

Key elements to support primary healthcare nurses to thrive at work: A mixed-methods sequential explanatory study

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Abstract

Aim: Develop evidence-based recommendations for managers to support primary healthcare nurses to thrive at work.

Design: A mixed-methods sequential explanatory design.

Methods: National data were collected in 2020 via an e-survey based on a meta-analysis of antecedents of thriving from 213 primary healthcare nurses across New Zealand. Structural equation modelling analysis identified the key factors supporting primary healthcare nurses to thrive. This informed a second open-ended e-survey in 2022 of 19 nurses from one primary healthcare organization. The thematic analysis provided recommendations for improving management strategies to support thriving primary healthcare nurses.

Results: The vitality component of thriving significantly reduced burnout and intention to leave organization and profession. In contrast, the learning component of thriving had a significant positive effect on burnout. The key factors that support thriving at work are empowering leadership and perceived organizational supports (decreases burnout and intention to leave organization and profession through enhanced vitality). Recommendations for improving thriving were made in eight key areas: communication, effective management, professional development, scope of practice, autonomy, effective orientation, reward and work-life balance.

Conclusions: Vitality is important in reducing burnout and turnover intentions. While learning was identified as increasing burnout, professional development and training for managers were identified as essential. Hence, the vitality dimension of the thriving at work construct should be studied at the dimension level, but more research is needed into the impact of learning on thriving over time. Primary healthcare nurses have identified that empowering leadership and perceived organizational support are critical factors in supporting them to thrive, and they provide specific recommendations for managers to improve these factors in the clinical setting.

No Patient or Public Contribution: This study collected data from Registered Nurses only.

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What Is Already Known:

- A plethora of existing research focuses on resilience in nurses rather than thriving at work.
- Enabling employees to thrive at work contributes to improved well-being and sustainable organizational performance.

What This Paper Adds:

- Empowering leadership and perceived organizational support are the key factors that support primary healthcare nurses to thrive at work.
- The vitality dimension of the thriving at work construct should be studied at the dimension level, and further research is needed into the impact of learning on thriving over time.
- Primary healthcare nurses recommend that managers focus on improving communication, management efficiency, professional development, scope of practice, autonomy, orientation, reward and work-life balance.

KEYWORDS

burnout, nursing, primary healthcare, thriving, workforce development

1 | INTRODUCTION

The New Zealand Primary Healthcare Strategy (Ministry of Health, 2001) and the New Zealand Health Strategy (Ministry of Health, 2016) suggest that healthcare will increasingly rely on providing services aimed at helping patients to self-manage their health closer to where they live, work and play. Ageing populations and increasing chronic disease prevalence are placing growing pressure on health systems to ensure a sustainable supply of nursing staff willing to work in the system (Moloney et al., 2017). Nurses play a critical role in providing healthcare within primary healthcare settings, and they work in organizations that can either empower or disempower them.

Nurses are at greater risk of job burnout compared to other professions (Biksegn et al., 2016). In New Zealand, over half of nurses surveyed reported wanting to leave the profession or reduce their hours due to burnout (Moloney, Gorman, et al., 2018). To achieve safe staffing levels, New Zealand requires a further 4800 nurses immediately, while a shortage of up to 8000 is predicted by 2032 (Te Whatu Ora – Health New Zealand, 2023). Workplace factors are reported as the main cause of burnout in New Zealand nurses (Tabakakis et al., 2020). Workloads are often intense and demanding, making nurses emotionally and physically exhausted (Huntington et al., 2011). Job demands such as workload can threaten engagement when they generate burnout, a syndrome of exhaustion and cynicism (Maslach et al., 2001; Schaufeli & Taris, 2019). On the other hand, job resources have motivational potential and foster employee engagement, a state of mind characterized by vigour, dedication and absorption (Bakker & Schaufeli, 2008).

Due to the impact of burnout, nurse educators have focused on better-preparing nurses for sustained professional resilience (Jackson et al., 2007), described as having the determination to succeed, rather

than retreat, in the face of challenges (Yu et al., 2019). However, while resilience is important in an often challenging profession, it is only one factor in keeping nurses engaged and continuing to work in the profession (Moloney et al., 2017).

1.1 | Background

The Social Embeddedness of Thriving at Work model (Spreitzer et al., 2005) guides this research because, while it includes resilience, it also focuses on identifying the personal and organizational factors that influence the ability of staff to be energized and engaged, thereby reducing their intention to leave. Thriving is indicated by the collective experience of (1) vitality, the sense that one is energized and feels alive at work, has a zest for work; and (2) learning and growing through new knowledge and skills. Paying attention to thriving at work is an important means by which managers and their organizations can improve both employee health and unit performance (Walumbwa et al., 2017).

A recent meta-analysis of thriving at work extends the work by Spreitzer et al. (2012), and identifies a network of associated antecedents and outcomes (Kleine et al., 2019). Antecedents of thriving at work are separated into individual characteristics and relational resources. Outcomes include health, attitudes and performance. The conceptual network of assumed antecedents and outcomes of thriving at work informed the standardized e-survey in this study and provided data on the key factors supporting primary healthcare (PHC) nurses to thrive at work. The strengths-based appreciative inquiry action research model (Cooperrider & Srivastva, 1987) then informed the open-ended e-survey, allowing nurses to make specific recommendations for improved management systems in the future.

1.2 | Aim

To develop evidence-based recommendations for managers to support PHC to thrive at work, resulting in improved nurse well-being and organizational outcomes.

2 | ETHICAL CONSIDERATIONS

Ethics committee approval was obtained from the University of Auckland Human Participants Ethics Committee on 16 December 2019 (Ref. 024124). Study participation was voluntary, consent was assumed when the participant chose to complete the survey online and the questionnaire data were stored and analysed anonymously.

3 | METHODS

3.1 | Phase 1 design: National standardized e-survey of PHC nurses

The research hypotheses are summarized in the model of antecedents and outcomes of thriving at work (see Figure 1) based on the meta-analysis by Kleine et al. (2019). The model contains the individual characteristics of self-efficacy and relational resources, including empowering leadership and perceived organizational support. These independent variables are antecedents of thriving at work. Thriving is a positive psychological state in which individuals experience both a sense of vitality and a sense of learning at work (Kleine et al., 2019). Thriving employees experience growth and momentum

marked by feeling energized and alive (vitality) and a sense that they are continually improving and getting better at what they do (learning) (Porath et al., 2012). The outcomes of thriving at work include health (burnout) and attitudes (intention to leave the organization and profession). We further considered the demographic variables of gender, age, tenure, position, hours (of work) per week, education and area of work. As the conceptual links between demographic variables and thriving are weak (Spreitzer et al., 2005), we did not preregister any hypotheses concerning these relationships.

3.1.1 | Vitality

A sense of vitality gives employees the energy to deal with challenges at work, leading to reduced burnout (Demerouti et al., 2001). Burnout is characterized as the manifestation of prolonged stress on the job and includes feelings of exhaustion, cynicism and detachment (Maslach et al., 2001). Vitality is assumed to counteract the development of burnout (Yu et al., 2019). Thriving at work has been shown to relate negatively to burnout (Hildenbrand et al., 2018; Niessen et al., 2017) and turnover intentions (Anjum et al., 2016; Ren et al., 2015).

- H1a.** Vitality is negatively related to burnout.
- H1b.** Vitality is negatively related to intention to leave the organization.
- H1c.** Vitality is negatively related to intention to leave the profession.

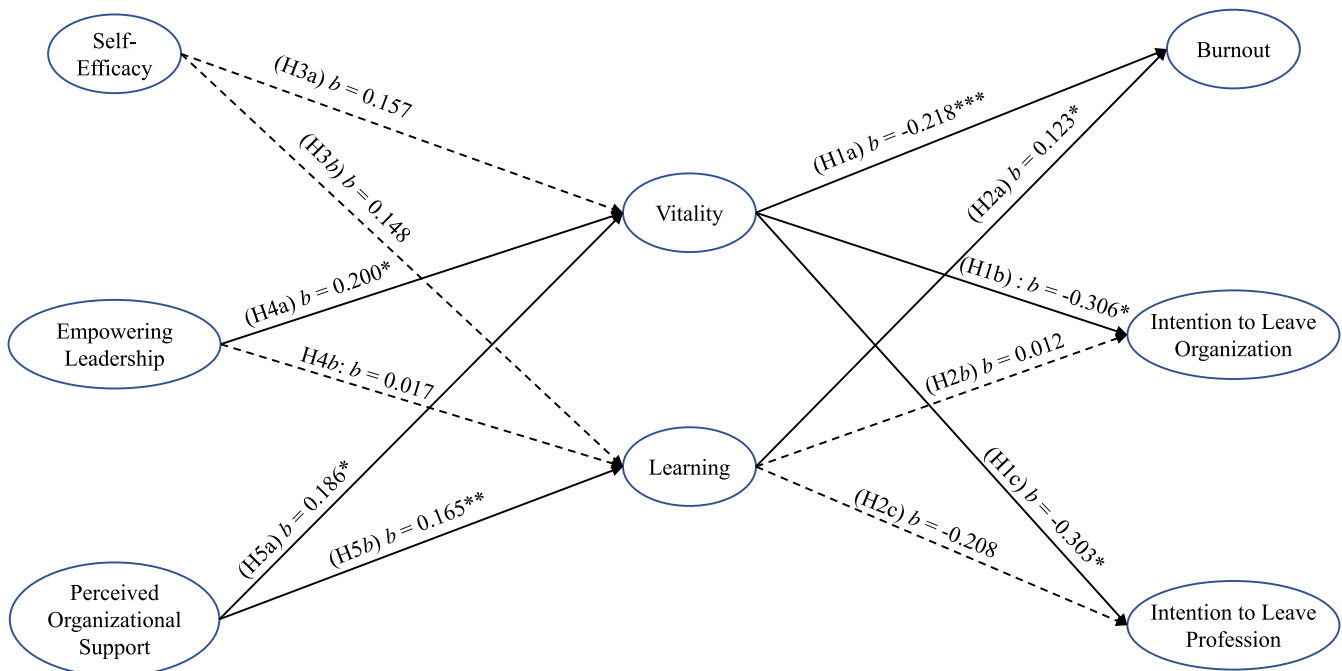


FIGURE 1 Unstandardized path coefficients of hypothesized model. $N = 213$; * $p < .05$; ** $p < .01$; *** $p < .001$; paths in solid lines are statistically significant and paths in dotted lines are statistically non-significant.

3.1.2 | Learning

Burnout and exhaustion are often avoided when employees acquire knowledge to cope with work demands (Stewart & Ruckdeschel, 1998). Indeed, feelings of learning are assumed to counteract the development of burnout (Spreitzer et al., 2012), and thriving at work has been shown to reduce burnout (Hildenbrand et al., 2018; Kleine et al., 2019). However, there is a risk that learning without experiencing vitality or a sense of energy may instead diminish thriving and lead to burnout (Spreitzer et al., 2005). If employees are able to experience feelings of vitality and energy through learning at work, they are likely to perceive their work environment as supportive of their self-development and goal pursuit, leading to enhanced intentions to stay (Cho et al., 2009). Indeed, thriving at work has been shown to relate negatively to turnover intentions (Anjum et al., 2016; Ren et al., 2015).

H2a. Learning is negatively related to burnout.

H2b. Learning is negatively related to intention to leave the organization.

H2c. Learning is negatively related to intention to leave the profession.

3.1.3 | Psychological capital (self-efficacy)

Psychological capital is a higher-order construct consisting of self-efficacy, optimism, hope and resilience (Luthans et al., 2007) and has been shown to impact thriving at work positively (Flinchbaugh et al., 2015; Paterson et al., 2013). This study focuses on the self-efficacy component, arguing that employees are more likely to thrive when they have confidence in their ability to master different tasks (Kleine et al., 2019). Self-efficacy and thriving at work improve employees' confidence and optimism, resulting in reduced burnout (Okros & Vîrgă, 2022). Furthermore, self-efficacy lowers intentions to leave organization and profession (Moloney, Boxall, et al., 2018).

H3a. Self-efficacy is positively related to vitality.

H3b. Self-efficacy is positively related to learning.

3.1.4 | Empowering leadership

Empowering leaders focus on power sharing and granting autonomy to employees to activate their intrinsic motivation and enable self-directed learning (Harris et al., 2013). Empowering leadership helps employees perceive their work as meaningful and contributes to feelings of vitality (Albrecht & Andretta, 2011). Higher levels of structural empowerment and access to informal power positively impact employee thriving at work (Ali et al., 2018; Moloney et al., 2020).

Studies suggest that organizations that empower their employees create a great sense of fit with the organization and, in turn, lower employee burnout (Greco et al., 2006). Empowering leadership has been shown to reduce intention to leave both organization and profession (Zurmeily et al., 2009).

H4a. Empowering leadership is positively related to vitality.

H4b. Empowering leadership is positively related to learning.

3.1.5 | Perceived organizational support

Perceived organizational support refers to employees' beliefs regarding how much the organization values their contributions and cares about their well-being (Eisenberger et al., 1986). High levels of perceived organizational support result in less burnout and greater vitality (Rhoades & Eisenberger, 2002). Employees feel obligated to repay the organization (Eisenberger et al., 2001), resulting in motivation to acquire new knowledge to help the organization achieve its goals, leading to increased learning at work. Perceived organizational support has been found to have a positive relationship with thriving at work (Abid et al., 2016; Riaz et al., 2018) and reduced intention to leave (Kleine et al., 2019; Moloney, Boxall, et al., 2018).

H5a. Perceived organizational support is positively related to vitality.

H5b. Perceived organizational support is positively related to learning.

3.2 | Phase 2 design: Open-ended e-survey of PHC

The results of Phase 1 informed the development of an open-ended e-survey of nurses employed by an individual PHO.

3.3 | Data collection

3.3.1 | Phase 1 participants

In 2019, all PHC nurses working in New Zealand (approximately 8000) were invited to complete the national e-survey based on the antecedents and outcomes of thriving at work (Kleine et al., 2019) when a link was advertised on the social media platforms Twitter and Facebook, on the University of Auckland's website, in the University of Auckland's biannual magazine to showcase research and news and through an email sent to all nurses employed by a single primary PHO within Auckland. These efforts resulted in 213 usable responses. The sample was made up of 98.5% women and 1.5% men.

The age of respondents ranged from 21 to 70, with a mean age of 45.4 years. Ethnicities included New Zealand European (63.1%), New Zealand Māori (11.7%), European (7.3%), Asian (7.3%), Pacific Peoples (2.8%), Other (7.3%) and MELAA (0.6%). Years of tenure were <1 year (12.3%), 1–5 years (39.1%), 6–10 years (25.7%), 11–15 years (8.9%), 16–20 years (6.1%) and >20 years (7.8%). Nurse managers comprised 15.2% of the sample, while nurses (non-managers) accounted for 84.8%. Hours of work included <20 (8.9%), 21–30 (25.7%), 31–40 (46.9%) and >40 (18.4). Some 63% had a postgraduate qualification. Areas of work included Accident and Medical (11.2%), District Nursing (2.2%), Family Planning (0.6%), General Practice (62.4%), Mental Health (1.7%), Occupational Health (0.6%), Other (14.6%), Plunket (2.2%), Public Health (3.4%) and School Nursing (1.1%).

3.3.2 | Phase 2 participants

In 2022, the link to a second open-ended e-survey was emailed to all ($N=83$) nurses employed by an individual PHO. This resulted in 19 responses. The sample was 100% female. Ages ranged from 29 to 59, with a mean age of 48. Ethnicities included Asian (50%), New Zealand European (40%) and MELAA (10%). Years of tenure were 1–5 years (40%), 6–10 years (10%), 11–15 years (20%) and 16–20 years (20%). 20% were nurse managers, and the remaining 80% were nurses (non-managers). 90% of respondents had some level of postgraduate education.

3.3.3 | Phase 1 measures

The national e-survey included six validated measurement tools. *Thriving at work* was measured using the Thriving at Work Scale, including five items for learning and five items for vitality (Porath et al., 2012). *Burnout* was measured using the Malach-Pines (2005) Burnout Measure Scale, short version (BMS-10). *Intention to leave organization* and *intention to leave profession* were measured by three items each, developed by Dotson et al. (2014), as part of a retention survey for nurses. *Self-efficacy*, a key component of psychological capital, was measured by six items from the PsyCap Questionnaire (PCQ) (Luthans et al., 2007). The phrase ‘People outside company (suppliers, customers)’ was changed to ‘outside work area (other health professionals, patients’ family members)’ to make the items more relevant to nurses. *Empowering leadership* was measured by a 10-item scale by Ahearne et al., 2005, which considers levels of meaningfulness of work, decision-making, confidence in high performance and autonomy. Perceived organizational support was measured by three items from a 9-item shortened version of the Survey of Perceived Organizational Support (SPOS) (Eisenberger et al., 1986). The three items from the SPOS scale that loaded highest (factor loadings of 0.93) in the factor analysis by Wayne et al. (1997) were used. We controlled for the age, tenure and roles of respondents in the analyses. Age was divided by 10 to produce a variance comparable to other variables. Tenure was measured with a 6-point

scale (1=<1 year, 2=1–5 years, 3=6–10 years, 4=11–15 years, 5=16–20 years and 6=>21 years), and the role was measured with 1=non-manager and 2=manager.

3.3.4 | Phase 2 measures

The two key factors of leadership and perceived organizational support identified in the national e-survey that impact thriving at work informed the questions asked in the PHO survey. These were based on a strengths-based appreciative inquiry approach, which encourages co-inquiry and addresses gaps in knowledge by revealing ways to take action and make specific recommendations for improving management systems (Cooperrider & Srivastva, 1987; Guo et al., 2022). The questions were as follows: How could your organization improve its leadership? How could your organization improve its support of you?

3.4 | Data analysis

3.4.1 | Phase 1 analysis

Structural equation modelling (SEM) with MPlus 8.8, using the full-information maximum-likelihood (FIML) estimator, was adopted for the analytical method. As a multivariate method, SEM provides a way to conduct a simultaneous analysis of an entire system of relationships. However, in contrast to traditional multivariate techniques, SEM explicitly takes measurement error into account when statistically analysing data and incorporates both unobserved and observed variables (Cheung, 2008; Jourdain & Chenevert, 2010). The first step was to conduct a confirmatory factor analysis with a measurement model, and then test the structural paths in a full structural model. The third step was to examine the mediating effects by estimating the bias-corrected confidence intervals (CIs) using bootstrapping (Cheung & Lau, 2007) based on resampling from the original dataset 2000 times.

3.4.2 | Phase 1 reliability, convergent and discriminant validity

We followed Cheung et al. (2023) procedure to examine the quality of our measurement scales. Since the model is very complex with 2s-order factors (empowering leadership and burnout), we simplified the model by using simple average scores to form parcels for each first-order dimension of empowering leadership and burnout. That procedure reduces the model to one with first-order factors only. We utilized Cheung et al. (2023) measureQ package to conduct a confirmatory factor analysis to generate Table 1. The fit indices of the measurement model are as follows: χ^2 with 508 degrees of freedom=822.66, CFI=0.930, RMSEA=0.057 and SRMR=0.057, indicating that the model fits the data well. Results in Table 1 show

TABLE 1 Descriptive statistics.

	Mean	SD	AVE	1	2	3	4	5	6	7	8	9	10
1 Learning	5.71	1.10	0.53	(0.84)									
2 Vitality	4.68	1.35	0.64	0.63	(0.90)								
3 SE	5.29	0.77	0.59	0.24	0.35	(0.90)							
4 Empower	4.96	1.55	0.73	0.27	0.45	0.63	(0.92)						
5 POS	4.42	1.89	0.81	0.34	0.44	0.43	0.63	(0.93)					
6 Burnout	2.06	0.61	0.68	-0.26	-0.62	-0.53	-0.59	-0.55	(0.86)				
7 ILeaveO	3.82	1.71	0.80	-0.33	-0.50	-0.27	-0.47	-0.62	0.55	(0.92)			
8 ILeaveP	2.90	1.41	0.60	-0.41	-0.52	-0.41	-0.39	-0.29	0.44	0.39	(0.82)		
9 Age	4.54	1.20	—	-0.04	-0.03	0.04	-0.07	-0.05	-0.06	-0.10	-0.10	—	
10 Tenure	2.81	1.37	—	-0.07	-0.01	0.07	-0.12	-0.09	0.11	-0.01	-0.10	0.51	—
11 Role	1.15	0.36	—	-0.03	-0.10	0.32	0.20	0.13	0.01	0.07	-0.01	0.08	0.27

Note: N=213. Diagonal elements in brackets=construct reliability.

Abbreviations: AVE, average variance extracted; Empower, empowering leadership; ILeaveO, intention to leave organization; ILeaveP, intention to leave profession; POS, perceived organizational support; SE, self-efficacy.

TABLE 2 Standardized regression coefficients for antecedents and consequences for vitality and learning.

	Vitality	Learning	Burnout	Intention to leave organization	Intention to leave profession
Age			-0.16*	-0.13	-0.07
Tenure			0.18*	-0.06	-0.10
Role			0.07	0.15*	0.08
Self-Efficacy	0.09	0.10	-0.28*	0.08	-0.21
Empowering Leadership	0.23*	0.02	-0.16	-0.15	-0.15
Perceived Organizational Supports	0.26*	0.28**	-0.18*	-0.49***	0.06
Vitality			-0.48***	-0.24*	-0.29*
Learning			0.22*	0.01	-0.16
R ²	0.25	0.13	0.60	0.48	0.35

Note: N=213.

*p<.05. **p<.01. ***p<.001.

that the construct reliabilities ranged from 0.82 to 0.93, indicating all constructs achieve good reliability. All average variance extracted (AVE) are higher than 0.5, indicating good convergent validity. None of the standardized factor loadings of all items, except one for learning and one for vitality, are significantly lower than 0.7. The two questioned items have factor loadings at 0.54 and 0.57, imposing only a minor concern on convergent validity. The largest correlation shown in Table 1 is 0.63, and none of the squared correlations is higher than the corresponding AVE, indicating good discriminant validity among the variables.

3.4.3 | Phase 2 analysis

A general inductive approach was used to thematically analyse the data (Thomas, 2006). This approach provides a systematic set of procedures for analysing textual data and enables it to be condensed

into a summary format. Data were entered into Microsoft Word and read many times to form codes, then condensed into themes. Links were then established between the research objectives and the themes. For rigour, external corroboration of the thematic analysis was undertaken between the authors to validate the identified themes. Any discrepancies were discussed, and the codes and themes were adapted accordingly.

3.5 | Results

3.5.1 | Phase 1

Results in Table 2 show that vitality has statistically significant negative effects on burnout ($\beta = -.48, p < .001$), intention to leave organization ($\beta = -.24, p < .05$) and intention to leave profession ($\beta = -.29, p < .05$). Hence, H1a, H1b and H1c are supported. However, while

the effects of learning on intention to leave organization and profession are not statistically significant, there is a statistically significant positive effect of learning on burnout ($\beta = .22, p < .05$). Hence, H2a to H2c are not supported. The effects of self-efficacy on vitality and learning are also not statistically significant, not supporting H3a and H3b. Empowering leadership has a statistically significant positive effect on vitality ($\beta = .23, p < .05$), supporting H4a. However, the effect of empowering leadership on learning is not statistically significant, not supporting H4b. Finally, perceived organizational supports have statistically significant positive effects on vitality ($\beta = .26, p < .05$) and learning ($\beta = .28, p < .01$), supporting H5a and H5b.

We further examined the effects of self-efficacy, empowering leadership and perceived organizational support on the outcome variables through vitality and learning using the bootstrapping technique. Results are summarized in Table 3. While the indirect effects of self-efficacy on burnout through learning and vitality are not statistically significant, there was a significant negative direct effect of self-efficacy on burnout ($\beta = -.30, 95\% \text{ CI} = [-0.52, -0.06]$). Furthermore, all direct and indirect effects of self-efficacy on intention to leave organization and intention to leave profession were not statistically significant. There were also statistically significant negative indirect effects of empowering leadership through vitality on burnout ($\beta = -.11, 95\% \text{ CI} = [-0.27, -0.01]$), intention to leave organization ($\beta = -.06, 95\% \text{ CI} = [-0.17, -0.00]$) and intention to leave profession ($\beta = -.07, 95\% \text{ CI} = [-0.19, -0.00]$). Finally, vitality fully mediated the negative effect of perceived organizational support on burnout ($\beta = -.12, 95\% \text{ CI} = [-0.28, -0.03]$)

and intention to leave profession ($\beta = -.08, 95\% \text{ CI} = [-0.21, -0.00]$). However, vitality only partially mediated the negative effect of perceived organizational support on intention to leave organization ($\beta = -.06, 95\% \text{ CI} = [-0.19, -0.00]$) because there is a significant negative direct effect of perceived organizational support on intention to leave organization ($\beta = -.49, 95\% \text{ CI} = [-0.64, -0.29]$).

3.5.2 | Phase 2

The thematic analysis identified eight themes: effective management, professional development, scope of practice, autonomy, communication, effective orientation, reward and work-life balance. The survey questions, codes and themes are presented in Table 4.

4 | DISCUSSION

Healthcare will increasingly rely on providing services aimed at helping patients to self-manage their health closer to where they live, work and play (Ministry of Health, 2016; Ministry of Health, 2001). Nurses play a critical role in providing healthcare within primary healthcare settings, yet those nurses face an ever-increasing risk of burnout (Biksegn et al., 2016; Moloney, Gorman, et al., 2018). Workplace factors, such as intense workloads, have the greatest impact on increasing burnout and intention to leave (Moloney et al., 2017; Tabakakis et al., 2020).

TABLE 3 Effect of self-efficacy, empowering leadership and perceived organizational support on burnout and intention to leave organization and profession.

Outcome variables	Burnout	Intention to leave organization	Intention to leave profession
Self-efficacy			
Self-efficacy → learning →	0.023 [-0.015, 0.111]	0.001 [-0.026, 0.049]	-0.017 [-0.128, 0.014]
Self-efficacy → vitality →	-0.043 [-0.171, 0.054]	-0.022 [-0.120, 0.022]	-0.026 [-0.128, 0.025]
Self-efficacy → (direct effect)	-0.280* [-0.499, -0.063]	0.079 [-0.138, 0.284]	-0.211 [-0.488, 0.094]
Total effects	-0.299* [-0.517, -0.063]	0.058 [-0.148, 0.282]	-0.254 [-0.513, 0.047]
Empowering leadership			
Empowering leadership → learning →	0.005 [-0.048, 0.075]	0.000 [-0.027, 0.030]	-0.004 [-0.097, 0.034]
Empowering leadership → vitality →	-0.110* [-0.269, -0.011]	-0.056* [-0.166, -0.003]	-0.067* [-0.193, -0.004]
Empowering leadership → (direct effect)	-0.156 [-0.437, 0.103]	-0.154 [-0.377, 0.060]	-0.154 [-0.470, 0.115]
Total effects	-0.261 [-0.550, 0.010]	-0.210 [-0.444, 0.012]	-0.225 [-0.521, 0.038]
Perceived organizational supports (POS)			
POS → learning →	0.062* [0.006, 0.162]	0.002 [-0.061, 0.080]	-0.046 [-0.161, 0.014]
POS → vitality →	-0.124** [-0.283, -0.033]	-0.063* [-0.188, -0.006]	-0.076* [-0.210, -0.004]
POS → (direct effect)	-0.184 [-0.361, 0.007]	-0.485** [-0.643, -0.288]	0.055 [-0.187, 0.267]
Total effects	-0.246* [-0.429, -0.044]	-0.546** [-0.699, -0.363]	-0.067 [-0.310, 0.158]

Note: $N = 213$. Entries are unstandardized effects, 95% bias-corrected confidence intervals based on 2000 bootstrapped samples (Cheung & Lau, 2007).

* $p < .05$. ** $p < .01$. *** $p < .001$.

TABLE 4 Thematic analysis results.

Question	Quotation examples	Codes	Themes
How could your organization improve its leadership?	'More emphasis on quality leadership'. 'Managers that are proactive and motivated to support best practice care'. 'More support from nurses leaders'	Empower individuals and skilled managers	Effective management
	'More funded education opportunities'. 'More push to go on courses'. 'More frequent performance reviews'	Training & Upskilling; Regular performance reviews	Professional development
	'Opportunity to work at scope of my practice'. 'Review current nursing roles'. 'Practice managers need to respect practice nurses'. 'Practice nurses are not doctors' handmaidens'	Allowing nurses to utilize their skills/knowledge; Recognition of scope as Practice Nurse; Better defined roles & responsibilities	Scope of practice
	'Being able to make decisions'. 'Involve us in decision-making'. 'More nurse led clinics/nurses working independently'. 'Inspire us to feel that we can be innovative'. 'Supporting innovation'	Allowing nurses to work independently; Permission for nursing staff to try new things	Autonomy
	'Better communication'. 'Listen to the nurses'. 'Chances to air out differences'. 'The ability to share with management how we are feeling'. 'Before implementing new services, nurses are sought out for their knowledge'	Regular meetings with management; Nurses want to feel heard; Acknowledge feelings of staff; Nurse engagement with quality/efficiency improvement; Nursing input on decision-making; Relationship building	Communication
How could your organization improve its support of you?	'Trust in the knowledge and expertise of the leadership team.' 'Supportive culture'. 'Advocate for nurses at the PHO level'. 'Manager that isn't afraid of hard conversations'. 'Better involvement with staff on the shop floor'	Connection with staff; Talking about feelings; Face-to-face meetings with new managers; Effective management and accountability	Effective management
	'Planned performance appraisal process'. 'More frequent performance appraisals'. 'Primary care-focused education/development'. 'A framework for continuous quality improvement in general practice'. 'Pay for education hours'. 'Access to career pathways and proper clinical professional development'	Regular appraisals/Feedback; Access to educational frameworks; Opportunities for training/upskilling	Professional development
	'Having proper orientation'. 'Extra funding and time for senior nurses to support and mentor new staff'	Well-structured orientation for new staff; Better staff resources for orienting new staff while managing full workload; Better support for nurses training less efficient new staff	Effective orientation
	'Pay parity with other nurses'. 'Pay equity with hospital nurses'. 'Improved remuneration'. 'Properly paid to reflect what we do and the responsibility we take'. 'Bonuses for extra work we do'. 'Treat practice nurses with respect and kindness'	Recognition for orientating new staff; Improved pay; Recognition and pay increases in response to delegated roles and professional development	Reward
	'Increased sick leave and mental health days to compensate for constant exposure to illness and disease'. 'Flexibility with time off'. 'Flexibility to work from home'. 'Work-life balance improvement'. 'More annual leave'. 'Family-friendly policies'	Flexibility; Working from home; Time off when needed	Work-life balance

In contrast, thriving at work improves engagement and reduces intention to leave (Anjum et al., 2016; Hildenbrand et al., 2018; Spreitzer et al., 2005). Given that the work environment is a major influence on nurses' intention to leave, this research aimed to develop evidence-based recommendations for managers to support PHC nurses to thrive at work. These considerations will be essential as countries like New Zealand face predictions of encroaching nursing workforce shortages (Te Whatu Ora – Health New Zealand, 2023).

4.1 | Vitality, not learning

The foundational literature stipulates that individuals thriving at work will experience positive psychological states of both vitality and learning (Kleine et al., 2019). Vitality relates to feeling energized and alive, while learning occurs through continual improvement (Niessen et al., 2017). Our results show that while PHC nurses identified vitality as important for reducing burnout and intention to leave organization and profession, learning had the opposite effect and increased burnout. This is in contrast to the core assumption that high levels of both vitality and learning need to be present for employees to thrive (Demerouti et al., 2001). Instead, nurses carrying heavy workloads may find that undertaking additional learning requirements contributes to feelings of burnout (Spreitzer et al., 2005). The statistically significant results for vitality are in line with the literature and support the notion that employees experiencing this psychological state are better able to deal with challenges and feel less stressed (Anjum et al., 2016; Porath et al., 2012). While vitality is seen as a pleasurable hedonic component of well-being, learning is a purposeful eudaimonic component and thriving will occur when constraints are minimized (Kleine et al., 2019). Nursing is a particularly strained workforce, with most having intense and demanding workloads, resulting in them feeling emotionally and physically exhausted (Huntington et al., 2011). Furthermore, nurses are at greater risk of physical and mental illness than the general public due to stress, burnout and psychological disequilibrium (Nelson et al., 2017; Szeto et al., 2013; Woods et al., 2015). Despite our results showing that learning will increase burnout, nurses did identify a need for professional development and training for managers. To date, there is little research on the impact of learning on nurses' thriving. Going forward, researchers should research vitality as a core factor impacting burnout and intention to leave, while more research is needed to clarify the impact of learning.

4.2 | Empowering leadership

We found that empowering leadership significantly enhances vitality, reducing burnout and intention to leave both organization and profession. This aligns with evidence that feelings of vitality instigated through empowering leadership help employees perceive their work as more meaningful (Albrecht & Andreetta, 2011). The

PHC nurses in this study identified five focus areas for improving empowering leadership: effective management, professional development, scope of practice, autonomy and communication. First, managers should receive appropriate management training and use practices to empower their employees through shared power and decision-making. Power sharing with nurses has been identified as an essential strategy for organizational transformation and results in improved work satisfaction and staff retention. It may include strategies such as providing role models and mentors, energizing staff, information sharing and inclusion in executive management meetings (Trofino, 2003). Next, PHC nurses value access to professional development through nurse educators, opportunities for upskilling and regular performance reviews. Nurses are often hesitant to, or prevented from, leaving clinical settings to attend continuing professional development due to lack of relief cover, having to use unpaid study leave and organizational constraints on implementing learning, resulting in reduced satisfaction and retention (Coventry et al., 2015).

PHC nurses want to be able to work autonomously in their roles and be able to work at the highest level of their scope of practice. Leaders who grant autonomy and decision-making freedom and allow nurses to work within their full scope enable them to experience improved psychological well-being, self-development and thriving at work (Moloney et al., 2020). The PHC nurses in this study recommended that organizations should have clearly defined roles and responsibilities for nurses, and leaders should create safe and supportive environments in which nurses feel enabled to try new things without fear of being reprimanded for mistakes. Further to this, PHC nurses want leaders with good communication skills and strategies. They recommend daily nurse huddles and regular meetings between nurses and managers, as well as leaders who listen to staff, acknowledge successes and concerns, set clear expectations for staff, focus on relationship-building strategies and engage nurses with quality improvement processes.

4.3 | Perceived organizational support

Our results show that perceived organizational support has a significant positive effect on vitality, which helps to reduce intention to leave organization. This aligns with research that suggests greater organizational support reduces burnout and increases work engagement, resulting in lower intention to leave (Moloney, Boxall, et al., 2018). Employees who believe their organization cares about their well-being are more likely to thrive at work (Guan & Frenkel, 2020; Riaz et al., 2018). PHC nurses have recommended five focus areas to improve organizational support: effective management, professional development, effective orientation, reward and work-life balance. As with empowering leadership, organizations can better support their nurses when their managers connect with staff, have regular face-to-face meetings with staff, provide constructive feedback, conduct regular appraisals and provide employees access

to ongoing education opportunities. Furthermore, organizations should focus on ensuring new staff are given well-structured orientations, including sufficient resources to manage their workloads and support experienced nurses in training new staff. Research shows that experienced nurses are often dealing with intense and demanding workloads in addition to mentoring new nurses, resulting in exhaustion (Ballem & MacIntosh, 2014). To support these nurses, managers should recognize their increased workload through performance reviews and build a mentoring culture through mentorship programmes that include prolonged orientation periods and long-term support with a consistent experienced colleague (Ballem & MacIntosh, 2014).

In addition to recognition for orientating new staff, PHC nurses want to be rewarded for being delegated additional work and attending professional development. Research shows that when employees feel they are not being rewarded for their efforts, higher levels of emotional exhaustion and burnout are experienced (Colindres et al., 2018; Leiter & Maslach, 2009). Indeed, a lack of reward is a barrier to professional development participation for advancement for many nurses (Moore et al., 2019). As the increasing acuity of patients increases nurses' workloads, it becomes harder for nurses to attend professional development sessions during working hours (Bjørk et al., 2009). Issues with insufficient funding for the implementation of professional development and timing of delivery need to be considered by organizations. Moreover, PHC nurses want to balance their professional and personal time, with flexible working schedules and time off when needed. Nurses often have difficulties balancing work time and personal time (Ghislieri et al., 2017). The physical demands and intense workload increase fatigue and decrease well-being, resulting in feelings of incompatibility with a satisfying home life (Navajas-Romero et al., 2020). The mental health of nurses has declined further since the global COVID-19 pandemic, and health-care organizations should support nurses by providing various provisions such as shorter shifts, adequate rest hours and sufficient flexibility (Varghese et al., 2021).

5 | LIMITATIONS

The findings come from cross-sectional surveys, limiting assertions about cause-effect relationships. Although the study identifies nurses' intentions, it does not follow up on these same nurses to assess actual turnover behaviour. Precautions have been taken to minimize the potential for common-method bias, including measures with well-established construct validity and internal reliability.

6 | CONCLUSIONS

The vitality component of thriving at work is an important factor in reducing burnout and turnover intentions in PHC nurses, but the

impact of learning is not so clear because while it may increase burnout in PHC nurses, they did ask for professional development opportunities. Hence, thriving at work should be studied at the vitality level, but more research is needed into the impact of learning. PHC nurses have identified that empowering leadership and organizational support are key factors supporting them to thrive at work. PHC nurses identified nine key areas for organizations and managers to address if they want to improve their nurses' thriving. These include communication, effective management, professional development, scope of practice, autonomy, effective orientation, reward and work-life balance. Health managers should take action on these recommendations to improve their nurses' well-being and organizational outcomes.

AUTHOR CONTRIBUTIONS

Made substantial contributions to conception and design, acquisition of data or analysis and interpretation of data: WM, SJ and GC. Involved in drafting the manuscript or revising it critically for important intellectual content: WM, SJ and GC. Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content: WM, SJ and GC. Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved: WM, SJ and GC.

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The authors have no conflicts of interest to declare.

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