the expatriate nurses in SBAHC. This can be extremely

emotionally draining for the nurses concerned and can exert an injurious effect on their physical and emotional wellbeing. Some participants expressed their frequent contact with death and dying and the need to comfort grieving relatives as being a source of stress to them. Three nurses (15%) with 15.6 years nursing experience as a mean commented in the following way about this stressor:

Nurse 3, with 28 years nursing experience says "I feel so sad, when a patient dies, because ahhh you are taking care of the patient, for him to have a long life, but I guess there is nothing else can we do, but still I get very stressed about it…"

Nurse 6, with 5 years nursing experience says "death is a big challenge … ok, it's a challenge, we are having deaths, in fact, and we don't like to see patients die. I feel too stressed when patient dies in front of me. Sometimes they die and maybe you are happy because they have suffered but in our mind, that's not what we want … death of a patient is stress in that you shall feel like you are losing … you've lost a battle. You'd like the patient to maybe improve and go to another ward"

Nurse 11, with 14 years nursing experience says ": … especially like when you lose a patient, you've done quite a lot and at the end of the day, Yeah, you have to let go, you have lost'

Two nurses, however, noted that death did not affect them negatively. This is what they said:

Nurse 1, with 7 years nursing experience says" about patients dying it doesn't affect me so much because nearly every day

they die (laughter). I don't cry, I don't feel anything about it. I take them to the morgue and I come back take another one and then go home"

Nurse 14, with 22 years nursing experience says "ok for pts dying, I'll just wait for the next admission (laughter)".

Such individual differences in attitude among nurses are not uncommon. When a professional such as nurses becomes deeply burned out, a degree of depersonalization develops that enables the person concerned to become hardened to the tragedies that surround them in the workplace and this may manifest as being completely unmoved by events that are deeply upsetting to other people. Hayes (2015) explains this by saying that the person suppresses the feelings of loss and grief associated with death because they need an emotional shield to protect their inner self against assaults so that they can carry out their duties without collapsing.

6.3.8 Discrimination

Discrimination was described by 13 nurses (65%), the mean years of nursing experience for those nurses were 10.9 years, feelings of discrimination were an experience felt significant by them and were described as very frequent. The participants felt discrimination in several ways including differences in salary and benefits compared to nurses from other nationalities, being looked upon as servants and treated as such, and different levels of respect between cultures from patients and family. In KSA, immigrant employees compare workplace inputs, job demands, remuneration and benefits received to those from different nationalities (Morrisey and Nelson 2007). Some immigrant nurses at SBAHC feel

dissatisfaction with their job and discriminated against because of the unequal salary and promotion scheme based on nationality and a lack of recognition from their supervisors. Some of the participants in this study expressed the opinion that an adequate salary or monetary remuneration is one of the most important factors in maintaining a person's faith in their career and employment situation. Seven of the nursing participants declared that the reason for working is to obtain sufficient funds to sustain a reasonable standard of human life. If employees therefore feel that they are being unfairly and inadequately remunerated for the work that they perform, then they are bound to develop stress in the long run because of the difficulties of trying to sustain the necessities of life and family on inadequate and unrealistic salaries. This was the view of some nursing participants in this study. Below are examples of statements by some nursing participants:

Nurse 3, with 28 years of nursing experience says "I admitted that nurses' I worked with earn half my salary, yet they are doing the same job with the same level of education. I felt the salary and benefits scale created problems in the workplace because a co-worker would say to me, "You are making more money than me, you do it……. There are Jordanian, Filipinos, South Africans, Malaysian…all of them are having the same work but not having the same amount of salary that they receive; just because they are Filipino or Jordanian, they have very low grade when it comes to the position, but they are on the same level…but different payment, we came for money and nothing else"

Nurse 5, with 9 years nursing experience says "I witnessed patients, families and physicians treating some nurses like servants'

Nurse 16, with 2 years nursing experience says "I feel disrespect from some Saudi patients and family because I am a female, non-Muslim, and non-Saudi"

Nurse 18, with 10 years nursing experience says "I witnessed different levels of respect from patients and families toward different nationalities in the hospital. For example, families speak down to Indian nurses but do not speak down to Filipino nurses"

Nurse 9, with 5 years nursing experience says "already twice salary increase I never received. Foreign nurses here don't have the rights, even though you are on the right side."

Nurse 1, with 7 years nursing experience says "it is very disturbing that I am only entitled to one ticket every two years when others are having it once a year because of my skin colour……. And again, there is a lack of motivation in terms of money. Because you toil like this, the same, if you are taken to the ward, you'll have a good time and yet you are not being recognized. As in now we are talking about ICU allowance, what is 2000 or 500. It's not motivating. Its better you work where you are relaxed, your mind is relaxed, you won't get ulcers, you won't get ma hypertension and you are just earning a little money. I mean there is no money!"

Nurse 7, with 9 years nursing experience says " I feel very bad when I see others get paid twice as I am paid when I have more experience and qualification than many others, it is not fair at all, it is just because of their nationality"

Nurse 2, with 17 years nursing experience says "when I apply for education leave, for a small training or course program, I was not given the opportunity in the same way like Saudi's or staff from Europe, this happens very often, and I am fade up to be honest from applying, I will not apply again, it is useless."

Nurse 17, with 12 years nursing experience says "in my opinion, there is too much discrimination in KSA, and at our hospital as well, I can give you many examples, one recent one is when I applied for a pass for exit re-entry visa, I was given single one, when another colleague of mine applied and because he is from Lebanon, he was given multiple exit re-entry visa."

Nurse 19, with 10 years nursing experience says "even in the Cafeteria there is discrimination, you go to Cafeteria, if you are from Philippine, and you had bad quality food, with separate cashier and separate entrance."

Nurse 20, with 11 years nursing experience says "If you ask about discrimination, my answers is surely yes, it is very clear, your salary, annual leave, contract etc…, depend on your nationality and not how you do."

Nurse 4, with 8 years nursing experience says "when I applied for maternity leave last year, I was paid only for 2 weeks while my colleague got paid for two months because of nationality…they deal with staffs according to their nationalities; some people from category D and doubled paid if category B… people should be treated according to their qualification and education level… like in other countries, they

said productivity is based on their CVs and their performance…"

One participant expressed the opinion that she would rather find another job with less salary than continue to experience the degree of stress that was afflicting her life.

Nurse 15, with 14 years nursing experience says "you can imagine it has reached a point where I've said even if I'm paid less money I'll go for that job. I don't want to like the same type of routine, the same kind of stress, the same kind of people. The people don't change; I mean the management never changes. It's you who is expected to cope with any changes that come along.

6.3.9 Stress Coping Techniques

The many stressors that confront the immigrant nurses were alleviated by the nursing participants as revealed in Table 6.2. The stress coping techniques included physical activities such as walking and spending time in the gym, making friends, praying and communicating with the family through email and phone calls and through self-appeasement where they simply laugh off stressful conditions by being at peace with themselves and not thinking about stress. This is summarised in table 6.3 below with the frequency.

Table 6.4 Content Analysis of Narratives about Stress Coping Techniques

Theme: Stress Coping Techniques		
Conceptual Categories	**Codes**	**Frequency**
Physical Activity	Walking	(3 nurses)
	Go to the gym	(3 nurses)
Taking break from work	Vacation	(5 nurses)
Praying/Communicating	Phone calls and emails	(5 nurses)
	Praying inside the room	(4 nurses)

6.3.9.1 Physical Activity

Claims for the psychological and mental positive effect of physical activity have been studied and confirmed, it is suggested that physical activity reduce the level of mental stress (Salmon 2001). In the current study, three nursing participants (15%) stated:

Nurse 4, with 8 years of nursing experience says "I always run in the compound, it is a very good way to make me busy, after I finish running I go and take shower, it is very relaxing."

Nurse 7, with 9 years of nursing experience says "the best way I use to cope with the environment around me is by going to the gym, I spend every day at least one hour, this keep me fit and happy."

Nurse 16, with 2 years of nursing experience says "living in the compound that has its own gym is great benefit, which is one of the main things I liked, it is very handy, I go twice a

week and use the treadmill, it is excellent advantage that makes me cope better with the environment around me."

6.3.9.2 Spiritual Activities and Communications

Some authors have reported a firm association between a having profound sense of being (that includes praying) and the levels of stress experienced (Duncan 2000; Powers et al 2007). Previous literature has additionally indicated a connection between life stress, spirituality and emotional well-being (Tarakeshwar and Pargament 2001). Power et al (2007) exhibited the positive effect of spiritual well-being, existential well-being, and spiritual outlook on negative moods in light of life stress. Four nursing participants (20) stated:

Nurse 18, with 10 years of nursing experience says "I use praying as a good way to have some emotional peace, even though there is no church and I am not able to pray in public because I am not a muslin person, still I am praying in my room and this is better than nothing, but when I go home, I used to pray every week"

Nurse 9, with 5 years of nursing experience says "as a muslin person, this is a great place for me as I am able to practise my belief anytime and anyplace, this is a holy land and I am able to go to Makah at any time, it is really great"

Nurse 12, with 7 years of nursing experience says "every day I go to my room I pray, it is a good way to cool down, I am religious person, but it is shame that there is no church and I can't practise my religion in public"

Nurse 3, with 28 years of nursing experience says "god is always there for me I know, I came to support my family at home, there is four families live on my salary back home"

Five nursing participants (25%) stated that the use of communication methods like emails, telephone calls or 'Skype' was a great way of helping them to adapt and to able tolerate staying longer at the workplace; at the same time, they stated that thinking of the vacation they will get to meet the family and beloved one was a great way of coping.

6.3.9.3 Taking Brake from Work

Five nurses (25%) (nurse 2, nurse 6, nurse 7, nurse 8, and nurse 16) with 8 years of nursing experience as a mean verbalised that they are looking forward to have their break and vacation to see family and friends, and they feel much better always after vacation.

6.3.10 Nurses' Intention to Stay at SBAHC

Drafke and Kossen (2002) state that many employees experience satisfaction when they think that their future projection is good. The main judge of a nurse's intention to stay is job satisfaction while the major judge for job satisfaction is psychological empowerment (Chiu et al 2009). Job stress is related to job performance both, directly and indirectly, to job satisfaction and the propensity to leave. If employees are satisfied, their performance and productivity increases (Fried et al 2008).

The conceptual categories when participants were asked about their intention to stay at SBAHC included salary and benefits and job satisfaction. The immigrant nurses were generally willing to stay at SBAHC because they were anticipating that they would be promoted based on their performance. If they thought conditions would improve and they would get a salary increase, they were willing to extend their stay at the City. This was a surprising finding for the researcher, as many staff that had shown some degree of frustration when asked about their feelings, and it was expected that many of them would be planning to leave. Seven nurses (35%) with 10.7 years of nursing experience as a mean stated that:

Nurse 7 with 9 years of nursing experience says "as long there is you know, the increase is still there, there is an increase in salary and there is ladder… as long as they keep what they have promised to us, and then we will stay."

One participant who believes in the good reputation of the City and its high standards elaborated that:

Nurse 2, with 17 years nursing experience says "I have no intention to leave the City yet. I think the management or the City should think about the things should make the people stay… I like the City because you know, because of its good background and its high standards…"

Another participant simply stated that:

Nurse 10, with 7 years of nursing experience says "I am not looking for another job. I will stay in the City as long as they still need me, the money I am making is tax-free, it's worth all

the stress, and the life is very cheap and can have big saving for my future retirement."

Social support from supervisors and co-workers increases the employees' intention to stay (Chiu et al 2009) and leads to a better perception of justice which in the long run reinforces the employees' intent to stay (Tepper 2000). Receiving recognition has been found to be one of the reasons why nurses stay with their employers (Wilson 2006; Nowrouzi et al 2015). Support has been linked to nurses' perceived job performance and intention to stay (Abu Alrub 2007) and to positive health outcomes and job satisfaction of experienced nurses (Evans et al 2015; Joseph 2013; Selinger 2015).

The immigrant nurses at SBAHC worked hard to reach the desired level on the ladder for the belief that the superiors would notice their performance and they would ultimately receive recognition from them. Some of the participants intended to stay until they finished their contract and some intended to renew their contracts as long as the City still needed their services. One of the nursing participants stressed that:

Nurse 4, with 8 years of nursing experience says "If I get support from the nursing the nursing management, I will stay for two more years."

Some of the immigrant nurses were willing to stay longer at SBAHC if job expectations were met. This was more likely to happen if they were given opportunities to attend training and other forms of professional development. One participant's job expectations revealed:

Nurse 5, with 9 years of nursing experience says "…one of these is salary satisfaction and all staff to be treated equally based on their qualification and experience"

Another participant's expectations:

Nurse 20, with 11 years of nursing experience says "…so I was expecting that I can handle cases which are more challenging than what I had before…"

One participant commented on his expectations on his current job:

Nurse 17, with 12 years of nursing experience says "…this much as working in rehabilitation facilities, so different…the routine that you have to do so, yah, it is a different thing …but I'm coping and learning…

Table 6.5 Content Analysis of Narratives about the Immigrant Nurses' Intention to Stay at SBAHC

Theme: Immigrant Nurses' Reason for Staying at SBAHC	
Conceptual Categories	**Codes** **Frequency**
Salary and Benefits	Waiting for salary increase (2 nurse) Anticipating to reach a level on the ladder (1 nurse) As long as the City needs my services (3 nurses)
Job Satisfaction	Support/Recognition from superiors (1 nurse) Good reputation and high standards (1 nurse) If job expectations are met (1 nurse)

6.3.11 Social Support

Social support from supervisors and colleagues is a vital and indispensable feature of a healthy and supportive nursing work environment. Roussell et al (2006) explain that a supportive climate results in clear communications that support the productivity of the nursing team and permit the accurate identification of problems. This, they explain, can only be achieved as a result of the development of close and respectful professional relationships between nurses and nurse administrators. Some nursing participants in this research explained that they did not get the required support from their nurse administrators and that this was a severe source of stress for them. Six nurses (30%) with 9.9 years of nursing experience as a mean stated:

Nurse 18, with 10 years of nursing experience says "sometimes we have very many problems and even we call for meetings, but when we raise our grievances, they're not addressed in any way, we do not get the support needed"

Nurse 7, with 9 years of nursing experience says "one thing, you have a complaint, it is not taken, that complaint as you have said it. It is taken now against you. They don't support you. You complain about somebody. Now, that complain of yours, it's now like you are doing a campaign for that person to be elevated … and you to be flattened, you lie like an envelope. What can you say about that? You complain about somebody … And it is not only one complaint. They are major complaints. And that … all those complaints, instead of the institution coming out and seeing. How comes it's only this person? Investigate that person. Then go ahead, give him a post. (Laughter) And that post, that person does not even have the qualification for it"

Nurse 11, with 14 years of nursing experience says "when people like our supervisors to be told of increasing ratios and they accept that, either they are protecting their jobs, they are … either protecting their job that is one. Secondly they don't want to be seen as defiant so they are more or else towing the line to achieve whatever they think is in order for them and actually it's not"

Nurse 15, with 14 years of nursing experience says "I don't think that I have enough support from my supervisor or colleagues, I think everybody come to the country with his agenda, want to finish his contract and go back home after achieving his goal"

Nurse 9, with 5 years of nursing experience says "I can't approach my supervisor to discuss any problem, also the same with the rest of my nursing colleagues, this is mainly affected my performance, I do not want to work hard, just come and do my shift and go home, even though I know that my skills and performance are outstanding"

Nurse 1, with 7 years of nursing experience says "I do not feel valued by my supervisor or administration, sometimes I feel my supervisor is in a very difficult situations, I think I have great performance but little appreciation"

6.3.12 Perception of Job Performance

The immigrant nurses' performance and perception of WRS was affected by their satisfaction and dissatisfaction with their job. They experienced satisfaction when they felt that they are well supported by their direct supervisor and when they

received recognition and positive feedback for their excellent performance.

Some of the immigrant nurses did not feel supported in their job even though they communicated effectively and constructively with their supervisor. Five nursing participants (25%) with 10 years of nursing experience as a mean stated that:

Nurse 16, with 2 years of nursing experience says "…I think my job performance is excellent, however not well recognised by my supervisor, which is frustrating…"

Nurse 12, with 7 years of nursing experience says "I think my performance is great, I have many years of experience and worked in many countries"

Nurse 3, with 28 years of nursing experience says "I think the main reason I am still working in Saudi is due to me be doing very well on my job"

Nurse 19, with 10 years of nursing experience says "you are asking me how do I rate my performance, if I was not doing very well you will not find me in here today, anybody who is not performing they will send home within three months"

Nurse 17, with 12 years of nursing experience says "I always do the difficult tasks and get the complicated patients as I think I am doing very well on my job"

6.4 Discussion

In order to understand the factors and their intensity that the nurses ascribed as being the root causes or impacts of WRS in the qualitative part of the study, the co-researcher asked the respondents to describe the challenges and stressors that they encountered in their work at SBAHC; they were asked to evaluate the level of stress as “Never stressful”, “Occasionally stressful”, “Frequently stressful”, “Very stressful”. The co-researcher also encouraged all participants to share their personal insights and experiences. What follows below is a discussion of the key issues that were a consistently raised by the immigrant nurses. Overall, job stress levels were found to be very high and of frequent occurrence. When asked in general about their perception of the level of WRS, 12 immigrant nurses stated that they had very high levels of WRS, 4 nurses described it as high and the rest described it as moderate. As described earlier, 8 conceptual categories emerged when the participants were asked about the sources and level of WRS. These were workload, cultural competency, inter-relational conflict, language barrier; physical environment; family-related matters, death and dying and discrimination.

Immigrant nurses in this study also reported that workload was the most common and main reason for WRS; in particular, not having enough numbers of staff to safely cover the units. Shift patterns often put an extra pressure on nurses providing services in complex environments and demanding interpersonal conditions. Nurses who were put under too much pressure with extra duties such as distributing food to patient’s raises legitimate concerns that need attention. Many immigrant nurses in this study stated that there was not enough staff to get the job done, resulting in them not having

the time required to provide psychological and emotional care to patients and to respond to patients' needs.

Some participants felt particularly unhappy about the issue of documentation because it was inevitable that their supervisors would reprimand them if they had not completed the necessary documentation – regardless of the number of patients that they were being required to handle. During the focus group discussion, participants made it clear that it was a common practice among nurses to document what they had not done in order to avoid the repercussions of not having completed the documentation.

Issues of dealing with patients and their families also commonly provided a source of stress for nurses. In particular, when the patients' families made unreasonable demands, when nurses were blamed for anything that went wrong, and when they did not know whether a patient's family would report them for inadequate care placed the nurses in especially difficult situations. Of much concern to many new immigrant nurses is the stress experienced when dealing with abusive patients and abusive patients' families. It is likely that impact of such experience could lead to psychological distress, self-doubt and a significant amount of loss of respect (Purpora and Blegen 2015). A study by Lin and Liu (2005) reported that violence occurring in hospitals was mainly due to misunderstandings, drunkenness, and personal problems, or from patients who were mentally unstable. Tabone (2001) suggests the solution for these problems is to identify the sources of this violence and to advocate on behalf of nurses to ensure the quality of the work environment and patient care. Having clear written policies as a guideline for dealing

with abusive patients and patients (Johnson et al 1996) is highlighted by the findings of this study.

This study also uncovered new understandings related to cultural diversity in a multicultural context. These issues, which were beyond the immigrant nurses' control, were perceptions of culture shock. Many of the participants experienced a dual culture shock due to their involvement in an unfamiliar culture, compounded by interacting with a large group of cultures that were different from their own. Such involvement led to the development of significant complications, including WRS, burnout, frustration, insecurity, and the inability to adjust to their new environment. It also extended to uncertainty, particularly during their interaction with their patients; they were not sure what kind of nursing practices were considered to be satisfactory within the KSA culture and which might unfavourably affect their professional performance and the quality and safety of care they could deliver. The literature review revealed similar problems from culture shock, but occurring in different contexts (Pyvis and Chapman 2005; Brown and Holloway 2008; McLeod 2008). The bulk of studies that have been reported so far have studied the experience of students studying abroad; however, no study so far evident has investigated the impact of culture shock on patient safety and quality of care among immigrant nurses in a diverse cultural setting.

Applying cultural competency programs prior to interacting with people from other cultures is important; it is about training staff to recognise personal prejudice, bias and stereotyping of other people. This process helps immigrant nurses to adapt to new cultural contexts and to develop

respect for patients' cultures and religious heritages (Campinha-Bacote 1999 2002 2003; Jirwe et al 2006). Cultural competency programs improve awareness of oneself that requires the self-reflection and understanding of one's own attitudes toward patients from other cultural backgrounds. Without such reflection on one's own attitudes, health care providers may impose their own culture on patient care (Campinha-Bacote 2003).

This study, as well as the previous research, has highlighted the importance of developing cultural competency programs when looking after patients from different cultures (Campinha-Bacote 1999; Flowers 2004; Taylor 2005; Jirwe et al 2009).

The language barrier was well highlighted as a source of stress among immigrant nurses: the nurses in this study couldn't speak the Arabic language and nurses from other countries would communicate through their own language, which resulted in a higher level of conflict with colleagues and resulting in WRS. It is important for nurses to be able to understand the fears, worries and anxieties of patients during hospitalisation and during the provision of care they need. This kind of connection is possible only if patients and nurses are able to communicate well together, for which language is an important part. It is proven that language barriers are associated with poor quality of care provided, lower efficiency for the health organisation and patient, more clinical tests on patients, more patient visits, low patient and staff satisfaction (Meredith 2001; Feinberg et al 2002; AlKhathami 2010).

Specifically, the immigrant nurses in this study demonstrated a limited knowledge of the beliefs related to health and illness

in the Saudi culture. This finding is consistent with many studies in the literature, which demonstrated the high level of stress that nurses experienced due to cultural differences between themselves and their patients in other contexts (Boi 2000; Murphy and Clark 1993; Cortis 2004; Thyli et al 2007; Høye and Severinsson 2008 2010; Lampley et al 2008; Mahabeer 2009). Prior research is supported by the findings of this study, emphasising the importance of cultural knowledge in the process of cultural competence, considered to be a crucial element in mitigating the complications of cultural diversity, which in the context of this study is WRS.

Immigrant nurses reported that the social support and recognition they received from their supervisors and work colleagues was not enough and left them feeling unsupported. The support from supervisors was perceived as a very important factor according to the findings of this study, correlating with the finding presented by Magnusdottir (2005). The researcher observed that immigrant nurses expressed mainly the instrumental support when exploring supervisor support. This finding provides some validation for the stress support matching theory that suggests that specific incidents elicit particular salient coping requirements and that social support is more likely to buffer the negative effects of stress if available support is capable of raising the requirements of the situation (Cohen and Wills 1985).

Supervisor social support focuses on effective support for personnel at work, whilst enabling the employee's ability to jointly manage work and family relationships. Within a job stress model, many scholars view that role ambiguity, role conflict and role overload, supervisor's social support and work intrusion on family conflict are highly interrelated

constructs. For example, the level of job stress will not become intrusive and cause family conflicts for employees when supervisors can adequately provide social support (e.g. emotional support, appraisal support and physical support) (Thomas and Ganster 1995; Allen et al 2000; Goldsen and Scharlach 2001; Yu-Fei et al 2012). Even though the nature of this relationship is interesting, the moderating role of supervisors' social support is given little emphasis in the workplace stress research literature (Galinsky et al 1993; Fu & Shaffer 2001; Yu-Fei et al 2012). Many scholars argue that the role of supervisors' social support as a moderating variable is given less attention in previous studies because they have used a segmented approach to separately describe the role of job stress features, supervisors' social support characteristics and work intrusion on family conflict. Many have employed a simple correlation method to assess the association of job stress and work intrusion on family conflict and neglected to explain the influence of supervisors' social support in increasing or decreasing the effect of job stress on employees' family affairs.

Consequently, results from these studies have not provided sufficient useful information that can be used as guidelines by practitioners in designing and managing employees' physiological and psychological stresses in agile organizations (Edwards and Rothbard 2000; Fu and Shaffer 2001; Yu-Fei et al 2012). Hence, it provides motivation for researchers to further explore the nature of this relationship.

The conflict between nurses and nurse administrators as identified in this study is a phenomenon that has been well documented in research as one of the leading causes of work stress in nurses and of job dissatisfaction. In a study

conducted by Milisen et al (2006) which was designed to ascertain how Belgian nurses experienced their professional environments, it was found that 63.8% (n=9,638) of the nurses reported that their communication with nurse administrators was inadequate while 43% reported that, in some instances, it was simply non-existent. Only 48.9% of the nurses felt minimally supported by the leadership of the nursing administrators and 39.1% felt the same way about their nursing management.

Death and dying were perceived as a source of stress in this study and this finding is consistent with other studies (Govender 1995; Florio et al 1998; Parikh et al 2004; Andal 2006; Emilia and Hassim 2007; Chang et al 2007; Brunero et al 2008; Rodrigues and Chaves 2008; Mohamed et al 2011). Cole et al (2001) suggest that the stress associated with caring for dying patients may result because nurses have traditionally focused on providing care to the living, with often dramatic efforts to preserve life. Research has shown that many nurses have difficulty dealing with death (Payne et al 1998; Servaty et al 1996). Research into the effectiveness of various educational programmes in death education as highlighted by Mok et al (2002) presents many challenges. Nurses have benefited from the programme in the areas of change in attitudes, increased self-awareness, having a positive attitude towards death and dying and acquiring the knowledge and psychosocial skills in providing culturally sensitive care for dying patients. Kuebler et al (2005) aimed through an intervention programme to improve care for serious illness through better information and decision-making.

Many factors are known to influence turnover among nurses. Job stress is one of the factors that increases the likelihood of turnover and intent to continue working in a hospital. Nurses in this study demonstrated a moderate likelihood of their intention to stay. Immigrant nurses seemed to have more freedom to manage their own work in taking care of patients; however, the workers were required to follow the orders of supervisors. However, it seemed that regardless of how nurses perceived their working environment or working experience, it was clear that they set a financial goal that they were aiming to achieve, and once achieved, they would depart.

Most studies on WRS among nurses have found that nurses who experience stress in their jobs consider leaving their current job, or nursing as an occupation completely, because of their damaging experiences (Quine 2001; McKenna et al 2003; Daiski 2004; Rutherford and Rissel 2004; Farrell et al 2006; Lewis 2006; Hart and Warren 2015; Jacob 2015; Nowrouzi et al 2016). A study by Quine (2001) found that nurses who have been stressed and bullied tend to have a greater negative perception of the organisational climate, lower job satisfaction, as well as a higher intention to leave their work compared to nurses who were not stressed or bullied. Thus, workplace bullying can have a serious impact on health-care providers that are already experiencing a shortage of nursing staff (Landry 2016).

In regards to the perception of discrimination, the majority of nurses (65%) who were interviewed in this study believed that discrimination is triggered by a struggle for power, promotion or to maintain one's place in the hierarchy. Other identified triggers included working conditions and the differences

between contract benefits in accordance with nurses' nationalities. From the different responses of participants as to why discrimination occurs in the workplace, there seemed to be interaction between work conditions and those existing in the work environment.

Participants described discrimination as favouritism towards a particular group or nationality, thinking of Saudi nurses, Westerner nurses and nurses from the Middle East in terms of a negative stereotype, or unequal wages. The content of the nurses' interviews provided evidence of discriminatory and racist bullying; hence, it can be argued that bullying in some cases was triggered by discrimination and racism. This type of bullying should be particularly tackled as a form of discrimination or racism (Allan et al 2009). KSA lacks legal measures against discrimination and there are no official laws that ban such acts. However, in the current nursing research, there is a very little exploration of cultural differences, or any examination of influences on work relations such as race, gender, social class, and ethnicity (Mulholland 1995; Culley 2006).

According to the literature, for years, the salaries and benefits of immigrant nurses contracted for employment in the Middle East have depended on what part of the world they came from or received their education in (Alkrashy and Al Moalad 2016). This has led to nurses receiving variable rates of pay. Several nurses in their interviews mentioned how unfair this was. Discrimination, with respect to wages, is supported by Alswaid's (2014) study, which found that Asian employees working in Gulf countries were discriminated against in terms of wages and remuneration when compared with local

nationals and Westerners who were assigned the same duties.

Several participants indicated that this practice has created a hot area for conflict between the different nationalities. In particular, those coming from developed countries such as the US and UK were paid higher salaries compared with those coming from the Philippines or India, although all were employed as qualified nurses with the same work conditions and frequently the same job responsibilities.

The majority of nurses coming from developing countries accepted this lower pay as a condition of employment and hence the practice has remained unchallenged (Kingma 2006; Alswaidi 2014). Part of the reason for choosing to stay and work, despite receiving lower pay, was the fact that they were still earning much more than they would back home. Nonetheless, this is still a violation of the principle of ‘equal pay for equal work’, and leads to frustration and dissatisfaction amongst some immigrant nurses (Atiyyah 1996). Unsurprisingly, this perceived injustice in the workplace might contribute further to the development of WRS.

6.5 Summary

This chapter outlined the research methodology that was used in this study; namely the case study. The philosophical perspectives in case study research were discussed including the different epistemological perspectives that can be used to conduct case studies, such as interpretivism and positivism. This research is an exploratory study that used the embedded case study design based on Yin's (2009) definition. The only unit of analysis was the immigrant nursing workforce.

A sampling strategy was used to recruit the nursing participants and a semi-structured interview technique was used with 20 immigrant nurses who met the inclusion criteria. The validity and reliability that are a reflection on the quality of case study research were maintained.

The sources of WRS were identified as workload, organizational stressors, language barrier, environment, family-related matters, acculturation and death and dying.

A number of participants found elements of their workload stressful, such as submitting documentation by a specified deadline, doing supply inventories, attending to floated assignments that resulted in late breaks, going home late and deprivation of vacation, complex tasks like making presentations, assuming greater responsibility when the doctors were not around and difficulty in the use of modern equipment. The immigrant nurses experienced organizational stressors including interpersonal relationships with doctors and colleagues, adapting to new policies in the hospital, interactions with uncommitted colleagues and the feeling of lack of trust and respect. Language, the physical environment, family-related matters, working in an alien

culture and death and dying also caused stress among expatriate nurses.

The immigrant nurses coped with stress by engaging in physical activity, making friends, taking breaks or vacations, praying, communicating with their families and through self-appeasement.

Immigrant nurses were willing to stay at SBAHC if there were prospects of their working conditions improving, receiving a salary increase, experiencing job satisfaction in terms of their relationships with their superiors and colleagues and if their job expectations were met.

The immigrant nurses' performance was affected by their level of satisfaction and dissatisfaction in their job. They felt satisfaction when they could effectively use the language to communicate ideas; when they were exposed to educational courses when they felt that their colleagues and supervisors were supportive of them and when they received recognition and positive feedback for their excellent performance.

Conversely, they felt dissatisfaction with their job because of the unequal salary and promotion scheme based on nationality, and lack of recognition from the supervisors.

In the next chapter, an in-depth discussion and recommendation for future research will be presented.

CHAPTER SEVEN

CONCLUSIONS AND FUTURE DIRECTIONS

7.1 Introduction

This final chapter will review the main findings and conclusions drawn from the preceding chapters. This chapter also debates the strengths and limitations of the research and proposes a way forward for future research and action.

KSA relies heavily on immigrant nurses to deliver necessary health care services to its people. With the constant deficit of nurses and the international race for nursing services, the KSA health care system and infrastructure are at risk. Immigrant nurses bring with them cultural norms, views, conducts, practices and languages that vary from those of the local people and their new place of work; such variations place a huge pressure on immigrant nurses. The study setting was Sultan Bin Abdulaziz Humanitarian City, Riyadh region (SBAHC). To examine the complexities of this scenario, two research methods were used, namely a quantitative survey and qualitative semi-structured interviews. The purpose of the study was to measure and explore perceived WRS, job performance, intention to stay and social support among immigrant nurses and to explore the relationships between the variables of the study. WRS is an important indicator of job performance, patient safety, patient outcomes and retention. At the same time, cultural diversity in the multicultural nursing workforce affects the safety and quality of patient care and the professional integrity of the nurses as indicated by the nurses' perception and experience of WRS

and social support. The focus of this research will enhance awareness amongst nursing health care leaders in KSA.

The theoretical framework guiding the study was the JDCS framework which the researcher considered to be the most appropriate for this study on account of its adaptability and on the grounds of its ability to identify the psycho-social enquiry about beliefs, perception, coping, views and practices related to WRS among immigrant nurses.

7.2 Main Findings and Implications

7.2.1 Nurses Perception of WRS

Despite numerous recent studies (e.g. Bakker et al 2000 Kirkaldy and Martin 2000; Bang et al 2015; Bernal et al 2015; Nowrouzi et al 2015; Evans 2016; Mauo et al 2016) demonstrating that nursing is by its very nature an occupation subject to a high degree of stress, nurses in the current study reported overall, moderate (occasional) levels of WRS. Unfortunately, it is not possible to make comparisons between nursing studies on the prevalence of stress given that different research methodologies, research setting, nursing samples, and sample sizes have been used. Furthermore, the majority of nursing studies have focused their research on sources of stress rather than levels of stress. Despite this, other empirical studies have also found that overall, nurses perceive their jobs to be moderately stressful (e.g. Wheeler and Riding 1994; DePew et al 1999; Lee 2003). It is possibly that nurses tend to be relatively resilient to work stress.

According to Evans (2016) nurses perceive most work stressors to be indissolubly connected to their profession, and as a result, they do not perceive them to be particularly significant. The current research includes measurement and exploration into the level and relationships of WRS, job performance, social support and intention to stay for immigrant nurses in KSA. The importance of the current study is that it provides reliable and validated data from which to strategically plan changes within the study's nursing departments. The study provides a basis from which nursing departments can improve the way toward managing WRS and recruitment and retention of immigrant nurses during a nursing shortage.

The qualitative data corroborates the quantitative findings regarding the presence of WRS, however the nurses who participated in the qualitative phase of the study indicated a frequent/very frequent occurrence of stress in all subthemes while the quantitative results indicates that nurses experience either 'no occurrence' of stress, or 'occasional occurrences' of stress. This significant difference between the results of the quantitative and the qualitative approaches struck the researcher and lead him to track down the responses for the same participants on the questionnaires; this was possible as all questionnaires and interviews were coded. When compared, the responses on the questionnaires rated the occurrences of WRS as 'never' or 'occasional' to most questions; however, in the interviews the same participants expressed very high levels of stress, which was created an interesting anomaly. It seems that in the interviews, nurses felt able to open up and were able to express in depth their feelings and perceptions. The researcher assumed that even though participants were assured of confidentiality, they

might have been worried about writing on a questionnaire and being identified or held accountable for what they had written. Nurses who had the opportunity to have a one-to-one human interaction in the interview setting were made to feel more comfortable by giving them the opportunity to express their own feelings.

The qualitative method was further beneficial by showing how these stressful occasions affected immigrant nurses themselves and their patients. Some nurses concentrated on the influence of these stressful occasions on their temper, attitude, relationships with co-workers and patients and even causing home problems. Other nurses were anxious about the outcome of nursing care and performance. While some causes of stress are related to the caring element of nursing (e.g. dealing with difficult patients, being responsible for a patient's recovery, caring for dying patient, heavy workload), the majority of nurses' stress results from organisational factors, especially management's unrealistic expectations of nurses. The current study revealed that the nursing role is characterised by heavy workloads, constant interruptions, multiple task demands and inadequate staff support: these findings was significant in both methodological approaches.

Many immigrant nurses verbalised that the physicians in their ward/units should show more respect for the skill and knowledge of the nursing staff and that doctors see nurses as subordinate and do not respect nurses; this finding was more prominent in the qualitative method. Studies have found that role conflict and ambiguity are positively correlated with job dissatisfaction and job stress and can generate low organizational commitment and increased psychological and physiological stress: it is important therefore that attention is

given to improving nurse-physician relationships (Sherman 1998). While some nurses reported that physicians at SBAHC generally understood and appreciated what nursing staff do, and would cooperate and work as part of a team, many still perceived physicians as looking down too much on the nursing staff (Tabone 2001).

In regards to the perception of discrimination as a source of WRS, the quantitative study did not reveal any significant result, and did show that discrimination was not an issue. However, during the interviews in the qualitative phase of the study, this was highlighted very strongly, with 12 participants reporting very frequent episodes of WRS due to discrimination.

A report produced in 2012 by the International Federation of Human Rights (FIDH), stated that migrant workers are totally at the mercy of their employers who behold their passports and limit their freedom of movement. They are prevented from changing job and cannot leave the place of their work. Some do not receive their salary and are mistreated. It also highlighted that the KSA government continues to fail to protect 9 million foreign workers.

Migrant workers are not adequately protected either by national or international legal regimes, leaving them vulnerable to exploitation by their employers, recruiters, and government officials. Protections are nearly non-existent for migrant workers for several structural reasons (Palese et al 2016), for example financial benefits accrue to countries traditionally known as the labour exporting nations when their workers leave the country and send remittances home. These benefits have resulted in governmental policies of exporting

labour with little oversight of workers once they arrive in their country of employment (Palese et al 2016).

Discrimination has been linked to a variety of mental health symptoms including a high level of WRS (Selcuk 2015). Discrimination-related stress has been shown to correlate with biological measures such as elevated systolic and diastolic blood pressure (Payne et al 2006; Popoli et al 2012; Goette et al 2015).

The qualitative findings highlight the importance of cultural competency training and its impact on nurses WRS, lack of proper orientation programs or any training, and the cultural diversity among nurses themselves and also the patients, caused a lot of issues for the immigrant nurses.

7.2.2 Perception of Social Support

Mojoyinola (2008) established that poor relationships between the supervisor and the nurses will result in high level of WRS experienced by nurses. Goswami (2012) stated that the nurses experienced a higher level of negative moods on days when they had distressing interactions with supervisors and co-workers and found that shift work can lead to many physical symptoms and can also interfere with family life.

The support from supervisors was perceived as a very important factor according to the findings of the qualitative study, correlating to the finding presented by Magnusdottir (2005). The findings from the quantitative study showed that nurses had a moderate perception of the level of social support and that nurses receiving higher levels of social support showed better performance.

However, in the qualitative study, findings indicated that participants did not feel very well supported by administration and supervisors, which consequently affected their WRS level and impacted their performance.

The feelings expressed by some participants are reflected by nurse participants in other research studies that have shown that nurses have a difficult time in making transitions to new work environments. In a study by Casey et al (2004), nurses described the difficulties they experienced with peer relationships. They felt that these difficulties were attributable to a lack of acceptance and respect on the part of other nurses and that this had made their transition into the role much more difficult than it should have been.

Participants in some cases felt that they were not supported and trusted by their immediate supervisors: they felt that they were unable to approach their supervisors about important problems in matters of procedure because of the fear of supervisors that had been instilled in them and because of the apparent un-approachability of their supervisors.

The feelings and opinions expressed by the participants in the semi-structured interview made it very clear indeed that this style of leadership in supervisors was a major source of stress for them. The conflicting relationship between nurses and their supervisors has also been confirmed by other research to be a root cause of other dependent stressors.

Nurse-administrator support is a vital and indispensable feature of a healthy and supportive nursing work environment. Hughes and Jennings (2008) explains that a supportive climate results in clear communications that

support the productivity of the nursing team and permit the accurate identification of problems. This, they explain, can only be achieved as a result of the development of close and respectful professional relationships between nurses and nurse administrators. The participants in this study explained that they did not get the required support from their nurse administrators and that this was a severe source of stress for them.

7.2.3 Perceived Intention to Stay

In both the qualitative and quantitative study, participants demonstrated a moderate willingness to stay in KSA. Even though WRS was described as very high during the semi-structured interviews, this did not reflect on the nurses' intention to stay. The main drive for the nurses to stay was the financial recompense, which could have a worrying negative impact on patient outcomes when it is considered that, nursing is a job that deals with vulnerable human being. |If the main drive for doing the job is financial and not because of the love of the job, nurses could lose the caring connection with their patients. The finding that WRS was inversely related to immigrant nurses' intentions to leave the profession is an important advance in the understanding of turnover among immigrant nurses. Although the effect is small, it suggests that pay may be one reason why immigrant nurses stay in the profession.

Several studies have found that turnover is principally associated with factors relating to co-workers, such as group cohesion (Shader et al 2001), collegial climate (Fochsen et al 2005), teamwork (Tourangeau and Cranley 2006) and

support from other staff and the nursing care team (Bowles and Candela 2005).

7.2.4 Perceived Job Performance

Immigrant nurses perceived job performance was consistent in both phases of the study. Nurses rated themselves at high-performance level. Participants indicated that high levels of stress and lack of social support impacted their own performance negatively and that the most experienced nurses were the better performers. Yozgat et al (2013) obtained similar results linking job stress and job performance among public sector employees, demonstrating a negative relationship between job stress and job performance. The current findings are also corroborated in a study by Jamal (2011) who found that overall job stress and four job stressors (work overload, ambiguity, conflict, and resources inadequacy) were negatively related to job performance. Siu (2003) in research in China also revealed a negative relationship between sources of stress and self-related job performance. The current findings are consistent with Siu et al (1999), who confirmed that sources of stress had a negative impact on job satisfaction, job performance, mental and physical well-being, and Donald et al (2005) found that the strongest predictor of productivity was psychological well-being. Mahan et al (2010) argued that as ongoing stressors increase in an employee's working environment, so does anxiety which affects their performance. However, findings by June and Mahmood (2011) suggest that when a good fit exists between employees and the job that they are doing, they tend to exert more effort in carrying out duties which may lead to greater job performance.

Work stress factors have significant cross-sectional and longitudinal associations with job performance. For example, Park (2007) indicated that high job strain was associated with reduced activities at work and taking at least one disability day during the previous two weeks; active jobs were also positively associated with taking disability days and physically demanding work was related to absence from work in the past week. Physically demanding work was associated with reduced activities two years later; active jobs were associated with reduced work activities, and self-perceived job insecurity was associated with subsequent non-employment.

Many other researchers (Jamal and Baba 1992; Donald et al 2005; Mahan et al 2010; Yozgat et al 2013; Naqvi et al 2013) have found significant relationships between WRS and employees' job performance, but most of this research work was conducted from a broad occupational perspective, thus very little evidence exists to understand job performance in those employed in unique working conditions (June and Mahmood 2011). The current study has added a significant source of information to the available literature on WRS and employees' job performance, especially amongst immigrant health care providers.

7.3 Strengths and Limitations of this Research

One of the most important strengths of this study is the combination of the quantitative and the qualitative designs. Although the quantitative approach included a large sample size, it was the qualitative approach, provided rich and meaningful information about the nurses' experiences with stress and related concepts. It provided a detailed and extensive understanding of how the nurses perceive their stress and how they and their practice were affected by the stress.

The extremely good response rates helped to ensure that the survey results were representative of the target population. A response rate of 76% may indicate accurate and useful results. The satisfactory response rate could be related to appropriate study design and giving the questionnaires to nurses by hand. The sample size was adequate to conduct this study as it represented all hospital nurses in KSA. The choice of big sample size of nurses in a specific area instils a high level of confidence that the sample represents the population under study and raises the power of the statistical tests (Robson et al 2002).

The focus of the current study is unique to immigrant nurses' WRS, job performance, social support and intention to stay while working and living in Saudi Arabia during a nursing shortage. Existing local literature in Saudi Arabia address quality of work-life with job satisfaction and WRS for all nursing staff (Abo-Znadh 1999; Ibrahim et al 2015), but ignores the interactional nature of WRS with the other selected variables of this study. Existing literature addresses WRS in other countries, but the countries do not share the uniqueness of KSA. Because of the findings from the current

study, the results add a new perspective to WRS, job performance, social support and intention to stay for immigrant nurses living and working in KSA.

Improving the nursing work environment presents an opportunity for leaders in KSA to inspire the nursing workforce and promote job satisfaction and tenure. The current study will be of significance to leaders that develop health-care policy. Nurses inherently want a practice environment that is conducive to learning, professional growth, respect, and dignity. Salary and benefits are important factors for all nurses working in KSA. The current study identified the factors that motivate the immigrant nurses. These factors included support from organizational leaders for staffing and ongoing education, qualified nurse managers who are able to lead and who support nurses, an environment where quality is fundamental in the nursing role, policies and procedures that are implemented and evaluated, and an environment that is safe and supports the profession of nursing.

For KSA, the research is significant as the first study to look at WRS amongst immigrant nurses who form the backbone of the health-care system. Aiken's (2002) study in the United States discovered a 7% increase in patient mortality within 30 days of admission and a 7% increase in failure-to-rescue by adding one patient to a nurse's workload. Associated with the mortality and failure-to-rescue statistics, job dissatisfaction and burnout were 15% and 23%, respectively. Foreign-trained nurses in Saudi Arabia are not employed to their full potential. The frustration is palpable within the quantitative and qualitative data obtained. The global recession may indicate that immigrant nurses will continue to travel to KSA

for work whilst the global nursing shortage still threatens the health-care infrastructure of KSA.

For those in global leadership who are studying the nursing shortage and migration of nurses, the current study opens a window into a life and work environment in KSA not seen by the outside world. The study provides themes centred on the lived experience of immigrant nurses in a unique setting. Participants identified the push factors for leaving their home countries, the issues that only international recruits' experience and the experiences that make them happy in their work and sad in their work. The work in KSA provides an income for not only the immigrant nurses but also his or her family in their home country. The life and work provides the means for some immigrant nurses to be closer to religious roots.

Globally nurses are experiencing increased work pressures due to an increasingly aging population, patients with complicated diseases and infections, and a lack of qualified staff to provide quality and safe patient care, a job description that goes beyond the responsibility of professional nurses, and administrators and patients who abuse nurses both physically and verbally. The added pressures for immigrant nurses in KSA are not being able to live with family members, the restrictions of the country that create security risks for single immigrant nurses, the diversity of the workplace and inadequate enculturation, and the language barrier that inhibits immigrant nurses' ability to provide total patient care.

Notwithstanding its strengths, the study has some limitations. Stress measurements were based on self-reporting rather than by physiological and/or biochemical assessments or by

the observer. One limitation of self-reported questionnaires about WRS, social support, intention to stay and job performance is that they provide subjective measures, representing the perceptions of individuals. Objective assessments are based on archival data such as sickness leave and biological measures (Tabanelli et al 2008). Physiological methods that are used to measure stress are substitutive for, or complementary to, psychological ones (Dawson et al 2015). Physiological methods may include cardiac function (Gray et al 2007), respiration (McDowall et al 2007), electrical skin conductance (Storm et al 2008) and analysis of stress hormones in the blood, saliva, or urine (Steptoe et al 2007). The investigator firmly believes that the above limitations have not defeated the purpose of the study.

The second argument pertains to the fact that participants were multi-lingual and that English was not always their first language. As a caveat, this may have evoked a number of errors in answers provided. However, given that the methodology of triangulation allowed for cross-checking and confirming of obtained data, the approach could 'auto-correct' for such moments of misunderstanding. The availability of such a broad array of multi-regional experts certainly also strengthened the study results.

The instruments utilised in the present study were based on American and European populations and may not have been culturally appropriate for some immigrant nurses in a unique cultural setting. Some procedures were implemented by the researcher to overcome this issue by using expert opinion and running a pilot study.

The fact that the researcher did not conduct the interview by himself, was at first considered as a disadvantage. However, after looking at the results of the interviews, this was not the case, and in reality it helped the nurses feel much more relaxed with the co-researcher so that they were able to give more in-depth information.

7.4 Conclusions and way forward

In conclusion, the present research makes a valuable contribution to our understanding of WRS, social support, job performance and intention to stay among immigrant nurses in KSA.

The present study demonstrated that immigrant nurses in KSA are stressed, albeit there was a significant difference between the qualitative and quantitative results. The most immediate stressors for nurses were work overload, conflict and lack of support from colleagues. Nurses, in general, tended to stay at their current job and they perceived their performance as high.

We presently lack approaches that report the psycho-social and working context in its entirety. Therefore, national and international efforts should be made towards addressing this comprehensively in close partnership with local, regional, national and other global stakeholders. The viewpoint endorsed in this thesis is that in order to address micro issues such as psychosocial risks and other emerging work related risks, these need to be viewed as being part of a stream of actions and policies trickling down from the macro, national or international levels. At the same time, we need to consider regulation of globalization processes to protect workers

worldwide, but particularly in the most vulnerable contexts of developing countries such as KSA.

Equity and equality are not a reality at this point in time and much needs to be done. There is no harm in wanting to strive for this, especially because progress will require vision and goals that are set high in order to achieve the maximum possible. Independently of the development status of a country, we should however not forget that human beings deserve to be treated with dignity and respect everywhere around the globe and that we should all strive for equity and equality in the spirit of a global community.

Replicating the current study will enable the comparison of results to the baseline data presented. Further research within the current study following the same methodology and data analysis plan can compare the progress of the immigrant nurses in terms of WRS, nursing work environment and the implementation of international labour law standards. Replication of the current study will compare the results of the demographic and work environment factors that constituted the foundation of the current study. Recruitment practices for KSA are expanding to countries such as China. The changing cultural environment for nurses plays a role in determining job satisfaction and WRS. Expanding the study to include all immigrant nurses in the KSA and all hospitals in the Kingdom is a grandiose project that is possible with the assistance of the Ministry of Health (MOH) and the Saudi Council.

A study to assess WRS among Saudi Arabia's nursing leaders is another recommended area for further research. The results might provide an indication of the challenges of being a nursing leader. Omer (2005) explored the leadership

styles of unit nurse managers at the National Guard hospitals. An expansion of research into the leadership styles of the nursing directors of the MOH and the private sector might help to provide a correlation with WRS.

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Appendices List

Appendix (A)

Participant Information Sheet

Date: 02nd June 2010

Version number: (1)

Study Title

PERCEIVED WORK RELATED STRESS, JOB PERFORMANCE, SOCIAL SUPPORT AND INTENTION TO STAY AMONG IMMIGRANT NURSES IN A CULTURALLY DIVERSE SETTING

You are being invited to take part in a research study. Before you decide it is important to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part in the study. Your participation is voluntary, and if at any time, you should decide to terminate your participation in this study, you are free to do so. By returning the completed questionnaire, you are consenting to the use of your responses in the study. A copy of this information sheet is for the participants to keep.

Thank you for reading this.'

What is the purpose of the study?

The purpose of the study is to measure the Work Related Stress among immigrant nurses and explore investigate the relationships between: (a) demographic characteristics (such as age, gender, nationalities, marital status, educational level, and the type of shift nurses work), (b) work related stress and job performance, and (c) the effect of perceived job-related stress on job performance and intention to stay (d) the effect of social support on stress level and job performance.

The study will finish in November 2010, and feedback will be given to participants in August/2011.

Why have I been chosen?

The participants of this study is Nurses (n=360). You have been chosen to participate in the study because you are currently employed as a nurse at SBAHC.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

You will be asked to complete the questionnaire once. After collecting completed questionnaire, data will be analysed, and final report will be submitted Nottingham University in the UK in August 2011.

What do I have to do?

If you agree to participate in the study, complete the enclosed questionnaires, you need Approximately 25 minutes in order to be able to complete the questionnaire. Directions for completing the questionnaire can be found with the questionnaire. Completed questionnaires need to be returned using the free internal mail service.

What are the possible disadvantages and risks of taking part?

There are no foreseeable risks or costs to participate in this study. There will be no costs related to participation in the study.

What are the possible benefits of taking part?

Even though there will be no personal benefits to participate in the study, the valuable information you provide may assist nursing administrators in providing supportive work environment.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. Your response to the questionnaire will be stored anonymously in safe place. Your name is not required in order to participate in the study. All returned questionnaires would be destroyed after anonymous response has been tabulated in a statistical form.

What will happen to the results of the research study?

The results of the study will be ready in August 2011; a copy of the study will be available in the library of Nottingham

University. Presentation also will take place in August/2011 to the participants at SBAHC

Who is organising and funding the research?

It is fully funded by the researcher himself; Hussam Al-nusair.

Who has reviewed the study?

The research Ethic Committee at SBAHC and Ethic approval from Nottingham University

Contact for further information

If you have any question about the study at any time, you can contact the researcher on extension 2186 or email hussam.alnusair@sbahc.org.sa

Appendix B

INTERVIEW SCHEDULE

Time: 40 to 60 minutes

Location: Hospitals' meeting room

Interviewer general guidance

The interviewer will start by:

- Explaining the purpose of the interview
- Address the terms of confidentiality
- Explain the format of the interview
- Indicates how long the interview usually takes
- Provide contact details of the interviewer
- Allow interviewee to clarify any doubts about the interview
- Prepare the recording machine

The interviewer will ask the following questions (General Interview Guide approach):

- Job Title
- Nurse level
- Years of experience as a nurse
- Years of experience as a nurse at SBAHC
- Age
- Nationality

- Religion
- Marital status
- Educational level
- Usual shifts worked
- Average number of hours worked per week
- Number of patient cared for per shift

Explain to me the stress that you may encounter as a nurse in your job

- Explain to me, what attracted you to come to work in Saudi Arabia?
- What issues and difficulties do you face working in KSA?
- Describe to me when you felt exceptionally happy at your work
- Describe to me when you felt exceptionally bad at work
- Criticism/conflict by /with colleagues
- Disagreement concerning patient treatment plan
- Lack of support from administrator
- Criticism from nursing administration
- Too much work
- Feeling not adequately trained to do what I am asked to do
- Being harassed or abused
- Having to deal with abusive patients
- Not able to speak the same language of the patients
- Feeling discriminated because of race, sex or religion
- Not having enough payments, equal payments and satisfactory work conditions

The interviewer will ask the following questions that relates to the nurse intention to stay in their job:

- How long are you planning to stay at SBAHC?
- Does this job meet all your expectation?
- Are you looking for another job?
- What will make you stay at this hospital
- Tell me three areas of improvement that would retain nurses in KSA.

The interviewer will ask the nurses to describe their feeling toward the social support and recognition of their supervisors of their performance:

- Do you feel that you have given financial compensation that you should be given comparing it to the amount of work and performance you do?
- Have you ever received a thank you letter from your supervisors, or any staff in the nursing department?
- Your supervisor provides a regular feedback about your performance to you and nursing administration
- Have you been given the chance for career development**/**shift in-charge?
- Given chance to participate in educating and training other staff
- Does your supervisor delegate patient care and administrative task to you?
- Have you been given the opportunity to attend education and training courses?

- Do you feel that you are treated equally to other staff when you do something good?
- You have been given enough time for professional development
- Achievements been announced in the hospital meetings
- Do you feel that your stress level could affect your allover job performance?

The interviewer will ask the nurse to express their feeling for leaving there beloved one, family and colleagues back home, and if this have any effect on them.

Appendix C

Demographic Questionnaire

Thank you for agreeing to participate in the study. The valuable information you provide will hopefully assist the trust in providing a supportive work environment. Please continue to complete the questionnaire only if you are an immigrant nurse who currently holds a job as staff nurse at Sultan Bin Abdulaziz Humanitarian City (SBAHC) in Riyadh; (b) Worked for at least three months at SBAHC in nursing during the last year; and (c). Had a minimum of three years' experience since attaining your nursing degree. Be assured that all your responses are confidential. Although there are a number of items, completion of the questionnaire should take no longer than 25 minutes.

Thank you again for your cooperation.

1. I have been employed as a staff nurse or nurse aid in nursing for at least three months during the last year:

    a. Yes

    b. No (*if your answer is "**NO**", then you are not eligible to participate in the study. Thank you. Otherwise Please continue)*

2. Your job title is----------

3. Years of experience as a staff nurse/Nurse Aid:
   Years: _____

   Grade: _____

4. Gender: Male_____ Female_____

5. Age: _____ Years

6. Marital Status: Married_____ Single_____ Divorced_____ Widow_____

7. Educational level: Diploma _____ Degree_____ Masters Others_____

8. Total length of time employed as a nurse at (SBAHC): _____

9. Work Status: Part-time _____ Full-time _____ Others: _____

10. Usual shifts worked: Day_____ Evening_____ Night_____ Rotating_____

11. Average number of hours worked per work week: _____

12. Average number of patients cared for per shift: _____

Appendix D

Gray-Toft and Anderson Nursing Stress Scale (1981)

Nursing Stress Scale

This part of the questionnaire relates to the stress that you may encounter as a staff nurse in your job. The Following is a list of sources of stress that commonly occur in the work place. For each item, please indicate *how often* you have found the sources to be stressful by using numbers from the following key:

0 = Never 1 = Occasionally 2 = Frequently 3 = Very frequently

	Subscale I: Death and Dying	**Never**	**Occasional**	**Frequently**	**Very Frequently**
1	Performing procedures that patients experience as painful	0	1	2	3
2	Feeling helpless in the case of a patient who fails to improve	0	1	2	3
3	Listening or talking to a patient about his/her approaching death	0	1	2	3
4	The death of a patient	0	1	2	3
5	The death of a patient with whom you developed a close relationship	0	1	2	3
6	Watching a patient suffer	0	1	2	3
	Subscale II: Conflict with Physicians	**Never**	**Occasional**	**Frequently**	**Very Frequently**
7	Criticism by a physician	0	1	2	3
8	Conflict with a physician	0	1	2	3

9	Physicians not being present when a patient dies	0	1	2	3
10	Fear of making a mistake in treating a patient	0	1	2	3
11	Disagreement concerning the treatment of a patient	0	1	2	3
12	Making a decision concerning a patient when the physician is unavailable	0	1	2	3
13	A physician not being present in a medical emergency	0	1	2	3
Subscale III: Inadequate Preparation		**Never**	**Occasional**	**Frequently**	**Very Frequently**
14	Being asked a question by a patient for which I do not have a satisfactory answer	0	1	2	3
15	Feeling inadequately prepared to help with the emotional needs of a patient	0	1	2	3
Subscale IV: Lack of Support		**Never**	**Occasional**	**Frequently**	**Very Frequently**
16	Lack of an opportunity to talk openly with other unit personnel about problems on the unit	0	1	2	3
17	Lack of an opportunity to share experiences and feelings with other personnel on the unit	0	1	2	3
18	Lack of an opportunity to express to other personnel on the unit my negative feelings towards patients	0	1	2	3

Subscale V: Conflict with other Nurses		Never	Occasional	Frequently	Very Frequently
19	Conflict with a supervisor	0	1	2	3
20	Difficulty in working with a particular nurse (or nurses) outside the unit	0	1	2	3
21	Criticism by a supervisor	0	1	2	3
22	Difficulty in working with a particular nurse (or nurses) on the unit	0	1	2	3
Subscale VI: Workload		**Never**	**Occasional**	**Frequently**	**Very Frequently**
23	Breakdown of computer	0	1	2	3
24	Unpredictable staffing and scheduling	0	1	2	3
25	Not enough time to provide emotional support to a patient	0	1	2	3
26	Not enough time to complete all of my nursing tasks	0	1	2	3
27	Not enough staff to adequately cover the unit	0	1	2	3
28	Floating to other units that are short-staffed	0	1	2	3
29	Too many non-nursing tasks required such as clerical work	0	1	2	3
Subscale VII: Uncertainty Concerning Treatment		**Never**	**Occasional**	**Frequently**	**Very Frequently**
30	Inadequate information from a physician regarding the medical condition of a patient	0	1	2	3

31	A physician ordering what appears to be inappropriate treatment for a patient	0	1	2	3
32	Not knowing what a patient or a patient's family ought to be told about the patient's condition and its treatment	0	1	2	3
33	Uncertainty regarding the operation and functioning of specialized equipment	0	1	2	3

Please document below if there are other sources of stress that you experience in your job.

_____

_____

_____

_____

_____

_____

Appendix E

Schwirian Six Dimension Scale of Nursing Performance (1978)

This part of the questionnaire relates to the performance of nursing behaviors. Following is a list of activities in which nurses engage with varying degrees of frequency and skill. For those activities that you do/did perform in your job, please indicate how well you perform them by using numbers from the following key. Please remember that all answers are completely confidential and they will not be seen by anyone but the researcher.

1 = Not very well **2 = Satisfactorily** **3 = Well** **4 = Very well**

X = Not expected in my job

	Schwirian Six Dimension Scale of Nursing Performance **Performance of Nursing Behaviors**	***Not* Very Well**	**Satisfactory**	**Well**	**Very Well**	**Not Expected in my Job**
1	Teach a patient's family members about the patient's needs	1	2	3	4	5
2	Coordinate the plan of nursing care with the medical plan of care	1	2	3	4	5
3	Give praise and recognition for achievement to those under your direction	1	2	3	4	5
4	Teach preventive health measures to patients and their families	1	2	3	4	5

5	Identify and include in nursing care plans anticipated changes in patient's condition	1	2	3	4	5
6	Evaluate results of nursing care	1	2	3	4	5
7	Promote the inclusion of the patient's decisions and desires concerning his care	1	2	3	4	5
8	Develop a plan of nursing care for a patient	1	2	3	4	5
9	Initiate planning and evaluation of nursing care with others	1	2	3		5
10	Perform technical procedures: e.g., oral care, Foleys catheter care, etc…	1	2	3	4	5
11	Adapt teaching methods and materials to the understanding of the particular audience: e.g., age of patient, educational background, and sensory deprivations	1	2	3	4	5
12	Identify and include immediate patient needs in the plan of nursing care	1	2	3	4	5
13	Develop innovative methods and materials for teaching patients	1	2	3	4	5
14	Communicate a feeling of acceptance of each patient and a concern for the patient's welfare	1	2	3	4	5
15	Seek assistance when necessary	1	2	3	4	5

16	Help a patient communicate with others	1	2	3	4	5
Schwirian Six Dimension Scale of Nursing Performance **Performance of Nursing Behaviors** Continued…		***Not* Very Well**	**Satisfactory**	**Well**	**Very Well**	**Not Expected in my Job**
17	Use mechanical devices: e.g., suction machines, Gomco, cardiac monitor, respirator, etc	1	2	3	4	5
18	Give emotional support to family of dying patient	1	2	3	4	5
19	Verbally communicate facts, ideas, and feelings to other health team members	1	2	3	4	5
20	Promote the patient's right to privacy	1	2	3	4	5
21	Contribute to an atmosphere of mutual trust, acceptance, and respect among other health team members	1	2	3	4	5
22	Delegate responsibility for care based on assessment of priorities of nursing care needs and the abilities and limitations of available heath care personnel.	1	2	3	4	5
23	Explain nursing procedure to a patient prior to performing it	1	2	3	4	5

24	Guide other health team members in planning for nursing care	1	2	3	4	5
25	Accept responsibility for the level of care provided by those under your direction	1	2	3	4	5
26	Perform appropriate measures in emergency situations	1	2	3	4	5
27	Recognize and meet the emotional needs of a dying patient	1	2	3	4	5
28	Use teaching aids and resource materials in teaching patients and their families	1	2	3	4	5
29	Perform nursing care required by critically ill patients	1	2	3	4	5
30	Encourage the family to participate in the care of the patient	1	2	3	4	5
31	Identify and use resources within your health care setting in developing a plan of care for a patient and his family	1	2	3	4	5
32	Use nursing procedures as opportunities for interaction with patients	1	2	3	4	5
33	Contribute to productive working relationships with other health team members	1	2	3	4	5
34	Help a patient to meet his emotional needs	1	2	3	4	5
35	Contribute to the plan of nursing care for the patient					5

36	Recognize and meet the emotional needs of a dying patient	1	2	3	4	5
37	Communicate facts, ideas, and professional opinions in writing to patients and their families	1	2	3	4	5
38	Plan for the integration of patient needs with family needs	1	2	3	4	5
39	Function calmly and completely in emergency situations	1	2	3	4	5
40	Remain open to the suggestions of those under your direction and use them when appropriate	1	2	3	4	5
41	Use opportunities for patient teaching when they arise	1	2	3	4	5

The following section is related to the performance of professional development behaviors by nurses. Using the following key, please indicate the number that best describes the frequency with which you engage in the following behaviors. Again, all your responses will be confidential.

1 = Never 2 = Seldom 3 = Occasionally 4 = Frequently 5 = Consistently

	Schwirian Six Dimension Scale of Nursing Performance Performance of Professional Nursing Development Behaviors	**Never**	**Seldom**	**Occasionally**	**Frequently**	**Consistently**
42	Use learning opportunities for on-going personal and professional growth	1	2	3	4	5

43	Display self-direction	1	2	3	4	5
44	Accept responsibility for own actions	1	2	3	4	5
45	Assume new responsibilities within the limits of capabilities	1	2	3	4	5
46	Maintain high standards of self – performance	1	2	3	4	5
47	Demonstrate self-confidence	1	2	3	4	5
48	Display a generally positive attitude	1	2	3	4	5
49	Demonstrate knowledge of the legal boundaries of nursing	1	2	3	4	5
50	Demonstrate knowledge of ethics of nursing	1	2	3	4	5
51	Accept and use constructive criticism	1	2	3	4	5

APPENDIX F

McCain's Intent to Stay Scale (McCloskey and McCain 1987).

This part of the questionnaire relates to the nurses' intention to stay. The Following is a list of nurse's perception questions of the likelihood of staying at your current job. By using numbers from the following key for each item, please indicate the likelihood of staying at your current Job

1 = Strongly agree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly agree

	STRONGLY DISAGREE	***DISAGREE***	***NEUTRAL***	***AGREE***	***STRONGLY AGREE***
1. Even if this job does not meet all your expectations, you will not quit?	**1**	**2**	**3**	**4**	**5**
2. I plan to work at my present job as long as possible.	**1**	**2**	**3**	**4**	**5**

3. I will probably spend the rest of my careers in this job.	**1**	**2**	**3**	**4**	**5**
4. I plan to keep this job for at least two or three years.	**1**	**2**	**3**	**4**	**5**
5. Under no circumstances would I leave my present jobs.	**1**	**2**	**3**	**4**	**5**

APPENDIX G

Mccain and Marklin social integration scale

*This part relates to the social support that you receive form your co-workers. Please put **x** on your **choice that most accurately represents your feelings for each item**.*

1 = Strongly agree 2 = Agree 3 = Undecided 4 = Disagree 5 = Strongly disagree

	STRONGLY AGREE	***AGREE***	***UNDECIDED***	***DISAGREE***	***STRONGLY DISAGREE***
1) I feel comfortable with my co-workers, and can talk to them easily about personal matters.	**1**	**2**	**3**	**4**	**5**
2) I am a good friend with some of the people I work with.	**1**	**2**	**3**	**4**	**5**
3) I enjoy working with the people on this unit.	**1**	**2**	**3**	**4**	**5**
4) There are well-defined groups of friends on this work unit, and I have not had much success at	**1**	**2**	**3**	**4**	**5**

becoming part of any these groups.					
5) I don't feel I have much in common with others who work on this unit.	**1**	**2**	**3**	**4**	**5**
6) I am able to turn to my co-workers when I need help on the job.	**1**	**2**	**3**	**4**	**5**
7) I would like to do more, socially, with the people on my unit.	**1**	**2**	**3**	**4**	**5**
8) I avoid the people on my unit as much as possible.	**1**	**2**	**3**	**4**	**5**

Appendix H

Ethics Committee Approvals

مدينة سلطان بن عبد العزيز للخدمات الإنسانية
SULTAN BIN ABDULAZIZ HUMANITARIAN CITY

Internal Memo

TO : **Mr. Hussam Al Nusair**
Director of Nursing Services

FROM : **Dr. Muwafak Al-Eithan, PhD.**
Chairman, Research & Ethics Committee/
Director of Research Center/
Chief of Psychology Service

DATE : **14th February 2010**

SUBJECT: ***Your Research Proposal, Title: "The level of perceived occupational stress, perceived social support, perceived staff recognition, Perceived intention to stay and it's relation to job performance among nurses working in Saudi Arabia".***

Thank you for resubmitting the above-mentioned research proposal.

The Research & Ethics Committee has today reviewed the revised version and happy to say that it has been approved with a number of changes and comments, to improve the clarity of your proposal.

1) It is advisable that you would put in title, "In a Rehab Hospital in Saudi Arabia".
2) Research summary there was not talk about, ("Interview" in details).
3) On Specific Aims, please replace the word "effect" with the word "relationship", since this is not an experimental (cause & effect) study.

Again, you may consider to put one specific aim to include all the variables.

Is there a way of testing "coping mechanism" with "Perceived Occupational Stress".

4) On Research & Design Method, you need to address "Qualitative Method" too.
5) In the "Tools to be used", you need to mention again about interview information.

You may need to review the listings of references (e.g., Mccloskey and McCain 1987).

After receiving your revised research proposal, you may proceed conducting your research.

Please provide us with a progress report after three (3) months from your start.

I would be happy to offer again any assistance that you may require.

Thank you and kind regards.

Direct line/e-mail
+44 (0) 115 8231063
Louise.Sabir@nottingham.ac

.uk17th December 2010

Mr Hussam AL Nusair
Director of Nursing Services
Sultan Binabdulaziz
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Nottingham

NG7 2UH

Tel: +44 (0) 115 8231063

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Dear Mr Hussam AL Nusair

Ethics Reference No: MS06122010 - Please quote this number on all correspondence

Title of Project:

The effect of Self-Perceived Occupational Stress On Job Performance, Staff intention To Stay, And Social Support Among Nurses Working in A Diversely Cultural Setting In The Kingdom of Saudi Arabia **Lead Investigator:** Mr Hussam AL Nusair, Director of of Nursing Services, Sultan Binabdulaziz Humanitarian City & MSc Postgraduate, Advancing Critical Care, School of Nursing, Midwifery and Physiotherapy.

Co **Investigators/Supervisors:** Dr Jacqueline Randle, Associate Professor, Dr Marion Leducq, Lecturer, School of Nursing Midwifery and Physiotherapy.

Thank you for your application which has already been reviewed and approvedby the Research & Ethics Committee at the Sultan Bin Abdulaziz HumanitarianCity on 14th February 2010 which is where the study will take place and enclosing:

- Application form dated 12/06/2010
- Copy of Research & Ethics approval letter from Sultan Bin Abdulaziz Humanitarian City REC dated 14th February 2010
- Research Proposal version dated
- December 2010 Volunteer Consent Form dated 06/12/2010

- Volunteer Information sheet version 1, dated 25.11.2010
- Appendix C Sections 1-6
- questionnaires.Interview questions and lay out
- Appendix 10 University of Nottingham: Risk Assessment form dated 27.11.2010

These have been reviewed and are satisfactory and the study is approved.Approval is given on the understanding that the Conditions of Approval set out below are followed.

Conditions of Approval

You must follow the protocol agreed and any changes to the protocol will require prior Ethic's Committee approval.

This study is approved for the period of active recruitment requested. The Committee also provides a further 5 year approval for any necessary work to be performed on the study which may arise in the process of publication and peer review

You promptly inform the Chairman of the Ethic's Committee of

(i) Deviations from or changes to the protocol which are made to eliminate immediate hazards to the research subjects.

(ii) Any changes that increase the risk to subjects and/or affect significantly the conduct of the research.

(iii) All adverse drug reactions that are both serious and unexpected.

(iv) New information that may affect adversely the safety of the subjects or the conduct of the study.

(v) The attached End of Project Progress Report is completed and returned when the study has finished.

Yours sincerely

Professor R C Spiller

Chairman, Nottingham University Medical School Research Et

Appendix I

Informed Consent Form (Survey)

Date: 06th December 2010

Version number: (1)

Study Title

PERCEIVED WORK RELATED STRESS, JOB PERFORMANCE, SOCIAL SUPPORT AND INTENTION TO STAY AMONG IMMIGRANT NURSES IN A CULTURALLY DIVERSE SETTING

Principle Investigator:

Hussam Al-Nusair, PHD (Cnadidate)

Co-Researcher: Mr X (SBAHC employee in the education department).

I have read the information presented in the information letter about a study being conducted by Hussam Al-Nusair (PhD student, University of Nottingham).

I understand that I am being asked to be interviewed to help, measure, explore and describe work related stresses, social support and how they interact and impact immigrant nurses' job performance and intention to stay at current job.

Any information which might potentially identify me will not be used in published material. I agree to participate in the study as outlined to me.

I understand that by signing this form I have consented to participate in the above mentioned study and to be interviewed. I understand that my participation is voluntary and that I may withdraw at any time. I understand that I will not benefit from my involvement in the study and that a copy of this information letter has been provided to me. I voluntarily consent to participate in this study.

Date----------

Participant name and signature----------

Contact for further information

If you have any question about the study at any time, you can contact the researcher on extension 2186 or email hussam.alnusair@sbahc.org.sa